MENTAL HEALTH SERVICES IN KOSOVO

by Dr Helen Bolderson and Karen Simpson
London, January 2004
### Mental Health Services by Region in Kosovo

#### Mitrovica Mental Health Region

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#### Prizren Mental Health Region

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#### Gjakovë Mental Health Region

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**Legend:**
- ![Community]: Community mental health centre
- ![Psychiatric]: Psychiatric ward/clinic
- ![Protected]: Protected house
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Acknowledgements

A report of this nature would not have been possible without the active participation and determination of numerous individuals. Its content pays tribute to their patience, collaboration and generous gifts of time and expertise.

I am especially grateful to the many dedicated professionals, humanitarian workers and organisations working hard to improve mental health care that have provided invaluable assistance throughout the research process. They cannot all be named here, but I wish to express my special appreciation to the list of contributors highlighted in Annex B, whose generous information sharing forms the essence of this report. Particular thanks go to my interpreter, whose voice is silent but who contributed much more than just interpreting words.

Lastly but perhaps most importantly, to my friends and colleagues in Kosovo, who honoured me with their trust, enriched me by their integrity and sharing in times of adversity and taught me most of what I know about hospitality and respect, I am truly grateful.

Së fundi por mbase më së rëndëshishmi, miqëve dhe kolegëve të mi në Kosovë, të cilët mënderuan me besimin e tyre, më pasuruan me integritetin e tyre dhe ndarjen e gjëra e gjatë kohërave të fatkeqësis dhe më mësuan të shumtën e asaj që e di rrëth mirëpritet dhe respektit, u jam sinqerisht mirënjohëse.

Karen Simpson
January 2004
Foreword

Five years ago Serbian special police and paramilitaries, assisted by the Yugoslav Army, launched a brutal campaign of repression and “ethnic cleansing” against the predominantly ethnic Albanian population of Kosovo, killing many civilians and torturing, beating and raping others. As the repression intensified, NATO forces intervened, launching aerial bombing raids against the perpetrator forces. These too resulted in civilian deaths and were accompanied by an accelerating exodus of refugees fleeing from the conflict and repression in Kosovo.

Five years on, Kosovo is peaceful once more and that peace is underpinned by the deployment of an international military force, KFOR, and civilian administration, UNMIK (United Nations Interim Administration Mission in Kosovo). Some of those who fled abroad as refugees have since returned, but many others have not; their homes were destroyed, their possessions looted and they see no future for themselves in Kosovo. Some, indeed, fear to return because they remain haunted by memories of what occurred before they were driven to flee abroad – memories of parents, children or other loved ones being butchered before their eyes, of being brutalised and beaten by men who showed no mercy, of being raped or sexually tortured in other ways so humiliating and degrading that they scarcely dare confide that it occurred. Such are the ordeals that were experienced – and indeed, still are being relived – by some of those who subsequently became clients of the Medical Foundation and who now, five years on, are threatened with being forcibly returned to Kosovo by the United Kingdom (UK) Government.

As an organisation dedicated to working with survivors of torture and organised violence, the Medical Foundation for the Care of Victims of Torture is most concerned to ensure that such survivors are not returned to situations where they face the risk of further torture or violence or where their suffering is likely to be prolonged. For this reason, the Medical Foundation decided in 2003 to undertake research in Kosovo to establish the extent to which there now exist facilities and services to which survivors of torture and organised violence can turn for the psychological, therapeutic and other treatment that they may need. We decided to focus especially on local mental health services, noting that an important Mental Health Strategic Plan had been drawn up in

Mental Health Services in Kosovo
2000 by a multi-disciplinary task force of national and international experts, and because the availability of such services and their capacity were seen to be an extremely important indicator for the needs of torture survivors.

This report represents the fruit of that research, which was undertaken as an empirical study. Essentially, it shows that remarkable efforts are being made by a small number of health professionals to address the psychological and physical consequences of the 1999 war and the repression that preceded it, and the widespread trauma it caused across the Kosovan population, among ethnic Serbs as well as the majority ethnic Albanians. It also shows that despite the dedication of those providing mental health services, these services are far from adequate at the present time even to address the needs of the population already present in Kosovo. Indeed, there seems little prospect that these services will be able to cope even with present levels of demand within Kosovo without a substantial injection of international financial and other assistance. There is little prospect, therefore, that these services would be able to meet the needs of Kosovan survivors of torture and organised violence who are currently in the UK or other countries and who would require ongoing treatment should they be forcibly returned in the foreseeable future.

Life in Kosovo remains difficult for its inhabitants despite the progress that has been made since the end of the war. Poverty, inflation, lack of employment opportunities, and other economic and social problems continue to hamper development. Kosovo today is still a deeply divided society where there is a widespread sense of disillusion and where many among the population are still effectively traumatised by the recent conflict. It is all the more encouraging and impressive, therefore, that a small group of mental health and medical professionals is among those struggling locally to meet this challenge, and it is to them as well as to those Medical Foundation clients who are survivors of torture or organised violence in Kosovo that we dedicate this report.

Malcolm Smart, Director
Medical Foundation for the Care of Victims of Torture
London, January 2004
I. Introduction

Objectives

Purpose
1. This report gives the findings of a project undertaken by the Medical Foundation for the Care of Victims of Torture, to provide information about mental health provisions currently available in Kosovo. It seeks to describe the nature, scope and availability of these services and to establish how, and by whom, they can be accessed.

2. The project was set up to be of practical use. Its purpose is to contribute to the quality of the decisions made, by individuals or public authorities, about the future of Kosovans currently living in exile in the United Kingdom (UK).

Aim
3. The report’s aim is to provide sufficiently up to date and accurate details where:
   i) Kosovans, displaced from their home country, voluntarily wishing to return, and in need of mental health services, require information about the availability of appropriate services on their return;
   ii) Kosovans’ cases are still under appeal and where decision-makers require detailed information in order to make an informed decision;
   iii) Kosovan asylum seekers, whose applications have failed, and who are in the process of being involuntarily returned to Kosovo, are in need of mental health services. In this situation the availability of services suitable for, and/or accessible to them in Kosovo may be one of the factors to be considered in decisions about removal.

Scope
4. It is not possible to make sense of the availability or potential use of mental health services without reference to other factors. Location, ethnic identity, gender, age, family structure, the processes of diagnosis and categorisation of a person as mentally ill, can affect the scope and nature of the services; their ability to help; and/or people’s willingness to come forward and seek help. All these factors form part of the discussion. The research therefore
includes information on the availability and accessibility of provisions for returnees who might be in a minority situation on account of ethnicity, and / or who are women or children.

5. The United Nations Interim Administration Mission in Kosovo (UNMIK) lists the four “basic provisions” required for “sustainable returns”: security and freedom of movement; access to public services (public utilities, social services, education and health care); access to shelter; and economic viability through fair and equal access to employment opportunities (UNMIK, 2003).

6. Mental health services are explicitly encompassed within the second of these basic provisions. However, it is not self-evident where ‘mental health services’ begin or end, especially in the context of post-conflict societies where shocking events of displacement and / or brutality have been feared, witnessed, or experienced. It may be difficult to draw a line between the effects of distress that are a ‘normal’ reaction and those that cause dysfunction and signal mental illness (Losi, 2000). The responses to these problems may range from the development of community infrastructures that take an integrated view of needs to the more direct medical treatment of the individual (Jones, 2000).

7. The central question addressed in this project (briefly, what is likely to happen to returnees who are regarded as being in need of mental health services) determined the choice of provisions to be researched. They include services that diagnose and treat severe mental illness or learning difficulties and those that attempt to support particular groups of distressed people (children, women, ethnic minorities) in a variety of ways. They encompass hospital and community, public and voluntary, psycho-therapeutic or socio-therapeutic measures. The report describes the provisions as they were found on the ground in Kosovo in August 2003, updated to the end of 2003 while in contact with respondents about further developments. Their availability in the particular contexts of returnees in a variety of circumstances is discussed in Section V.
II. Approaches and Method

8. From the start it was acknowledged that there would be major difficulties in obtaining up-to-date, accurate information about services on the ground in Kosovo from deskwork in the UK. One approach is the standardised, comparative account of countries’ mental health provisions contained in the Country Profiles produced by the World Health Organisation (WHO, 2002) but that information is based on questionnaires, mainly addressed to governments, about resources, financing, major legislation, etc, requiring ‘yes’ or ‘no’ answers. This approach is inevitable given the global scope of that exercise but there are marked limitations, set out by WHO as follows:

“Although this helped with quick gathering of information, it failed to take into account differences in coverage and quality. Thus information related to implementation of policies, programmes or legislation, type of disability benefits, distribution of resources among rural and urban settings, quality of services available at primary or community level, proportion of financing for rural or urban settings, quality of services available for special populations, quality of services provided by non-governmental organizations and quality of information gathering systems cannot be gauged from this data” (WHO, 2000a).

9. At the same time, more grounded data, in documents that do give accounts of coverage and quality, are often, not surprisingly, out of date, given the time and effort required to collect the data. Others are highly selective in the information they cover or they may mistake stated objectives for implementation, and / or organisational change for services actually delivered (see UK Home Office’s Country Information and Policy Unit, (CIPU), 2003).

10. The methods adopted in this project have tried to avoid at least some of these pitfalls. An initial résumé of documentary sources identified policy strategies, trends, shortages of resources and issues relating to minority groups, including returnees (Bolderson, 2003). It also highlighted gaps in information on the basis of which it was possible to draw up a checklist of questions (set out in Appendix A) that could be addressed to contacts in Kosovo.
11. The Medical Foundation decided that the questions should be discussed in situ, by a fieldwork researcher. Karen Simpson, who works in the area of mental health and is familiar with mental healthcare facilities and services in Kosovo, undertook the fieldwork (for her details, see Appendix D). She met and interviewed key people on the ground (listed at Appendix B) during a three-week visit to Kosovo in August 2003. This report is based on the findings from the interviews and additional documentary material collected in Kosovo or later received.

12. Fieldwork can have its own pitfalls, since researchers, fieldworkers, and interlocutors, like anyone else, have agendas that frame their view or practical pressures (timetabling busy people, providing for translation, etc). For some organisations there may be fine lines to be drawn between giving too bleak a picture and thereby disappointing funders, or painting too rosy a picture thereby encouraging demand from clients / patients, or giving false reassurances to potential clients, patients or returnees from abroad. From an individual’s point of view it may be natural for the person to give a positive impression of his or her work and achievements, especially at a time of great change and hopes of progress. It is inevitable too, that responses to questions tend also to be weighed up against the fieldwork researcher’s own observations of selected details during the visit. Fieldwork cannot claim to be entirely objective, and often elicits several perspectives.

