SOVEREIGN ORDER OF MALTA

# RECOMMENDATIONS

related to the

## Mental Health Component

of a programme of assistance to the

## Indo-China Refugees

in

## THAILAND

DAVID DRUCKER
14 OCTOBER 1981
BANGKOK
THAILAND

## SUMMARY OF RECOMMENDATIONS

It is recommended that :

1. UNHCR assign a staff member and (with the collaboration of the Volags and CCSDPT) create a 'core group' responsible for initiating establishing and following-through these recommendations and developing the approaches to this whole area of concern;

2. the volags in each camp collaborate in mobilizing existing staff into a Consultative Counselling Service;

3. a Social Service Co-ordinator be designated from the existing staff for every camp and that parallel provision be made (as for Medical Co-ordinators) at CCSDPT and UNHCR;

4. the above allocation of Volag staffs (for recommendations 2 and 3) be incorporated into the terms of formal agreements with UNHCR;

5. a refugee-manned do-it-yourself information facility be established;

6. especially for the emotionally disturbed, we extend the work of constructing an active collaboration and modus vivendi between traditional medical practitioners and modern Western facilities; that all assistance be given for the establishment of traditional medicine centres in the Hill Tribe camps in the north; and that such facilities be extended as appropriate to those camps where currently they are not established;

7. there be a complete detailed review of the procedures and processes in moving patients from camps to hospitals;

8. the above review (7) be followed by the preparation of a complete set of communication materials (i.e. standard letters, standard forms, flow charts and response tags etc.) in order to simplify the work of all concerned;

9. when the communication materials (8) are ready, a short Information Campaign be mounted to draw attention and to familarize the concerned persons with the procedures and ways of handling these, and to repromote a "system" which will continue to function despite the constant and rapid change of

personnel which charachterizes the situation in the camps;

10. the responsibilities be clearly delineated for :
    (a) maintaining the paper work of the referral 'system';
    (b) providing professional guidance, support and consultation in handling the patients who might be put into the system;
    The job descriptions of the persons appropriately assigned these roles should clearly reflect the tasks which are to be performed;

11. the Volags should recruit or replace nurses, so that there will be in each camp at least one nurse with training and experience in the care of the psychiatrically ill and emotionally disturbed. The most experienced of these nurses should be assigned strategically throughout the camps, i.e. in the larger camps (Panat Nikhom, Ban Vinai, Khao I Dang) or where there might be special need (for the boat people, Nakhorn Phanom? Lumpini?);

12. a buddy-system of refugee volunteers be established to assist the medical facilities by befriending and accompanying those patients who are disoriented and wander about the camps;

13. a social service staff member with experience of the mentally ill be assigned to reinforce the medical care and the work of the Medical Co-ordinator at Phanat Nikhom. The staff member should assist with the taking of case histories,and provide documentation and descriptive material outlining the behaviour which has led to referral. The staff member should assist the families of patients, protect their resettlement status and follow through the cases to and from Chonburi hospital or Lumpini. The staff member should assist the medical co-ordinator at Lumpini with these cases, and would be one of the 'core group' working with the person who had overall responsibility for the mental health programme.

14. a similar social service staff member link be established between Lumpini and Bangkok General Hospital (and, if appropriate with Samitivej Hospital). The staff member should regularly visit and assist the medical co-ordinator

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at Lumpini, and liaise closely with the Panat Nikhom-based staff member;

15. all efforts continue to be made to meet the boat people as soon as possible on landing and to give warm and sympathetic reassurance. Information should be given regarding the assistance that is and will be available to them. A psychiatric nurse or skilled counsellor should be added immediately to the CRS medical team;

16. an urgent attempt be made in Sikhiu (through IRFF who are the only Volag presence) and in Phanat Nikhom (for the present group of boat people) to make adequate provision so that directly or indirectly those who have experienced great trauma have the opportunity to "talk-out or "digest" and work through their emotional reactions;

17. systematic efforts should be made by the Consultative Counselling Service and others to write up case materials and case situations and for these to be compiled as a refugee case book;

18. work should continue on compiling an 'annotated bibliography' and a 'reader' for training purposes.

