Preventive Psychiatry Implementation in the Management of Traumatized Palestinian

Introduction

Many of the early advances in medicine, contributing to the increases in life expectancy that occurred in the 19th century, were due to developments in prevention. These particularly involved the infectious diseases, with identification of the causes and prevention of some of them, such as control of the sources of infection for cholera, enhancement of host immunity in vaccination for smallpox; and general improvements in host resistance as nutrition improved.

More recently the importance of prevention has again been recognized. Epidemiological studies have pointed to major contributing factors to cancer, chest disease and heart disease, such as smoking, diet and lack of exercise. Considerable investment has been made in public health programmes to modify these. Screening programmes have been set up to detect disorder while it is early and treatable, such as those for cervical and breast cancer.

In many aspects psychiatric disorders are considered major public health problems.

But despite the fact that psychiatric disorder causes considerable personal disability and distress in families, psychiatry has tended to be slower in preventive developments and the approaches have been more tentative.

Primary prevention

Primary prevention efforts are those directed at reducing the incidence (rate of occurrence of new cases) in the community. Primary prevention efforts are directed at people who are essentially normal, but believed to be “at risk” from the development of a particular disorder.

These can respond to improvements in psychiatric services for care of the primary disorders. Beyond these specifics, social causative factors have implications for primary prevention.

Similarly it is easier to tackle precipitating factors where the link with onset of disorder is closer, rather than predisposing factors. Coping responses are more amenable to intervention than is removal of social stresses themselves, many of which are bound up with the inevitable consequences of the life cycle. What is not at present feasible in primary prevention is to change dramatically cultures or societal structures.

Secondary prevention

Involves efforts to reduce the prevalence of a disorder by reducing its duration. Thus secondary prevention programmes are directed at people who show early signs of disorder, and the goal is to shorten the duration of the disorder by early and prompt treatment.

The situation is similar but the opportunities greater in secondary prevention. The use of screening techniques is highly feasible with many of the common disorders in psychiatry, particularly depression, anxiety and other common symptoms seen after exposure to trauma e.g., nightmares, irritability, avoidance. When combined with interviewing to establish presence of disorders which exceed thresholds for clinical criteria, it is straightforward and

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merits wider adoption. When it involves
detection of subthreshold disorders, it
requires evaluation in controlled de-
signs, to determine whether detection
and intervention in early disorders is
justified in terms of benefit and cost.

Tertiary prevention
Is designed to reduce the severity and
disability associated with a particular
disorder.

Here the situation is different; as it is
already well established in psychiatry. It
involves not only prevention of disabil-
ity but also prevention of recurrence.
The value of prophylactic maintenance
drug treatment is well proven in affec-
tive disorders and schizophrenia, and
there is good evidence for the effects of
family intervention in high expressed
emotion schizophrenic families. The
place of behavioral and cognitive ap-
proaches in anxiety and PTSD is grow-
ing. Service-related local case registers
can be useful for identifying and moni-
toring vulnerable groups.

Difficulties
Attempts to apply prevention in psychi-
atriy have encountered a number of dif-
ficulties. For primary prevention a pre-
requisite is an adequate base of knowl-
dge of causes. In respect of psychiatric
disorders this is only partly available,
but there is now a substantial body of
knowledge, particularly concerning so-
cial aspects.

A key issue is that most psychiatric
causation is multi-factiorial. Single
causes, such as adverse early home en-
vIRONMENTS or recent life stresses may
contribute to many disorders. A single
disorder commonly appears to have
many contributing causes. For instance,
causes of depression range from genes
and effects of some amine-depleting
drugs, to psychosocial factors such as
bereavement, interpersonal losses, and
threats to self-esteem.

From the point of view of secondary
prevention, the boundaries between pre-
disorder and disorder are vague, since
both can only be detected by the pres-
ence of certain symptoms, and the same
symptoms, at a more severe level, define
disorder. This is really a semantic issue
and it applies also in other areas where
screening has been used. A more sub-
stantive question is whether detecting
and treating early disorder will prevent
the development of major disorders and
of prolonged disorders, and is a cost-
effective method of doing so. It might be
the case that early and mild disorders
most often have a good spontaneous
outcome. These are questions for empi-
rical testing. The evidence available sug-
gests that milder and neurotic disorders
do not generally proceed to psychoses
but are often prolonged, thus secondary
prevention can be helpful.

