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Report on IRCT Fact Finding Mission to Georgia August 28 – September 3, 2008

1. Agenda:

A. Meetings and talks with the following organizations and people:

- Rusudan Beriashvili MD PhD, Associate Professor of Forensic Medicine, Tbilisi State Medical University
- Levan Labauri MD, Assistant Professor, Senior Officer of the Quality Assurance Department, Tblisi State Medical University, General Secretary of the Georgian Medical Association
- Lela Tsishkarishvili, Psychologist, Executive Director of the Georgian Center for Psychosocial and Medical Rehabilitation of Torture Victims (GCRT) and Staff
- Mariam Jishkariani MD, Psychiatrist, Director of Rehabilitation Centre for Victims of Torture „Empathy“and Staff
- Otar Toidze MD, Neurologist, Chairman of the Committee on Health and Social Affairs of the Parliament of Georgia
- Archil Talakvadze, Adviser to the Public Defender, and Sopho Benashvili, Lawyer, Office of Public Defender (Ombudsman) of Georgia
- Nino Makashvili MD, Psychiatrist, Director, and Jana Javakhishvili, Psychologist, Project Manager, Global Initiative on Psychiatry (GIP), Regional Center Tblisi
- Nana Agapishvili, Child Psychologist, Executive Director, Georgian Association for Psychosocial Aid „NDOBA“
- Dr. Rita Richter, Senior Program Officer, and Christoph Bierwirth, Chief of Protection, United Nations High Commissioner for Refugees (UNHCR) Tbilisi
- Richard Munz MD, German Red Cross, member of the International Committee of the Red Cross (ICRC) Task Force in the buffer zone along the border to South Ossetia

- Volunteers working in refugee camps
- UNHCR staff in refugee camps
- Teachers and School Directors in schools, which serve as refugee camps
- Local government officials in charge of refugee camps

- Municipal Nurses and Social Workers in charge of refugee camps
- General Practitioners, Primary Care Doctors in charge of refugee camps

B. Visits to Refugee Camps:

- UNCHR tent camp in Gori
- Refugee camp in School in Rustavi near Tbilisi
- Refugee camp in College of Economics and Law in Muchiani near Tbilisi
- Coordination group for Gori refugees meeting in school no. 3 in Gori, chaired by Otar Toidze

C. Interview with two local radio reporters in Gori on purpose of IRCT fact finding mission

2. Effects of the War on the Civilian Population

(Estimated figures at the time of the mission)

Estimates speak of 500 dead civilians, 34 disappeared minors, 116 unaccompanied minors.

120.000 internally displaced persons (IDPs) from destroyed villages in South Ossetia and the buffer zone and from other Russian occupied territories were settled in and around Tbilisi in about 750 collective centers in schools, colleges, kindergardens etc.

After the armistice and the partial withdrawal of Russian troups about 30.000 were able to return to their homes. The government is planning to move most of the refugees out of the Tbilisi area to the town of Gori, where the UNHCR and the Italian Red Cross have set up a tent camp for several thousand people. However this plan does not seem to work out, because the refugees prefer to remain in and around Tbilisi, and because tent camps are unknown and unfamiliar to Georgians and were never used in the previous armed conflicts.

From the Abchasian war in the early 90ies there are still 300.000 „old“ IDPs, some of whom live in very poor conditions. They seem to have been abandoned by the government. Some seem to have a good supportive network by relatives. The „new“ IDPs do not have this network.

Some of the old refugees were affected by the recent war which reawakened the previous war trauma.

3. Main Problems in refugee camps

- Lack of coordination between government agencies, UNCHR and NGOs.
- Unequal distribution of aid (food, beds, blankets, cloths)
- Lack of information. Many families were separated – some elderly and sick people could not escape and were left in the occupied territories. Nobodys knows about their fate. Refugees are not told by the authorities how long they will stay in camps (schools are opening Oct. 1st, and many of camps located in schools have already been emptied by now), wether they shall ever be able to return home. They are not informed where they can get assistance.
- Poor sanitary conditions in some camps

- Tension between IDPs from recent conflict and IDPs from the Abchasian war in 1991. The latter have been living in camps for the past 17 years in very poor conditions and have been abandoned by the government. IDPs of both groups sometimes are put side by side.
- Primary medical care – which government promised to provide for each camp – is only partially available and not well coordinated between government agencies and NGOs
- Social assistance and psychological support, which are badly needed and explicitly demanded by most refugees are scarce.
- Some psychiatrists and GP treat refugees with signs of acute stress reactions with neuroleptics and tranquillizers because they misdiagnose them as psychotic.

