

**AN ASSESSMENT OF
THE MENTAL HEALTH & PSYCHOSOCIAL SUPPORT NEEDS
OF THE CONFLICT-AFFECTED POPULATIONS**

October 2009

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Children of Georgia (CoG)*
Georgia Red Cross Society (GRCS)
Global Initiative on Psychiatry (GIP) – Tbilisi
Health and Social Programs Agency (HeSPA)
Hellenicare Georgia
International Organization for Migration (IOM)
International Orthodox Christian Charities (IOCC)
International Rescue Committee (IRC)
United Methodist Committee on Relief (UMCOR)
United Nations High Commissioner for Refugees (UNHCR)

*This report has been prepared by Children of Georgia.

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Rationale

As a result of the sudden Russian-Georgian conflict in Georgia during 2008, large numbers of ethnic Georgians from South Ossetia and Shida Kartli fled into Georgia. In doing so they lost their homes, their livelihoods, their societal frameworks and their intergenerational roots. Almost overnight, they became Internally Displaced Persons (IDPs).

A conservative estimate would suggest that some 120,000 IDPs lived initially in around 800 “collection centers” in Georgia, with a significant proportion in Tbilisi and Gori. Efforts were made to return IDPs from Gori and surrounding villages back to their homes, where these had not been destroyed or damaged in the conflict. Others who were unable to return to their home or villages in the still disputed areas have gradually been housed in “new settlements” of which most are placed on the plains between Tbilisi and Gori. A significant number remain in “collection centers” and are unlikely to be rehoused in the short term. None from this group or those in the new settlements will be able to return to their former homes or livelihoods. Many have experienced several compulsory relocations since the war as a result of government decisions.

At least a proportion of these IDPs suffered multiple traumas, in the sense of being victims of both the conflict and of post-conflict harassment, assaults, rape and plundering of their possessions by unofficial vigilante or quasi-military personnel operating in the conflict zones. There is now evidence from satellite data that ethnic Georgian villages in South Ossetia have been razed, which adds further distress and enhances the sense of loss and isolation and brings into sharp focus the reality of their inability to return to former homes and livelihoods.

Others remained in their homes but found themselves continuing to live amongst conflict over borders, in so called “hot zones” or “Buffer Zones”.

The trauma for all those who have fled from, or remain trapped in, conflict often results in a variety of mental health disorders such as Major Depression, Anxiety Disorders, Stress Disorders such as Post-traumatic stress Disorder (PTSD), Somatization and Conversion Disorders, Dissociative Disorders, Brief Psychotic Disorders and Substance Abuse. These disorders are evident in both adults (Briere & Scott, 2006; Taylor 2006) and children (Cohen, Mannarino, & Deblinger, 2006; Smith, Dyregrov, & Yule, 2007). There is evidence from studies of risk factors that increased susceptibility is found among children and the elderly, among female victims, people who are poor and/or with limited education, persons with a pre-existing psychological disorder, those who have had previous trauma exposure and those who experienced high levels of distress during and immediately after the trauma exposure. Post-traumatic reactions of guilt, shame or anger may also contribute to higher risk of symptom development (Briere & Scott, 2006).

In addition, research on Post-Traumatic Stress Disorder (PTSD) among refugee populations (e.g., Paumovic & Öst, 2001) indicates that the proportion of post-traumatic

disorder is higher (10-86%) in refugee (IDP) populations than the lifetime prevalence in the general population not at risk of PTSD (1.0-1.3%). This is an extremely disabling psychological disorder that can be hard to detect, especially in the initial stages as it evolves after some delay (DSM IV-TR: American Psychiatric Association, 2000) and it requires a high level of professional expertise to assist the sufferer. Even taking the lowest IDP population percentage of 10%, it can be anticipated from 120,000 IDPs that about 12,000 will develop some significant post-traumatic symptoms.

Initially, an influx of international (e.g., Red Cross; UMCOR; World Health Organization) and Georgian organizations, both secular and church, responded quickly to the Russian-Georgian conflict and assisted with emergency physical care such as shelter, blankets, medicines, clothing and food for those in need. Many families around Gori and in Tbilisi provided shelter for relatives and the Georgian government seconded educational and other government-owned buildings as temporary shelter. Some organizations, such as Medicin Sans Frontiers, WHO, Global Initiative on Psychiatry, World Vision, Children of Georgia, and Save the Children (to name a few) also endeavored to respond to the initial and natural psychological shock that many people were experiencing. Some of these initiatives focused on setting up facilities called “child friendly” places for children to gain respite from the conflict and others focused on immediate term emotional support. There were several barriers, however, to providing psychological support appropriate for trauma victims: First, the unstable and transient nature of the IDPs living arrangements often made it difficult to make contact; second, some Georgian organizations felt that international organizations were sometimes unaware of cultural mores that impacted on assessment of mental health; third, state services primarily focused on medication alone; fourth, there was a dearth of mental health professionals in Georgia properly trained in evidence-based trauma assessment and assistance; and finally, it was not long before a very small number of NGO staff were aware of, but not funded, to meet the evolving and increasingly debilitating nature of trauma with large numbers of IDPs. Several of these factors remain fundamentally the same over a year later.

It needs noting that exposure to traumatic events can result in both short term effects (such as intense fear, helplessness, and highly disorganized thoughts and behaviour) and longer term effects (such as flashbacks, emotional numbing, sleep problems, startle reaction and inability to concentrate). The short term effects often go undetected until the longer term effects are impacting not only on the sufferer's ability to function (e.g., depression, anxiety and panic attacks) but also on their families' (e.g., increased alcohol or drug use, anger, and domestic violence), their communities' (e.g., grief, social isolation and lethargy) and ultimately their society's (dangerous rumour, social dissatisfaction, factionalism).

Although PTSD can only be diagnosed after a month has passed since traumatization (American Psychiatric Association, 2000), the diagnosis is not time limited in the sense that it can still be made if symptoms emerge after months or years have passed, although long delay is considered rare (Briere and Scott, 2006). It is also noted by Briere & Scott that up to 80% of persons with PTSD have at least one other psychological disorder and

that common co-morbid disorders include major depression, anxiety disorders and substance abuse.

Trauma victims also have increased risk of medical complications following trauma, particularly if diagnosed with PTSD (Briere & Scott, 2006), with back pain, hypertension, arthritis, pulmonary disease, cardiac and circulatory diseases (including strokes), digestive and gastrointestinal disorders, cancer, and nervous and endocrine system disorders all being identifiers. Persons exposed to chronic interpersonal violence (e.g., women exposed to partner violence) evidence significant health problems. Consequently, medical assessments are also important in evaluation of trauma victims.

Notably, however, with proper diagnosis, and early and appropriate interventions and support, trauma victims can learn to cope more effectively and return to more normal functioning in a relatively short time. Left untreated, problems can increasingly arise over lengthy periods of time.

AIMS & PROCEDURE

With the above in mind, the Mental Health and Psychosocial Support (MHPSS) sub-cluster group of the World Health Organization in Georgia met on a regular basis to discuss the needs of conflict-affected persons and co-ordination between the Governmental and Non-Governmental Organizations (NGO) representatives trying to assist them. These NGO services had experience working with IDPs and those within the Buffer Zones and were concerned at the lack of resources being put into what appeared to them to be a growing problem. They believed that the needs of the traumatized people in the Buffer Zone (BZ) and in the IDP settlements (IS) were urgent but were not being addressed.

Hence, the WHO (Georgia) commissioned the current assessment and report on the mental health and psychosocial needs of two populations, those in the Buffer Zone and those in the newly created IDP settlements. These groups were considered to be differently homogeneous groups with different lifestyles and needs. The information from these groups was to be compared to those of a general population group in or near Tbilisi. It needs noting, however, that it is unlikely that this general population group was such a homogeneous group because it obviously contained Georgians who had lived through the Russian-Georgian conflict last year and also, as this writer later found out, some of these were probable IDPs from the Russian-Abkhazian conflict in the 1990's.

It was considered essential that the view of three groups of persons should be obtained from each of these three areas in order to gain as comprehensive and impartial picture of the situation. These three groups were

- a) community members themselves
- b) teachers in schools in these areas
- c) local health and psychosocial support service providers.

A series of three (3) questionnaires for each of these groups was devised by those with working knowledge of these populations obtained over the year since the conflict. Their aim was to create questionnaires that were unbiased, and had face validity and therefore relevant to the populations who would complete them. The contributing organizations, in alphabetical order, included GIP, GCRT, CoG, MERLIN, “Ndoba”, WHO and WV and the questionnaires were then refined by AVNG, CoG, GIP, GRFCF, IOM, WHO and UNHCR.

The three forms of questionnaires were subsequently distributed to, and completed by

- a) Community members, teachers and service providers in the Buffer Zone (BZ)
- b) Community members, teachers and service providers in the IDP Settlements (IS)
- c) Community members, teachers and service providers in the Tbilisi Districts (TD)

They were distributed by NGO representatives because they were some of the few who had access to the Buffer Zone, sometimes only sporadically because of the dangers there. A total of 473 questionnaires was completed over the summer period of 2009. Every effort was made to have similar sample sizes across the three regions but access (particularly to the Buffer Zone) and school holidays restricted the number of BZ teachers available to complete them. Appendix 1 outlines the numbers of questionnaires completed and returned, locations, and distributing organizations.

The results are reported below by a New Zealander (Dr JaneMary Rawls) who has several years experience as a researcher in the area of interviewing children and as a clinical psychologist working with abused and traumatized children and adults. She has worked within Georgia at least twice a year for the last 13 years, and also in New Zealand, practicing and teaching evidence-based assessments and therapies to professionals (psychologists and psychiatrists) in these areas.

FINDINGS

A. Community members

1. Sense of safety

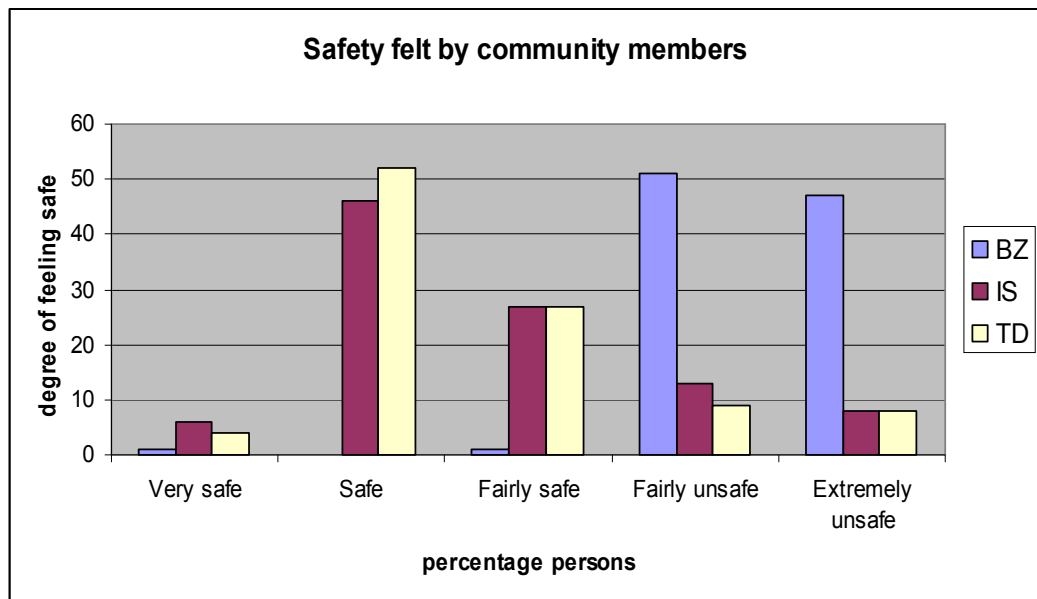
More than a year after the Russian-Georgian conflict only a minute proportion (1%) of the people from the Buffer Zone (BZ) who answered the questionnaires feel very safe or even fairly safe (1%). The vast majority of them either feel fairly unsafe (51%) or extremely unsafe (47%) where they live (see Figure 1).

In contrast, those community members living in the Tbilisi Districts (TD) and in the IDP Settlements (IS) say they now either feel safe (52% and 47% respectively) or fairly safe (another 27% from each sample). Some of this may be because there are Police in both areas monitoring levels of safety and to whom the public may turn. Nevertheless, as might be expected of those who have directly experienced or run from conflict, a proportion of both the IDP settlements (IS) and TD groups still feel

either fairly unsafe or extremely unsafe, with slightly more of these belonging to the IDP settlements (combined IS = 21%, combined TD = 17%).

Clearly, the respondents from the Buffer Zone remain the most unsettled of the three regional groups. Unlike the IS people, they do not have Police in charge of local security. The research on trauma shows us that people living under circumstances that continue to be unpredictable and have many reminders of traumatic events are highly likely to develop the symptoms of trauma such as hyper-arousal and vigilance, heightened anxiety levels, sleeplessness and emotional “numbing” (Taylor, 2006).

Figure 1



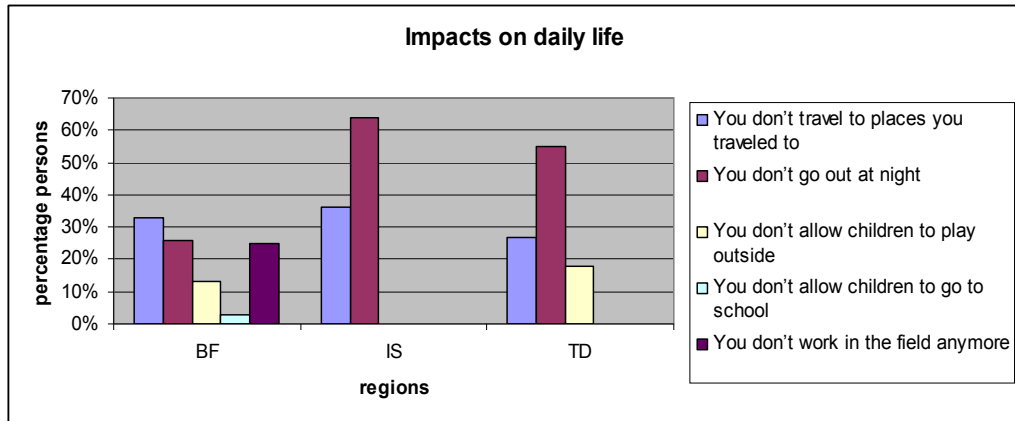
2. Impacts on community members

This sense of insecurity is a direct result of the conflict and has impacted on people’s lives in different ways. According to the questionnaire answers, BZ people’s lives are the most impacted overall. Despite the fact that they have remained in their districts, one third say they no longer travel to places they used to go, a quarter no longer go out at night, a quarter do not feel able to work in the fields, 13% do not allow their children to play outside and a few (3%) no longer allow their children to go to school.

A larger number of people from the TD and IS regions also feel much more unable to go out at night since the Russian-Georgian conflict (55% & 64% respectively), over a third (36%) of the IDP settlers say that they also do not travel as they used to, and similar numbers (18%) of the families in Tbilisi Districts no longer allow their children to go out to play outside. The major difference for BZ people is the more comprehensive breadth of impact upon their lives and the fact that they now also feel unable to work on (or live off) their land. This becomes all

the more significant if this has been a traditional and major source of food and exchange/income as is the case on much of rural Georgia.