13. Consumers’ views were not sought in this research, as they would have involved the additional expense of drawing and interviewing representative and stratified samples. However, a substantial number of professionals, administrators and others, who were centrally involved in delivery of services, as well as policymakers, gave accounts of coverage, processes, treatments, demands, resources, etc. (For details of respondents, see Appendix B.) Respondents were sent a final draft of this report to check that it accurately reflected their contributions.

14. Meetings took place, in August 2003, with officials of international organisations concerned with mental health issues and returnees (WHO, 2003); International Organisation for Migration (IOM, 2003); and UNMIK (2003a). All hospital psychiatric wards (with one exception), including Shtime (described as a ‘social institution’), community mental health centres (CMHCs) and protected apartments, as well as a selection of key non-
governmental organisations (NGOs) in the mental health field were visited and their directors or equivalent interviewed. The exception was the ward in Mitrovicë hospital. At the time of the fieldwork the area was dangerous and could not be visited on account of the killing of an UNMIK official by a Serb sniper.

15. The report begins with an overview of mental health policies and organisation in Kosovo (Section III). The services on the ground provided by the Ministry of Health, Environment and Spatial Planning (in this report referred to as Ministry of Health) and the Department of Work and Social Welfare, as well as by NGOs, are described in Section IV and their implications for returnees discussed in Section V. The details gained in the fieldwork and quotes from interviews and correspondents are used in these sections to give the fullest and most specific pictures possible. Section VI provides a summary that itemises general findings, that is, points on which there was sufficient agreement amongst respondents or the information was supported in documents.
III. Overview of Mental Health Policies and Organisation

Legal framework

16. The legal framework governing mental health is still that of the Republic of Yugoslavia’s legislation of 1974 and now considered as inadequately defending the rights of patients and not in any case applicable in Kosovo, which lacks the institutions to implement it (Agim Muhaxhiri, Chief of Municipal Court, Gjakovë, telephone conversation, August 2003). The situation, as described by Liliana Urbina, WHO’s Mental Health Officer in 2001 in the excerpt below, still pertains:

“The vacuum on mental health legislation characterizes the legal frame in Kosovo. The only applicable law is vague and not applied. Many users are illegally detained in social institutions and neuropsychiatric wards. Patients that need treatment leave the wards uncured...International Agencies like OSCE or Mental Disability Rights International (MDRI) assessments on human rights revealed a totally irregular situation characterized by severe violations in many levels, being mental health a particular field of concern.” (WHO, 2001, par. 2)

At the time a working group was drafting legislation but, apart from visitor boards consisting of a group of NGO members, and UNMIK’s administrative instructions, there is still no protection against non-compliance with international conventions against illegal detentions and forcible use of drugs. There have been six drafts of a Mental Health Bill since 1999, but, despite the efforts on the part of professionals, it has not been possible to agree on its contents because of the different relative requirements of the Mental Health and Penal Systems (Aliriza Arenliu, WHO Mental Health Programme Manager, interview August 2003). These systems are currently closely allied, as will be seen from the descriptions of the psychiatric wards given below.
Overall Policies

17. A Mental Health Strategic Plan was drawn up in 2000 following the establishment of a multi-disciplinary Task Force in November 1999. The Fourth Draft of the Plan gives an account of the state of the mental health services as they were in 2000, and an abbreviated form of that section of the draft is given here to show the distance that the mental health services have attempted to travel in the three years since then:

“The system of services is completely centralised with total lack of services outside of the hospitals such as, for example, the ones based in the community. The front and the last line of services are the Department of Neuro-psychiatry UCC in Prishtinë / Pristina and the regional Neuro-psychiatric wards. The professionals are extremely overloaded because of the low number of personnel and the high number of patients in need for this type of services. The patients are mainly treated in a strict biological approach with little or no use of other tools. There are two institutions, Shtime / Stimlje Special Institute for the mentally retarded people and Prishtinë / Pristina Elderly House, with a high number of long term psychiatric in-patients, in extremely bad condition. A non-defined number of patients from Kosovo / Kosova are abandoned or kept in institutions in Serbia, Montenegro or Macedonia.” (Multidisciplinary Task Force, 2000, p. 2)

18. The Strategy set out to provide a community based mental health system with training programmes for all the disciplines involved, including training given by the University, and with emphasis also on the family doctor. The Plan was to establish seven community mental health centres (CMHCs), 14 protected apartments providing shelter for patients in remission, half of which would give 24-hour cover, and six intensive care psychiatric units, distributed on a territorial basis, based almost entirely on the existing locations of the general hospitals. The disciplines of psychiatry and neurology were to be separated with psychiatric
wards split off but remaining within the grounds of the general hospitals.

19. Developments since the formulation of the Plan have included the establishment of the post of Mental Health Officer within the Ministry of Health, the inclusion of a mental health module in the training for primary care, the continuing development of the six psychiatric wards that each include an intensive care unit, and the gradual opening of the seven CMHCs as planned.

20. The buildings of the centres are mainly funded from abroad and are located in Ferizaj, Gjakovë, Pejë, Prizren, Gjilan, Prishtinë and Mitrovicë. Two full-time protected apartments for the rehabilitation of long-term psychiatric patients who are in remission now function in Gjakovë and Gjilan providing a total of 20 beds, and two further apartments are being built in Prishtinë and Prizren.

21. Child and adult mental health services have been separated and a new mental health centre for children is being built within the University clinical centre in Prishtinë and will provide out-patient care. However at present there are only three specialists in child psychiatry who were trained as neuropsychiatrists who have since orientated themselves in child psychiatry. The Faculty of Psychology has been operating for the past two years and provides a three-year BA degree and a further two-year MA in applied psychology.

22. A further important development according to the WHO Mental Health Unit Manager is that there is now general support for the Strategic Plan: it is no longer thought as unachievable (Arenliu, 2003, op.cit). Nevertheless, WHO’s 2003 Overview of the Mental Health situation Kosovo states:

“The psychiatric treatment provided is biologically oriented using pharmaceuticals and hospitalisation as main tools if not as only tools. Due to lack of clinical psychologists and few psychiatrists there is almost no time for psychotherapy...There are no proper mental health structures for chronic psychiatric patients, thus the returnees from the western countries and other regional countries have great difficulties in treatment and care.” (WHO, 2003a, p.1)
23. Policy priorities now are training of staff in management and alternative therapeutic models and the building of more community services for chronic patients. There are pressing problems of resources and gaps in training for specialised counselling and budget management (Arenliu, interview 2003, op.cit).

24. Health policy states that health services should give access to all, to prevent the exclusion of minorities. There are training provisions for Serb nurses in Graqanica and a car has been donated for home visits in Serb villages around this town. However there are problems in setting up a community centre in Mitrovicë North as the Ministry of Health, while willing to fund the centre, requires the centre’s salaries to be paid by UNMIK, instead of the authorities in Belgrade, as at present. There are similar problems in the area of Ferizaj, where there are unresolved issues about funding and control in attempts to open another CMHC in Shtërpre.

Organisational Structure of the Mental Health Services

The Ministry of Health

25. The Mental Health Officer is situated within the Ministry of Health and exercises responsibility for provisions through six Regional Mental Health Officers to whom the directors of the community mental health centres, the directors of the psychiatric wards and the head nurse of the protected apartments report (see Chart).

26. The Ministry of Health finances the services. Ninety per cent is raised from taxation, and ten per cent from donations. Donations decreased in the period 2002-2003 but recently a large donation was obtained from the Danish Government to fund the protected apartments in Prishtinë. Salaries are approximately 200 euros per month for a psychiatrist, 170 for a psychologist, 150 for a counsellor, and 114 euros for a nurse.

The Regions

27. For mental health service administration and resource allocation Kosovo is divided into six Mental Health Regions, overseen by six Regional Directors in the Ministry (see Chart). The Regions were originally referred to as zones in the Mental Health Plan, and were based on the catchment areas of the pre-existing neuro-psychiatric wards in five regions – Prishtinë, Mitrovicë, Pejë, Gjakovë, Prizren.
As there were no wards at that time for acute cases in Ferizaj or Gjilan, a psychiatric ward was planned for Gjilan, which constitutes a sixth region.

28. Each Region delineates an area covering several municipalities, which are institutions of local government and do not have responsibility for mental health provisions. Each Region has one hospital psychiatric ward and one CMHC with the exception of Gjilan, which has two Centres (see Map for the relationship between regions, municipalities, location of wards and CMHCs).

29. The Regions cater for populations of around 250,000 – 330,000, except for Prishtinë, which has 500,000 inhabitants. They (and their constituent municipalities) vary in the extent to which they include diverse ethnic groups.
IV. Services on the Ground

Mental Health Services Provided by the Ministry of Health

Hospitals

30. Interviews were conducted with the Head of Neuropsychiatry in Pristina University Hospital and with the Directors of the regional hospital psychiatric wards in Prizren, Gjakovë and Pejë. In Gjilan (which was not however opened until September 19th 2003) the interviews were with the Regional Director. The ward in Mitrovicë, which has 36 beds for the use of the Serb population, was not visited for reasons of security given in par. 14 above.

31. The largest of the hospital psychiatric wards is in Pristina and has 72 beds in an old building in which it was observed that three to four beds without sheets were crowded into one room. The catchment area of the ward encompasses Pristina, Glogovë, Podjevë, Fushë Kosovë, Obiliq, Vushtrri, Skënderaj, Lipjan and Mitrovicë South, and covers approximately one third of Kosovo’s population. In 2003 attacks on staff resulted in broken bones, arson was committed and 2 murders took place. It was observed on the visit that armed police guarded a section of the ward. At present UNMIK requires that 12 of the beds are reserved for criminal cases but this is not a policy favoured by the clinic directors.

32. There is a child psychiatry section within the main Pristina psychiatric clinic but it does not provide in-patient facilities for children. For in-patient care the paediatric department of Pristina general hospital has to be used, where there are, however, no designated beds for children with mental health problems. In Gjilan the neuropsychiatrist specialising in child psychiatry in the regional hospital treats children. There are no provisions for the in-patient care of children in any of the psychiatric wards.

33. The psychiatric ward in Prizren is small, in a prefabricated building (referred to as a ‘barrack’), with 23 patients in six rooms and covers Prizren, Dragash and Suhareka municipalities with approximately 300,000 inhabitants. The department in Pejë hospital is very small, with 18 beds that have to cover 300,000 inhabitants across Pejë, Decan and Istok municipalities. The ward in Gjilan hospital, which has opened since the end of the fieldwork, has 15 beds for the municipal regions of Gjilan, Kamenica, Viti, Shtërpe, Kacani, Novo Berde and Ferizaj, and covers 425,000 inhabitants.
inhabitants. The psychiatric ward in Gjakovë had 34 beds but the Ministry has reduced them to 26. The ward covers the municipalities of Gjakovë, Decan, Rahovec and Malishevë, containing around 330,000 inhabitants. The general hospital in Ferizaj does not have a psychiatric ward, which is in line with the decisions taken, on allocation grounds, in the development of the Mental Health Plan but the ward in Gjilan, where there was no pre-existing neuropsychiatric ward, has now been opened to cover the Gjilan and Ferizaj populations.