4. Assessment of refugee trauma

This Assessemnt summarizes on site visits to refugee camps, listening to refugees being interviewed by caregivers, of talking to caregivers, politicians and NGO staff from the above mentioned organizations. Important data were integrated from the results of „Mental Health and Psychosocial Rapid Assessments of Georgian IDPs in Tbilisi“ by International Medical Corps and GCRT, August 22, 2008 and from written assessments, which were sent to me after the mission by the directors of GIP and GCRT. Supplementary information was collected from the daily updated website of UNHCR http://relief.migration.ge

4.1. Specific traumatizing factors during the war

Bombings occurred of Georgian villages in South Ossetia and „surgical“ bombing of military targets and civilian infrastructure (bridges, railway, pipelines) all over Georgia particularly in Tbilisi, Poti and Gori. The town of Zkinwali was heavily destroyed by Georgian airforce and artillery at the beginning of the conflict. In South Ossetia abuses were committed by South Ossetian militias and armed gangs roaming the villages after the occupation by Russian troups. Abuses included killings, beatings, humiliations, being robbed of property and personal items, deliberate destruction of houses, fields, cutting and burning of trees and forests. Some villagers were taken hostage, they were held in provisional prisons under very bad conditions, beaten and abused. Some of the hostages report that the ICRC „saved“ them, because after their visit conditions got better and they let them use their mobile phones to contact their relatives. The farmers from the villages suffer badly from having lost their house, ground, orchards, fields and cattle. A number of IDPs from South Ossetia are two-time refugees, many of them have lived for years in an environment of low key armed conflict and constant threat. Children resp. adolescents who have lived through both wars and displacements are especially affected. None of the IDPs know when and if they will be able to return home. Those from the inner parts of South Ossetia assume they will never be able to return. There is also great uncertainty for how long they will stay in provisional camps („collective centers“) in schools, kindergardens etc. and/or if they will be moved elsewhere by the government.

There are reports of rapes – however not systematic on a mass scale - which various international NGOs and the Ombudsman of Georgia are in the process of investigating.
The most vulnerable prove to be old people - particularly old men - children and adolescents.

GMA General Secretary Dr. Levan Labauri reports that the GMA is working hard to help rebuilding a medical infrastructure in the destroyed parts of the country. He says that during the war two hospitals (military and civil) and an ambulance station in Gori were bombed with four doctors and one nurse killed and one physician and ten nurses wounded. When doctors in white coats later tried to return to their destroyed hospital Russian air force appeared and shot at them. Ten were wounded, two of them severely. One doctor's kidney had to be removed. An unexploded mine was found in one hospital. The GMA sent these informations to the World Medical Association, who contacted the Russian Medical Society but got no reply.

4.2. Situation in the Buffer Zone along the South Ossetian Border and inside South Ossetia

From Archil Talakvadze, Adviser to the Public Defender and Dr. Munz, ICRC, I got some first hand information about this area, to whom Georgian and other NGOs have no access. Mr. Talakvadze unofficially travelled to South Ossetia and talked to people. He shows me fotos he has taken from the destroyed villages and reports, that the villages are deserted except for a few remaining old people, who are completely helpless and hide because they are afraid of further looting by Ossetian militias. The only ones that provide some help and protection are the priests.

Dr. Munz every morning drives with a mobile ICRC ambulance staffed with Georgian doctors and nurses into the buffer zone and returns at night. The villages in the South have been looted but not completely destroyed. The further North one gets the more villages have been affected by the war, burnt down and now are completely deserted. They try to provide basic medical care, do tracing service to reconnect dispersed families. When they arrive the villages seem empty, but when they see the Red Cross vehicles people come out of their hiding places and meet for the first among eacht other and exchange information. There is no electricity, people can't communicate to the outside world. So ICRC staff lets people charge their mobile phones or lends them theirs. It is the first opportunity to talk to their relatives in IDP camps. Dr. Munz reports people are deeply depressed and the opportunity to contact their relatives and only talk to a Georgian nurse or doctor for a couple of minutes is a kind of relief for them. He witnesses how this has some therapeutic effect and enhances peoples coping strategies. The Russian soldiers at the checkpoints allow private Georgian citizens to enter the buffer zone. In the long run Dr. Munz thinks, people may be able to return to the villages in the buffer zone and rebuild them.