19. the 'core group' should assist in devising training for social service staffs on an "as needed" basis and that on-the-job consultation and tutoring should be the main method. As similar needs are recognised in a number of camps special workshops might be mounted.

20. every effort should be made to stimulate policy and programmes that will lead to resettlement (or repatriation) of communities rather than individually sponsored families. International agencies (UNDP, FAO, UNICEF, WHO etc.) should be encouraged increasingly to promote development projects (within the context of country planning and support programmes) which are especially designed for the receiving of refugee communities.

INTRODUCTION

The mental health component of the revised Sovereign Order of Malta programme for handicapped/disabled refugees in Thailand was set out as follows:

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"This programme seeks to examine and evaluate the mental health needs of refugees while indentifying and mobilizing available resources. A contribution will be worked out in collaboration with the many existing agencies.

This programme offers active support and, where required, training for staff who are called upon to provide services to the mentally disturbed. In addition to this an attemptwill be made to reduce the general level of anxiety within sepcific camps by constituting methods for improving the flow and reliability of information available to refugees."

Since 1st July 1981, DAVID DRUCKER and JAN WILLIAMSON, with the collaboration of RICHARD SCHMITT and the S.O.M. Rehabilitation Counsellors, have concerned themselves with this aspect of the programme.

The service activities that S.O.M. has initiated have at the same time provided an element of action research, and the "findings" and recommendations which are briefly outlined here are a direct outcome of this servicing work/*.

IDENTIFICATION OF THE PROBLEMS

There is a consistantly reported impression that the incidence of psychiatric illness and emotional disorder in the refugee camps is much on the increase/**. Nevertheless, despite these reports, the clinically psychi-

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Foortnote:

/* The activity of the Mental Health Consul tants is detailed in three periodic reports : July, August, September/October 1981

/** It is not clear what processes are at work here:
1. More people breaking down?
2. The well-known delayed action response by those who have been caught in situations demanding concentration on plain physical survival?
3. The debilitating experience of prolonged living under refugee camp conditions?
4. Emergency situations subsiding and the medical profession more readily identifying such disorders?
5. Provision by the S.O.M. of a new resource for the psychiatrically ill leading to a growing rate of referral? etc.

atrically sick under medical treatment seem suprisingly few in number. However, there is widerspread reporting and concern in relation to psychosomatic disorders, family dissension, some child neglect linked to the general apathy and dependency associated with confined institutionalised living conditions, and a high level of anxiety, depression and hysterical symptoms related to emotional trauma (attack, flight, deaths of family members,assault, rape etc.).

All the indications are that this constitutes a massive "at risk" incidence in the camp population and is the latent explosive in the so-called "psychological time bomb" that is being experienced and reported in the receiving countries and in the professional literature. It is clear that anything that can be done in the camps here to relieve these pressures is a prophylactic contribution of major importance in the preventive public health sense.

It is self-evident that any approach to these problems goes far beyond medical-care into the realm of social service programmes, which have an all important role to play. Crucial for draining the dangerously dammed-up disturbance present in the camp populations will be the manner and effectiveness with which the caring agencies and their staff can reach fundamentals at the same time as they perform their immediate and specific tasks of relief and provision.

Much can be achieved by raising and maximising efforts which will:

(a) assist in providing the stimulation and impetus for the repair reconstruction and improvement of traditional and familiar community cohesion and support processes;

(b) repromote the sense of personal identity, belonging and mutual concern which can come from undertaking tasks and learning new skills in small group situations;

(c) provide the opportunity for expressing, reviewing and reflecting upon what has befallen them as individuals, members of family groups and close-knit communities, and which has violently precipitated them (from familiar and interlocking roles, personal

expections, rights and duties,) into the puzzling and frightening ill-defined status of refugees ("displaced persons", "illegal immigrants", "economic adventurers");

(d) prepare the way as smoothly as possible for the refugees, to realistically appraise their present and future options; explore the range and magnitude of the adjustments that will need to be made; anticipate the problems; and seek out the knowledge, and practice the skills and attitudes, which will be helpful in the new conditions.