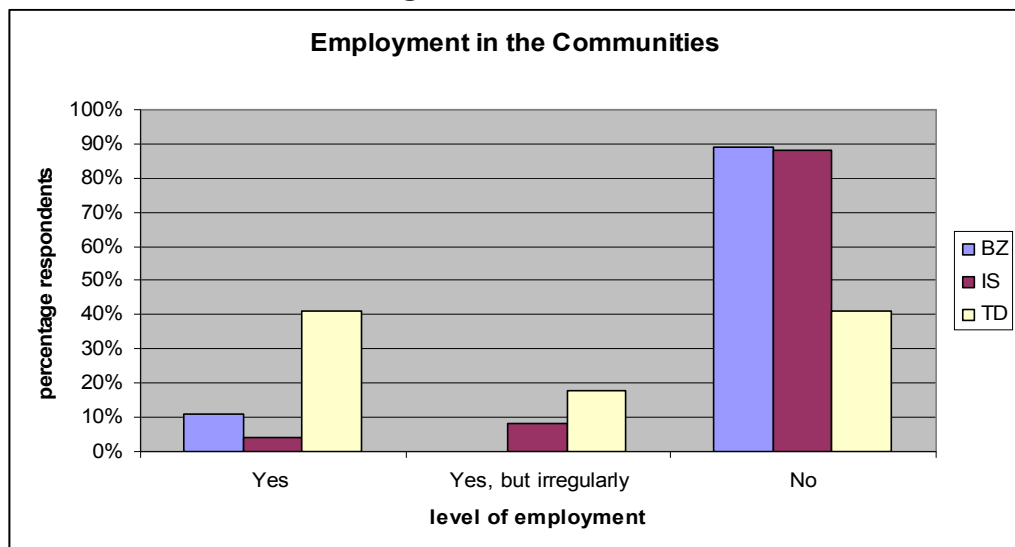
Figure 2



3. *Employment rates*

This takes on additional significance given the questionnaire information obtained from community members on their employment (see Figure 3). Although the employment figures for Georgia are believed to be lower than for many OECD countries, the Georgian people in Tbilisi Districts are much more likely to be employed either regularly (41%) or irregularly (18%) whilst, very clearly, the overwhelming number of people from both the Buffer Zone and the IDP settlements are unemployed (89% & 88% respectively). Access to work and income allows people independence and, through that, some dignity and a sense of building for the future. It is therefore important that this is facilitated without further dislocation from land, family and support networks.

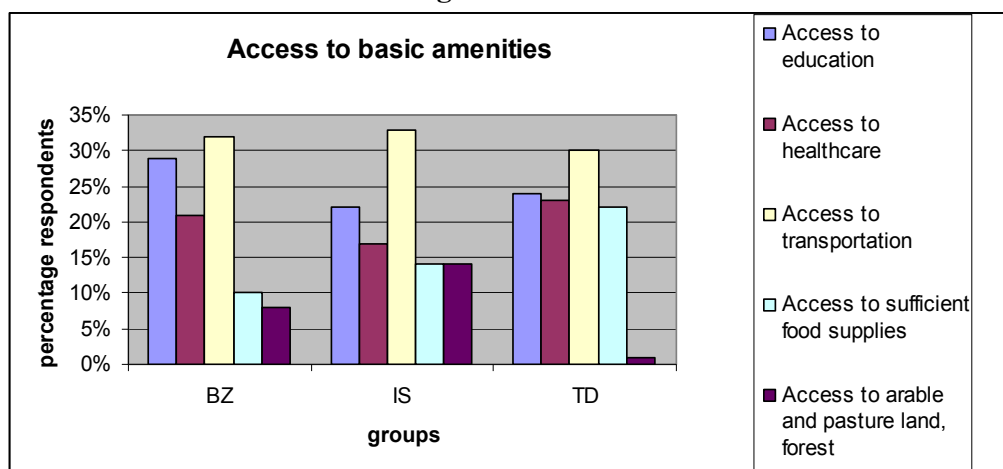
Figure 3



4. *Access to basics*

All people, especially after disruption and displacement, need to be able to access basic services and amenities in order to rebuild their lives. These amenities should include sufficient food and/or arable land on which to grow food or forest for wood and heating, education for their children, healthcare, and transport to get to these places. Surprisingly, as Figure 4 shows, all three regional groups say that they have relatively limited access to these sorts of amenities and facilities: Only around a quarter say they have access to education and only a third have access to transport. In addition, about 1 in 5 BZ (21%) people and only slightly more TD (23%) people say they have access to healthcare whilst IS people have even less access (17%). Their reasons for this may vary from lack of funds through to lack of transport.

Figure 4



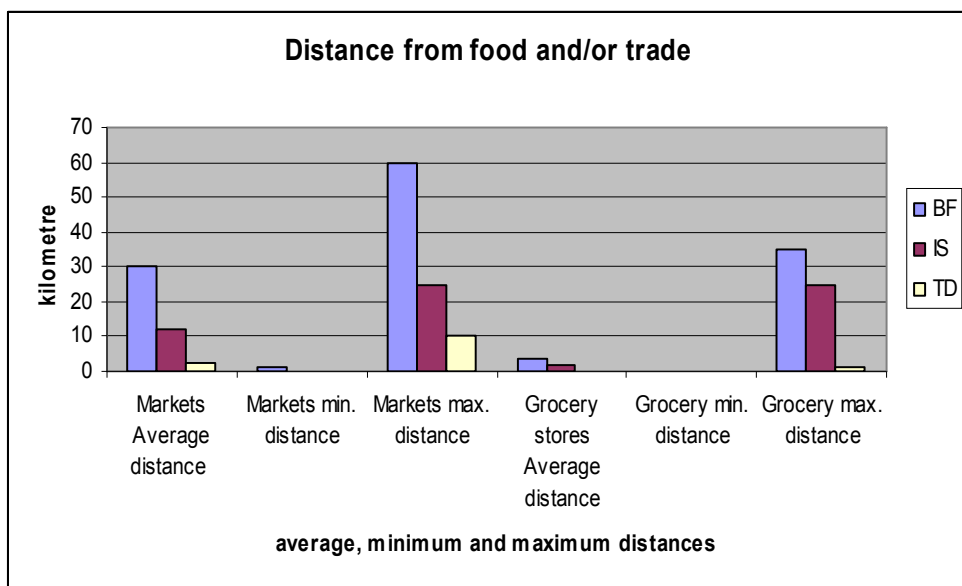
Obviously, access to sufficient food and/or the arable land to grow it is of primary importance and yet only a few Buffer Zone and IDP village people have access to these (10% food access and 8% land access for Buffer Zone and 14% for both food and land access for IDP settlers). It is likely that the BZ people feel unable to access their fields simply because they are unsafe places, and this inability to feed family is likely to add to psychosocial stress with the BZ communities. In comparison, the IS people might feel safer but feel they have very limited amounts of arable land available to them compared to life before the conflict (restricted to small plots adjacent to each house). As might be expected, almost no Tbilisi Districts people actually have access to land (1%) probably by virtue of living in the city, but many more (22%) have access to sufficient food than their more rural counterparts.

Again, it is the Buffer Zone people who presently appear to be the worst off with IDP village people in an almost similar position.

5. *Distance from food and trade* Without the same access to arable land as before, people generally are more reliant on trading at markets and buying food. The following figure (figure 5) clearly indicates that BZ people live furthest away

from markets - averaging 30 kilometers away with a maximum range of 60 kilometers. IS people are an average of 12.15 kilometers (maximum 25 kilometers) making them still reliant on transport to get there. TB people, however, would be more likely to be able to walk (or minibus?) to markets as the average distance is 2.34 kilometers (maximum 10). At first glance it appears that access to grocery stores and hence buying goods is similarly convenient for all three groups of people but some people in the BZ and IS communities have maximum distances to these of 35 and 25 kilometers respectively making them still further reliant on the expense and availability of transport - or trying to find means of self-sufficiency.

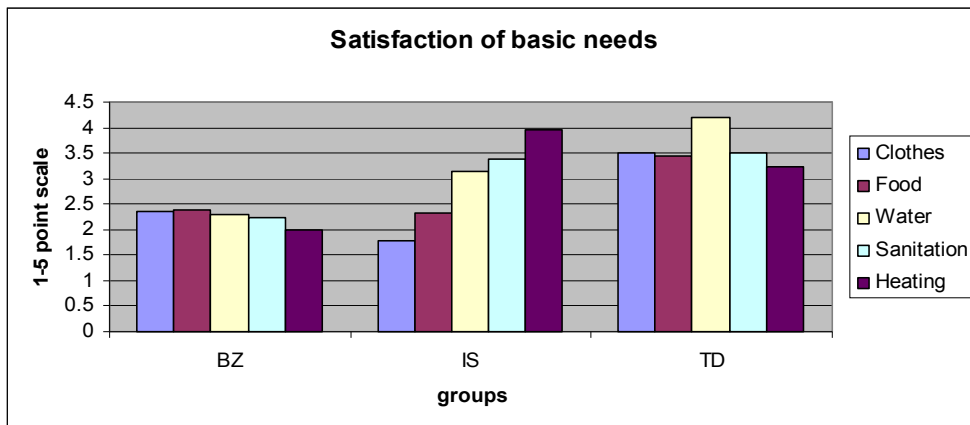
Figure 5



6. *Satisfaction with basic needs*

Given these factors, it is not surprising that the Buffer Zone people very consistently indicated on a 1 – 5 point scale that fewer than half of them feel that their basic needs - such as clothes, food, water, heating and sanitation - are being met (see Figure 6). In contrast, Tbilisi Districts people generally feel satisfied that all their their basic needs are being met, particularly water. IDP settlers’ sense of satisfaction (with those basic needs outlined above) varied more than their counterparts from the Buffer Zone or Tbilisi districts. They are less happy than Buffer Zone people about clothing, similarly unhappy about food needs not being met, but happier about heating and sanitation needs being met. This may reflect a perceived improvement over the crowded “collection centres” that many IDPs lived in prior to their moves to the settlements.

Figure 6



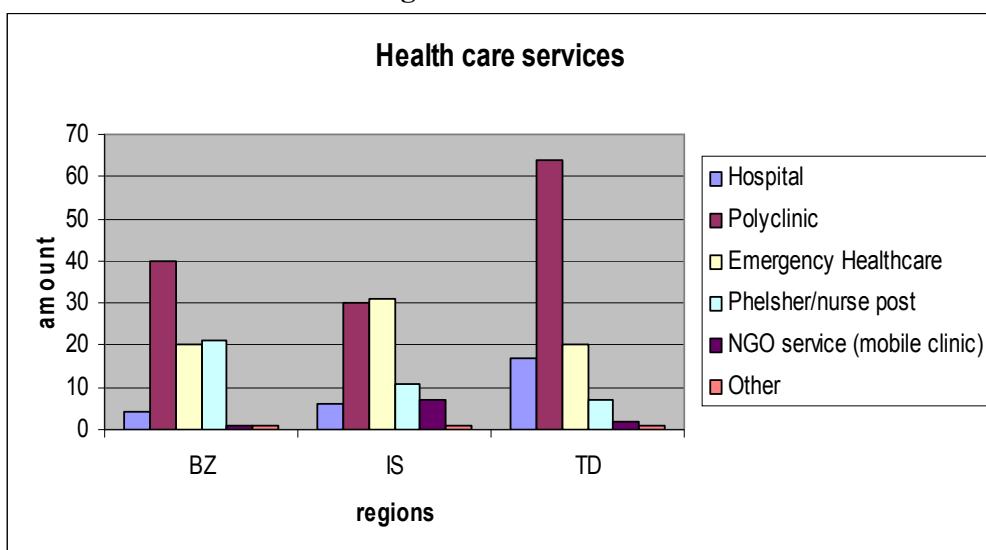
7. *Physical and mental health care*

Two types of support are particularly important for those who have been exposed to war and/or deprivation. These are healthcare and psychosocial support. The data for these are now examined from the community members' point of view.

8. *Access to Healthcare facilities*

The graphed data in Figure 7 illustrate what kinds of healthcare facilities are available for families in the Buffer Zone, IDP settlements, and Tbilisi Districts. They show that all three groups describe polyclinics and, to a lesser degree, the emergency healthcare facilities as the primary services available in their districts, with Tbilisi District people very much more aware of the existence of these two services plus hospitals, probably because of the sheer numbers and ease of access within the city. In comparison, BZ people are more aware of the Phelsher/Nurse posts (21%).

Figure 7



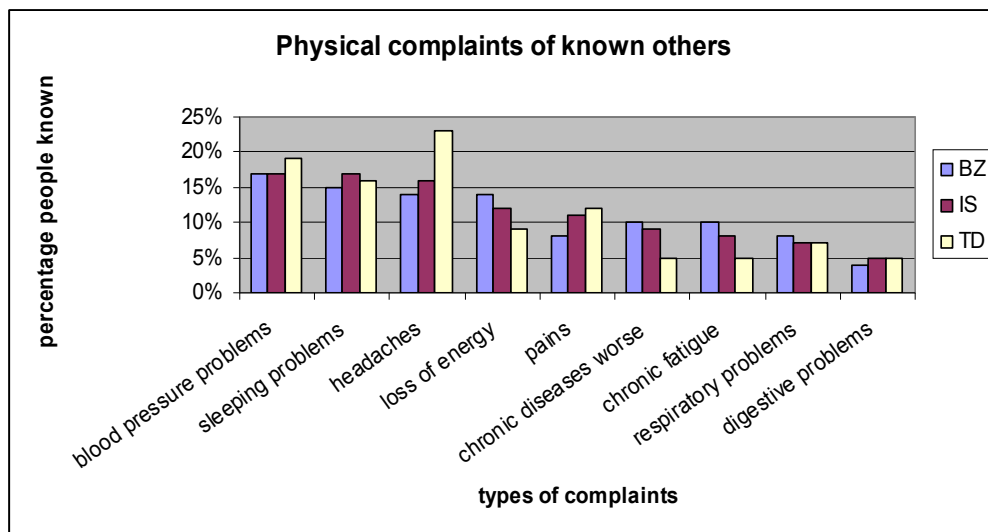
Conversely, NGO healthcare services make up a very tiny minority in all three regions but are slightly more likely to be known in the IDP settlements.

Fortunately, in Georgia, transport to medical emergency facilities is free. However, the costs and options available for getting to non-emergency healthcare facilities can vary from having to go by foot, going by bus, car or metro and these factors can affect healthcare (and therefore health) in a region. Questionnaire responses indicate that, as might be expected, people in the TD are more advantaged than the BZ or IS community members in that they are more likely (60%) to live less than 30 minutes by foot from medical healthcare, are more likely than BZ people to use transport to get to it and have no facility further than an hour away.

9. *Physical ailments of people known to community members*

The types of physical complaints since the August 2008 conflict, by other people who are known to the respondents, vary only a little across the three groups with the exception of the large number of headaches experienced by TD people (see Figure 8).