34. In each case the hospital wards provide for severely chronically and pathologically ill adults whose treatment depends entirely on drugs, which are, however, in very short supply. In Prishtinë hospital amitriptyline, haloperidol and chlorpromazine are the main drugs in use. Although fluoxetine is occasionally used, SSRIs (modern antidepressants and the mainstay of pharmacotherapy in post traumatic stress disorder (PTSD)) are not routinely available. The range of antipsychotics is very limited, and there is total absence of some classes of drugs e.g. bipolar medication. In Pejë hospital the Regional Director referred to the shortage of drugs as “a misery and catastrophe...we don’t even have elementary drugs in the psychiatric ward.” (Dr Gani Rama, Director of Psychiatric Hospital and Regional Mental Health Officer for Pejë, interview August 2003).

35. The budget for Prishtinë hospital was said to allow 25 euros per year per patient. None of the hospitals has out-patient facilities or follow up services, “they are left on their own if their family rejects them” (Dr Afrim Blyta Head of Neuropsychiatry, Prishtinë University Hospital Psychiatric Clinic, interview, August 2003). Some patients in Prishtinë have been in the ward for four years for lack of alternatives, such as protected apartments, that are not yet ready in Prishtinë.

36. All respondents reported severe shortages of staff. The psychiatrists have to spread themselves thinly, sometimes taking on several jobs as regional director (e.g. in Gjilan), in the CMHCs, and/or in the wards. One director reported that he had conducted 3,500 consultations in 2002, and that

“...there is no one to do counselling work and no one has the time...all of us here are suffering from chronic fatigue syndrome as we have no support or
supervision, nobody is taking care of us." (Dr Afrim Blyta, op.cit)

and that

“we have nobody trained to do psychotherapy or child psychiatry, we have only two clinical psychologists and there is a huge gap between needs and capacity.” (ibid.)

37. None of the hospitals runs a waiting list. It was reported that in Prishtinë people are

“dumped by the police, dragged / forced in by family members, sent from the Centre of Social Work and Prisons... they wait in the corridor all day and every day. Up to 20 a day on an organised clinic once a week but to up to 60-70 a day outside of this.” (ibid.)

38. Minorities are not excluded from treatment and there was specific mention of minority in-patients in Prishtinë. However, Serbs do not use the wards in Prishti, Gjakovë or Pejë hospital. They go to Mitrovicë North or Belgrade and Kosovan Albanians cannot go to Mitrovicë North and instead use the hospital in Prishtinë.

Community Mental Health Centres

39. The seven community mental health centres envisaged in the Mental Health Strategic Plan are now open. The Table gives details of location, staffing, sources of funding and activities. Each centre caters for one region and its component municipalities with the exception of the Ferizaj Centre, which covers three further municipalities and is included, for administrative purposes, in the Gjilan Region.

40. Each of the centres was visited by the fieldworker and the director interviewed with the exception of the centre in Prizren, where the Head Nurse stood in for the Director, who was absent, and in Pejë, where the Regional Mental Health Officer stood in for the Director.
## Mental Health Services in Kosovo

### Directors
- **Prishtinë**: Dr Sarije Doko
- **Gjilan**: Dr Shkelzen Kadiu
- **Ferizaj**: Dr Bahri Goga
- **Pejë**: Dr Skender Kandic
- **Gjakovë**: Dr Agon Zajmi
- **Prizren**: Dr Shykran Shala
- **Mitrovicë**: Dr Gani Shabani

### Staff
- **No. Psychiatrists**: 3
- **No. Nurses**: 16
- **No. Psychologists**: 2
- **No. Psychosocial Counsellors**: 2
- **No. Social Workers**: 2
- **Vehicles**: 4
- **Other Staff**: 1 adm., cleaner, 1 cook, 1 guard

### Activities Available
- Music
- Singing
- Gardening
- Art
- Chess
- Sports
- Drama
- Handicrafts

### Built By
- **Prishtinë**: ECHO (Europe), Swiss Red Cross, Japanese Gov’t
- **Gjilan**: Swiss Red Cross, Japanese Gov’t
- **Ferizaj**: Netherlands, Japanese Gov’t
- **Pejë**: UK
- **Gjakovë**: Italy
- **Prizren**: Spain, Italy
- **Mitrovicë**: Spain

### Date Opened
- **Prishtinë**: 9 Sept 2003
- **Gjilan**: 7 April 2003
- **Ferizaj**: 13 July 2001
- **Pejë**: 16 Jan 2003
- **Gjakovë**: 3 March 2001
- **Prizren**: 8 July 2002
- **Mitrovicë**: 10 Oct 2002

### Protected Apartments
- **Prishtinë**: In process of being built (24-hour cover)
- **Gjilan**: In process of being built (24-hour cover)
- **Ferizaj**: In process of being built (24-hour cover)
- **Pejë**: In process of being built (24-hour cover)
- **Gjakovë**: In process of being built (24-hour cover)
- **Prizren**: In process of being built (24-hour cover)
- **Mitrovicë**: In process of being built (24-hour cover)

### Inhabitants
- **Prishtinë**: 500,000
- **Gjilan**: 250,000
- **Ferizaj**: 250,000
- **Pejë**: 300,000
- **Gjakovë**: 330,000
- **Prizren**: 300,000
- **Mitrovicë**: 300,000
41. The Centres work to a pattern outlined by the Strategic Plan. The following is a composite account of the CMHCs, organised according to the main themes covered in the checklist of questions to the interviewees.

42. With the exception of Pejë centre, which is in a renovated building, all the Centres are purpose built and attractive. Foreign donors have funded all the buildings.

43. The CMHCs are day centres, which seek to rehabilitate / reintegrate adults and young people who have severe chronic mental illness and are in remission. Acutely ill adults are referred to the hospital psychiatric wards.

44. Children are not accepted in the CMHCs. The forthcoming Child and Adolescent Centre within the University Clinical Centre in Prishtinë will be linked with paediatric services and is planned to provide an out-patient clinic, day activities, parenting and group programmes, and work with families. There are also out-patient facilities for children with mental health problems run by neuropsychiatrists in training who are orientating themselves to specialise in child psychiatry. These facilities are situated in the main Family Medicine Centres that form the major plank in general primary care in Kosovo.

45. In Ferizaj, where the CMHC is located in the regional hospital grounds but where the hospital has no psychiatric department, children with chronic conditions are referred to Shtime, the ‘social institution’ described below (pars. 55-62). However, it was noted that the TOGETHER Foundation counselling centre for children (pars. 94-100) operates in this region and there was also mention of an initiative by the American government to identify children in families with mental disorders, due to start in September 2003.

46. None of the Centres caters for women who have been raped, and this was explained by one Centre Director as follows:

“No Centre deals with these cases because of the mentality, we would need to be very careful and keep this confidential, we would send these people to CPWC.” (Centre for the Protection of Women, see below pars. 82-86). (Dr Shkelzen Kadriu, Director CMHC, Gjilan, interview August 2003)
47. Cases of PTSD are not excluded but do not attend. In one Director’s view:

“Nearly everyone in the population is suffering from the delayed onset of trauma now that the dead are being reburied. Such traumatised people, while possibly needing treatment for PTSD, do not wish to be associated with mentally ill people.” (Dr Bahri Goga, Director of CMHC, Ferizaj, interview August 2003).

Another Director stated:

“People who have PTSD do not accept very well to stay with people who have schizophrenia as the stigma is very big so they do not come to the Centres, if they need some oral therapy they will go to see a psychiatrist privately.” (Kadriu, op cit).

However, the purchase of drugs on the private market is quite out of reach of most people, in the context of professional salaries (par. 26), very high unemployment and poverty rates (World Bank, 2002, p.7) and social assistance benefit levels that pay 62 euros for a family per month (par. 131). The drugs are said to cost 150-200 euros for a month’s supply (par. 134).

48. In principle the CMHCs are open to all ethnic groups. The centre in Ferizaj has Turkish and Ashkaelia clients but is not used by Serbs although they constitute over half of Ferizaj’s population. Mitrovicë CMHC, situated in the South of the Region, receives Albanian, Roma, or Bosnian clients but, although Serb clients are not excluded, they are unwilling to use it. In Gjilan most of the clients are Kosovan Albanian, Roma and Bosnian. In Gjakovë there are a small number of Serbs consisting of six elderly people staying in a church, and some others in pockets of the Region outside the city, but none of these will use the CMHC and prefer to go to Belgrade, often under escort.

49. The CMHC in Mitrovicë cannot refer patients to the hospital in North Mitrovicë and instead refers them to the more distant, and already overcrowded, Prishtinë Clinic.
Referrals to the centres are made by family members, the family medicine centres, hospitals and the centres’ own mobile home treatment teams. The head nurse takes the prospective user’s history, the psychiatrist makes a diagnosis, using a generic assessment form, and the case is then passed on to the Centre’s multi-disciplinary team consisting of nurses, social workers and counsellors.

General medical services are not offered in CMHCs, but nurses give injections and oral medication although there is a shortage of drugs. The only drugs available in Ferizaj Centre were: Fluphenazine (injection) Haloperidol (injection and oral) and Biperiden Hydrochloride (injection). Drugs are given only to the most serious cases, as anti-psychotic drugs are very expensive.

The emphasis is on social work and working with the family as a group by means of home visits every day. In addition the Centres provide activities as part of the attempt to resocialise and find employment for clients. The home visits (made to six families per day, undertaken by two teams) are to assist families in managing the mentally ill member and to oversee and monitor the effects of their medication. Psychosocial counsellors are said to work with individual clients but this requires reorientation, lengthy training, arrangements for supervision and also space and privacy.

“We have been introduced to individual and family therapy for the first time in Kosovo. Up until now the family doctor has educated the family to look after the family member who is mentally ill, psychotherapy is just starting.” (Dr Gani Shabani, Director CMHC, Mitrovicë, interview August 2003)

Training has been provided for nurses and counsellors. Most of the nurses have had no previous experience of working in the mental health field. They have received training in the basic care of mentally ill people from colleagues in Europe, from a seven-day workshop and conference about community mental health provided by WHO, and a workshop on the identification of trauma and stress led by the Kosova Rehabilitation Centre for Torture Victims (KRCT, see below, pars. 67-74). Psychosocial counsellors have received training given by the International Organisation for Migration (IOM) consisting of a two-year course providing first
clinical, then more practical approaches. This course was based on IOM’s psychosocial notebook ‘archives of memory’, supporting traumatised communities through narration and remembrance.

Protected Apartments

54. The two apartments in Gjakovë and Gjilan referred to above each have 10 beds and provide shared accommodation. They are covered for 24 hours and house long-term chronic cases in remission who have no home to go to. They aim to shelter patients who are in remission and do not have families or have been abandoned by them.