From the standpoint of tertiary pre-
vention, the major question is whether
this is to be regarded as prevention
rather than treatment. However, much
psychiatric disorder developing after
trauma are recurrent and have chronic
course; effective measures to eliminate
recurrence can have major effects in
reducing prevalence and do not neces-
sarily involve treatment of, or presence
of, any active symptoms.

Application of concepts in dealing with trauma
The human chaos of disasters is not
random. Rather traumas and disasters are
structured by the complex feelings,
thoughts and behaviors which are part of
every disaster and trauma. For most
individuals these feelings, thoughts and
behaviors are transitory. For some, they
linger long after the traumatic event has
passed, recalled in memory by new ex-
nperiences which serve as a reminder of
the past trauma.

Traumas and disasters affect thou-
thousands of Palestinians: victims, their
relatives, their friends, disaster work-
ers, and witnesses. Recently, there has
been a significant increase in number of
people affected directly by violence.
During this war like situation, which is
still ongoing, people have been trau-
matized in many ways. Traumatic ex-
periences range from being injured to
witnessing killings and injuries of rela-
tives and friends or loosing family
members or close friends. Many were
victims of home demolitions and de-
structions of farms including uproot-
ing of trees. The ongoing closure of the
Gaza Strip prevents thousands of fa-
thers from reaching their working
places and deprives their families of
their income. The unemployment rate
and the poverty are increasing daily.

Internal closures between the north
and the south of Gaza prevent people
even to move within the Gaza Strip.
This has also a serious effect on the
functioning of the schools, because
many teachers as well as students can
not reach their schools. Shooting from
helicopters, Jet fighters and tanks trau-
matizes thousands of people and
leaves them with anxiety.

The number of Palestinians killed at
the hands of the Israeli Army and set-
tiers is more than 2000, while the num-
ber of people injured is well above
30,000. When examined across differ-
ent regions, people living in areas near-
by settlements and near police stations
are at higher rates of exposure to trau-
matic incidences.

The psychological responses of indi-
viduals to trauma vary greatly. The
meaning of any traumatic event is a
complex interaction of the event itself
and the individual’s past, present, and
expected future as well as biological
givens and social context (Ursano, Full-
lerton, 1992). The meaning of the trau-
ma affects not only how the trauma is
experienced initially, but also the way
in which recovery occurs and life is
reestablished. Overall, most individuals
exposed to traumatic events and disas-
ters do quite well and do not suffer
prolonged psychiatric illnesses. But for
some, psychiatric illness, behavioral
change, or alterations in physical health
result. Certainly, no one goes through
profound life events unchanged.

The ability of communities to plan
for, and recover from, a disaster must be
the focus of a community’s leadership
and rescue services. If disaster plans do
not consider the psychological effects of
trauma, the consequences can over-
whelm all available services and re-
sources, exhausting rescue workers as
well as victims.

Defining traumatic events and disasters
A traumatic event is recognized by the
nature of the events, by the effects of the
trauma on individuals and groups, and
by the responses of individuals and
groups to the event. In general, trau-
matic events are dangerous, overwhelming,
and sudden (Figky, 1985). They are
marked by their extreme or sudden
force, typically causing fear, anxiety,
withdrawal, and avoidance. Traumatic events have high intensity, are unexpected, infrequent, and vary in duration from acute to chronic.

The traumatized nation in 
Gaza Strip—outlook
The Gaza Strip is described as an area of extreme, impenetrable complexity—geographic, demographic, economic, social, political, and legal. Geographically, it lies wedged between two larger, more powerful countries, Egypt and Israel both of which rolled over it in turn. Gaza strip is an area of highly traumatic experiences. For the last 54 years it has passed through many wars and political and economic instability. The experience of violence is pervasive among Palestinian living in the Gaza Strip.

The prevalence of direct and witnessed exposure rates amongst Palestinian children to tear gassing, physical injury and house searches, to name a few, by Israeli soldiers has been well documented in numerous reports (see Nixon, 1990; Graff, 1991; Abu Ham et al., 1993). Documentation of the health impact on these children as a result of that trauma exposure, particularly during the beginning of the Intifada had, until recently, been confined to its effect on their physical health. Less was understood about the emotional or psychological impact of living under conditions of military occupation and resistance to that occupation.

Palestinians in Gaza Strip are suffering from the harsh life conditions of the Gaza Strip, but more so during Alaqsa Intifada as they were shot, arrested, and exposed to tear gases, they had their homes shelled and demolished, their friends and relatives injured and even killed. During the last 2 years almost 2000 Palestinians were killed and 10’s of thousands were injured with 2500 were left with permanent disability. As a response Palestinians were themselves involved in violent attacks against the Israeli Army and civilians leading to 570 deaths and almost 5000 injuries. The Israeli Army in turn responded with more aggression generating more and more anger and frustration.