4.3. Observed post traumatic reactions in the refugee population

From August 10-21 GCRT held focus group discussions with IDPs from two collective centers. The groups of 7-8 participants each included members of a South Ossetian NGO (Georgian and Ossetian Women for Peace and Progress), GPs, farmers, social workers, teachers, housewifes and the director of a kindergarden.

Their observations (including my own): Extreme stress related to hopelessness and helplessness, depression, anxiety, increase in alcohol abuse and aggressiveness. Among children fear, depression, lethargy or hyperactivity are reported as well as regressive behavior like bedwetting and thumb sucking. Many children have nightmares, others lost their appetite.

Also from August 10-21 three medical doctors with mental health training from GCRT carried out 240 medical consultations in three collective centers and completed a short survey of each patient designed to assess their mental health and psychological well being. The survey tool was adopted from the National Center for PTSD's Field Operations Guide, which was designed to rapidly assess behavioral, emotional, physical aand cognitive problems among populations exposed to disaster, displacement or other stressful events.

The patient interviews revealed similar results like the focus groups. The psychosocial well-being of IDPs assessed is under significant strain, with the majority of respondents – 53 % - experiencing acute grief reactions (126 of 240) and – 74 % - anxiety (177 of 240). 79 % (189of 240) reported sleep difficulties, 60 % (144 of 240) despair/hopelessness, 47 % (112 of 240) worsening health conditions and 16 % (38 of 240) extreme disorientation. On the average each respondent faced nearly 10 emotional, behavioral, physical and cognitive problems.
It should however be mentioned that the rapid assessment was carried out right in the aftermath of the crisis and the rate of disturbances over time will naturally decrease.

Empathy with its team of surgeons, forensic physicians, psychiatrists and psychologist in cooperation with the Georgian Medical Association (GMA) has been assessing numerous victims of bombings (including victims of cluster bombs). I was shown an impressive large collection of foto documents of heavily injured patients treated in hospitals for burns, head trauma, fractures and polytrauma etc. Empathy also created a mobile intervention team staffed with 27 people working in five refugee camps (in kindergardens and schools) as well as in 6 hospitals. They have a 24 hour hotline with a doctor on duty. Between August 11 and 24 they have fully examined 212 persons. Based on the evaluations of standardized PTSD scales they found a PTSD rate in this sample of 73,9 %. They also submit reports to the Ministry of Refugees. Empathy's treatment approach is exposure therapy and relaxation according to Foa, Riggs and Davidson.

For illustration some case examples from my own observations during visits to refugee camps are presented:

1. In a refugee camp in a school a mother asks the visiting psychosocial support team to speak to her 18 year old son, who they say is severly disturbed after having been humiliated and robbed by militia men, scaring him by shooting around his feet. He suffers from sweat, tachycardia, fits of trembling, nightmares and sleeplessness. He is apathetic and feels no joy in life. During the interview he appears deranged, intimidated, suspicious, speaks with a low voice with his head down. The consulting psychiatrist does some psychoeducation with him and his mother and arranges for regular appointments with a psychotherapist.

2. A psychosocial support team is called to a refugee camp in a gym to a 65 year old man, who together with his cousin had witnessed his 60 year old brother being hit by a cluster bomb. The brother's skull had been cut open by a shrapnel with his brain protruding and blood flowing down his throat. The men were hiding in the forest, could not get any first aid or an ambulance and had to helplessly stand by for four hours to see the brother dying a long and painful death. The 65 old man now suffers from an acute stress reaction with mutism, panic attacks and hallucinations. However a psychiatrist had diagnosed this as an acute psychosis and given him neuroleptics. The psychosocial support team on its first visit provides psychoeducation and support

to the cousin (who was in a somewhat better condition) and gives the client some herbal tranquillizers.

3. In a refugee camp in a school the GP in the psychosocial support team is called to examine a 75 year old farmer from a village, who for days has been lying apathetically in his bed with a fever. It turns out that he is severely depressed because he had to leave his sick wife behind in the village. The GP diagnoses hypertension and gives him antihypertensive and antidepressant medication.

4. A social worker of an NGO is running a children's play group in a refugee camp aimed at helping the children to overcome the traumatic experience and foster their personal growth. The social together with the NGOs psychologist and psychiatrist arranges a meeting with the mothers to discuss the children's problems. A group of 16 women, mothers, aunts and grandmothers gathers. They report that the children are not like they used to be. They have sleeping problems, wake up from nightmares of shooting and bombs, and are constantly on the alert. They generally have lost interest in things, lost basic trust, do not believe that things will settle down, think that the war will continue and they are too afraid to ask questions about the future. They refuse to go to school in the new environment. During the invasion of their villages some recorded Russian tanks and soldiers with their mobile phones and now they disseminate and exchange these video-clips among each other and watch them over and over again. They play war games all the time, Ossetians and Russians against Georgians and also Americans. They clash with the children of a nearby Abchasian IDP camp. Along with tales about their children the women spill over with stories of their own war-experiences with bombings, destructions of their houses, witnessing atrocities, relatives and neighbours including very old people being beaten and killed, running for their lives.