Mental Health Provision by the Department of Work and Social Welfare

Shtime Social Institution

55. The Institution was visited and observed and its work described for this project by its Director, Kujtim Xhelili.

56. Another source of information about Shtime is the extensive document ‘Not on the Agenda: Human Rights of People with Mental Disabilities in Kosovo’ (Mental Disability Rights International (MDRI), 2002). MDRI, an advocacy organisation based in Washington DC, USA, made several investigatory visits and held discussions with users of mental health services in Kosovo, leading Kosovan and WHO professionals, staff of various facilities and officials from international organisations.

57. Shtime is categorised as a ‘social institution’. It is officially designated for individuals with intellectual disabilities, but appropriate diagnostic criteria have not been applied and the residents include mentally ill people and ‘social patients’ who “have only minor disabilities and reside at the facility because they have no place else to go” (MDRI, op.cit. p.20 citing UNMIK).

58. MDRI are highly critical of Shtime on the grounds that it institutionalises its residents; lacks facilities; disregards human rights; relies on drugs for treatment; and allows occurrences of sexual abuse. The present director refuted the allegations of sexual abuse and physical violence but drew attention to the problems he has encountered which have included lack of food supply; a massive number of clients; a huge mixture of cases; insufficient staff; and lack of planning for proposed changes.
59. Shtime currently has 205 residents including children in two children’s houses funded by UNICEF and operated by Doctors of the World – USA. Sixty percent of the residents are Serbs but others have come from all over the former Yugoslavia.

60. There are 176 members of staff amongst whom there is only one visiting psychiatrist. Nurses undertake most of the work. The staff has received some training from the Norwegian Red Cross and from KRCT. Training on human rights has been conducted by OSCE.

61. In its 2002 report MDRI refer to “a UN Master Plan for Shtime” that “calls for the institution to be reduced in size but to remain permanently as an institution for people with intellectual disabilities” (p. 20). MDRI are critical of this plan, as well as of the investment of six million euros in new wards, since it retains Shtime as an institutional corner stone of the mental health provisions, which should be replaced by community services.

62. The director reported that the current plan is to withdraw psychiatric cases and refer them to the CMHCs. Another protected community house for 10 people will be provided in Shtime town and only the most severe cases (estimated at 30-40 people) will stay in Shtime. The facilities in the institution will be used for physiotherapy, dentistry and laboratory services. Fifty to 100 beds will be available for out-patients and a day care centre for occupational therapy is planned: the aim is to make Shtime into a community facility.

Provisions for Vulnerable Groups made by Non-Governmental Organisations (NGOs)

63. The voluntary sector grew in Kosovo in the 10 difficult years leading up to the establishment of the international administration in 1999. The developments are described by MDRI:

“Local human rights activists emerged, and a multitude of local non-governmental organizations were established. ... Some of these NGOs filled roles within the parallel service system established by the Kosovar Albanians.... Other local NGOs have offered services for people with disabilities (though not specifically for people with mental disabilities) and
some services for women and children that included psychosocial components.” (MDRI, op.cit. C)

64. The public mental health services, described above (pars. 30-62), are not able to provide socio-therapeutic or psychotherapeutic treatment. Dr Ferid Agani explained:

“There are no facilities available for any non psychotic disorders. There are no facilities for the treatment of PTSD in the institutions because there are no experts... counselling is not available in public health institutions.” (Dr Ferid Agani, Director of Department of Strategic Management, Ministry of Health, Prishtinë, interview August 2003)

65. People suffering from post traumatic stress disorder (PTSD) or related conditions (acute stress, adjustment disorder, severe distress) arising from torture, war, abuse or other shocking events thus have no access to appropriate treatment unless it is provided by NGOs.

66. The directors, managers or equivalent of six NGOs – the Kosova Rehabilitation Centre for Torture Victims (KRCT); medica mondiale; the Centre for Stress Management and Education (CSME); the Centre for Protection of Women and Children (CPWC); TOGETHER; ONE to ONE – were interviewed, although the length and depth of the interviews varied depending on the availability of the staff and their time. In some cases additional discussions were held with members of staff and in each case documentary material was obtained that illustrated the organisation’s role in meeting the needs of vulnerable people requiring non-biomedical treatment / support. A visit to Gjakovë Safe House and interview with its co-ordinator are also included in this sub-section.

Kosova Rehabilitation Centre for Torture Victims (KRCT)

67. The account of KRCT given here draws on the interview with its Director, its six-monthly Journal (KRCT, 2002) and a Narrative Report submitted to its funders in July 2003 (KRCT, 2003). A Statement (KRCT 2003a), drawn up for the Medical Foundation in the UK relating to the situation of returnees, is discussed in Section V.
68. KRCT was founded in October 1999 and began work in January 2000 with the support of the International Rehabilitation Council for Torture Victims (IRCT) and with funds from the European Commission Humanitarian Office (ECHO). It is a Kosovo based, non-governmental, non-profit and non-political organisation providing psychosocial and medical assistance to victims of war. CORDAID in the Netherlands, and the European Commission currently share the funding of KRCT, each contributing 50% until 2005. Previous funding was from the Ministry of Foreign Affairs in Denmark (DANIDA) but this ended in September 2003.

69. KRCT has seven centres of work in Kosovo, in Prishtinë, Skënderaj, Besianë, Therandë, Pejë, Decan and Gjilan, but employs only 12 professionals, consisting of the director, five psychiatrists, including Dr. Agani, who is the visiting clinical supervisor, one psychologist (who works part-time), one sociologist, two General Practitioners (of whom one specialises in gynaecology), one social worker, one lecturer and an interpreter. It aims to work with victims of torture and trauma, ex prisoners, hostages of war, rape victims, widows, orphans, family members of torture victims and returned refugees, but in a separate Statement it is made clear that victims of torture receive priority and that limited resources make it impossible to meet the needs of all these groups, with consequences for returnees from abroad (See Section V par. 135).

70. The services are for adults over 18 years old, although children are not excluded as part of family therapy, and they are provided irrespective of ethnic membership, religion or community. KRCT has worked with Serbs, Roma and Bosnians as well as Albanians.

71. Referral to KRCT is via doctors in the family medicine centres, within which KRCT satellite centres are located, other doctors who live in the villages and members of the family. KRCT does not have a system of waiting lists but people have to wait long before they can be treated. Psychiatrists run a surgery once a week in the satellite centres. A psychiatrist can see 14 clients per day, allowing half an hour for each. There is no appointment system: people ‘just turn up’.

72. Psychosocial and medical assistance is said to include individual psychotherapy, group psychotherapy, family therapy, expressive creative therapy, psychodrama, body therapy, gestalt therapy, debriefing, testimony and acute crisis intervention. However, there
is only one psychologist who is a body psychotherapist and who works part time for both KRCT and CSME (see below, par. 76), and the medical staff are not fully trained counsellors, although they have had some training in counselling. In effect, the therapies mentioned are conducted by a part time worker with the exception of a very small amount of family therapy and work with rape victims. The gynaecologist is part of the team and links in with the department of gynaecology in the Prishtinë Hospital. Direct practical help can be given by the social workers and in extreme cases application can be made for social assistance from Social Services.

73. KRCT works in partnership with government institutions, other NGOs, its funders, regional networks and international organisations, and is active in training its own staff and also public sector workers in Kosovo. It conducts workshops, holds seminars and has also been instrumental in Kosovo’s ratification of the UN Convention Against Torture. The range of its developmental and fieldwork puts great pressure on resources and is described in the main conclusions drawn from the visit of an adviser from the Rehabilitation and Research Centre for Torture Victims in Denmark (RCT):

“Due to the fact that most NGOs and donor agencies have now left Kosova, the pressure on KRCT is increasing. On top of the demand for treatment, the clients also urge KRCT to assist them to generate income to support their families. The organisation appears to be rather sensitive towards the various needs of the target groups and tries to respond to them by initiating new activities…A general dilemma in the work of KRCT appears to be the process of finding a balance between taking on a large quantity and variety of activities and ensuring that the quality of the activities is satisfactory…” (KRCT, 2003, p. 17)

74. The Director’s Statement also draws attention to overload, putting it into the context of the socio-economic post war circumstances of Kosovo:
“As a consequence of the war the Health system of Kosovo come into very difficult situation and is under severe strain with a lack of family doctors and mental health professionals. Because of these circumstances, KRCT is playing a significant role in dealing with torture victims. The actual situation for the moment is that the needs of the population are much higher than our possibilities and capacities to offer such services. The numbers of clients are rising everyday. The overload has meant a significant waiting list for the clients to get appropriate treatment from us. From the overall clients in KRCT the largest are those clients with PTSD (approx 60%). The professional staff engaged in KRCT is in the developmental phase and consequently requires more professional capacity building to cope with the requests of potential clients.” (KRCT, 2003a)

Centre for Stress Management and Education (CSME)

75. In addition to the interview, staff at CSME provided a Declaration (CSME, 2003a) and two progress reports (CSME, 2002:2003). It is a small organisation that operates out of Gjakovë and it is concerned with treating and supporting families who suffer from post-traumatic stress as a result of conflict in Kosovo. It covers people in 10 villages surrounding Gjakovë that were severely affected by the war. In the period April 2002 – January 2003 its work was concentrated on the villages of Lipovec, Jasiq, Goden, Junik, Rakovine, Kramovik and Kralan.

76. CSME began working in September 1999 and refers to itself as a “young, local NGO” (CSME, 2003a). Its staff consists of one part-time psychologist (shared with KRCT) and four psychosocial consultants, who are professionals, qualified as experts in their own fields of cardiology, paediatrics, biochemistry, education, and law. They have received training in psychosocial therapy from the psychologist and from international experts in Croatia, Austria and Kosovo.

77. Members of the staff have themselves witnessed inhumanities in the war and, as the authors of the Declaration state:
“It was not [therefore] easy for us to be in the position of helping others. Despite this we have collected all our strength and with empathy started to respond to those in great need.” (CSME, 2003a, p.2)

medica mondiale Kosova Team

78. The Project Manager of the medica mondiale interdisciplinary team (a local project of medical mondiale, based in Germany) provided documentation (medica mondiale, undated) and described its work in interview and gave comments (see par. 122). The team supports women and girls who have experienced trauma and violence. It includes a journalist and Political Project Manager focused on awareness raising activities and lobbying for women who have survived sexual violence. The team conducts its work from its base in Gjakovë, using fieldwork vehicles and a mobile ambulance, covering 24 villages in the vicinity.

79. medica mondiale has been supported by the German Government for the past four years. This funding will expire at the end of 2004. The organisation is in the process of becoming a local NGO and it is hoped that a centre might be opened in Prishtinë.