People on both sides were trapped in the vicious cycle of violence which still cultivates innocents on both sides (Fig. 1).

This violence has not only affected the social and political status of the Palestinian population but the psychological well being of a vast number of Palestinian people.

Information that was available on those psychological effects was collected mainly by mental health workers, psychologists and researchers who reported mostly descriptive accounts, case histories or narratives of children’s reaction to trauma exposure (Graff, 1991; Garbarino, 1991).

Standardized tests investigating cognitive function have also been conducted with the attempt to correlate change in performance with living under occupation (Baker and Arafat, 1990; Quta, Punamaki and El Sarraj, 1995).

More recently symptom-related behaviors have been observed. The general focus has been to determine rates of symptoms and behaviors of Palestinian children such as nightmares, fighting, bed wetting, fear and anxiety, to list a few. Attempts were made to relate these symptoms to various traumatic events or participation in the Intifada. For instance, Quta, Punamaki and Sarraj (1993) studied the psychological effects of collective punishment and home demolition on children in Gaza and found a positive correlation between exposure and neurotic symptoms, fighting, and fears.

In a separate study, they investigated in 108 children the relation between traumatic experiences and cognitive and emotional responses among children in Gaza (Quota et al., 1995). Among their findings they concluded that children exposed to a higher frequency of traumatic incidents showed increased psychological distress in the form of neurotic symptoms and greater risk taking.

In the past few years, researchers have begun to assess more formal diagnostic psychiatric outcomes like Post Traumatic Stress Disorder (PTSD). In adults, Khafis (1993) determined the rates of PTSD amongst a selected group of men who incurred serious physical injuries due to participation in the Intifada. She found a rate of PTSD of approximately 50% amongst the male population. Thabet and Vostanis (1999) have found that between 35-40% of children ages 6 to 11 in Gaza are suffering from moderate to severe levels of PTSD.

In the most recent research carried out by Gaza Community Mental Health Programme Research Department (Quota, 2001) in one highly affected area by shillings in the Southern Governate of Gaza Strip where 121 children aged 3-16 years of age were studied it was found that there was an increase in the rates of exposure to trauma, 99.2% of the group’s homes were bombarded, 97.5% were exposed to tear gas, 2.5% suffered from burns, 1.7% were hit by rubber bullets, 2.5% were hit on the head and were rendered unconscious, and 2.5% were prevented from reaching medical care.

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*Fig. 1*

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Mise en place de services de psychiatrie préventive destinés à des Palestiniens traumatisés

Résumé La psychiatrie préventive en rapport avec les traumatismes subis par les habitants de la bande de Gaza s'intéresse à la réduction des événements traumatisants, de la durée des symptômes et de l'importance de la souffrance individuelle. La crise et la terreur au quotidien font que les difficultés deviennent chroniques et que les patients sont traumatisés. La violence directe touche maintenant plus de personnes qu'avant. A ceci s'ajoutent des problèmes sociaux comme la pauvreté et le chômage.

Une distinction est effectuée entre le traumatisme subi par l'individu et celui qui est subi par la nation. Les enfants surtout sont constamment soumis à des vécus traumatisants. L'auteur a examiné en détail leurs réactions, ainsi que les effets tragiques des traumatismes au niveau psychologique et social.

Plusieurs approches sont mises en évidence, qui permettent de pratiquer la prévention et d'offrir un soutien dans le domaine social et personnel/familial. Dans ce contexte, l'auteur pose la question de savoir si le psychiatre, le psychothérapeute, le travailleur social devraient s'exprimer en public – dans les médias et dans la société – sur les interconnexions entre traumatismes, vie sociale, pression politique et utilisation de la violence. Il considère comme important qu'ils contribuent à ce que les individus soient moins stigmatisés et stigmatisent moins autrui.

Also there was an increase in the rate of exposure to trauma as a result of witnessing it: 96.6% of the children witnessed shootings, 51.7% saw injured or dead who were not relatives, 35.1% saw their neighbors injured or killed, 22.9% saw family members injured or killed, and 95.8% witnessed bombardment and funerals. The increase in exposure to trauma led to an increase in the rate of PTSD symptoms:

- 54.6% of the children started to develop severe PTSD symptoms
- 34.5% of the children started to develop moderate PTSD symptoms
- 9.2% of the children started to develop mild PTSD symptoms

In addition to the increase in PTSD symptoms, it was discovered that 13.3% of children are suffering from a sharp increase in mental and behavioral problems such as sleep disorders, hyperactivity, speech disorders, lack of concentration, and aggressive behavior.