5. In the Gori tent camp, a woman sits crying among a crowd of about 15 people with her 7 year old daughter on her lap clinging feafully to her mother. The woman tells the psychologist from the psychosocial team that her husband and brother in law went back to their village in South Ossetia by car on a clandestine trip to explore the situation, the degree of destruction, who has been left behind etc. She fears for their lives. The psychologist just listens and says a few calming words.

6. The psychosocial team is called by the administrator of a refugee camp in a school to look after a disturbed 37 year old man. They find the man crying, with an empty gaze, very suspicious of people, afraid to go to sleep, because something may happen to him. He has blood in his urin. It turns out that he was held hostage by South Ossetian Militia. He together with 11 people was kept in a 2 m2 facility, they were severly beaten every day. He was forced to bury several dozens of rotting dead bodies of Georgian soldiers. He had a small business selling vegetable and fruit from the local farmers. They give him herbal tranquilizers. When they return the next day, he is surprised and grateful to see them again. He says he feels relieved after talking to them and is now making plans how to open a new business.

It is noteworthy that there is considerable resilience among those refugees who happen to be in the camp with people from the same village or with their extended family. Often the women in these communities are the key persons in providing stability and mutual support.

5. Situation of caregivers

The number of psychiatrists, psychologists, social workers and volunteers working in the large refugee population is very small. Many of the caregivers I met were themselves more or less directly affected by the war, by experiencing bombings, being cut off from relatives in armed conflict and occupied areas (e.g. young mothers being cut off from their infants staying with grandparents in these zones), locked in for several weeks in Western Georgia, where some were on vacation when the war started, while Russian troops blocked the main road connecting East and West Georgia. Everybody in Georgia goes on vacation in the beginning of August and many workplaces are closed down. All those caregivers who were were not locked in broke off their vacation immediately and started working. Their work ethic is admirable and the workload is extreme, they have been working day and night without interruption since the beginning of the war. In such an emergency situation they mobilize enormous energy and personal ressources and so far most of them have managed to function pretty well on the surface. However they will not be able to sustain for long and some already report signs of burnout. The war took their vacation from them and after things have calmed down they are now taking short vacations in shifts.

I was impressed about the high degree of professionalism of the Georgian psychosocial and human rights teams and their specific approach. While I accompanied various teams (GIP, GCRT, Ombudsman, NDOBA) to the refugee camps I saw them working in a very modest, low key and non-intrusive style, explain who they are, offer practical help such as organizing supply with missing material items such as mattresses, blankets, let the refugees make phone calls from their mobiles to communicate with relatives etc. Some teams have a GP with them who serves as the first contact person, which is of vital importance because people traditionally have trust in doctors and many refugees present physical complaints behind which psychological problems may linger. The interventions of the psychosocial teams follow the model of the „watchful waiting concept“ (according to the National Institute for Health and Clinical Excellence – NICE/ UK – guidelines for the management of PTSD, **www.nice.org.uk/cg026quickrefguide**), which for them means not actively talking people into treatment, but doing psychoeducation and modestly offering them the opportunity to seek help if needed. They see their main role in observing and monitoring the camp population, looking out for persons at risk, the most vulnerable such as children, adolescents and the elderly, as well as potential triggers and additional traumatizing conditions in the camps. The GCRT and GIP teams explicitly criticize approaches of other (including foreign) professionals who screen large numbers of refugees with a set of PTSD questionnaires to then find rates up to 70-80 % of PTSD among the population. This, they say contradicts figures from other desasters and the confirmed notion, that PTSD symptoms do not appear immediately after a trauma but only after several weeks and that the average PTSD rate then is only about 25 %.

My partners say their experience from the previous war tells them that the refugees in this immediate post-disaster period are still in the heroic phase. They are full of energy, there is a strong bonding and spirit of community, they want to cope, to help each other. However they expect that this will change over time, there will be more frustration, anger and increasing conflicts within the refugee community.