Figure 8



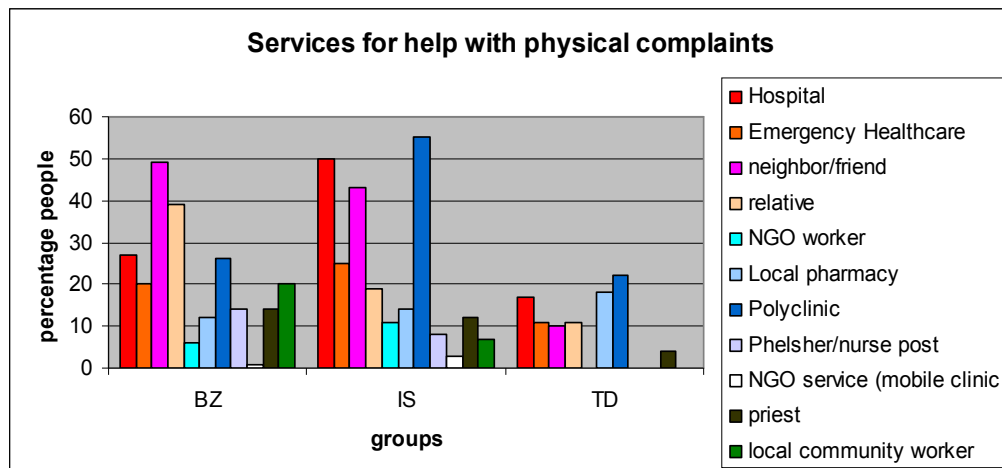
The ailments are presented in descending order and, in general, blood pressure, sleeping problems and headaches are more prevalent. The BZ people know marginally more people with loss of energy, aggravation of chronic diseases, chronic fatigue and respiratory problems, IDP settlers report marginally more sleeping problems and the TD people report marginally more blood pressure problems but far more headaches than the other two groups. Hence, in general, all persons within each of the three groups report some increase in physical problems appearing since the Russian-Georgian conflict in 2008.

10. *Services for help with physical health problems*

Interestingly, differences exist across the three groups over whom they might approach for medical help with these problems. Figure 9 indicates that nearly half (49%) and over a third (39%) of BZ people would seek help from their friends/neighbours and relatives respectively. A preference to stay close to home unless absolutely necessary and/or lack of funds for medical or transport to relatively distant services may account for this result. The IS people also are more likely to seek help from neighbours/friends (43%) than the TD group (9%) but they much more likely to go to a hospital or polyclinic.

Of interest is the fact that a total of almost a third of BZ people (additive total of 29%) and a quarter of IDP people (additive total of 24%) would turn for help with physical problems to an array of professionals such as local community workers, nurses, NGO workers, pharmacies and priests. This array is absent with the Tbilisi District persons except that 4% still turn to priests for help to cope with physical ailments.

Figure 9



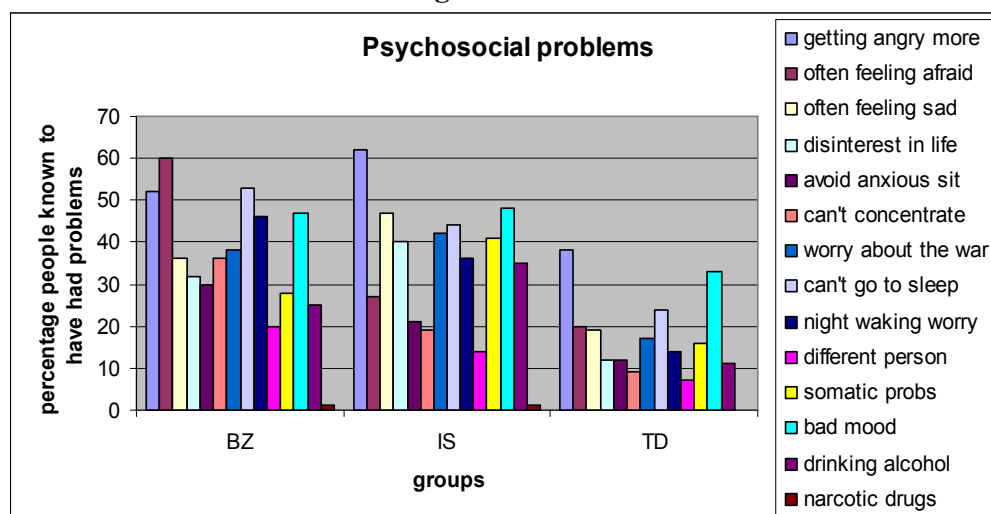
11. Psychosocial problems of community members

The graph that follows (Figure 10) illustrates how different psychosocial problems have been experienced by the three different groups of people. Clearly, and importantly, the TD people have experienced fewer psychological problems since the conflict than either the BZ or IDP groups of people. In contrast, the IDP settlers report knowing others in their community who have got more angry more often, often felt sad or wanted to cry, lost interest in life or activities they used to enjoy, have more worrying thoughts about the conflict both in the day and at night, have somatic complaints such as head and stomach aches, heart or breathing problems, and also now have bad moods and drink more alcohol (35%). The pattern of these problems is indicative of a group of people who are depressed and/or angry in response to trauma and displacement. The accompanying high level of alcohol use is of concern. It also might be a stress response and/or may be a way of passing time (when time might have been spent working in the fields or on community matters in their pre-conflict lives and villages) but, given the other psychosocial

problems described, its use should alert us to the probability of future increases in domestic violence.

The BZ persons also have more psychosocial problems than their Tbilisi District counterparts but in some respects the pattern of these varies from their IS counterparts and comprise more often feeling afraid and avoiding situations that make them afraid, problems with concentration, trouble with going to sleep and having night waking problems, bad moods, drinking more alcohol and sometimes feeling they are a different person (derealization). This combination should really alert us to the possibility of fear-based problems such as generalized anxiety, numbing and flashbacks associated with post-traumatic stress disorders (PTSD).

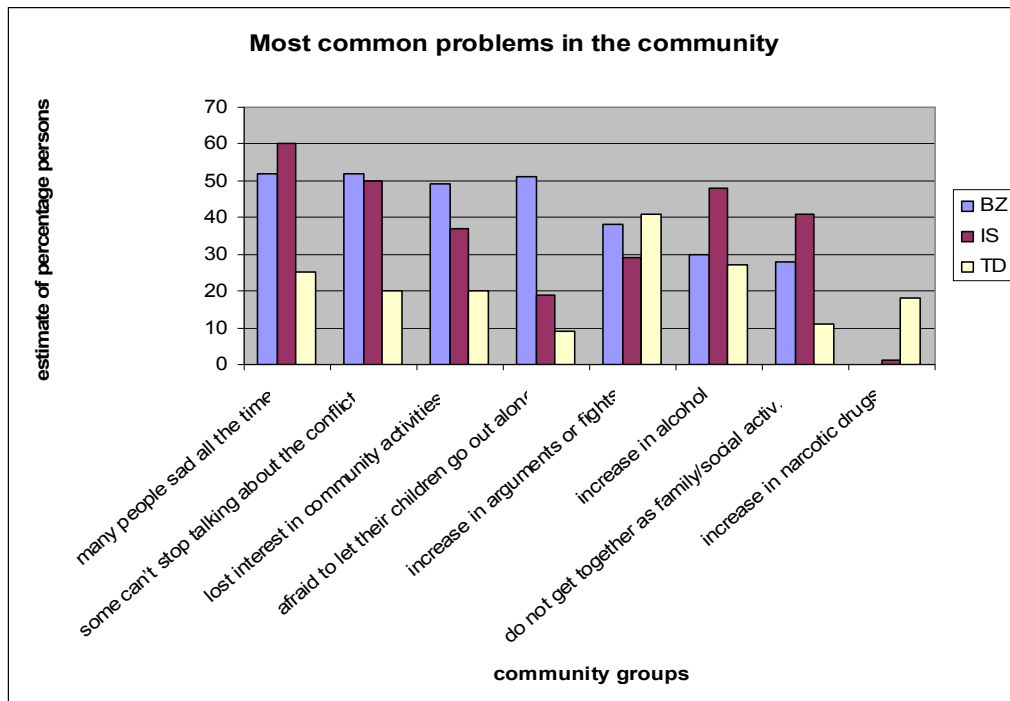
Figure 10



12. *Psychosocial problems thought to be in the communities*

Figure 11 illustrates information obtained from community members when they were asked about 8 possible types of problems that they might think are most common in their community. The BZ people and IS people consistently have elevated levels of sadness (52% and 60%), over half of their communities cannot stop talking about the conflict (52 and 50%), people have lost interest in community activities (49 and 37%) or are no longer get together for family or social activities like they used to (28 and 41%). Unsurprisingly, a much larger proportion of BZ persons (17%) feel afraid to let their children go outside compared with others in the IDP settlements (7%) and Tbilisi Districts (5%).

Figure 11



A larger proportion of IS persons are increasingly using alcohol (48%) compared with BZ people (30%) and TD people (27%). The reasons for this may vary across the groups. For example, reasons may include personal avoidance (e.g., a desire to emotionally numb oneself) in the BZ, grief over loss of home and livelihood and fewer activities to occupy oneself than before in the IS, and living in closer proximity in the TD. Arguments and fights also are happening in all three communities especially in the BZ and TD which is an expected result when there is a combination of alcohol and stress. One additionally unhappy result is the fact that 18% TD persons feel that members of their community are now turning to narcotics (compared to zero reported by the other two communities). This may reflect ease of access to drugs or be a matter of how the question was interpreted if you take into account reports (and personal observation) of the use of marijuana and valerian in the villages.

Hence, people's psychosocial problems have flowed into the BZ and IS communities in particular.

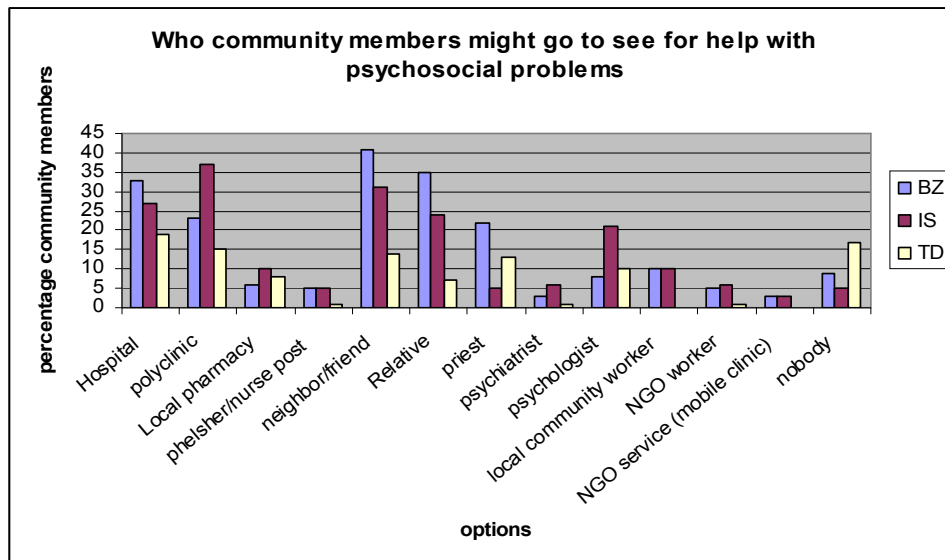
13. *Options for Psychosocial Support*

A series of three questions focused on options for psychological assistance for community members: First, who they might see themselves for psychological help; second, who they currently are seeing for such help; and third who others they know have seen.

Out of 13 possible options on who community members might seek assistance for themselves, Figure 12 shows that the TD people stand out in that generally they

would seek less help for their problems than those in BZ or IS communities, and 17% would not see anybody.

Figure 12



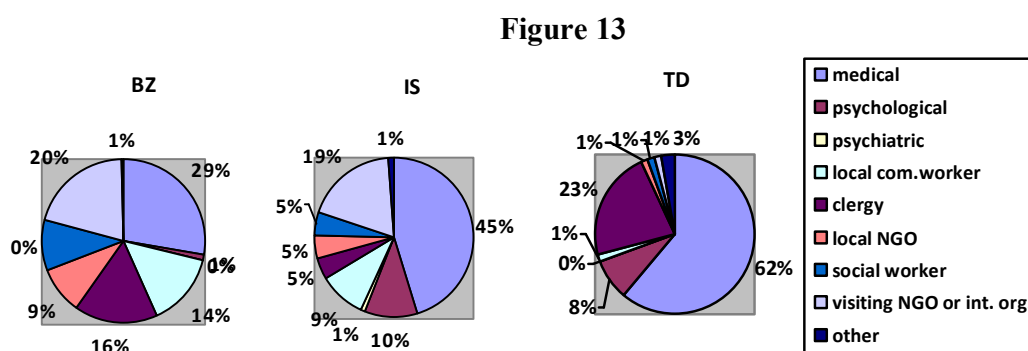
In comparison, people in the other two areas are more willing (or needy?) to seek assistance. The assistance they seek is primarily from neighbours/friends and relatives (presumably because of fewer accessible services), especially in the Buffer Zone district but also in the IDP settlements (neighbours/friends 41% and relatives = 35% for BZ; 31% and 24% respectively for IDP settlements; 14% and 7% for TD). This is followed by hospital staff (BZ = 33%; IS = 27%; TD = 19%), polyclinic professionals BZ = 23%; IS = 37%; TD = 15%) and, in TD and BZ, priests (22% & 13% respectively) and psychologists (8% in BZ, 21% in IS and 10% in TD).

Hence, in BZ and IS communities, community members themselves as well as hospital and polyclinic professionals, priests and psychologists are clearly seen as important possible resources to turn to for psychological help. This is an important finding that could be utilized to effect positive changes in the future for people in these communities.

People in BZ and IS seek help from an array of other, possibly more mobile, professionals including NGO workers, NGO mobile clinics, community workers, Phelsher nurses, and psychiatrists. This combination of professionals would be sought by only a few TD residents (3%), more by BZ people (23%) and most by IS people (30%). This group comprises both governmental and non-governmental funded professionals. Community members from these districts would therefore benefit if this array of professionals had the financial support to continue their work and also if they coordinated with one another and with the other professionals in the hospitals and polyclinics (see later in report).

14. *Who people are currently seeing for Psychosocial Support*

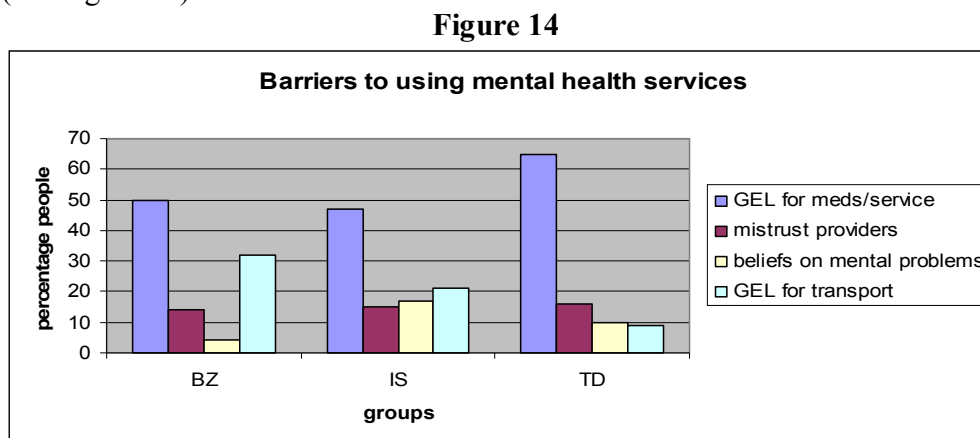
The series of three pie charts in Figure 13 below underscores the graphed data in Figure 12 by indicating that similar and significant numbers of people in the BZ and IS communities are currently seeing (and therefore psychologically dependant on) local NGO or visiting NGO workers and/or clergy (combined BZ = 45% with 29% comprising NGO professionals; combined IS = 29% with 19% comprising visiting NGO professionals), compared with 25% in Tbilisi Districts (with 23% comprising Priests).