It became clear that the effects of trauma involved every Palestinian in the Gaza Strip mandating large-scale interventions to overcome both the short-term and long-term consequences of trauma.

This was clearly due to the continuous exposure to violence and traumatizing incidents after the outbreak of Al Aqsa Intifada in September 2000 in response to these incidents the Gaza Community Mental Health Programme decided early in-Nov 2000 to establish a Special Committee on the Place of Crisis Intervention. The broad aim of the program was to counteract the effects of acute traumas on the Palestinian population. As part of its activities the committee commissioned activities covering the primary, secondary, and tertiary prevention levels.

Implementation to mental health of traumatized Palestinians

A pleasing issue is that the general principles of prevention as formulated in other health areas apply equally to psychiatry despite, as yet, incomplete knowledge about the etiology of many disorders. As psychiatric disorders may have multiple causal pathways, direct approaches to prevention of causes are likely to have diffused effects across several disorders, but such efforts are nevertheless worthwhile.

It has been argued that, while this model of prevention is quite useful where specific diseases or other causal factors are easily identifiable, it is less helpful in the field of mental health where precise definitions and specific disease entities with known etiologies are the exception rather than the rule. However, these arguments would only seem to hold up in relation to primary prevention; they do not mitigate any more against secondary and tertiary prevention than in physical medicine.

In the case of dealing with trauma, the cause is clear but can it be preventable?

Primary prevention encompasses activities which are directed towards specifically identified vulnerable high risk groups in the community who have not been labeled psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or enhance their level of positive mental health. Thus, prevention, by this definition, is directed at specific targets rather as well as the whole population. Thus it would include indicated and possibly selective measures and certainly universal measures.

One of the major challenges to our activities was targeting. In order to clarify the issues surrounding targeting it is necessary here to introduce two further definitions (Gordon, 1983).

Universal prevention Activities are those which are regarded as desirable for everyone, and the decision to implement them is taken if their benefits clearly outweigh the costs and risks of implementing them. These include activities that are directed to the general public regardless of the amount of trauma they have been exposed to. These activities included public awareness activities directed through mass media-live TV programs addressing psychological sufferings commonly seen at times of war and ways of handling them both with adults and with children. Topics that were covered here included:

- Sleep disorders after Trauma exposure
- Enuresis as a reaction to trauma
- Overcoming Stress
- Somatic symptoms seen after crisis

In addition to that public awareness publications were distributed through the whole Gaza strip-these publications included brochures against the stigma encouraging people to consult the mental health professional when necessary, others were directed to educate people to handle different symptoms seen in childhood.

In addition training courses were carried out to school counselors, teachers and volunteers about stress handling.
and dealing with children under difficult circumstances.

Micro vs. macro proactive primary prevention

There are different levels of intervention, especially in relation to proactive primary prevention, which can be classified on a continuum ranging from micro to macro, which Catalano and Dooley (1980) have condensed into two broad categories of the macro-environment (social and large organizational conditions) and the microenvironment (family and individual characteristics).

At the microlevel, proactive prevention might take the form of education about parenting to reduce the occurrence post-traumatic reactions after exposure to trauma which is done during home visits.

At the macrolevel, proactive prevention involves media education to enhance good child rearing practices and support from society to victims.

In general, people have been optimistic about microlevel prevention at the family level, but have avoided thinking about macrolevel prevention. This has arisen because conditions such as unemployment, political violence, poverty and so forth are not always regarded as within the purview of mental health, and Palestinian psychiatry has tried to learn from the lessons of the 1960s and '70s when some psychiatrists went far beyond their areas of expertise to treat the community as the patient. Also, such considerations may sometimes involve sufficiently controversial social values that it is deemed politically wise to avoid them.

Selective prevention measures are deemed to be appropriate when an individual is a member of a subgroup of the population whose risk of becoming ill is above normal.

"Indicated" measures for groups at sufficiently high risk, for groups who have experienced severe, clearly defined emotional stress (e.g. children exposed to disasters or to violence, families of martyrs, injured people, people living near shelled centers etc.).

For these people primary prevention measures are carried out which include family education, and relaxation training.

But most of selective measures are considered as secondary prevention.