80. The work focuses on traumatized women, in particular women who are victims of sexual and domestic violence and / or suffering post traumatic stress. Priority is given to sexually abused women. The services are provided regardless of ethnic origin or religion and clients include Roma women, with whom two groups are run, and Bosnians. Services for children are not provided.

81. The team provides psychosocial, gynaecological and legal and counselling services. Two doctors, three midwives and an office assistant run the gynaecology department. They adopt a psychomatic approach and have developed tools for screening and assessing patients and clients. The psychosocial department includes eleven psychosocial counsellors in the total staff of 31 women and four men. Counselling is offered one to one, as well as in a group, with a focus on psychodrama and body psychotherapy, couple and family intermediation and eclectic support. The counsellors, all of whom are women, have received sessions of intensive training over a four-year period from psychologists and gynaecologists from Germany and Bosnia.
Centre for the Protection of Women and Children (CPWC)

82. The description of the work of the Centre was given by its Executive Director and is also drawn from its Annual Reports (CPWC, 2002; 2003). Her comments on the implications of violated women being returned to Kosovo are included in Section V.

83. Executive Director Sevdie Ahmedi has co-operated with the International Criminal Tribunal on Former Yugoslavia (ICTY) at the Hague in relation to the indictment of war crimes against Milosovic, writing a 58-page chronicle of the war submitted to the tribunal. She remained in Kosovo during the war and was tortured, and five members of her family were arrested and held in prisons in Serbia. She has co-operated with Human Rights Watch and was nominated for the title of international monitor in 1999. She has been instrumental in campaigning for the UNMIK Regulation 2033/12 for the protection of women against violence. Her office was recently burgled, and carefully assembled statistics about the extent of violence and rape were removed.

84. The Centre is currently funded by Novib (a Dutch NGO), the Organisation for Security and Co-operation in Europe (OSCE) (for anti-trafficking work) Christian Aid (London) and KtK (Sweden) until 2005. It is located in Pristina and covers, and has satellite stations in, Mitrovica, Skenderaj, Peja, Malishevci, Gjakove, Rahovec, Theth, Kacanik, and Decan. It also has two shelters and day centres in undisclosed locations. There is a total staff of 45 women that includes doctors, social workers, lawyers and psychotherapeutic workers.

85. The work focuses on providing services for women and children who have been subjected to violence, trafficking, or forced prostitution many of whom are likely to experience post-traumatic stress or mental health problems. The services include gynaecological treatment, psychological counselling, and psychotherapy in group and individual sessions, occupational therapy and courses on computer learning and web browsing.

86. In 2002, 5361 cases of women and children who had been subjected to violence were identified (CPWC 2003, p.9). The number has increased greatly over the last three years. Waiting lists are not run – people are seen as they present but raped women and domestic violence cases receive priority. There are no exclusions on grounds of ethnicity or religious affiliation. A new Centre is being planned in the Serb area of North Mitrovica.
Safe Houses

87. The work of the Gjakovë Safe House was described by its Coordinator.

88. The House provides 24-hour shelter for women, children, and girls, who are victims of domestic violence, sexual abuse and trafficking. Another safe house is in Pejë, and there is a shelter in Prizren that is mainly for young trafficked girls but also takes children between 2-18 years. A further safe house and a women’s empowerment centre, orchestrated by the Human Rights Officer, in the OSCE, will soon be opened in the Gjilan region. A centre planned for Ferizaj has not been able to secure donor funding.

89. The Gjakovë safe house was the first safe house in Kosovo. It works closely with the Department for Work and Social Welfare and with the courts but relies on donor money from Caritas, Austria. Referrals are made by the police, the Kosovo Force (KFOR), Centre for Social Work, Department for Work and Social Welfare, and other organisations helping women and children. Eleven cases of trafficked women have been brought to the safe house by the International Organisation for Migration (IOM).

90. The shelter provides accommodation and full board. It has 14 beds but accepts up to 20 people including women and children. Males over the age of 12 are not accepted. It is always full and the waiting time is currently two weeks. An SOS confidential telephone line operates and daily calls for “any beds available” are received.

91. Trafficked women stay from four to five nights to a maximum of one month to undergo medical checks from the local GP and then they are returned to their family. Other residents can stay for up to two years but most leave and are forced to return to the place of violence after about two to three months.

92. Gjakovë House does not take cases of mental or physical illness but a psychologist from Prizren visits twice a week and conducts individual and group therapy with the women. Four counsellors are also employed and have a strong intermediation role with the families. A pedagogue works with the children. A day carer acts as cleaner and cook and there is a night guard.

93. The shelter has provided for clients from all over Kosovo, including Roma clients, and some have come from Bosnia and Montenegro but no Serbs have come to stay. Activity projects (e.g. schemes that market cosmetics made from honey) aim at trying to
enable women to gain some independence and income to help them escape from abusive situations.

Counselling Centre for Children and Parents – Ferizaj

94. The Information was drawn from discussion with the Chief of the Curriculum Division in the Ministry of Education, Science and Technology in Kosovo and documents and email correspondence from the Consultant Psychiatrist and Programme Director of the Foundation TOGETHER.

95. The Counselling Centre for Children and Parents was established in the region of Ferizaj, covering the municipalities of Ferizaj, Lipjan, Shtime, Shtërpe, Kaçanik and Viti. It was established through cooperation between, and in partnership with, the Centre for Promotion of Education in Ferizaj, the Foundation TOGETHER (from Ljubljana, Slovenia) and OMEGA (from Graz, Austria) and has received financial and moral support from the Austrian Government. The overall responsibility for the projects lies with the Foundation TOGETHER.

96. The Ferizaj Centre undertakes visits to schools and professional and therapeutic work in the Centre and in the schools. It also runs summer schools with children with learning difficulties and uses up to 200 volunteers to engage with children on creative projects.

97. The school visits involve interactive lectures for teachers and parents and therapeutic work with some of the pupils. Ninety visits have been made, covering 21 schools, by mobile teams consisting of a physician, a psychiatrist and a pedagogue. Over 700 teachers and parents have participated in the visits and over 500 children have been helped directly and 20,000 indirectly. In some areas – Reçak, Kotline and Sllovi – where many people were massacred during the war, creative workshops including art work and games have been organised to enable children to express their feelings freely.

98. The professional and therapeutic work in the Centre is conducted in teams or individually. Children are treated by means of giving advice to their parents and teachers, or referred to other experts or to special treatment in mental health institutions. A large number of patients with learning, psychological or psychiatric difficulties have been treated professionally, despite hesitation on the part of some parents to bring their children to the Centre.
99. However, there are problems of scarce resources and inaccessibility. Some rural areas are geographically too distant from the centre; there is a lack of special materials needed for work with children; and there are too few professionals who can assess children with special needs. Time is needed to identify and engage local professionals because there is a lack of mental health professionals in Kosovo in general and especially in the region of Ferizaj (Psychosocial Counselling Centre, 2003).

100. The Centre has an Executive Director; a Program Director; and Coordinators, who cooperate with schools, communities and volunteers. The professional staff consists of two psychologists, three speech therapists, two psychiatrists, one paediatrician, two social workers and three special pedagogues. It is also able to use other professionals working in the schools.

ONE to ONE Counselling Centre for Children and Families

101. The description of the Centre had to be given in a short interview with the Manager and was supplemented in London in a meeting with the organisation’s Consultant in psychotherapy.

102. ONE to ONE children’s fund is a UK NGO that developed its work from a daily shelter started in Albania for Kosovan refugees in November 1999. It is funded until 2005. In April 2000 it opened its crisis centre in Pejë for families, providing mainly couple counselling. After the first year, in response to changing demand, the centre started to work with survivors of trauma, trafficking and domestic violence. It does not now offer shelter, and relies on the Safe House for providing accommodation.

103. There is now an additional counselling centre in Prizren (where the Head Office is located). ONE to ONE was involved in a media campaign against domestic violence and referrals are received from all over Kosovo from the KPS (Kosovo Police Service), KFOR and the Centres for Social Work. The staff consists of 13 counsellors, some of whom are part-time, including two part-time teachers, two co-ordinators, two housekeepers, two drivers, and an administrator and a manager.

104. Much of the work is concerned with traumatised children in primary schools. ONE to ONE is the only organisation working with children in Prizren and is experiencing difficulties in co-operating with the Ministry of Education in relation to its work with young trafficked girls.
105. Developmental work concentrates on the provision of training for family therapy and on working with the education system.

Other Organisations Working with Children

106. The Manager of ONE to ONE outlined other organisations working with children, and the situation of children, as follows.

107. Hope and Homes for Children, UK and SOS Kinderdorf, Austria run seven small family homes between them each with capacity for 10 children. SOS Kinderdorf accepts only infants (0-3 years). Hope and Homes for Children UK runs a shelter for infants (0-3 years) who have been abandoned and other shelters for orphans aged 3-17. However, all accommodation is temporary.

108. It is UNMIK and UNICEF’s policy that there should be no state run orphanages. The comments on these arrangements were that children end up on the streets (and this was confirmed in observation by the fieldworker) and that a large number of children are still left in collective centres in Kosovo.
V. Implications for Returnees
Requiring Mental Health Services

109. This Section first outlines the principle of ‘the right to return’ and
some concerns, voiced by UNHCR and UNMIK, about the imple-
mentation of a policy of ‘sustainable return’ in certain circum-
stances. Next, it draws on material from comments (made by key
respondents in Kosovo) about the availability and accessibility of
mental health services for returnees, with particular reference to
the special circumstances of ethnic minorities, women, children,
and people subjected to torture and atrocity.

‘Sustainable Returns’

110. The principle of the ‘right to return’ has been established under
international standards on Minority and Internally Displaced
Persons’ Rights (e.g. ICERD, Article 5 (d) (e) and (f)) (UNMIK,
2003, p. 61). The principle forms the basis of UNMIK’s returns
policy for Kosovo in conformity with the UN Security Council
Resolution 1244 (1999) and Kosovo’s Constitutional Framework.
Responsibility for the protection of minorities and the “safe and
unimpeded return of refugees and internally displaced persons”
rests with KFOR and UNMIK (ibid. p. 7).

111. The implementation of a policy aimed at ‘sustainable returns’ is
complex, requiring the presence of favourable conditions and
involving joint action by international and local institutions and
agents. Successful implementation of ‘sustainable returns’ varies by
location and the assessment of its feasibility requires information
from village profiles that give details of the prevailing conditions.

112. Two broad types of obstacles to return are identified by
UNMIK:

“material obstacles such as lack of or poor
infrastructure, housing reconstruction or rehabilitation
needs, unresolved property issues, unemployment and
poor opportunities for economic livelihood”

and
“situational challenges, such as security, freedom of movement and / or possible lack of access to agricultural land, need for confidence building both for the receiving and returning communities, lack of access to public services due to a discriminating environment, among others.” (ibid. pp 19-20).