6. Coordination among relief organizations, local NGOs and government

Officially the UNHCR is in charge of coordinating the relief work. UNCHR organizes daily task force meetings with Red Cross Societies, Care, World Vision and other relief organizations. This coordination seems to be pretty well organized and efficient.
Rita Richter, UNHCR Tbilisi, says that UNHCR has worked out an IDP action plan together with the government. An amendment was passed shortly before the war to integrate the old IPDs into Georgian society, providing permanent housing, land and job creating programs. The problem with UN funds for the action plan is that Georgia is a small player in the allocation of refugee funds compared to countries with large numbers of refugees like Sudan and Afghanistan. She sees the tent camp in Gori, which was not planned at all, only as a very temporary solution because accomodating refugees in tents is something unknown and alien to Georgian culture. UNCHR wants to focus on special programs for youth (sports, clubs) housing and income generating and vocational training projects, where they can build on good experiences in the past with the Chechnyan refugees in the Pankisi valley. In the long run they want also to focus on community building and a dialogue with the aim of reconciling the hostile ethnicities, Ossetians and Georgians.

Mrs. Richter and Christoph Bierwirth, UNHCR chief of protection see a big need for psychosocial care of the refugees. Among the old refugee population they see problems of extreme lethargy and inactivity, among the new IPDs they see the hostages as a high risk group in need of mental health care. They doubt the government's confirmation that all health needs of refugees are covered. To their knowledge the GPs in the camps are not trained and capable of dealing with mental health problems. They have been successfully cooperating in the past with GCRT in providing services for the Chechnyan refugees in the Pankisi valley and they intend to repeat this cooperation now with the new IDPs. They see chances to acquire funds for this work from EU, US AID, UNICEF and UNIFAM (Gender related projects).

According to my sources the Georgian government claims it provides primary health care in all refugee camps. However this does not always seem to be the case. There is a list of doctors for the various camps, but in reality in many camps no primary health care is available. Concerning mental health there is an official state program on psychiatry which includes outpatient services for patients with PTSD. Because there are efforts by the Ministry of Health to privatize health care, the availability of such services for refugees is uncertain.

I witnessed a coordination meeting between state and local government and NGOs in school No. 2 in Gori, chaired by Otar Toidze, Chairman of the Committee on Health and Social Affairs of the Parliament of Georgia. Hosted by the two school directors, representatives from the Municipality of Gori, from the Ministry of Education, discussed with NGO social workers, psychologists, child psychologists, kindergarden nursery teachers, psychiatrists, school teachers and volunteers how to solve the most urgent problems: training school administrators and teachers in psychotrauma, demining of schools, repair windows without glass, provide electricity and water, warm cloths, coordinate local population's spontaneous help in providing equipment (kitchen, beds, blankets), organize mobile teams for vulnerable kids in the tent city, provide space for leisure activities, collect toys.

I was impressed how highly competent professionals from different backgrounds were working together hard to deal with the overwhelming difficulties.

7. „Disaster Tourism“

A special incident during the above mentioned coordination meeting sheds light on a disturbing phenomenon in recent disasters: The so-called disaster tourism, resp. airplane consultancy business. A team of an Israeli charity called „Brit Olam“ at some point bumped into the meeting. Without listening to the Georgians first, without asking for their needs they presented themselves in lengthy monologues in an insensitive, intrusive and self-centered manner as top trauma experts and asked the school director to let them use school facilities and space to train aid workers in trauma for the next couple of weeks. They continued to show up in the same manner in various other coordination meetings, attacking Georgian professionals for not working with EMDR. Israeli colleagues from the trauma community tell me that they never heard of this organization and doubt its sincerity. My Georgian colleagues felt overrun and alienated by the people of Brit Olam, yet they did not feel in the position to exclude them from meetings.

Brigitte Lueger-Schuster, Prof. of Psychology at the Universit of Vienna and an expert in disaster intervention has reported similar incidents during the hostage taking of school children in Beslan/North Ossetia. So has James Munroe, psychologist at the Boston Veterans Administration and consultant of the American Red Cross during the hurricane Kathrina. The ARC has therefore developped a strict filtering procedure on whom they accept as volunteers and partner organizations in disasters. I suggest to develop a strategy for the future how to keep such groups and individuals from interfering and obstructing the relief work.