The debate about secondary and tertiary prevention has focused on whether they qualify as "prevention" proper at all, rather than simply aspects of good clinical practice (e.g. Bower, 1987; Newton, 1980). (Indeed this viewpoint illustrates how little doubt there is of the effectiveness of secondary and tertiary prevention.) My opinion is that they do qualify as prevention simply because they do prevent something. Secondary prevention shortens the duration of illness, and hence prevents chronic morbidity and even mortality, as well as preventing some of the knock-on consequences of depression to other people, e.g. to children and spouses.

At this level many early intervention activities have been carried out. These activities include home visits to areas exposed to shelling, demolition or infiltration as well as families of martyrs and injured people.

During these visits debriefing as well as psychoeducation are carried out. These are to some extent are screening visits as cases needing prolonged interventions are discovered and referred to the clinic.

Risk factors for development of acute stress disorder and posttraumatic stress disorder include

They are considered as main target aimed for intervention

- Persons who lost a loved one
- Individuals who suffered injury
- Persons who witnessed horrendous images
- Persons who had dissociation at the time of the event

- Those who experience serious depressive symptoms within a week and lasting for a month or more
- Individuals with numbing, depersonalization, sense of reliving the trauma, and motor restlessness after the event
- Those with preexisting psychiatric problems
- Persons with prior trauma
- Loss of home or community
- Extended exposure to danger
- Toxic exposure
- Individuals with a lack of social supports or whose social supports were also traumatized and are unable to be adequately emotionally available

Signs the patient needs help

- Task-oriented activities are not being performed.
- Task-oriented activity is not goal-directed, organized, or effective.
- The survivor is overwhelmed by emotion most of the time.
- Emotions cannot be modulated when necessary.
- The survivor inappropriately blames himself or herself, and the self-blame generalizes to the entire self.
- The survivor is isolated and avoids the company of others.

Another intervention on the secondary level is hospital visits; here victims exposed to injuries are seen and debriefed. Also screening is done for cases needing further intervention.

These activities are carried out 48 hours after the incident as debriefing is mandated at this period.

Apart from the immediate intervention activities, the trauma counseling program of GCMHP does School Based Interventions or Short Term Interventions, here the team members make visits to schools known to be in an area affected by any form of violence. The intervention then will take 3 steps:

Step 1: Coordination and needs assessment are done
Step 2: Teachers are given a lecture concerning detection and handling Traumatized Children.
Step 3: Brief school session is carried out as follows:

Brief school intervention

Intervention lasts 1–2 hours and uses 4 therapists per class. Teacher is present, and parents are informed.
- Introduce the therapists and ask students to guess why they have come to the classroom.
- Explain that therapists have come to talk about the disaster and encourage students to share what they know for 10–30 minutes; validate correct information; be calm.
- Have children draw, while therapists circulate and ask students to tell them about their drawings.
- Reassure students that their symptoms are normal and will ease, that people have different symptoms, that disasters are rare, and that teachers, parents, and counselors are available to help them.
- Thank the students and teachers and redirect their attention to learning.

Tertiary prevention minimizes handicap and disability and thus prevents many of the associated sequelae of chronic illness.

Here we deal with cases that already established disorder and in need of prolonged intervention. Mostly these cases are referred to the clinic and long-term psychotherapy and medications are indicated here.

This intervention can also be considered as secondary as it prevents the complications of PTSD.

Cognitive behavior therapy

Individuals are aided by the following:
- Seeing that people are concerned about them
- Learning about the range of normal responses to trauma and hearing that their emotional reactions are normal responses to an abnormal event (rather than a sign of weakness or pathology)
- Being reminded to take care of concrete needs (food, fluids, rest)
- Cognitive restructuring (changing destructive schema, such as "having fun is a betrayal of the injured," "the world is totally unsafe," "I am responsible for the disaster," or "life is without meaning," to more constructive ones)
- Learning relaxation techniques
- Undergoing exposure to avoided situations either via guided imagery and imagination or in vivo

Severe, relatively common destructive cognitions may arise after a traumatic event and need to be addressed. On the left side of the table are malignant schema that an individual may have after a traumatic event. On the right side are more constructive schema that a clinician can suggest the individual consider (Table 1).

In addition to that medications can be sometimes mandated to overcome the symptoms of arousal, such as propranolol, benzodiazepines, and alpha-agonists, and may reduce the future development of PTSD. Diphenhydramine may be helpful for sleep. If these agents are inadequate, valproic acid may be useful. Atypical antipsychotics may also be necessary.