Returnees in Special Circumstances: UNHCR and UNMIK Concerns

113. Sustainable return may be additionally difficult for people in special circumstances (e.g. relating to their ethnicity or their forcible return to a situation where their safety is in doubt) or for those with special needs (e.g. ill or disabled people, women, children and in some cases those who are deeply distressed due to torture and whose return would destabilise them). For example, UNHCR has reported that

“the security situation of minorities continues to be a major concern....Significantly, Kosovo Serbs, the Roma, the Egyptians and, in many cases, the Ashkaelia continue to face serious security threats.” (UNHCR, 2003, par. 3)

114. UNHCR urges that returns for members of these ethnic minorities should be strictly voluntary, and based on fully informed individual decisions. It also draws attention to certain categories of Kosovan Albanians, who are not a minority but may experience similar problems to those confronting minorities. They may be vulnerable because they originate from an area where they constitute a minority; because they are in an ethnically mixed marriage; or because they are perceived as having been associated with the Serbian regime after 1990.

115. A further vulnerable group identified by the UNHCR report is that of traumatised individuals and those suffering from various medical conditions that will require special attention. Elsewhere UNHCR has stated:

“It is frequently recognized that a person who – or whose family – has suffered under atrocious forms of persecution should not be expected to repatriate. Even
though there may have been a change of regime in his
country, this may not always produce a complete
change in the attitude of the population, nor, in view
of his past experiences, in the mind of the refugee.”
(UNHCR, 1992, par. 136)

116. For this group the provision of adequate, available and
accessible services in Kosovo is crucial.
117. There is strong concern in UNMIK that people who are ill are
being returned to Kosovo forcibly. A paper on Non-Voluntary
Returns requests that

“no-one with an illness or injury that is untreatable in
Kosovo should be forcibly returned until such time as
the need for treatment has ended.” (UNMIK,
Introductory Note, Information Format for Non-
Voluntary Returns to Kosovo, undated)

This statement is based on the experience of mentally ill people
being returned where

“in most cases, the arrangements are not in place to
take care of these people or the treatment they need is
not available” (ibid.)

118. As a result, UNMIK has devised a form, attached to the
Introductory Note, to be used by sending countries in the process
of screening individuals for deportation. The form includes
questions about the deportees’ states of mental health, and asks
whether the deportee is currently being treated; whether an
assessment has been made of the availability and accessibility of
treatment for him / her; how seriously lack of treatment would
affect that person; whether he / she was a victim of, or witness to,
serious violation of human rights law that could be expected to
lead to trauma (see Appendix C).
Mental Health Services for Returnees: Comments from Providers

Returnees’ Multiple Profiles

119. People requiring mental health services may also have needs arising from experiences related to ethnicity, gender, or age and to having been forcibly returned to Kosovo. The checklist used for the fieldwork contained questions about the extent to which returnees would be covered by the provisions currently on the ground. It also included questions on the service’s ability to respond to ethnic minorities, women and children since these may feature amongst those returning. Written comments and some quotes from the providers of services who were interviewed are given below (verbatim, as written, in the case of statements).

Service Providers’ Responses to Vulnerable groups of Returnees with Special Needs.

120. Difficulties of access to mental health services for ethnic minorities were not given a high profile by interviewees although the problems caused by the separation of services for the Serb and Kosovan Albanian populations in Mitrovica and the failure to set up new CMHCs under the Ministry’s umbrella in predominantly Serb areas were raised as issues. It may be that no-one wished to seem to be exercising discriminatory measures or that the problems are related less to deliberate exclusion of individuals from access to services and rather more to issues of insecurity, lack of freedom of movement, and territorial, financial, administrative and linguistic divisions between Serb and Kosovan Albanian populations. These issues influence whether people can reach services and have great significance for returnees. They are extensively documented in UN Security Council (2003 pars. 28-41), Organization for Security and Co-operation in Europe (OSCE) (OSCE, 2003) and UNHCR (2002:2003a: 2003b).

121. The position of women was described in interview by Sevdie Ahmedi, Executive Director, Centre for Protection of Women and Children. She expressed concern about the situation of women who have been violated and the implications for women returning to Kosovo for whom it was not possible to provide help.

“There is no safety secured for the returnee who has been violated and I would not recommend a return of..."
a raped woman at present....At present there are no economic conditions for return and a women would need to have economic independence to be free from violence....Right now status affects the well being of individuals and a woman in this position has no status, she is marked. Despite the increase in domestic violence no one is taking accountability for these women. There is no mandate in the government but UNMIK say the government should be responsible, it is like a game of cat and mouse and the victim is the one who suffers... the last persons who should be sent back are women of rape.... They will be watched constantly and policed by their relatives if they were returned. They would not have a free life. Families believe that a victim brings bad luck and will bring shame on the family, because of this she will be isolated, she will suspect everyone close to her and bear the bullet all her life. She will be labelled / marked and will experience re-victimisation if returned.... The organisation can only offer words. We cannot offer safety, food, or the existence for survival. The situation is so bad that some women will not even want to be associated with me and avoid me in the street.” (Sevdie Ahmedi, Executive Director, Centre for Protection of Women and Children, interview, August, 2003)

122. Similar statements were made by respondents from the Centre for Stress Management and Education (CSME) and medica mondiale.

“There are particular persecutions on women who have been raped. The mentality in our society amounts to them being stigmatised. We can say that no one in our organisation provides counselling to this group, it is a taboo subject and if a woman would return she would be on her own.” (CSME, Official Declaration, August, 2003 par.4)
And:

“How will a woman returned be able to cope with the realities here? She will not only have problems within herself but added to this she will have economic stress. Does she have a family to care of her? Her family may not accept her as they think that they got rid of her when she left. They were free from her problems and will be suspicious as to why she has returned. The women herself will go right back to the first stage of what she hoped had changed.” (Selamete Peni, Project Manager, Medica mondiale, interview August 2003)

123. Comments in discussions about children focussed on the extensive damage to children caused by the war, the scarcity of specialist professional resources and the need for community and school based services. Thus:

“How Concerning the child mental health protection in Kosovo just one important fact. Very rarely are children (who were) in most traumatised villages in contact with some mental health professionals. In many villages which suffered massive massacres no child was seen by a mental health professional. .... I think that much stronger emphasis should be given to community based and school based models of psychosocial support to children. The practical impact of specialised services concerning the population of children is minimal in Kosovo as elsewhere in the region where services have not been developed and where people have no habits and possibilities to reach existing services.” (Dr Anica Mikus Kos, Consultant Psychiatrist and Programme Director of the Foundation TOGETHER, correspondence, Nov 10th and Nov 12th 2003).
And:

“We do not have special mental health services for children provided by the public institutions.” (Dr Mimoza Shahini, Head of Child and Adolescent Psychiatry Section in Prishtinë Neuro-Psychiatric Clinic, correspondence, Nov 6th 2003)

Returnees Requiring Health Services on Arrival in Kosovo

124. The International Organization for Migration (IOM) collaborates with UNMIK and UNHCR in meeting returnees at the airport, providing transport assistance and

“[giving] special attention to the vulnerable individuals / groups by providing specific transport in accordance with their needs. Included in this category [are] the elderly, the handicapped, unaccompanied minors, single women travelling with children, the sick and minorities.” (IOM, 2003a, p. 13)

125. Discussions were held in Prishtinë with members of IOM’s Operations and their Operations Officer Sheremet Kukaj. IOM is involved with voluntary returns only but provides transport from the airport for those who have been returned involuntarily when the UK Immigration Service requests it. This is an informal agreement reached between UNMIK and the UK Home Office, which pays for the costs and is prompt in sending information about arrivals to all the agencies concerned (IOM, correspondence, September 27th, 2003).

126. Voluntary returns are co-ordinated through IOM’s office in London and the Prishtinë office receives details of arrival and information, including medical information, about the returnee(s). Dr Ruhije Hoxha, who was part of the team interviewed, informs IOM in London whether the illness can be treated in Kosovo and, in the event of return, Dr Hoxha or IOM’s medical section takes care of medical cases. They are met, a medical assessment is completed, and they are accompanied to their final destination and given assistance in connecting with appropriate services. However, the UK Government no longer provides funds for any longer-term further re-integration.
127. Involuntary returnees are not eligible for any services given by
IOM to ill returnees and there are no equivalent services for them.
Dr Ruhije Hoxha comments:

128. “For those who are referred where treatment can not
be guaranteed, don’t bring them back…In respect of
cases of trauma they will be left on their own. If they
are psychiatric cases they will be sent to the
psychiatric clinic in Prishtinë Hospital. While they are
an in-patient they will receive free drugs but in-patient
stay is short term and they will have to pay for their
drugs when they are discharged. Drugs are in short
supply and are very expensive, most people will not
be able to afford them.” (Dr Ruhije Hoxha, IOM
Medical Officer, interview, August 2003; see also par.
47 on problems of paying for drugs).

Nature and Availability of Medical and Psychosocial Treatment
and Implications for Returnees

129. Dr Ferid Agani (Director, Department of Strategic Management,
Ministry of Health) was visited and gave a written statement about
the nature and availability of treatment for people with conditions
corresponding to WHO’s classification in ICD-10 (WHO, 1992):
F20 (schizophrenia); F23 (psychosis); F32 (depression, including
mild depression); F43 (acute stress, PTSD, adjustment disorder,
other reactions to severe distress).

130. On the nature of services, Dr Agani writes:

“Available treatment is mainly biologically orientated
(pharmacotherapy) with very little or no
psychotherapy and sociotherapy…” (Agani, (2003)
Memorandum, par. 2)

and on availability he emphasises the scarcity of resources despite
the advances made since the war with the help of a great deal of
support from donors:

“In Kosova health sector doesn’t exist minimum of
services to provide emergency and intensive
psychiatric care for patients in need for forced
treatment and/or hospitalisation. Also there are no institutional and human resources to provide forensic psychiatric services. Child and adolescent mental health services are still represented with only one child psychiatrist. Total of twenty seven (27) psychiatrists, eight social workers, 14 psychosocial counsellors and 90 nurses are providing necessary services for two million population within in-patient psychiatric services and community based mental health programs. Their priority are chronically mentally ill for whom we have in disposal only twenty community based beds in two PA [protected apartments].” (ibid. par. 12).