In addition, medical (government funded?) professionals are major sources of assistance in TD (62%) and IS (45%) districts but less in the BZ (29%). However, BZ and IS people are generally seeing someone from an array of non-medical personnel such as a local or mobile NGO professional, a local community worker, a social worker, or clergy. Psychiatrists are notably not being seen in TD or BZ and minimally in IS (1%). In essence, this is a similar picture to the data on services that people have heard of being used by people they know, although psychiatrists are thought to have been seen by others a little more in BZ and TD (3% each district) and some more (5%) have seen social workers in TD.

15. *Barriers to accessing Mental Health Professionals*

Information was obtained on the barriers to people using mental health services (see Figure 14).



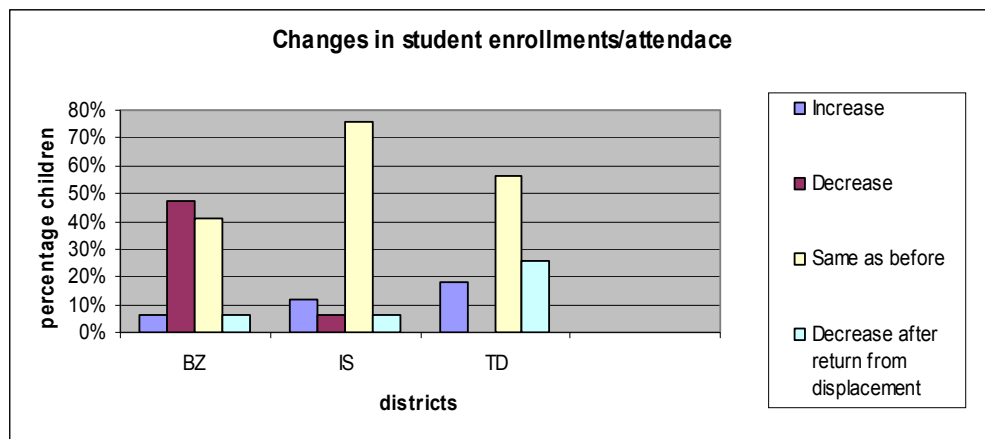
Clearly, insufficient money to pay for services or medicines is considered a major barrier for around 50% of those living in the BZ and 46% of those in the IS, but this is apparently more of a barrier for those living in TD (65%) – perhaps because the fees for services in TD is higher than elsewhere. The second barrier for BZ (32%) and IS villagers (21%) is the lack of money to pay for transport to access support services. This is less of a problem for TD residents (9%) who are clearly living more closely to more services. In addition, all three groups of people had similar levels of mistrust of service providers (14% BZ; 15% IS; 16% TD). This is a problem that may require further research and/or public information made available in the future. Interestingly, BZ people are not so impeded by personal or other’s beliefs about mental problems (4%) as those from TD (10%) or IS (17%). Psychosocial education of community members or leaders as primary support workers, especially in the IDP settlements, may be helpful in reducing this barrier to seeking psychological assistance.

B. Teachers

1. *Student enrollments and attendance*

Teachers from the Buffer Zone say that there has been a large decrease (47%) in student enrolments and/or attendance at their schools since the August 2008 conflict and only 41% of children have remained at their schools (Figure 15). There could be a variety of reasons for this including families leaving the area, families keeping their children at home more, and transport problems. In contrast, enrolments/attendance has mainly stayed the same (76%) in schools for IS children although it is not clear if it is the same children who are attending or merely student enrolment numbers remaining at similar levels. The data from TD school teachers may reflect more variation in population movement, with around half enrolments/attendance remaining the same as before the conflict, some increase in attendance (18%), and some decrease after return home from displacement (24%).

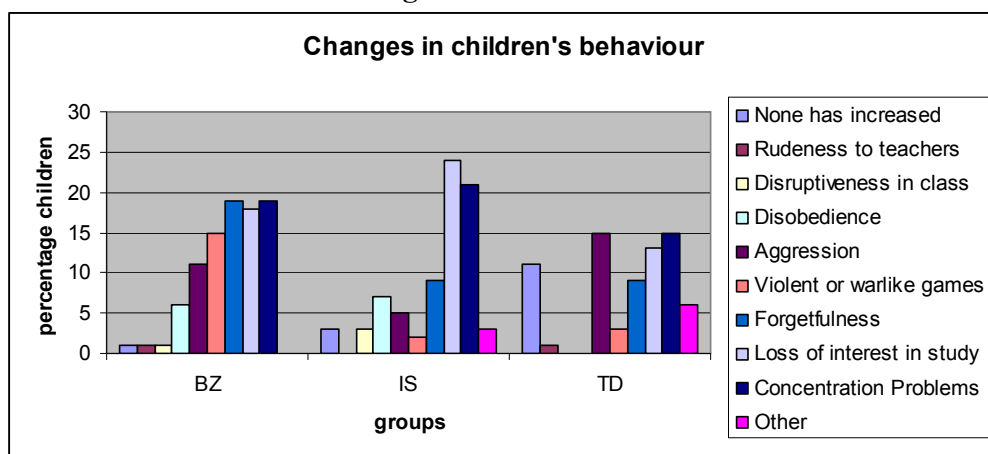
Figure 15



2. Children's behaviour

Teachers were asked whether their students' behaviour had changed since the conflict and, if so, which three out of ten possible options had changed most. Three different behaviour change profiles emerged: First, according to the BZ teachers, around 1/5th of their students are now more forgetful, a similar proportion have concentration problems and a similar proportion are less interested in their studies (Figure 16). It is possible that these are an array of problems shown by the same children. If this is the case then this combination of memory and focusing problems are consistent with trauma effects (e.g., Cohen, Mannarino and Deblinger, 2006).

Figure 16



A proportion (12%) of BZ children also more aggressive since the conflict but so are some TD children (15%). However, unfortunately, the BZ children clearly are the ones playing most warlike games (15%). This is a worrying problem that reflects how they are absorbing life in a Buffer Zone and acting out experiences. Given the teacher's reports of an increase of aggression, this is a problem that needs addressing urgently but carefully.

Second, in the IS schools, concentration (21% children) and loss of interest in study (24%) now seem to be major problems for the children there. These could well be symptomatic of a different pattern of trauma effects from the types evidenced by the BZ children (also see the following information on gender specific effects). Third, there has been no change at all in a proportion of TD children (11% "none has increased") but there has been an increase in aggression (20%), loss of interest in study (17%) and concentration problems (20%). These behaviours also are of concern.

Although teachers from all three groups outline changes in the behaviour of the vast majority of students since the conflict last year, apparently these have not resulted in either disruption in the classroom or rudeness to teachers.

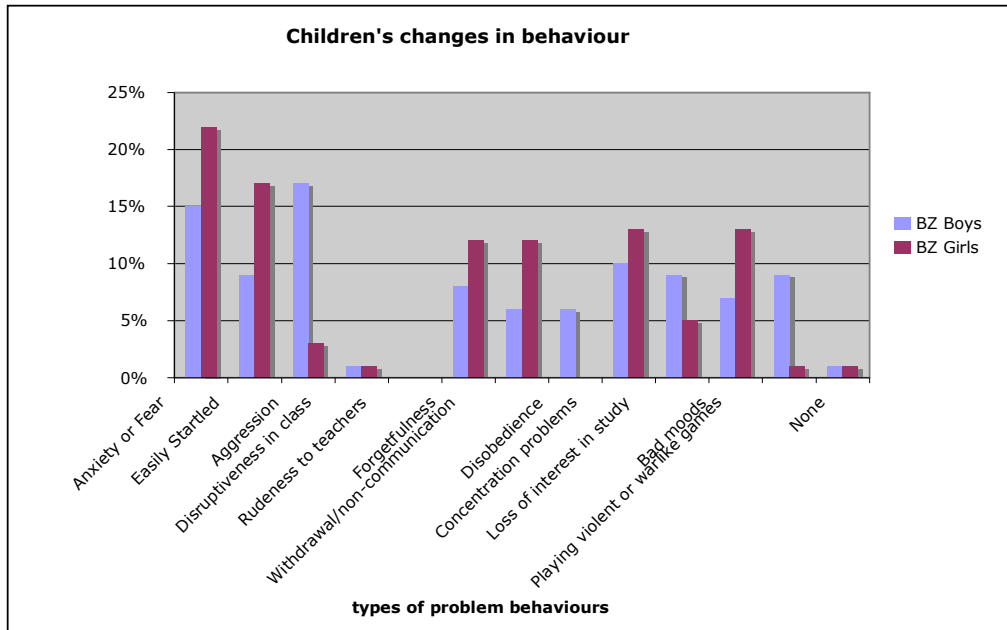
3. Gender and changes in children's behaviour

Teachers were also given a second array of possible changes in child behaviour that included three additional options: These included “anxiety or fear” “easily startled”. and “withdrawn or non-communicative”. These behaviours were included because they can be indicative of trauma effects, particularly those ones that typically go unnoticed because they do not disrupt classroom or group activities.

When this array of possible changes in student behaviour are analyzed in terms of gender and possible problem behaviors (see 3 tables below, Figures 17 (a), (b), and (c)), it can be seen that these typically exist for less than 30% of students overall. This proportion, however, is significantly high and signals possible major psychosocial problems for many children, particularly if they have been exposed to trauma and conflict and are, therefore, vulnerable to PTSD. Added to this is the fact that teachers from all three regions are finding that the children with most problems are entering into puberty (13 years and older) and, in my professional experience, will be more likely to find it difficult to communicate and be in need of structured behaviour change programs.

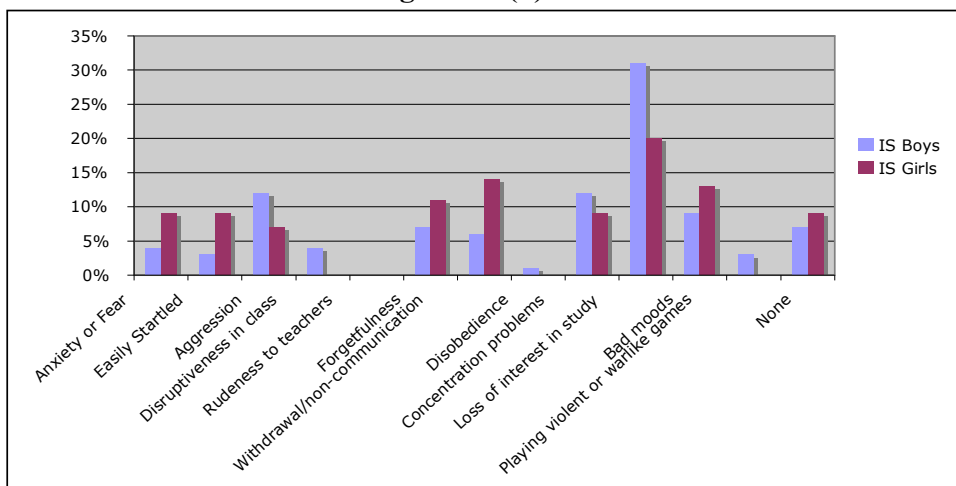
Evidence of emotional trauma is often more difficult to detect in girls than boys because they typically are quieter and less overtly aggressive than boys and often evidence withdrawal or internalizing after traumatic events (Briere and Scott, 2006). However, examination of the table for BZ children shows that well over 20% girls are anxious, over 15% are easily startled, and around 12-13% are forgetful, withdrawn and have bad moods. This combination is indicative of likely trauma effects and should alert us that these girls are in real need of expert psychological assistance if the long term effects of PTSD are to be ameliorated. Similarly, and significantly, 15% of the BZ boys also are anxious, 9% are easily startled, 10% have concentration problems and 17% are aggressive (10% play violent games). Again, this combination of behaviour points to the effects of trauma unfolding and indicate that the boys from this region also need urgent psychological assistance.

Figure 17 (a)



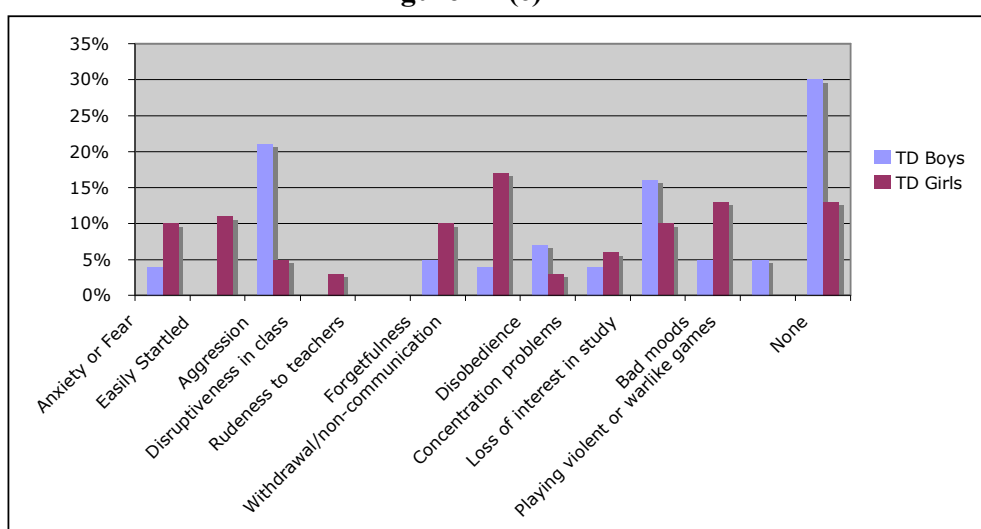
Children from IS villages have different types of problems: A large proportion of boys (31%) are no longer interested in their studies (which is twice the rate of TD and/or three times the rate of BZ boys), and over 10% have both concentration problems and are aggressive. They are not reported to have the cluster of other problems outlined above with BZ children and are therefore more likely to be evidencing problems resulting from displacement and relocation rather than trauma-related experiences in most instances, although the minority with problems of aggression and concentration problems may also be showing signs of trauma. Nevertheless, it is important to address this quickly if Georgia wishes to avoid generating a group of disaffected, uneducated and angry young men in a very short period of time.

Figure 17 (b)



In sharp contrast to the BZ and IS groups of children, many of the TD children (30%) have no problems according to their teachers. Some girls, however, have withdrawal problems (17%), bad moods (13%) and approximately 10% get anxious, startled, lose interest and/or are forgetful. This may reflect general stress that could be caused by a variety of things such as dislocation, elevated levels of family arguments or grief over the loss of a loved one. The boys are not reported to have as large an array of problems but some 16% have lost interest in their studies and a large 21% are aggressive, possibly reflecting denser city life, poor role models from males at home and/or depressed or stressed mothers having problems managing teenage sons.