- Propranolol: May limit hyperarousal and thereby perhaps decrease possibility of PTSD developing.
- SSRIs: SSRIs can be helpful in dealing with anxiety, depression, and avoidance.
- Benzodiazepines: May limit hyperarousal and perhaps decrease possibility of PTSD developing. Continuous administration may interfere with grieving and readaptation, because they interfere with learning. Longer acting agents are particularly beneficial when medication is administered at the emergency site.
- Antihistamines: No controlled studies are available to evaluate efficacy in separation anxiety disorder; however, possible adverse effects include a decrease in sleep latency and awakenings in mid sleep.

A multidisciplinary approach

In all fields of medicine preventive activities involve a wider framework than simply those who undertake treatment, and include workers in the fields of public health, education, public policy and the political arena. In psychiatry, prevention also involves those in the social and psychological disciplines. Psychiatrists can make useful contributions in care and aftercare of patients so as to avoid subsequent consequences such as disability, recurrence and suicide, in the management of mentally disordered offenders and potential offenders, and in the education of others. The other members of the multidisciplinary psychiatric team, including psychologists, psychiatric nurses and community psychiatric nurses are also of crucial importance in applying preventive strategies.

There is a need for education of school counselors, postgraduate education of psychiatrists, general practitioners, teachers and other mental health workers, other kinds of staff members in appropriate settings, and the general public. Some of these aspects are within professional education; some are aspects of health education to the general public. Education of the public is needed about mental disorder, availability of local treatment facilities, and facts to lessen stigma. In respect of some other educational activities aimed at developing more mentally healthy life styles, coping mechanisms, and positive mental health, caution and evaluation as to real benefits are required.

Preventing the risk factor and improving the coping response: a distinction

Catalano and Dooley (1980) have distinguished, within primary prevention,
between preventing the occurrence of the risk factor and improving the coping response triggered by stressors. The first strategy assumes that it is possible to control or prevent the occurrence of the causal agent while the second strategy assumes that the agent, is unavoidable, can be resisted. They cite the Public health examples of eliminating breeding grounds of malaria-carrying mosquitoes as preventing occurrence of the risk factor, and vaccinating for Polio and smallpox as improving the coping response triggered by stressors, and they have termed the first approach "proactive primary prevention" and the second "reactive primary prevention". Reactive primary prevention can occur before or after the stressor, but is aimed at preparing the individual to react effectively to the stressor. In contrast proactive primary prevention attempts to avoid the stressor altogether (Fig. 2).

Strategies based on life event and social support theory

Important factors attenuating the effects of stress include the availability of social support or a helping social network for people undergoing life stressors, and social competence or coping ability and style. Both factors lend themselves to the development of preventive strategies.

Developing natural support systems

Facilitating the development of natural support systems in the community relies on the evidence that social supports act as a buffer protecting individuals from the effects of external stressors (Cassel, 1973; Caplan, 1974; Bloom, 1979). These strategies may be further categorized:

a) Supporting existing providing consultative services to natural support systems
b) Creating a new but natural support system. E.g. self-help groups
c) Educating carers. The knowledge and skills of professional and non professional carers can be improved so that they will be more effective in the future (Caplan, 1970).
d) Organizational consultation. This aims to create more responsive organizations. This is based on the premise that schools, social services and other key organizations have a profound effect on attitudes and behavior, and are not neutral in their influence (Maclellan et al., 1975).
e) Development of alliances. Coalition building aims to develop community networks to bring together the relevant agencies, and also to increase the community's involvement in health issues. The community may then start to develop on advocacy role as well, arguing for more resources, lobbying for support and so forth.

f) Mental health education. This is aimed at several different levels. Mental health education seeks to inform the general public about mental health problems and about available treatment and health promoting resources.

It is particularly important to reduce stigma, and here, school and the media have an important role; it aims to develop important competencies within normal and at risk groups, in order to improve the capacity to cope both with predictable life transitions and with less predictable stresses. The premise is that disorders can be avoided by strengthening an individual's or group's capacity to handle environmental stress or life issues (Covens, 1977); it can be used to increase the knowledge and skills of both patients and their relatives; and can be specifically targeted by providing important information to people a community who are in key positions to affect lives of others - formal and informal, such as clergy, teachers, employers and doctors. Lastly, it is important to influence public policies which affect the mental health and well-being of individuals and groups in the community. Keeping policy makers informed about mental health issues and sensitive to the effects of service programmes on human lives, and developing position pape on key policy issues, are among the strategies open to health promotion professionals who wish to influence the public policy process.

References