8. Long-term mental health needs of the refugee population

GCRT and the International Medical Corps draw the following conclusions and recommendations from their August 22 rapid assessment (see above):

- A larger, population based assessment needs to be developped and undertaken to truly understand the size and depth of the mental health issues facing the IDPs

- A comprehensive coverage of basic services including water, food, shelter, health and protection needs must be addressed

- Information about the nature of these services and how IDP communities can access them needs to be widely available. This will eventually help to alleviate many issues related to hopelessness and anxiety about the immediate future

- Given the widespread presence of mental health problems among the IDP communities psychological first aid needs to be immediately available and screening for acute disorders conducted with appropriate systems for referrals to specialized care

- Children of school age need to be in school to create as much sense of normalcy and purpose as possible. Sports and recreation activities need to be organized to engage children and adolescents outside of schools.

- As long term settlement patterns become clearer income generation/vocational and life skills training should be established and community integration efforts initiated.

- Mental health programming must be mainstreamed into primary health care programs. Doctors and nurses should be trained on identification, management and referral of mental health issues with an emphasis on recognizing the connections between mental distress and somatic health issues.

9. Needs of NGOs doing mental health work with refugees

Based on my own observations and my talks with Empathy, GIP, GCRT and the other partners mentioned above I see a number of needs, most of which require additional funds. Following the war NGOs have shifted all their capacities to the urgent care of the new IDPs. But they will eventually have to go back to their previous fields of work with old IDPs, torture victims, prisoners, iuvenile delinquents, victims of domestic violence, street children, training for probation officers and prison doctors, public awareness and advocacy work on torture.

- Basic training of primary care doctors, who are the ones who see lots of IDPs and don't have any mental health training.
- Funding to set up additional centers in target areas like Gori and Zugdidi. According to the Committee on Health and Social Affairs of the Parliament of Georgia only 20 % of IDP camps get some sort of psychosocial care.
- Operate via out-reach mobile teams who offer support instead of waiting for clients to come to counselling centers
- Funding for carrying on activities with refugees from South Ossetia who do not have a chance to return and will probably remain in and around Tbilisi
- Training on working with severely traumatized children
- Funding autumn camps for children and adolescents
- Convince international organizations like UNICEF, World Vision, WHO, Merlin, Save the Children etc. to recognize local expertise and support the growth of local service providers with long-term projects instead of spending great amounts of money on short term projects with involvement of international staff. The problem is that all current international money focusses on the first six months after the crisis and not much of it will reach the beneficiaries since most of it goes into coordination. After these six months everyone will pull out leaving thousands without assistance.
- International donors should not channel aid money for mental health care of refugees by NGOs through the government, because there is a high risk that a large share will be diverted by pre-selected pro-governmental NGOs or be settled down in ministries and will not reach affected communities.
- Assure that psychosocial intervention teams include medical doctors. This is of vital importance for the reasons described above (see chapter 5, 2nd paragraph). Donors tend to think this is a waste of money since the government makes believe that all health needs are covered by the state (which is not the case).
- Funding for research, e.g. to do practically applicable and operationalized studies for improving and better planning of interventions
- Fund conferences, exchanges and master classes for validating and conceptualizing experience
- Capacity building for teachers, school psychologists and nurses working in IDP camps as well as in conflict and buffer zones
- Capacity building of broad network of volunteers

- Additional human ressources and core funding. All NGOs are understaffed and staff is underpayed. Wages which some years ago were reasonable at the time of funding by EU etc. have since been eaten up by the high inflation. Unless appropriate wages are paid NGOs risk to loose qualified staff.
- Last but not least care for caregivers program including supervision and organizational consultation

10. Care for caregivers

Care for caregivers tends to be neglected in disaster situations, because there never seems to be time and space for it. The extremely high case-load and the enormous plight of clients puts caregivers in a moral conflict. Every minute caregivers take time off for themselves seems like abandoning clients. I heard statements like: „I feel like a traitor....How can I relax and enjoy myself, when so many people are suffering.“ In large parts of the professional community (be it medical, disaster relief or human rights organizations) it is not considered necessary and in some organizations it may be considered as a threat to their traditional ways of functioning. Yet when I talk to caregivers on a personal level I see how desperately they need rest, clearing, compensation and opportunity to process their experience and recreate themselves. I met two of my partners shortly after my visit at an international conference abroad. They told me that this trip by itself is helping them to cope with their burnout by getting away and enabling them to reflect upon their situation from a distance.

Care for caregivers should include: opportunities for further training, teaching, travelling abroad on an exchange with colleagues from other organizations, opportunity to take time off, sabbaticals for writing and doing research, adequate pay that takes into account the high demands and enormous workload (like risk workers get higher wages in industry) and last but not least external clinical supervision on an individual and a team level as well as organizational consulting. Stress and tension at work can often be reduced by simple structural reforms in the organization.