131. In relation to the effect on returnees, Dr Agani states:

“The patient that is forcedly returned to Kosova before the treatment has been concluded would very possible quickly face serious deterioration of his/her mental health state due to the fact that he/she at least would not be able to get needed psychotherapy and sociotherapy treatment supposing that they have at least 30-50 Euros per month to buy their medications (Fluoxetine, Paroxetine, Sertralin, Olanzapin, Risperidone). For your information government social assistance is providing social financial support of 62 Euro per family, per month.” (ibid., par. 15)

Treatment of After-effects of Trauma including PTSD

132. Dr Agani emphasises the complexity of the treatment required for mental traumas:

“[the treatment] definitely cannot be reduced in taking antidepressants or antipsychotics for one period of time. Psychotherapy, counseling and strong social support are necessary elements for effective treatment. Unfortunately this kind of treatment is still not available for majority of Kosovar population despite large efforts and initial results of the Ministry of
Health and UNMIK to improve situation in this field.” (ibid., par.17)

133. Dr Feride Rushiti, Executive Director of KRCT, writes that

“Even though we feel a moral obligation to accept all people who seek for our assistance, the limited capacities (human and financial) that KRCT possess make it impossible to cover the treatment needs of the potential returnees with PTSD.” (KRCT, 2003a)

She added, in an email sent subsequent to the interview:

“As you know KRCT is the only organisation who is providing psychological and medical treatment in Kosovo with low capacity comparing with the huge request of people who need to be treated from PTSD. Currently the KRCT centres are involved with specialist neuropsychiatrists and one psychologist (who is engaged only 50%). Considering the fact that we didn’t have an education in this field, the few experts who got some training are not able to provide the same treatment for PTSD like in the UK. Therefore we beg the government of the UK to offer treatment to the Kosovan families who are suffering from PTSD and other mental disorders as we don’t have enough human resources and professionals to deal with such important and complex issues.” (Rushiti, November 6th 2003)

Trauma and the Effects of Disrupted Treatment on Return to Kosovo

134. The Head of the Neuropsychiatric Department in Prishtinë University Hospital, Dr Afrim Blyta, stated in interview that:

“PTSD / Depressives etc …will be totally on their own if they return and probably find their way to the Hoxha [the Muslim Priest] or traditional healer to find an alternative way of help. If they have money they can buy drugs from the pharmacy at 150-200 Euros for a month’s supply or find a private clinic.”
135. The KRCT Statement also describes the ill effects of disrupting treatment on return to Kosovo:

“…returning here in the environment where he / she encountered traumatic experiences will inevitably result in a deterioration of their mental and physical health and unfortunately most of the good work achieved [by a] therapist in the UK will be undone as no one will be able to support their needs on return.”

(KRCT, 2003a)

136. An Official Declaration given by CSME states:

“Our respect for British Government is very high. We as CSME staff express our admiration for the support that Albanian people have received from the British people and the government and respectfully ask careful considerations [to be given to] returning our victims of war in order to prevent increased risk to their mental health and overload our already, overstretched, limited service.”

(CSME, 2003a)
VI. Summary of Findings

[relevant paragraphs in text marked in boxed brackets]

i) There is no operative legislation in Kosovo that protects patients against wrongful detention or the forcible use of drugs. The establishment of patients’ rights awaits agreement on controversial draft legislation [16].

ii) The Mental Health Strategic Plan is gradually being implemented, with the opening of six psychiatric wards for severely chronically and/or acutely ill patients and seven Community Mental Health Centres (CMHCs) [19]. Two out of 14 protected apartments are now functioning, and two further apartments are in the process of being built [20].

iii) Despite the advances in support of the Plan and its implementation, including the gradual introduction of more socially and family orientated community services, psychiatric treatment remains biologically orientated [22][130].

iv) A mental health module has been included in the training for primary care [19], and degree courses in psychology have been established [21]. More training for professional staff in non-biomedical approaches, as well as budget management, and further development of community services are now policy priorities [23].

v) The psychiatric wards provide 154 beds between them [31][33]. There are 36 additional beds in the ward in North Mitrovica, which has a Serb population and cannot be accessed by Kosovan Albanians. The beds in Pristina (72), in Peja (18) and in Gjakova (26) are not used by the Serb minority population [38].

vi) The psychiatric wards do not provide out-patient treatment or care or follow-up support [35]. The material conditions are basic [31]. They are severely short of qualified staff and do not have the resources to meet the demand [36][37]. The
treatment depends entirely on drugs but there is only a limited range and they are in short supply both in the wards and in the CMHCs [51].

vii) A wider range of drugs than those available without charge in the hospital wards and the CMHCs can be bought privately but their cost puts them entirely out of reach of most people [47][128].

viii) The seven CMHCs are purpose built rehabilitative Day Centres that cater for chronically ill people who are in remission. Except for Prishtinë, which covers a larger area, they cater for regions with populations of 250,000-330,000 and each at most employ two psychiatrists, two counsellors, one social worker and one shared psychologist [Table, p. 24]

ix) The CMHCs are not attended by people suffering from post traumatic stress disorder [47] and do not cater for children [44] or women who have been violated [46].

x) There are no CMHCs used by Serbs in Mitrovicë or Ferizaj [48][49]. Negotiations about providing additional CMHCs for the Serb population in North Mitrovicë, and in Shtërpeç, which borders on Ferizaj, have so far failed [24][120].

xi) Accessibility of hospital and community based services is affected by the problems caused by separate provisions for Serb and Kosovan Albanian populations [120]. People living in areas where they form a minority are reluctant to use the local services [48].

xii) The emphasis in the CMHCs is on supportive therapies undertaken in the Centres and in the community, including some counselling. Some training of nurses and psychosocial counsellors has taken place [52][53].

xiii) Shtime is an old style mental institution intended for people with intellectual difficulties but also housing patients with mental illnesses. It has a poor human rights record. Facilities for rehabilitation have recently been introduced in new
buildings in the grounds. There is a plan to withdraw psychiatric patients and move them to community provisions [55-62].

xiv) There are as yet no special mental health services for children [123]. There is no in-patient care for children in any of the psychiatric wards [32]. CMHCs do not cater for children but a Child and Adolescent Mental Health Centre providing out-patient care is being built within the University Clinical Centre. There are also limited out-patient facilities for children in Family Medicine Centres where neuropsychiatrists are practising as part of their training in child psychiatry [44].

xv) The public mental health services are not able to provide socio-therapeutic or psychotherapeutic treatment [64][65]. Non-Governmental Organisations (NGOs), using more relational and community orientated methods, aim to respond to stress resulting from war and / or provide protection for vulnerable women and children: KRCT [67-75]; CSME [75 – 77]; medica mondiale interdisciplinary team [78-81]; CPWC [82-86]; Safe Houses [87-93]; Counselling Centre for Children and Parents [94-100]; ONE to ONE [101-105].

xvi) NGOs are overwhelmed with work and have to provide services with insufficient psychiatric and other qualified staff [74]. KCRT and CSME Official Declarations state, with regret, that they are too overloaded to be able to give effective help to returnees who have mental health problems [133][136].

xvii) Problems articulated by one NGO are common. They refer to scarce resources; inaccessibility of services for those living in rural areas; lack of materials; too few professionals who can assess people with special needs; and the general lack of mental health professionals in Kosovo [99].

xviii) Strong concern is expressed in the public sector [130][134], by NGOs [121][133] and by UNMIK [117] about the
unavailability and unsuitability of treatment for returnees who are in need of mental health services and the lack of safety and appropriate provisions for women and children amongst them.

xix) Voluntary returns are co-ordinated through IOM’s office in London. The Prishtinë office receives details, and, in the case of illness, informs London whether it can be treated in Kosovo. On arrival voluntary returnees who are ill are met and assisted [125][126].

xx) The UK Government no longer provides funds for any longer-term further re-integration of voluntary returnees [126].

xxi) Involuntary returnees are not eligible for services given by IOM to ill returnees and there are no equivalent services for them [127].
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Appendix A: Checklist of questions to be addressed in the course of the fieldwork

Description of Catchment Area

• Municipalities covered
• Size of population
• Urban and rural distribution of population
• Distribution of ethnic composition (Kosovan Albanian, Serb, Ashkaelia, Goran, Bosnian)
• Involvement of area / villages in past conflict and its effects

Range of Provisions available

Hospitals

Location

• Is it the only hospital in the catchment area with mental health facilities
• Do people living in the area have access to other hospitals with mental health facilities
• What is the furthest distance people may have to travel to get to a hospital with mental health facilities to which they are allowed access

Target Group

• What forms of mental illness is the hospital meant to cater for: e.g. acute states, chronic illness, distress, PTSD, severe learning difficulties, trauma in children, dementia in elderly

Funding and administration

• Who funds the hospital (Kosovo’s Ministry of Health; Belgrade, international organisations etc)
• Who runs it (central Ministry, Municipality etc; get organisation chart if possible)

Referral and waiting lists

• How / by whom are patients referred
• How long does it take before they are seen / treated
• Do people pay for hospital out-patient care, admission, stay, treatment
• If so is this because they are insured

Admission
• What happens to a person in an emergency (e.g. attempted suicide)
• What are the admission procedures (in emergency and otherwise)
• Who does the admitting (in an emergency and otherwise)
• Can ‘anyone’ be admitted and treated here
• Is ‘anyone’ admitted here

No. of beds
• How many beds are available
• How many of these are in wards for mentally ill people

No. of psychiatrists / other professionals
• How many psychiatrists are employed here
• How much time do they give to their work in the hospital
• What is their approach to treatment
• How many nurses
• Does the hospital employ any psychologists
• How many other workers (care workers)
• What training has been available to each of these professions

Treatments
• Is ECT used and how frequently
• What drugs are used
• Are the drugs safe and how are they obtained
• Are any drugs not available (say which)
• What other kinds of treatment are used (e.g. psychoanalysis, psychotherapy, family therapy, counselling, special help for people suffering PTSD, special help for women suffering violence / rape, special services for returnees, other(e.g. OT))
Average length of stay as in-patient

Links with community services
- What happens when people are discharged (where referred to etc)

Community-Based: Sheltered / Safe / Housing

Catchment area
- What is the size and nature of the catchment area (get map if possible)
- Are people admitted from outside the area
- From how far away do people come here; how do they travel
- What other related provisions are in the area and of what kind (e.g. Govt., private, NGOs)

Target Group
- Are the provisions for any particular group, e.g. women, elderly, children, adolescents, families, children of mixed ethnic marriages, children of mothers who have been raped
- What circumstances are catered for e.g. homelessness, mental or physical illness, PTSD, victimisation (torture, rape)
- Are there any groups of people who would qualify by circumstance and group but who are disqualified on other grounds (e.g. ethnic minority membership, returnees)
- Is there a waiting list, and if so how many people are currently waiting and how long are they likely to wait
- Are there some people who have priority

Referral and waiting lists
- How / by whom are people referred
- How / by whom are their needs assessed
- How long does it take before they are given a place
- Do people pay for accommodation / food...

