

## Hearing the voices: mental health services in East Timor

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In September, 2002, at a remote mountain retreat in Maubisse, central East Timor, a mental health team gathered to reflect and distil lessons from their previous 3 years' experience. In postconflict countries, many such experiences are typically lost, and mistakes may be repeated.

East Timor, with a population of 800 000 people, lies to the east of the Indonesian archipelago. The territory was invaded by the Japanese during World War II and in 1975, after a brief period of independence and a short civil war, Indonesia invaded. A low-grade war of independence ensued for 24 years, during which the Indonesian military was accused of torture, extrajudicial killings, mass sterilisation of women, and forced displacement of villagers. Indonesia bowed to international pressure, allowing a referendum in East Timor in 1999 that strongly endorsed progress to full independence for the territory. After the vote, pro-Indonesian militia groups, supported by the military, mounted a concerted campaign of terror that destroyed 70% of the infrastructure and displaced 80% of the population of East Timor. An Australian peacekeeping force, followed by a UN contingent, secured peace and stability in the territory, and the United Nations Transitional Authority in East Timor was established to provide interim administration for East Timor, leading up to the country's full independence in May, 2002. 3 years after the humanitarian emergency, the emerging nation still has major difficulties, including underdeveloped infrastructure, widespread poverty, unemployment, poor health indicators, and limited health services.

Throughout the 1990s, mental health professionals in Australia provided support to East Timorese refugees living in exile. In 1999, following a request by the exiled East Timorese leadership, a consortium of agencies led by the Psychiatry Research and Teaching Unit, University of New

South Wales, formed PRADET (Psychosocial Recovery and Development in East Timor).

In a context where no mental health services had previously existed, the dilemma for PRADET was how to attend to three major objectives: to respond quickly to those people who were mentally ill and in the most urgent need, to promote general psychosocial recovery of the population as a whole, and to build the skills base of local workers in mental health. Attention to the suicidal, violent, or otherwise disabled mentally ill people contributed to the core humanitarian mission of supporting individuals and families who were least able to cope with the demands of survival.

At the outset, a group of mostly nurses was recruited and trained in an intensive programme in Sydney, Australia, who then returned to establish outreach clinics in and around Dili, the capital of East Timor. Mobile outreach teams later extended the work to the most disrupted communities in the west of the country. Meetings, pamphlets, and radio broadcasts aimed to normalise stress, destigmatise mental illness, and encourage community support for families affected by mental illness.

Close links with the emerging Ministry of Health, key non-governmental agencies, and other service providers were established to encourage coordination and to maintain the priority of mental health as an emerging service. Policies and procedures were implemented to ensure that patients with mental illness could be seen in designated clinics or at home. The mental health team reviewed cases daily and discussed the treatment plan for individual clients. Psychotropic drug procurement and distribution systems were set up, a wide range of

### Obstacles to learning in the humanitarian sector

- Tendency to approach every crisis as unique
- Action-oriented nature of the humanitarian ethos
- Prevailing lack of accountability
- Hierarchical "top-down" management and control that stifles innovation
- Poor information management
- Competition for profile and funds, encouraging agencies to highlight success stories and downplay problems
- Profound financial insecurity based on reliance by many agencies on short-term funding
- High rates of staff turnover, in part due to funding mechanisms
- Limited rewards for organisations that consciously invest in learning
- Absent documentation from which to learn
- Different people involved in each setting



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health workers were trained, and visiting psychiatrists and trainers from Australia and elsewhere provided additional support.

Systems were put in place within the team to share the patient load and run the emerging primary care health clinics after PRADET had trained their personnel. The absence of dedicated hospital beds for people who were mentally ill meant that some of those with the most severe illness had been imprisoned, so PRADET gave priority to establishing a consultation service to assist prison staff to manage incarcerated persons with identified mental health disorders.

The effect of mental health care on those disabled by mental illness was dramatic. One patient in a remote village had been chained up by his own family for 15 years because they were unable to cope with his psychotically motivated violent behaviour. He was released after 2 months of treatment by PRADET, including low-dose antipsychotic drugs and family education and support. After release and with ongoing treatment, the man could assist his family working in the rice fields. Such cases show how mental health treatment can support families to re-establish their stability in a highly volatile and unstable situation in which day-to-day struggles of survival can be further stressed by having to care for a member who is severely mentally ill.

A key issue raised at the Maubisse workshop was the extent to which ongoing uncertainty about the long-term future of mental health services, typical of postconflict settings in resource-poor countries, placed the staff of PRADET under considerable strain. Partly because of the uncertainty, key trainees were lost to the programme, although all went to other posts in the health system. At the same time, this uncertainty galvanised the team to advocate strongly for mental health, thereby promoting a sense of common purpose, and encouraging the organisation to develop strategies for managing change, a valuable experience for potential future managers of health services. At the workshop, staff particularly noted the team-building value of the daily PRADET meeting that focused on case presentations, but also provided a vehicle for developing a shared approach to problem solving, planning, and a forum for a sensitive critique of each others' practice.

Staff indicated that the success of this project has been a major factor in encouraging the new East Timorese government to reach an agreement with AusAID to fund a nationwide mental health programme over the next 3 years, to ensure that mental health continues to receive attention in that emerging nation.

The Maubisse workshop provided a safe and trusting environment in which PRADET staff were able to reflect not only on successes but also on shortcomings. The Timorese community routinely consults traditional practitioners for health problems, but the team had not determined how best to interact with these providers, although it now has plans to do so. Barriers to collaboration may include competitiveness between traditional and mainstream services, as well as the privileged

nature of spiritual knowledge, not revealed to outsiders. Another limitation identified by the team was that the reservoir of untreated severe mental illness uncovered by PRADET, particularly psychoses such as schizophrenia, meant that most of its resources were committed to treating this group, restricting the organisation's capacity to identify and assist those with severe trauma-related reactions. Unlike those with psychosis, people who are traumatised may suffer "quietly" and hence may not come to attention. Lastly, the team recognised that despite its commitment to develop research and evaluation as an integral part of its work, this



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**Amidst all the destruction in East Timor, shoots of green persevere**

component has proved difficult to implement given the nature of emergency funding, limited resources, and the compelling priority of delivering urgent services. The team concluded that future projects in postconflict countries should advocate strongly for rigorous evaluation to be a core component of donor-funded programmes, a strategy that will be crucial if the evidence base supporting the value of mental health initiatives in humanitarian emergencies is to be deepened and extended.

The Maubisse workshop provided the PRADET team with some time and space to commit to further reflection and writing about their experiences, providing the group with the capacity to draw on insights learned from the community and patients. By coordinating and extending the process of recording and debriefing, PRADET aims to leave as much as possible of the knowledge gained from the project behind—for their own families, their community, and for mental health workers worldwide. Bringing together shared experience, in a context of mutual support and critique, the motivation behind the Maubisse workshop, is a key first step in placing acquired insights into postconflict mental health services in the public domain.

We prepared this article as an output from the workshop in Maubisse, which was attended by ourselves, PRADET team members (Manuel Mausiri, Marce Soares, Jose Carlos de Oliveira, Florentino de Carvalho, Aristedes Soares, Teofilo Tilman, Antonia Maria, Joao Fernandez, Zulmira Fonseca Amiral, Deus Dado Martins, Tim Armstrong), and Solvig Ekblad and Cynthia Grant. PRADET is funded by AusAID, the Australian Government's overseas aid agency.