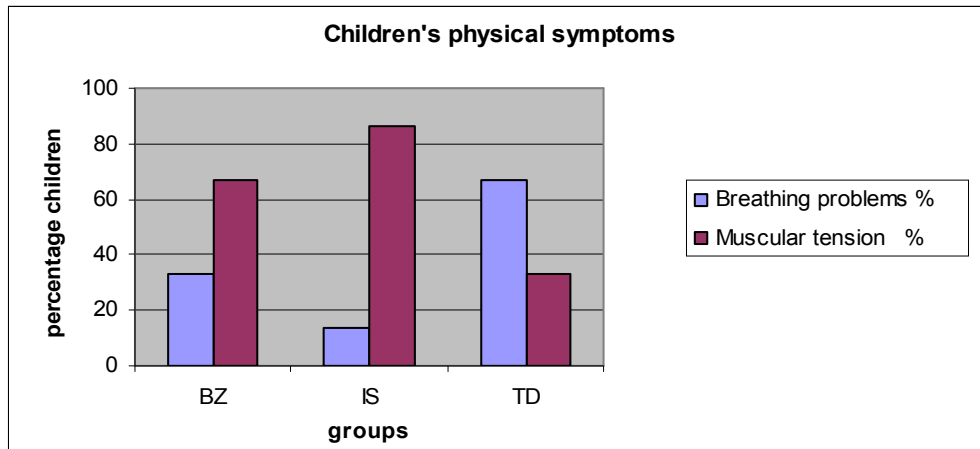
Figure 17 (c)



4. *Children's physical symptoms*

Physical tension and breathing problems can reflect elevated anxiety, efforts to contain aggression, mood problems and problems with sleep. Based on the observations of teachers, many more BZ (67%) and IS (87%) children are more physically tense than their TD colleagues (33%) (Figure 18). Conversely, more TD children have been seen to have breathing problems (67%) than children in BZ (33%) and IS (14%). This counter-intuitive result may reflect tension for a variety of reasons, including major emotional upheaval, or could reflect the belief in Georgia that Tbilisi air has become increasingly polluted. This needs further examination.

Figure 18

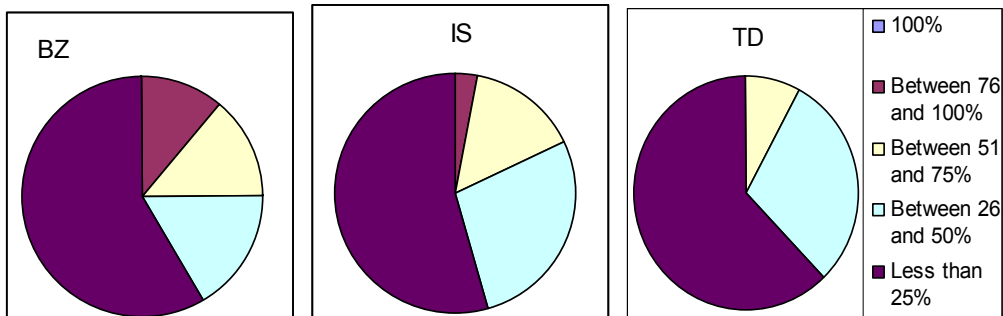


Those Buffer Zone children who have these two types of physical problems plus the cluster of psychosocial problems outlined previously have an unhappy combination that is very likely to affect their sleep, mood, and behaviour. Fortunately, so far, more than half of all the teachers from all three regions believe that the school performance of less than a quarter of the children in their schools has been affected by the conflict last year (see next paragraph). However, unless something is done to reduce tension in these children that have been affected, their psychological problems are likely to rise even further. Fortunately, there are some relatively simple but effective procedures that could be taught to them and/or their parents to help reduce physical tension, such as breathing and relaxation programmes. Obviously, additional work would need to be done if this was the result of psychological trauma.

5. *Effects on children's performance at school*

According to the teachers completing the questionnaire (see Figure 19), the majority of teachers in each region (BZ = 58%; IS = 55%; TD = 62%) felt that less than a quarter of the children at their respective schools had been affected by the conflict in ways that disrupted their school performance (see Figure 18). Of the remaining TD children, the school performance of 30% were thought to be affected between 26-50%, and a small group of 8% between 51-75% affected. The IS children had a similar (30%) percentage affected between 26-50% but a larger group (15%) than the TD group affected 51-75%. Also, unfortunately, a very small group (3%) of IS children were thought to be affected almost all of the time (between 76-100%). Again, the BZ children are clearly the most affected, with a smaller group (17%) affected at the lower level of 26-50%, 14% affected at the upper-range of between 51-75%, and 11% thought to be affected at an intolerable level of between 76-100%. These data indicate that school performance is being affected for an unacceptably large number of children and that their teachers might be suitable professionals to receive relevant training to support these children.

Figure 19

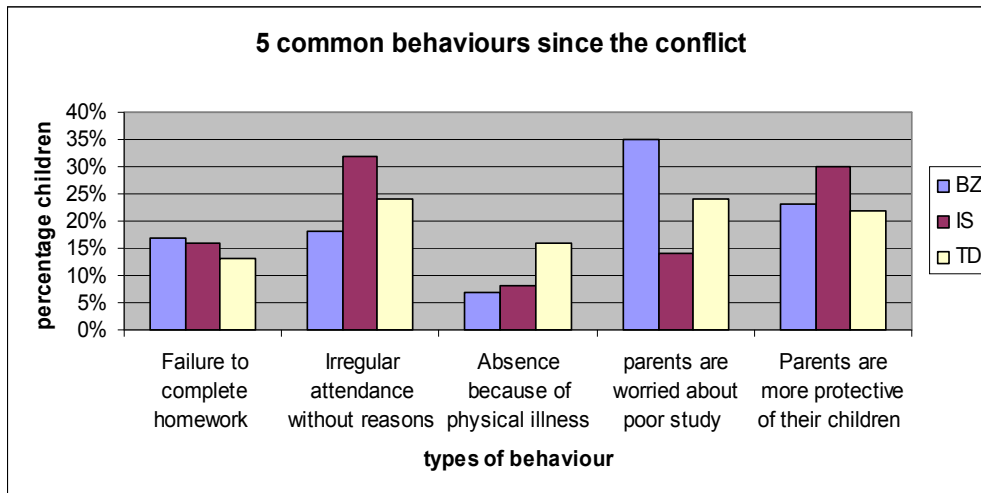


6. *Other effects including parents' responses*

Parents from all groups seem to have become more protective of their children since the conflict (22-30%) and, with good reason, it is the parents of BZ children who are the most worried about the changes in their children's study habits (35% compared to 14% IS parents and 24% TD parents)(Figure 20). Nevertheless, the BZ children are only marginally more likely than the other groups of children not to complete their homework, are more likely to attend school regularly and less likely to be absent from school because of physical illness. This further suggests that the problems they are experiencing are psychological in origin rather than physical and it is all the more important, therefore, to recognize these problems and their effect they can have on children's education and general welfare.

Of interest, also, is the fact that the IS children are the most likely of the three groups of children to attend school irregularly (a third compared to a quarter of TD children and just under 1/5th of BZ children). There could be several reasons for this including transport problems and/or the fact that 30% of their parents are slightly more likely to be worried and protective of their children traveling away from home than the TD and BZ parents (22% & 23%) about them traveling away from home. One possible reason might be the bus transport conditions in which these children travel to school and the notoriously busy highway adjacent to their settlements between Tbilisi and Gori. Alternatively, it seems that the IS parents are less worried than their BZ and TD counterparts about their children's poor study habits, which may account for the high percentage of IS boys who have lost interest in their study (see Figure 17 (b)).

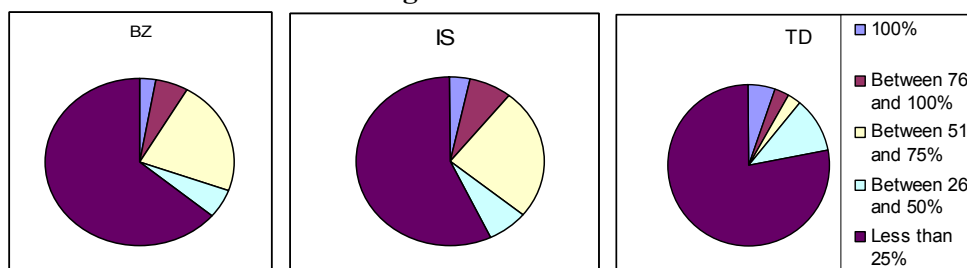
Figure 20



7. Effects on Teacher's performance

It needs remembering that teachers themselves are human and are likely also to have been affected by the conflict and that this, in turn could affect their own performance at school. Information from the teachers (Figure 21) in all three groups (BZ = 63%; IS = 57%; TD = 77%) suggests that the performance of teachers in their schools have been affected 25% or less. Unfortunately, around a quarter in both the groups outside of Tbilisi (BZ = 22%; IS = 25%) feel the performance of teachers at their schools has been affected between 51-75%. Furthermore, smaller groups (BZ = 6%; IS = 7%) are thought to have their performance affected a great deal (76-100%). Although small, this is double that of TD teachers (3%). There are some in all three regions, however, whose performance is thought to be affected 100% since the conflict with TD teachers effected the worst (TD = 6%; IS = 4%; BZ = 3%).

Figure 21

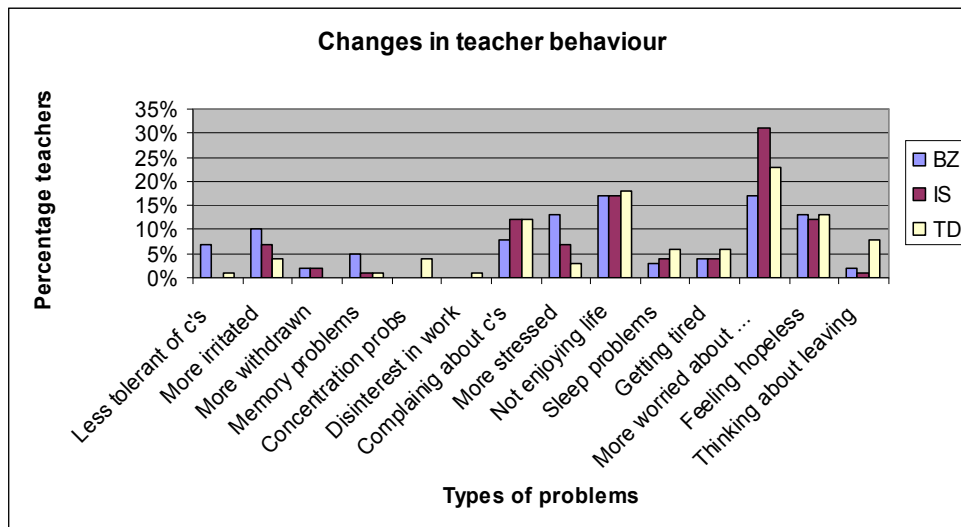


8. Changes in teacher's behaviour

The graph below (Figure 22) shows the array and extent of changes in teachers' behaviour since the conflict last year. It can be seen that many, especially those in IS are more worried about the future – and, perhaps unexpectedly, the BZ teachers are less worried than their counterparts (IS = 31%; TD = 23%; BZ = 17%). All regions have a similar proportion of teachers who are feeling more hopeless (12-13%) and not enjoying life so much since the conflict (17-18%) but

there are more BZ teachers (13%) who feel more stressed (IS = 7%; TD = 3%) are getting more irritable (BZ = 10%; IS = 7%; TD = 4%) and who are now less tolerant of children (BZ = 7%; IS & TD = 0%). Added to this is a small percentage of BZ teachers (5%) who are having memory problems which is another indicator of stress and/or, possibly the precursor of a developing trauma history.

Figure 22



In essence, there are groups of conflict-affected and stressed teachers who are trying to teach classes of similarly affected children. Teachers could benefit from assistance and training in the recognition of trauma symptoms (especially the less noticeable ones often evidenced by girls and women) and also in class management that works to limit the effects of these symptoms on school performance.

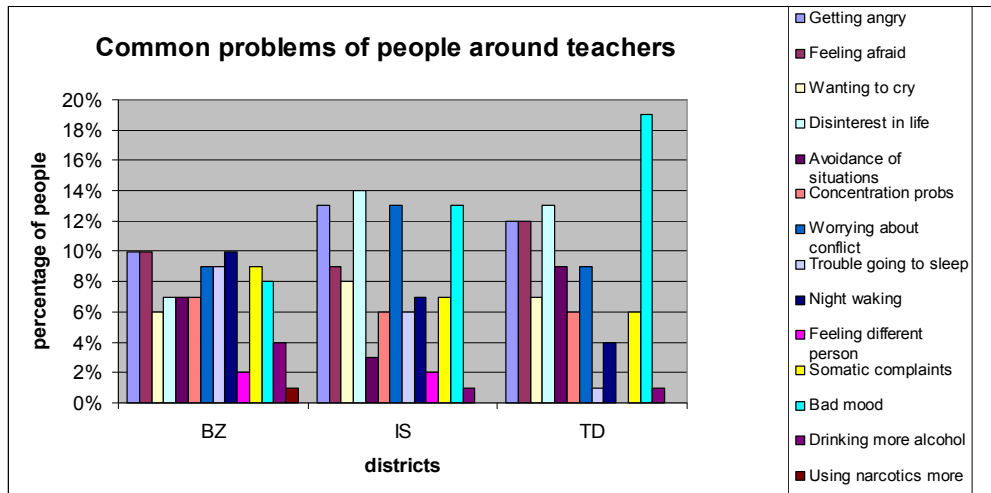
9. *Changes in people known personally by teachers*

Teachers were also asked about the types of problems they felt were more common in people they actually know around them. As can be seen from the graph below (Figure 23), Buffer Zone teachers feel that 10% or fewer people around them had a solid block of problems, and that these were (for 8-10% people): Getting angry, feeling afraid, avoiding situations that make them afraid, worrying about the conflict, trouble going to sleep, somatic complaints and bad moods.

IS teachers feel more people (10-14%) around them have problems such as getting angry, disinterest in life, worrying about the conflict and bad moods.

TD teachers name getting angry, feeling afraid, and disinterest in life as problems for between 12-13% people around them and bad moods as problems for nearly 1 in 5 (19%) of the people around them.

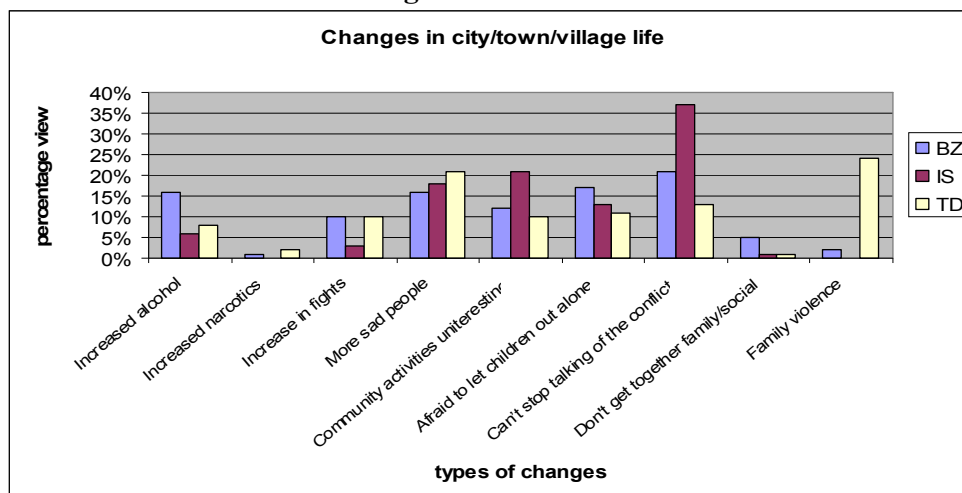
Figure 23



10. *Changes in community life*

Teachers are pivotal in any community because they often are aware of community life, and any changes in it, through their daily contacts with children and interchanges with their parents. The following bar graph (Figure 24) illustrates a number of changes that teachers feel have occurred in their communities. First, a large proportion of IS teachers (37%) feel that there are community members who cannot stop talking about the conflict and a good portion (21%) have lost interest in community activities and/or are sad all of the time (18%). Despite living together, the effects of being displaced and unable to go home are obviously being felt keenly in the IS villages, possibly because these lack community resources such as churches, community centres and markets which contribute to community living. The need to re-build a positive sense of community becomes additionally important in the light of the information on IS boys behaviour outlined above.

