traumatic stress field with an evidence-informed, consensus document, “Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings” (Weine et al., 2002). These guidelines highlight the key areas to address in order to achieve practical, effective, and culturally competent psychosocial training internationally. The guidelines are broken into values, contextual challenges, core curriculum, and monitoring/evaluation.

**COMPREHENSIVE AND INCLUSIVE PLANNING**

Without inclusive, comprehensive preparation and planning, local community leaders may not recognize how any foreign-based interventions may be of assistance to their community. Despite high needs, the community may erroneously determine that the supports offered will not be effective and may hesitate or refuse to work with international assistance agencies in the current situation or in the future. Additionally, without comprehensive planning, those involved in the implementation of services may be unable to successfully carry out or support the community mental health response process. Such failure has the potential to cause harm, as it may create a false sense of incompetence or even decrease the confidence that the community had in their recovery potential prior to the arrival of aid organizations.

Comprehensive preparation and planning activities for community psychosocial mental health emergency response include the following:

- Identification of those who may benefit from psychosocial services—a process of assessment as well as monitoring and surveillance of the community members involved in all activities;
- A strategy as to how to conduct successful outreach, identifying special populations in need and properly referring those with more extensive, or alternate, related needs;
- How properly to coordinate the delivery of services;
- How to organize and coordinate community group meetings, self-help groups, peer supervision groups, and training;
- Knowledge and skills to manage group dynamics;
- Knowledge and skills necessary to coordinate or conduct an evaluation.

The complexity of implementing comprehensive programs may discourage or limit culturally appropriate psychosocial work as part of overall community trauma response planning. These challenges must be addressed prior to starting the work (Young, Ruzek, Wong, Salzer, & Naturale, 2006).

**PRACTICE CONSIDERATIONS**

**Uganda During a Long-Term, Post-Conflict Community Mental Health Response Effort**

**Background**

The Republic of Uganda is 93,000 square miles, about the size of the state of Oregon in the United States. Like much of central Africa, Uganda was originally a land of farmers and cattle
herders. About 70% of the country is woodlands and grassland. In the 1830s, slave traders invaded the area, and, by the 1860s, British explorers and abolitionists became interested in the region as they searched for the source of the Nile. In 1962, Uganda was granted independence from Britain. Although Uganda was a republic, tribally based local kingdoms retained a strong role in government.

In 1966, Uganda’s Prime Minister Milton Obote assumed all governmental powers and abolished the traditional kingdoms. Idi Amin Dada overthrew Obote in 1971 and gave himself absolute power, beginning 8 years of social decline and massive human rights violations aimed primarily at the Acholi and Langi ethnic groups. Amin’s henchmen murdered between 100,000 and 300,000 Ugandans. Uganda gained international attention in 1976, when Amin took Israeli hostages in Entebbe (Amnesty International, 1978; International Commission of Jurists, 1977).

The atrocities of Amin’s reign were finally brought to light and, in 1979, he was forced out of the country. Disputes over the powers of the presidency continued, and, by May of 1980, Uganda was ruled by a military commission. Obote was returned to power as president. Human rights violations by the Obote’s security forces were said to be the worst in the world during the next 5 years (United States Department of State, 2009). In 1985, Yowari Museveni’s National Resistance Army took the capital, Kampala. From 1986 to 2003, more than 100,000 people of the Acholi region in northern Uganda were killed, an estimated 1.5 million were displaced, and over 20,000 children were abducted by armed rebel groups trying to destabilize the state (United States Department of State, 2009). After regaining control, President Museveni put an end to human rights abuses and is promoting economic reforms and increased freedoms. Most displaced Ugandans have returned. However, many difficulties exist in relation to reclaiming and resettling land, rebuilding homes, and reestablishing relationships with those who remained.

Although Westerners created the legal borders for the country, the inhabitants of the area consider many members of tribes from nearby Sudan, Kenya, and the Democratic Republic of the Congo as family and, thus, speak the many languages of their neighbors. It is not unusual to meet a Ugandan man or woman who speaks six to eight local languages. The country has a 70% literacy rate through primary school. Eighty-five percent of the people in Uganda are Christian, and 12% are Muslim. Traditional rituals and religious customs from a time prior to the conversion of so many Ugandans by Christian missionaries can be witnessed in most of the small villages throughout the countryside.

Uganda remains a primarily rural, agricultural society, growing coffee, tea, sugar cane, and flowers to sell, as well as bananas, corn, cassava, potatoes, and millet for consumption. The temperature is quite moderate owing to softly rolling hills. Rainfall is regular. Uganda has many natural resources, but continuous conflict has resulted in the country being one of the poorest and least developed in the world. In addition, many non-governmental organizations and other psychosocial service delivery agencies are working in Uganda to provide humanitarian assistance and education and to promote stronger links with other countries (United States Department of State, 2009).

A Community Mental Health Initiative

A large-scale community emergency response education and training mental health program is being conducted in the Tesso region of Uganda. Activities are structured by the International
Trauma Studies program at Columbia University, USA, and the Transcultural Psychosocial Organization (TPO) located in the Ugandan capital city of Kampala. This psychosocial training of trainers (TOT) designs and implements culturally adapted education and training sessions in small group settings in various villages throughout the region. The TOT provides a thorough integration of the IASC and ISTSS guidelines, with significant attention to culture.

The contextual challenges of cross-cultural training are addressed by the inclusion of local stakeholders at a meaningful level. Local leaders are involved in every aspect of the project. This allows for consultation and feedback to address concerns with a sense of mutuality. Village leaders promote individuals from within their community to participate in training exercises with the international mental health professionals, with the goal of becoming psychosocial workers themselves. Representatives from Western-based humanitarian aid organizations, mostly mental health professionals, are paired together, and the training responsibilities are equally shared.

While training activities are conducted, variations in the community norms are addressed by establishing rules in the group setting with mutual agreement. This type of group training allows for a natural integration of traditional rituals. The villagers ask questions, make comments, and talk openly about how they might apply the newly learned concepts to their daily lives.

The group training also encourages the members to speak among themselves and to help each other. Often during these times, thoughtful conversation emerges with regard to the relationship between traditional, ritual healings and modern or Western health-care practices. Western trainers remain observers, promoting “teaching moments” for the local leaders and others from within the community to establish themselves as the experts. In one circumstance, when an elderly “herbalist” healer announced that the traditional mix of herbs could heal fetal alcohol syndrome (FAS), his peers confronted him quite harshly. A local leader took control and he not only challenged the healer by asking if the traditional herbs cured AIDS, but he suggested the healer consider the new information that was being taught about FAS in the training.

Attending to the short- and long-term needs of the community is addressed by having local Ugandans become the new trainers. After initial training activities are completed, the TPO supervisors and new trainers from the Tesso region meet regularly with villagers. The Ugandan trainers continue to help these leaders in developing the process by which the most salient issues for the different villages are identified (Bolton & Tang, 2004). TPO provides group supervision and case conferencing for all the local trainers, instructing them on how to work with difficult group members and also how to refer people with serious emotional distress to appropriate resources. They also work with the program evaluators coordinating group meetings to determine the outcomes of the training activities. This model of training in community mental health emergency response exemplifies the community capacity building and sustainability that psychosocial training programs strive to achieve.

SUCCESSES IN CROSS-CULTURAL COMMUNITY MENTAL HEALTH INTERVENTIONS

The most successful aspect of community mental health interventions focuses on bringing together groups of community members to receive the same information and to process this