Services offered
- Housing without any further services
- Hostels
- Accommodation with services and warden
• Safe Housing for women and families
• Where services are provided, are medical services offered, and of what kind (e.g. special gynaecological services for women?)
• Where facilities are provided do these include social therapeutic services (counselling, social work) and direct help (daily living help)

Length of Stay
• How long do people stay here on average
• Have some people stayed for substantially longer, and, if so, for what reason
• Is there a shortage of places

Resources and administration
• How many staff and what is the ratio of staff to clients
• How much time do the staff give to the work
• What are their qualifications
• What is the budget allocation
• How is the budget broken down into salaries for different staff
• Where does the money come from
• Who runs the service offered

Links with other services
• What other services are in the area that relate to the work being done
• In which ways are they complementary to what is being provided

Community Mental Health Centres

Catchment area
• What is the size and nature of the catchment area (get map if possible)
• Are people able to use the Centre from outside the area
• From how far away do people come here
• What other related provisions are there in the area and of what kind (e.g. Govt., private, NGOs
Target group

- Does the Centre focus on any particular group, e.g. women, elderly, children, adolescents, families, people who have been tortured / traumatised
- What circumstances are catered for e.g. mental or physical illness, PTSD
- Are there any groups of people who would qualify by circumstance and group but who are disqualified on other grounds (e.g. ethnic minority membership, returnees)

Referrals and waiting lists

- How and by whom are people referred here
- How and by whom are their needs assessed
- Is there a waiting list of people wishing to use, or being referred to, the Centre
- Is the Centre open to anyone in the area
- Are there some people who have priority for attention / treatment

Treatments / help offered

- Are medical services offered, and of what kind (e.g. special gynaecological services for women? Disabled people?)
- What other therapies are available (e.g. psychoanalysis, psychotherapy, family therapy, counselling, social work, direct help in the home, special help for people suffering PTSD, special help for women suffering violence / rape, special services for returnees (e.g. re-integration, follow up) other (e.g. OT))

Resources and administration

- How many staff are there and what is the ratio of staff to clients
- How much time do the staff give to the work
- What are their qualifications
- What supervision and support do they receive
- What is the budget allocation
- Where does the money come from
- Who is ultimately responsible for the Centre
- Who runs the Centre
- Who monitors what the Centre is doing
Other relevant community-based services

• Role of Ambulanta
• Role of Workers Dispensary
• Private Consultations
• Spiritual leaders

Voluntary Organisations

Area covered in Kosovo

• Does the organisation have a permanent presence in Kosovo; If the organisation is not permanent are there any arrangements for handing over its work
• What parts of Kosovo does the organisation cover
• Is there a Head Office and if so where
• Are there satellite stations and if so where are they

Target Group

• Does the organisation focus on any particular group, e.g. women, elderly, children, adolescents, families, people who have been tortured / traumatised
• What circumstances are catered for e.g. mental or physical illness, PTSD, homelessness, destitution, integration of displaced persons
• Are there any groups of people who would qualify by circumstance and group but who are disqualified on other grounds (e.g. ethnic minority membership, returnees)

Treatments / help offered

• Are medical services offered, and of what kind (e.g. special gynaecological services for women? Disabled people?)
• What other therapies are available (e.g. psychoanalysis, psychotherapy, family therapy, counselling, social work, group work, advice, direct help in the home, special help for people suffering PTSD, special help for women suffering violence / rape, special services for returnees e.g. re-integration))
• Does the organisation give direct practical help

Referrals and admissions

• How and by whom are people referred to the organisation
• Is there a waiting list for some or all services and if so how many people are currently waiting and how long are they likely to wait
• Are there some people who have priority for help / attention / treatment

Resources and administration
• How is the organisation funded (short-term; long-term)
• How many staff are employed

Links with other services
• What other services are in the area that relate to the organisation’s work
• In which ways are they complementary to the organisation’s work

Resources for Mental Health Services and Institutional Frameworks (General)
Overarching issues that might be discussed in meetings with key people, including members of ethnic minorities:

National policies / guidelines / monitoring systems
• What have been the outcomes of the Strategic Plan
• What are the main achievements
• Have there been changes in legislation since 1999 and what are they
• What changes in provision have come about in the last year
• Who has oversight of provisions
• Who holds the purse string
• Who monitors what goes on
• Have funds increased / decreased since the Plan was drawn up
• Has anything replaced the Plan

Policy Development
• Training
• Is there a Faculty of Psychology in Pristine
• Funding (short-term; long-term)
• Special services for children
Opportunities for members of ethnic minority groups

• Is there any active government policy that ensures that ethnic minorities have equal access to mental health services
• Are there policies designed to prevent exclusion of ethnic minorities
• Are there special schemes for training people to work with ethnic minorities
• What barriers are there for ethnic minorities in access to mental health care
• How do ethnic minorities experience mental health treatment
• What possibilities are there for members of ethnic minorities to obtain work in the mental health field

Priorities

• If more money were available for mental health services in Kosovo what would be the priorities for their allocation?

Problems

• Are there some main pressing problems (e.g. relating to resources, training gaps, administration, ethnic divisions)
Appendix B: List of contributors to the research

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Appendix C: UNMIK ‘Introductory Note: Information Format for Non-Voluntary Returns to Kosovo’

Introductory Note

The UNMIK Information Format for Government Authorities Sending Forced Returnees back to Kosovo

On numerous occasions over the past three years UNMIK has received displaced persons from Kosovo that have been forcibly returned from host countries throughout Western Europe. We have been grateful to those States for the kindness and humanitarian spirit that they showed in accepting and assisting those individuals and families so gravely affected by the period of conflict in Kosovo.

In order to facilitate an orderly return within Kosovo, UNMIK has consistently requested that both sufficient information and notice be given to our border and returns authorities of coming deportations. Such notification ensures that the appropriate reception arrangements can be put in place before the deportees arrive.

To this end, in respect of Kosovo Albanians only, we have asked that host governments give UNMIK a minimum 3 working days notice before the deportation of ‘normal’ cases and 7 working days for ‘special’ cases, i.e. those persons with mental illnesses or with some form of criminal record.

While we appreciate the burden that the prolonged stay of Kosovo asylum seekers has placed on the host countries, it should be reiterated that only Kosovo Albanians should be considered acceptable for repatriation at present. Minorities should not be forcibly returned due to security concerns that still exist in most minority communities and potential return locations throughout the province. We further ask that no one with an illness or injury that is untreatable in Kosovo should be forcibly returned until such time as the need for treatment has ended.

Unfortunately, repatriating authorities have not always followed this policy nor have they always passed on adequate information to ensure that minorities and the disabled are not returned. This has resulted in cases of vulnerable minorities, persons with mentally-
illnesses, and even individuals not from Kosovo being forcibly returned to Pristina. In most such cases, the arrangements are not in place to take care of these people or the treatment they need is not available.

To remedy this information and notification gap, UNMIK has designed a form to guide host country authorities in the screening process for deciding whether to deport an individual or not. In practice this form should be filled out and sent to UNMIK as part of the deportation notification process which has been spelled out above. This form asks host authorities for the key information needed by UNMIK to prepare adequately to receive these forced returnees. This information will also allow UNMIK authorities to alert host countries to reconsider deportation orders in cases where a vulnerable individual is slated for repatriation.

UNMIK would greatly appreciate host countries cooperation and assistance in making the forced repatriation of individuals from Kosovo a more smooth and consistent process.
1. Name of Returnee (or head of household): 
........................................................................................................

2. Sex: M / F

3. Marital Status of Returnee: Single / Married / Divorced

4. Family Size: ................................................................................

4a. No. of school age children: ......................................................

4b. # of dependents traveling with individual: ..............................

5. Ethnicity: ...................................................................................

6. Place of origin (village / municipality / region): .......................

7. Last place of residence in Kosovo (village / municipality / region):
........................................................................................................

7a. Has the host country made any assessment of the sustainability of living conditions (access to public and social services, including medical care, and utilities or special security considerations) for the individual / family in their place of former residence (i.e. A Kosovo Albanian returning to the Northern Mitrovica area)? If so to attach a copy:
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8. Does the individual / family have relatives remaining in Kosovo?
Where (exact address)?: .................................................................
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.................................................................................................
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9. Have other relatives or community members returned to Kosovo?
Where?: ..........................................................................................
.................................................................................................

10. Does individual / family own property or have a house?
Condition of house: .................................................................
.................................................................................................

11. Address or names of relatives / friends where individual / family intends to stay upon return:
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.................................................................................................
.................................................................................................

12. Does the individual / family member have travel documents?
Type / Issuing authority:
.................................................................................................
.................................................................................................
.................................................................................................

13. Date of arrival in host country: ................................................

14. Reason for deportation: ............................................................
.................................................................................................

15. Was individual / family give notice prior to deportation? ............
15a. Who was notified? (individual / family member / relative / friend / neighbour / physician / lawyer / contact person in Kosovo / NGO):

........................................................................................................

15b. How far in advance was notice given?: .................................

15c. Did the individual / family objected to or appeal against the decision to deport? If yes, on what grounds did they object and what reasoning was given by the competent court / tribunal? (Please attach any letters, written appeals, or court / tribunal decisions)

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16. Did the individual or a family member being returned have a criminal record while in Country of Asylum? (if yes, please specify):

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17. Does the individual or a family member being returned have any medical conditions, including mental illnesses or mental / physical disabilities, for which they are currently receiving treatment in host country? (if yes, please specify individual, diagnosis, type of medical condition / illness / disability, and type of treatment being received):

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17a. Has the host country assessed whether any treatment for this medical condition / illness / disability is available in Kosovo and whether such treatment would be accessible to the individual / family member?

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17b. How seriously would the lack of available treatment for this condition affect the returnee’s health? Potentially life threatening / severely disabling / moderately disabling / no significant affect on day-to-day activities (please supply any medical assessment)

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........................................................................................................................................
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18. Was the individual / family a victim of or witness to serious violations of human rights or humanitarian law that led or could be expected to lead to trauma? If so, please provide a copy of any assessment that has been made of the likely psychological effects of return to Kosovo – or if no assessment has been made, explain why this was not thought necessary:

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........................................................................................................
........................................................................................................
........................................................................................................

18a. Are such incidents or individuals responsible still a concern for the individual / family?

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Appendix D: About the authors

Dr Helen Bolderson


Mrs Karen Simpson

Karen Simpson is a counsellor with a special interest in working with asylum seekers and refugees. She has worked for the last 10 years with this group both overseas in Africa and in the Balkans on public health and psychosocial programmes as well as at home on therapeutic projects towards promoting better mental health of refugees in the statutory and voluntary sector.

She currently works as a Counsellor within a Refugee Psychology Service for North East London Mental Health Trust based in the Borough of Waltham Forest and provides a service combining one-to-one clinical work, community development, awareness raising and training.

She was first introduced to the people of Kosovo working for the British Red Cross in 1999 through the reception of Kosovan Albanian refugees in the UK. She subsequently worked in Kosovo from 1999 to 2001 with Tearfund and the International Catholic Migration Commission on a post war, humanitarian public health and psychosocial programmes and was involved in the initial stages of the development of the Mental Health Strategic Plan for Kosovo. She returned to Kosovo on behalf of the Medical Foundation for the Care of Victims of Torture in 2003 to conduct the research for this paper.