Figure 24



In the Buffer Zone, there is still 21% of the community who can't stop talking about the conflict and, given their location, understandably more people (17%) than in the other two communities (13% in BZ and 11% in TD) who are afraid to let children go out on their own. In addition, comparatively many more from the BZ are thought to have increased their alcohol consumption (BZ = 16%; IS = 6%; TD = 8%), but marginally fewer are sad all of the time. Tiny proportions of both BZ and TD communities are increasing narcotic use (BZ = 1%; TD = 2%). It needs noting that there are no data on base rates for either alcohol or narcotics, nor on what these substances might comprise.

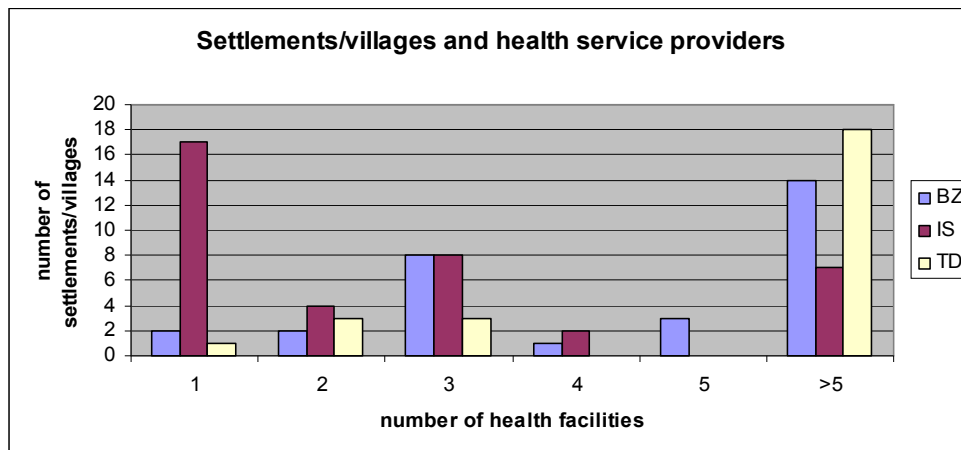
It might be important to note that there is a reported 10% increase in arguments and fights in both BZ and TD districts but a disproportionately large increase in family violence within the Tbilisi Districts. This may be a matter of under-reporting in the other two districts given the increases in stressors, or due to other factors such as high density accommodation, stress from unemployment or financial constraints.

C. Health care provider

1. *Number of communities served by healthcare service providers*

Healthcare providers from each of the three regions were asked how many IDP settlements and/or villages are served by each health facility. The data are shown in Figure 25. The number varied across the regions. In the IS region, for example, the majority (17) of their health facilities serves one settlement, some (8) serve three and a similar number (7) serve more than five. Hence, this group focused primarily on single settlements. In comparison, a number of BZ healthcare facilities (14) serve more than five settlements although some (8) each serve three settlements. These facilities do not serve just one village.

Figure 25



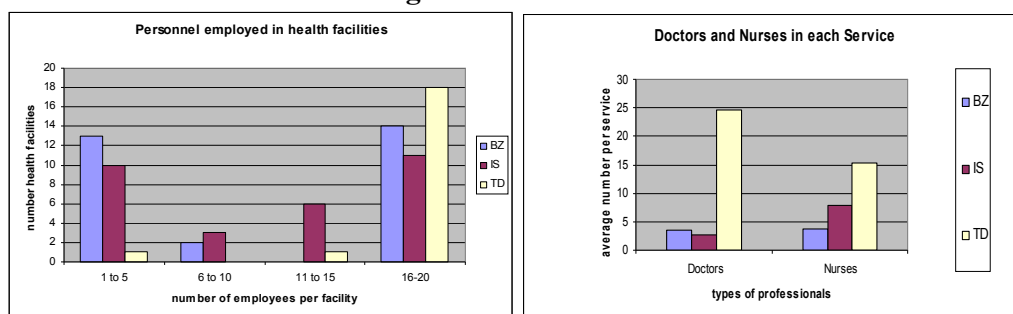
Unexpectedly, the majority of TD providers (18 health facilities) say that they typically serve more than five settlements. When enquiries were made about which IDP settlements the TD group might be serving, it appears that one facility served a community of IDPs from Abkhazia who had fled from the previous Russian-Abkhazian conflict – and perhaps from the recent conflict as well. This raises the question as to how this question was interpreted by respondents from the healthcare facilities in general.

2. Staff at healthcare facilities

Figure 26 shows that just under half the BZ facilities (13) have 1-5 personnel and half (14) have 16-20 personnel. Hence there are two very different sizes of health services serving BZ people (perhaps in proportion to the different sizes of BZ communities). The IS facilities vary more in the numbers of personnel per facility, varying from 10 facilities with 1-5 personnel, 10 with 16-20 personnel and some in between of 3 with 6-10 personnel and 6 with 11-16. In essence, however, when the number of doctors and nurses of each health facility are also taken into account (Figure 27), the staff in the BZ and IS health facilities are both spread thin: The BZ facilities have an average of just over 3 doctors and a similar number (3.6) of nurses, and the IS facilities have more nurses than doctors with an average of just under 3 doctors and just under 8 nurses.

In comparison, the TD region has the most health facilities, the most employees per healthcare centre and the most nurses (over 15 per centre) and an almost overwhelming number of doctors (nearly 25 per centre). It is presumed that many of the TD facilities are polyclinics.

Figures 26 and 27

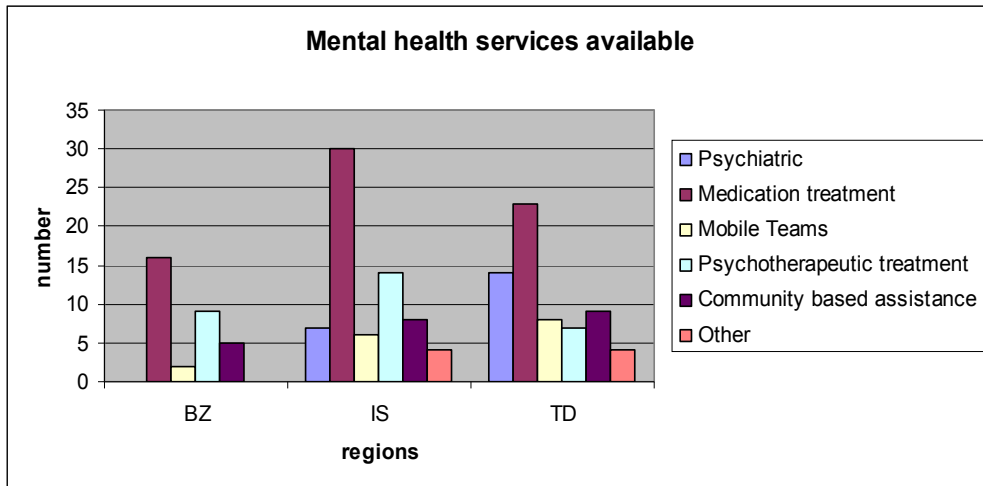


3. Mental Health (or Psychosocial support)

When service providers were asked about the different types of mental health (as opposed to physical health) services they provided from or through their facilities, major differences occur across the three groups (see Figure 28). One dominant feature is the medical approach to mental health with the use of medication (unspecified) as the treatment of choice for all groups, especially for the IS group. The TD group place greater emphasis on psychiatry combined with medication, perhaps because they are likely to live in the TD, and the IS group also use psychotherapeutic treatment (unspecified). In essence, the BZ facilities are least

equipped to provide mental health assistance: They have no psychiatrists, use less medication treatment, have fewer mobile teams than are going to IS or TD groups, and slightly less community based assistance than the other two groups.

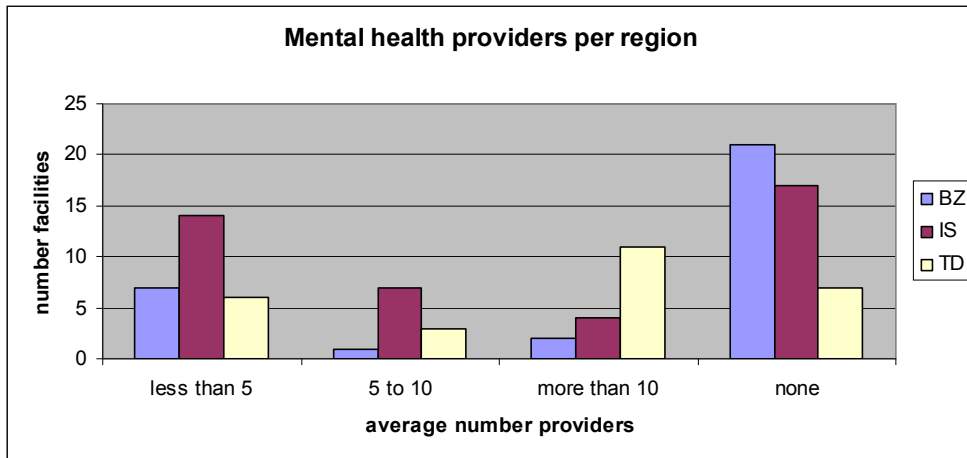
Figure 28



4. *Service providers for people with mental health problems*

The numbers of personnel available to provide mental health services necessarily impacts on what can be offered and how often. The graph data in Figure 29 (below) illustrates the data for the average number of people in facilities providing mental health services. These need to be viewed in the light of the numbers outlined above of personnel (see Figure 26), especially doctors and nurses (see Figure 27), available or able to provide services additional to physical/medical care of patients. Immediately it can be seen that many BZ (21) and IS (17) facilities have no-one providing specialist mental health care. If they have anyone then it is more likely they have less than 5 per facility in these two groups. Conversely, TD facilities are most likely to have more than 10 mental health providers they can use, again reflecting the lower likelihood of relevantly trained mental health professionals (both psychologists and psychiatrists) living in the BZ and IS regions. Methods of getting professional assistance to these groups in future are suggested later.

Figure 29

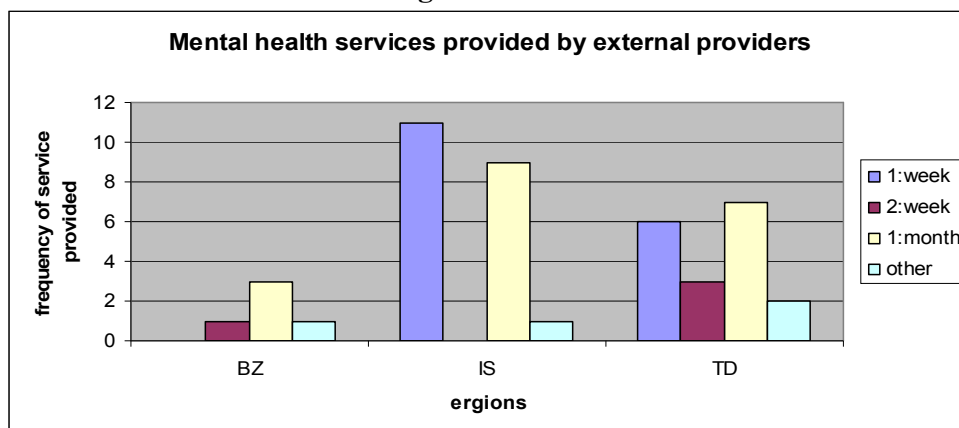


5. *External providers of mental health/psychosocial support*

The frequency of mental health services provided by external providers also was examined. Unfortunately, as the data in Figure 30 indicates, the mental health requirements of the BZ communities are served less than those in either of the IS and TD regions. The IS communities typically can access external mental health providers either once a week or once a month. This is likely to be from a small (possibly mobile?) group providing psychiatric, medication or psychotherapeutic services. The TD group has more contact options because services are available from twice a week, through once a week, to once a month. These are likely to be from fixed clinics/centres which are, not surprisingly, more available in Tbilisi than in the regions.

When the previous data on healthcare facilities are taken into account, the BZ group is the least likely to be able to access mental health services either through their healthcare services or through external providers despite the fact, as previously outlined in the sections on Community Members and Teachers, they have very high needs.

Figure 30

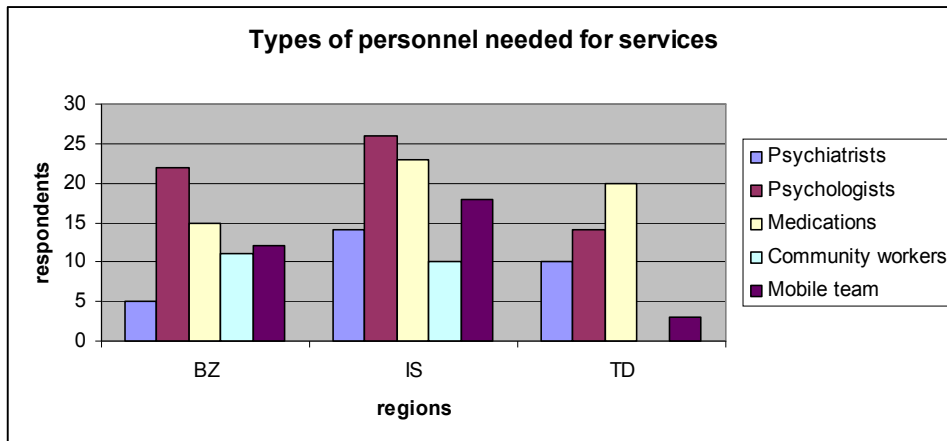


6. *Assistance wanted by service providers*

Interestingly, all three groups of service providers want more medications to assist patients. However, BZ and IS service providers place most emphasis on non-pharmaceutical options and say they need many more (presumably adequately trained) psychologists and, to a lesser degree, psychiatrists (Figure 31). This makes sense given the complexity of needs within the BZ and IS groups, the intensity of problems for those adults and children in the BZ, and the limited benefits of medication alone for those trauma or acute stress-related disorders typical of exposure to conflict/war (Briere & Scott, 2006).

These two groups also want more mobile teams than do TD healthcare providers, presumably in order to be able to access patients who cannot easily access services themselves because of poverty, transport problems and/or the unsettled nature of the Buffer Zone.

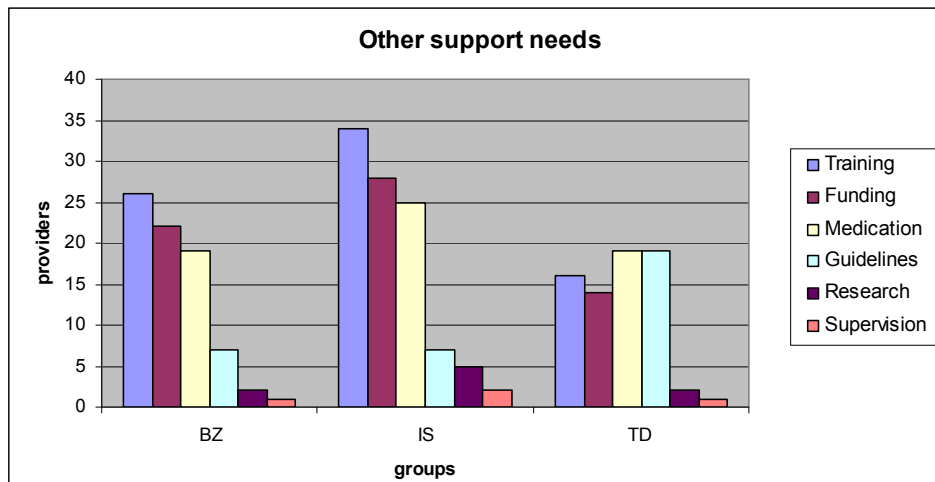
Figure 31



7. *Other support needs for professionals*

A clear picture emerges of service providers, especially in the IS and BZ areas, wanting more professional support in their efforts to meet the mental health needs of their communities (see Figure 32). In this order, both these groups want more training (26 of the 31 providers – 83% - from BZ and 34 of the 40 providers – 85% - from IS), more funding (22 or 71% from BZ and 28 or 70% from IS) and more medication (19 or 61% from BZ and 25 or 62% from IS). The TD service providers place a less variable emphasis across their preferred support needs with between 38%- 51% wanting first medication and guidelines, training and then funding.

Figure 32



Hence, BZ and IS service providers are crying out for more trained professionals such as psychologists, psychiatrists, and community workers, more mobility, more medication and more funding in order to meet the mental health needs of their war-impacted communities.

8. *Mental health/psychosocial support referrals*

Very few of the service providers from any of the groups had mental health referral services. Only nine of the IS service providers say they have referral services and a meager 4 BZ and 4 TD service providers have them. Despite that, or in spite of it, the mental health referral service from each of the three regions is seen as adequate for 20% (IS), 25% (BZ) and 28% (TD) service providers and/or satisfactory by the majority of service providers (BZ = 75%; IS = 70%; TD = 72%). Only 10% of the IS service providers indicated that referral services were not functioning. It is not known, however, how these mental health referrals are conducted and/or what networking there is amongst professionals. This is an area for further examination especially given the minimal number of service providers and the types of mental health problems in the IS and the BZ communities that may or may not be being adequately diagnosed or treated.

Service providers from all three groups were asked whether mental health referral sources have increased since the August 2008 conflict and who was referring them. The BZ service providers say that there have been absolutely no additional referrals to them from external sources. This suggests that the increased workloads for these providers, referred to before, has come from BZ people directly referring themselves.

A large proportion of increased referrals (45%) to TS providers and to a lesser degree (37%) to IS providers also have not been referred by a professional, but another large proportion (41%) has been referred to TS providers by local medical professionals. In comparison, the sources of IS increased referrals for mental health matters is more heterogeneous. About a quarter of the increased referrals to

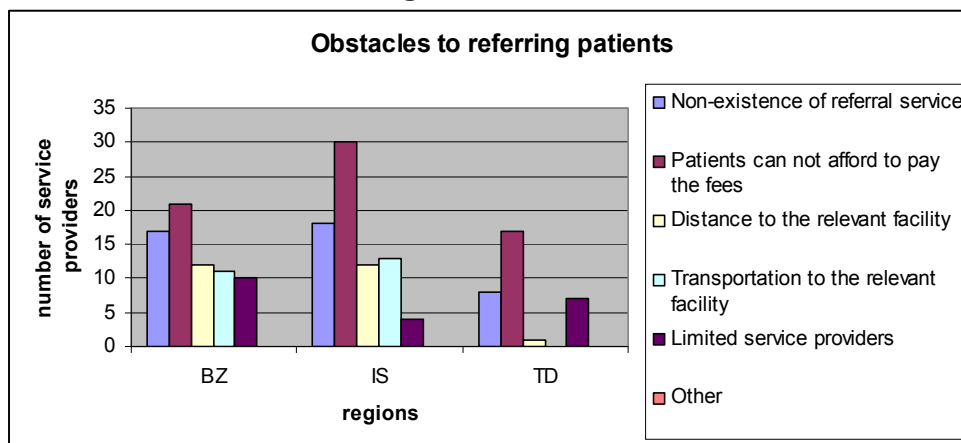
IS providers have come from local medical professionals and another quarter (24%) have come from professionals from a combination of international organizations plus NGO staff. This probably reflects the move by such organizations to be involved in and assist the IDP communities in the new settlements.

Both IS and TD groups have received increases in referrals from community workers (IS = 13%; TD = 14%) but no such referrals have occurred in the BZ group – even though there are more community workers in that region. This may highlight a need for some further networking and psychosocial education for these workers.

9. *Barriers to referrals*

All three service provider groups indicate that the primary obstacle to being able to refer people to mental health professionals is that the people themselves cannot afford to pay the fees (see Figure 33). This is thought to be the case by 21 of the BZ providers, 30 of the IS providers and 17 of the TD providers (possibly reflecting the differences between city and rural incomes). The second major reason is purely the lack of a referral system for another quarter of referrals in each group (BZ providers = 17; IS = 18; TD = 8). Transport problems such as the distance to relevant facilities or the transport costs to get there are much less of a problem for the TD population but still act as obstacles for the BZ (11%) and the IS (13%) groups. More BZ providers than IS or TD providers feel that limitations on number of service providers is another obstacle to people getting mental health services.

Figure 33



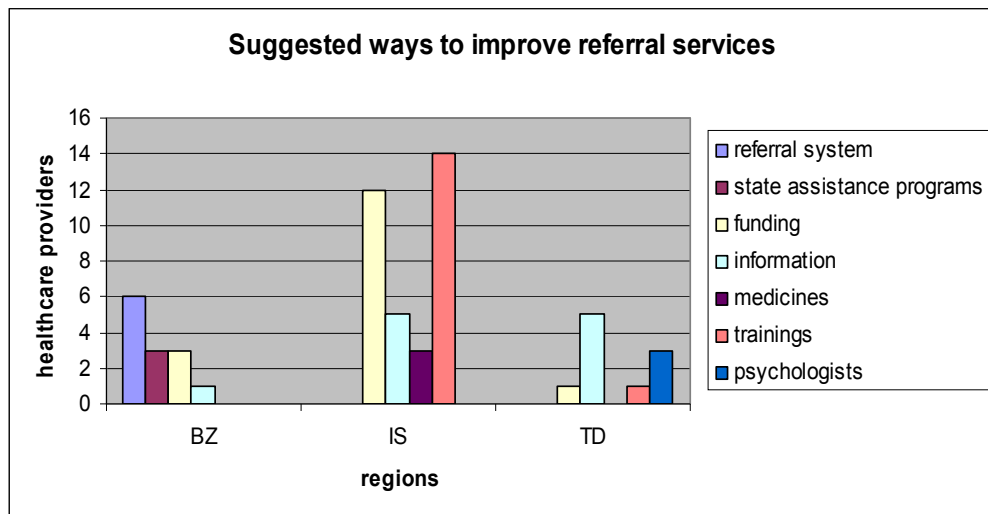
10. *Service providers views on how to improve referral services*

Service providers were asked to describe what they would need to improve their referral service (Figure 34). Most answers came from the IS service providers who suggest very very clearly that referrals would be maximally improved by more training and more funding. A smaller number of them suggest more information (presumably on which agencies exist to whom they can refer patients or ways they can be of assistance to patients) and a minority suggest more

medicines. A similarly small number of TD providers also suggest information and a few suggest more psychologists. In contrast to the IS service providers, training and funding is seldom suggested. The BZ group wants improved referral systems, more funding and some support from the State-assistance programs. Very few wanted more information.

It might be useful if these groups developed a trans-disciplinary network system, upskilled their working knowledge of trauma and its relevant treatment modes, and liaised on a regular basis.

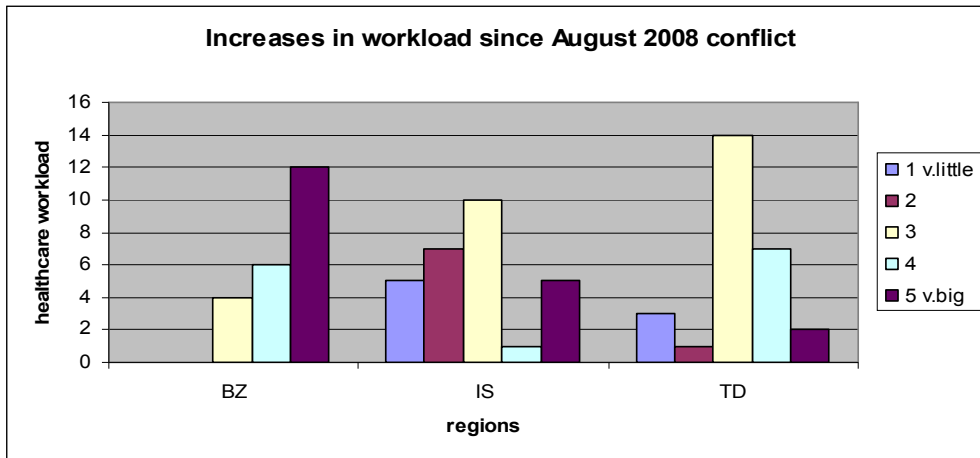
Figure 34



11. *Workloads of Service Providers*

Service providers were asked to indicate whether their workloads had increased (in the year) since the August conflict 2008 and to rate any increases on a 5-point scale from 1 (representing very little increase) to 5 (representing a very big increase). The results are presented in Figure 35. Although all service providers, regardless of region, feel that their workloads have increased, the Buffer Zone service providers stand out as feeling that they have had major increases in workload with 12 of them rating their increase as 5 (some say more than 5!), 6 rating it at 4 or above the midpoint and 4 at the midpoint. The responses from IS service providers fell across a broad range, from 5 of them indicating very little increase in workload and 5 indicating a very big increase in workload, and the majority of 7 and 10 providers rating their workload increase below the midpoint at 2 and 3 on the scale respectively. The greatest majority (14) of service providers to rate their increased workload at the midpoint of 3 came from the TD area, but another 7 rated it 4, another 3 rated it 1 (very little) and 2 rated it 5 (very big).

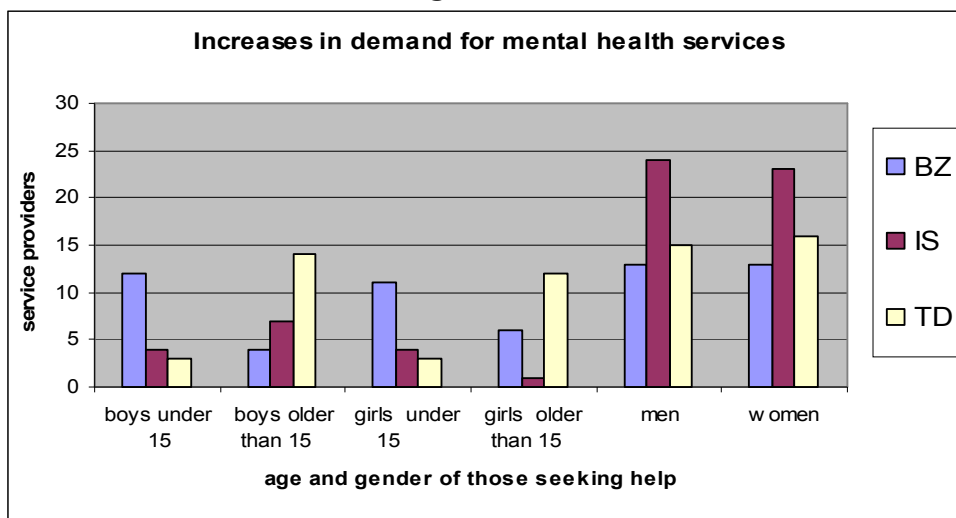
Figure 35



12. *Referral Sources*

Figure 36 shows that some providers feel that the greatest increase in referral demand for mental health services is coming from the men and women of the ID settlements.

Figure 36



At first glance this would suggest that the adults are more in need of help to overcome mental health problems than the children. However, when considering the previously presented information from the BZ and IS teachers about the behaviour of children at their schools, an alternative hypothesis might be that the adults are simply more likely to refer themselves. A different picture might emerge if the children felt able to come forward for help and/or their problems were diagnosed appropriately or recognized as significant. As it is, lower but still significant and similar levels of help are being sought by women and men from TD and BZ, TD girls and boys older than 15 years old, and BZ girls and boys under the age of 15 years. Hence, most of the oldest self-referers live in IS

villages and most of the youngest live in the Buffer Zone. These two age groups are often more vulnerable to the effects of trauma (Briere and Scott, 2006).

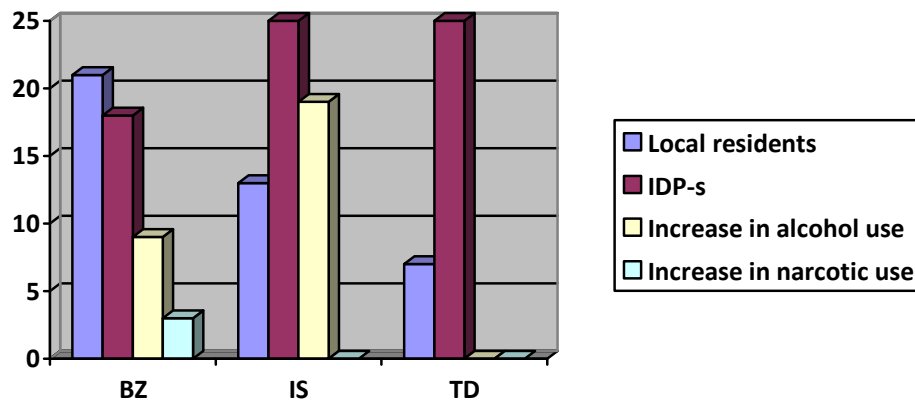
13. *The need for mental health/psychosocial support services*

According to the BZ service providers, the greatest demand for mental health assistance has come first from local residents affected by the conflict and, at a close second, from IDPs who have moved into the region because of the conflict (see Figure 37). Both groups have therefore experienced, and continue to experience, fear and anxiety over the unsettled border situation close by to them and are seeking help to cope with these stressors.

It is not really surprising that the IS service providers report that greatest demand for help comes from IDPs who live in villages set up for them. But with them comes an increase in demand for help with alcohol dependence (consistent with reports from community members). It is important to note this increase in alcohol dependence in both the BZ and IS communities and, in the BZ, the added increase in the use of narcotics. Assisting people with addiction problems is a specialized field that requires particular training of mental health professionals to try to reduce this problem (and the family and community problems typically associated with it).

These data confirm that the TD people who answered questionnaires might have included answers from IDP people – or at least those working with that group.

Figure 37



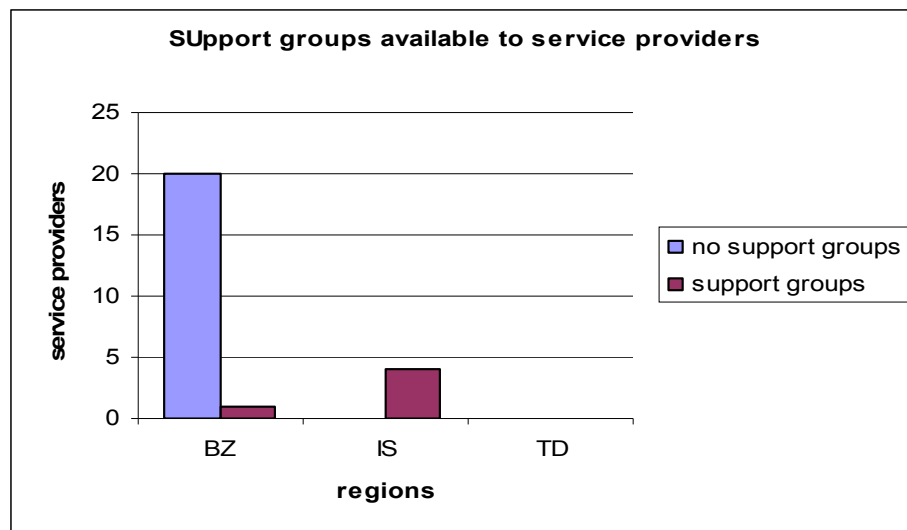
14. *Personal & professional support for service providers*

It is well acknowledged, through evidence-based research, that good clinical practice requires practitioners working with mental health populations to have meaningful professional support. This is especially important for mental health service providers if they are working with extreme or complex cases, with large numbers of patients (clients) and/or trauma victims. This is clearly the population group with whom Georgian service providers are working. Without it, service

providers of mental health/psychosocial support are at high risk of “burn out” themselves.

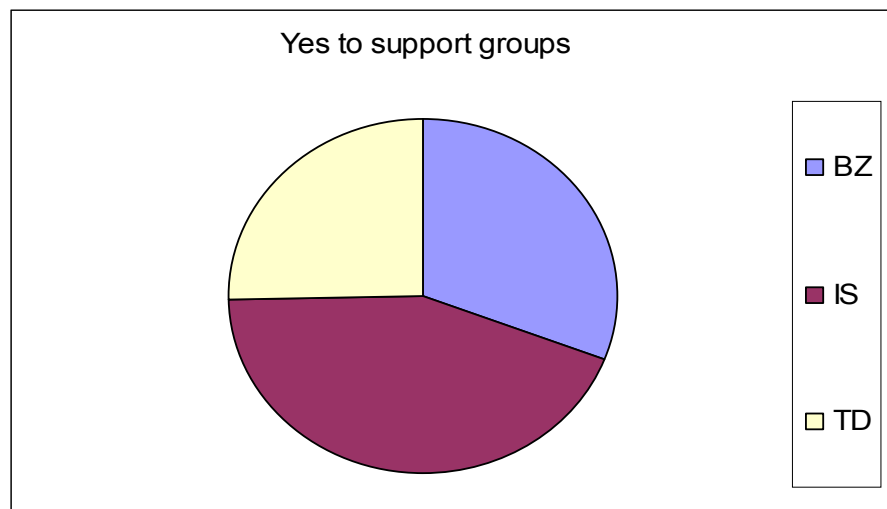
The service providers who responded to the questionnaire in this study overwhelmingly indicate (Figure 38) that they had no support groups. Only one service provider from the BZ says they have support and 20 say they don’t, TD service providers all do not have any support, and 2 IS service providers rely for support on friends and relatives and one on an IOM member.

Figure 38



15. Not surprisingly, therefore, when service providers were asked whether they themselves needed such support groups there was a resounding “Yes” in written replies (see Figure 39 below).

Figure 39



Summary and Recommendations

1. The lives of Georgians have been impacted by the August 2008 conflict with Russia in both physical and psychological ways.
2. The majority of BZ community members feel unsafe. Several avoid travel, avoid working in the fields, and keep their children close by. People in IS and TD have access to local Police and feel safer but still feel unable to out at night. The IS families no longer travel as they used to and some TD families no longer allow their children out alone.
3. Both BZ and IS communities have been used to living off the land but now both groups have limited access and both have very high unemployment rates. They are trapped in poverty and need to live off the land or to trade. However, few people in these groups live close to amenities or have access to sufficient food or healthcare. BZ people are the worst affected in these ways. Unsurprisingly, BZ people, and to a lesser degree, IS people are not very satisfied with the lack of basic needs such as clothes and food, but IS people are more content with sanitation and heating. This may reflect perceived improvements over crowded conditions in previous collection centres.
4. Although transport to medical emergency centers is free in Georgia, distance and transport costs impact on access to medicines and other hospital- or polyclinic-based healthcare services for these groups more than for TD people. The Phelsher nurses are more mobile healthcare providers and are therefore more known about in the BZ than elsewhere. Many people in the BZ and IS communities look to friends, neighbours or relatives for help with both physical and mental health problems as well as to professionals in hospitals and polyclinics. They also turn to an array of professionals within and/or visiting their districts such as Phelsher nurses, priests, pharmacists and local and international NGO workers.
5. People in BZ, IS and TD know others who have physical ailments that have increased since the conflict. The main ones are blood pressure problems, sleep problems, headaches and loss of energy. Many could be consequences of trauma and could signal associated psychological distress. Health professionals need to be able to differentially diagnose these in order to provide appropriate care.
6. The TD group has fewer psychosocial or mental health problems, IS members have more and BZ residents experience the most. These include mood (e.g., anger, depression) and sleep problems; worry, fear and anxiety; somatic problems; and concentration and derealization problems. A number of their problems suggest stress reactions and/or PTSD symptoms. Alcohol and, to a much lesser extent, narcotics are being used. They also argue more and have less interest in family or community life. These problems have overflowed into their communities and have the potential to further erode family and community life.

7. Again, BZ and IS residents say they are just as likely to go to relatives or friends for psychological advice and support as go to hospital or polyclinic personnel, psychologists (in IS) or priests (in BZ). Currently, however, many BZ and IS community members are seeing (and therefore dependant on) visiting and local NGOs, community workers, psychologists, social workers and priests for help with their psychological problems. Hence, in general, non-medical persons are being sought out for psychosocial support.
8. The major barriers to people using mental health professionals and services is insufficient money for services, medicines and transport. The latter is obviously particularly important for those living in dangerous areas and/or far from services.
9. Information from teachers shows that school enrollment have decreased most in the BZ but IS children are more likely to attend school irregularly. Many children from all three districts are simply tense and/or have breathing problems. Children's school performance is being detrimentally affected and at intolerable levels for a small proportion of BZ and IS school children. Not surprisingly, their parents are worried about their children's poor study.
10. A small but very worrying proportion of children, especially from BZ and IS, also are behaving in ways consistent with emotional trauma such as forgetfulness, loss of interest in study and concentration problems. The BZ children also evidence withdrawn behaviour, anxiety or fear, and are easily startled. These symptoms are of real concern. Girls and boys are evidencing this in gender-specific but classic ways: Girls are more withdrawn and anxious, and boys are acting more aggressively with some BZ boys now also playing war games. Both groups of children need help as soon as possible.
11. Teachers from all three groups (including TD) also are more stressed, enjoying life less, complaining more about the children, and are worried about the future. They know others who are similarly affected and some who are also afraid, angry, get bad moods, and/or have lost their interest in life. Feeling like this can affect their work and interactions with already stressed children, and has the potential for a negative flow-on effect.
12. Teachers have also noticed changes in the behaviour of people in their communities. To varying degrees, these changes include more people being sad and uninterested in life, feeling afraid, more protective of their children, continuously talking about the conflict, drinking more alcohol, having more fights and arguments, and using narcotics. These are matters than can erode communities and make them jittery (a security risk), especially when this is mixed with numbers of children with mental health problems, displacement and lack of access to basic needs.
13. In these circumstance people need proper support services to avoid the risk of major problems inside Georgia. Service providers are expected to provide both

physical and psychological aid. The TD region serves the most people, has the most personnel per facility, most nurses and unusually large numbers of doctors. In comparison, the IS and especially the BZ services have very few doctors or nurses and they are spread thin. In many cases there is no one to provide specialist mental health care and yet they have the most urgent and complex cases. These facilities therefore require additional but relevant professional assistance. Medication currently is the treatment of choice but this, in my professional experience, masks rather than solves psychological problems, especially ones resulting from trauma. Some psychotherapy is also used in the IS and, to an even less degree, community based treatment (unspecified). Some assistance from external mental health providers is occurring, mainly on a weekly or monthly basis in the IS and more comprehensively in Tbilisi District. The unsafe nature of the BZ probably accounts for the minimal input by external mental health services.

14. According to the service providers, the major barrier to people accessing mental health services is that, firstly, potential beneficiaries cannot pay for services; secondly, referral systems are either absent, unknown or inadequate; thirdly, for some BZ and IS people, there are problems with transport costs and, finally, there are just insufficient providers in the BZ.
15. Nevertheless, service providers feel that their workload has actually increased. The largest group seeking help are the men and women living in the IDP settlements. Their problems are likely to reflect the unfolding nature of emotional trauma after a place of safety has been found. Help is also being sought for boys and girls under the age of 15 years who live in the BZ. Their problems are likely to reflect the ongoing pressures of feeling unsafe. Most BZ people are self-referred perhaps highlighting the shortage of professional mental health services for people in this area. The IS group includes self-referrers and referrals from NGO and international organizations and community workers, and the TD referrals are mainly from local medical professionals and some community leaders.
16. Service providers in the Buffer Zone and IDP settlements urgently want assistance from additional personnel such as psychologists, community workers and psychiatrists, mobile services, and medication. They also seek training for themselves and more funding for services. They are working under very difficult emotional circumstances but do not have professional or personal support. This suggests they are at high risk of “burn out”.
17. Given the information outlined previously in this report, any mental health or psychosocial support providers who work with traumatized clients need to have skills in interviewing appropriately to obtain correct differential diagnosis, an evidence-based approach to therapies, and clear referral and networking systems. They also will need to be aware of domestic violence issues. Any specialists

should make sure that they have/gain expertise in treating PTSD, depression, alcohol and drugs.

18. It is incumbent on those that now know of the IDPs circumstances in Georgia, including any readers of this report, to do what they can to alleviate the evolving and acute anxiety of those remaining inside the Buffer Zone as well as the complicated traumatic grief reactions that they and the displaced people living in the IDP settlements (or remaining in “collection centres” elsewhere in Georgia) continue to have.
19. Given the information gathered from some community members, teachers and health service providers and presented in this report, the following recommendations are made:
 - a) A three-level system is developed that incorporates those at people at the grass roots (Level 1), facilitates referrals to appropriately trained psychosocial support service providers (Level 2), who can then make referrals of difficult case to trauma specialists (Level 3) or be supervised in their treatment of patients by these specialists. Level 3 personnel will train Level 1 people as well as up-skill and provide professional practical supervision and support to the Level 2 service providers.
 - b) The grass-roots level naturally comprises school teachers and community members/workers. They are people who are living and working within the communities of people affected by the conflict and therefore closest to the problem. A number of representatives from these two groups need some “group-specific” (e.g., just for teachers) and some “in common” (e.g., for both groups together) education and basic skills in recognizing problems that might be trauma-related, in appropriate child management of those affected, and in basic relaxation techniques to help alleviate distress and some sleeping problems. In these ways, early detection and early referrals to psychosocial support professionals (level 2) is encouraged. In this regard, the Level 1 people could be seen as providers of basic “first aid” only for psychosocial problems.
 - c) Level 2 comprises two groups also. They are the relatively homogenous groups of medical professionals (doctors and some nurses) working in hospitals and polyclinics; and the more heterogeneous group of allied professionals comprising psychologists, psychiatrists, some local and international NGO workers, social workers, Phelsher nurses and some priests. These two groups very much need the trauma-assistance training and professional support that the service providers request. Georgia has now an influx of traumatized people and most professionals will not have been trained to deal with either the intensity of size of the problems. Training should comprise specific theoretical and practical training in evaluating mental health problems in those groups most likely to be psychologically affected by trauma

(children generally, special needs children, the aged, the poor, and those with mental health histories).

After training, these two groups, collectively, would become psychosocial support specialists (PSPs) who will have a better working knowledge of the effects of trauma and know what to do to help the sufferer. Some PSPs subsequently could be selected to form a Gori-based coordinated team focusing on trauma assistance (see below)

- d) It should be remembered that trauma can result in physical ailments (e.g., headaches, insomnia, blood pressure problems) that interlink with and/or signal psychological ones (e.g., intrusive thoughts and images, anxiety, depression, and acute stress). Hence, both medical and psycho-social professionals would need to have some joint understanding of this interaction and be able to use a relevant referral system accordingly.
- e) Training for both levels of service providers should be done by the same people. This maximizes the chances of agreements over diagnoses and supports needed to address these problems. Clearly, also, trainers need to have a good ability to teach, a specialized knowledge of trauma, and a thorough grounding in internationally accepted evidence-based assessment and cognitive-behavioral therapies because these currently are the most effective approaches.
- f) After the August conflict Georgia had a flurry of sponsored short workshops on trauma for a variety of professionals. Unfortunately, a number of these were too brief, irrelevant, and/or culturally-inappropriate. Teaching professionals to work effectively and ethically with emotionally vulnerable people requires both pass/fail written coursework and a series of supervised practicum sessions spread over a period of time.
- g) All groups may benefit from learning referral systems and a map of referral networks would be a useful adjunct to this. A coordinator/advisor would be necessary to achieve this.
- h) Access to trained service providers needs to be supported. The following model is suggested:
 - i) A Trauma Assistance Office (TAO) is set up in Gori for 12-18 months. Gori is relatively central to those professionals and trainees who would have to come from Tbilisi and the surrounding region. Initial training of selected PSPs, some initial assessment and therapy for some service beneficiaries, and coordination of supervision, referrals and mobile services could be done from there.

ii) Mobile teams of selected PSPs are needed to go regularly from that office to beneficiaries in both the Buffer Zone and the new IDP settlements. They need to be able also to liaise with other trained PSPs who continue to work in their particular professional field and in different regions.

iii) The TTEs also require mobility to run the trauma assistance training program for PSPs in Gori and also to provide weekly supervised practicum and monthly follow-up supervision, over a period of 9 months. They also would require access to facilities in the Buffer Zone and the IS to meet with and train the Teacher-groups and the Parent groups. This could be spread over a period of time to fit around training of professionals.

Finally, although these recommendations have been made, it is appropriate that the NGO representatives who are trying so hard to assist the victims of last year's conflict, wherever they might reside, should be consulted for their opinions on this report. They have the fortitude to forge excellent networks that are so necessary for any future program to succeed, they have extraordinary motivation to effect positive change and that should be applauded, and they consistently have done excellent work with few other people ever knowing about it.

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30th October 2009

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