The above presents the background thinking to the recommendations. However, given the very fluid situation and the constant turnover of field staff there needs to be a few "fixed-point" staff members and someone responsible for developing a mental health programme should be clearly one of these fixed points.

Our experience has been that there is a constant need for "trouble-shooting" in this field where there are so many unexpected problems and so much collapsing of "systems". The troubles need to be tackled as they arise, it needs to be known who to contact as need arises in the camps, These troubles are also excellent take off points for diagnosing the more deep rooted problems in the refugee situation. A competent and alert Mental Health group drawn from the Volags and given leadership would have much to contribute generally in improving services and ensuring their effectiveness. This means personnel are required.

## UNHCR SOCIAL SERVICE NEEDS TO BE REINFORCED

UNHCR has one Associate Welfare Planning Officer who has very many responsibilities - allocation of funding to the voluntary agencies; vocational training; self-help projects; family reunification movements for Kampucheans; and monitoring all the voluntary social services programmes. Clearly he is not in a position to fulfill all these duties and take on the additional work needed to carry through these mental health recommendations.

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It will become very obvious from the recommendations and from the three months work that has prompted them that the Mental Health Consultants have merely touched the surface and identified the crudest parameters of meeting the mental health needs of the Indo-China refugee populations/***.

The mental health situation of refugees is attracting more and more concern and work throughout this field has been thin. There is much to done here in Thailand and in the region which might eventually be important for refugees everywhere. UNHCR seems to be in the best position to initiate and coordinate efforts in this Mental health field yet presently lacks the staff, therefore it seems to us imperative and we so recommend that :

1. UNHCR assign a staff member and (with the collaboration of the Volages and CCSDPT) create a 'core group' responsible for initiating, establishing and following through these recommendations and developing the approaches to this whole area of concern.

The UNHCR staff member would also work with the various social service programmes now operating to assure that on a case-by-case basis they assisted the handicapped refugees and following through on the individual treatment plans developed in 1981.

THE CONTRIBUTION OF THE WORK OF THE VOLAGS IN MEETING SOME OF THE MENTAL HEALTH NEEDS.

Special provision for the psychatrically ill or emotionally disturbed will only be necessary when efforts at the general level of service are not adequate to the situation. Therefore, a major approach to the psychological problems surfacing in the camps must be to assist in orienting and mobilising the existing service resources and upgrading their performance at the operational level, so that they will be better able to focus some attention

Footnote:

/*** There is not one population. In Thailand the refugees are from many different ethnic groups with different histories and different futures open to them. Althrough they all share the experience of being displaced (recognised officially or otherwise as refugees) their experience and expectations differ dramatically from camp to camp.

Social Service Co-ordinator at the camp level would facilitate the collaborative work of the Volags and strengthen the whole situation. The Co-ordinator could assist the UNHCR field officer in stimulaing the refugee section leaders to carry more and more effective community responsibility. Co-incidentally, of course, this would enhance the picking up and provision for the not-anyone's - specific - responsibility situation (the mentally and emotionally disturbed, for example).

Because the recommenddations of both the Consultative Counselling Service and the Social Service Co-ordinator require Volog staff-time outside of exclusive time given to each agency's projects,

It is recommended that:

4. the above allocation of Volag staffs (for recommendations 2 and 3) be incorporated into the terms of formal agreements with UNHCR. It there were to be a UNHCR(and/or CCSDPT) based Social Service Co-ordinator (as there is a Medical Co-ordinator) it would complete the links in the chain and the above recommendations would much strengthen the operational and organisational strength of the UNHCR officials responsible for the Social Services

THE LACK OF RELIABLE INFORMATION TO REFUGEES FEEDS ON MUCH DISTURBING RUMOUR, WHICH RAISES ANXIETY AND DEPRESSION LEVELS IN THE CAMPS.

It is recommended that:

5. a refugee-manned do-it-yourself information facility be established.*

TRADITIONAL MEDICINE AND INDIGENOUS HEALERS PROVIDE MUCH REASSURANCE AND SUPPORT

Especially for many emotional disorders displayed by those deeply

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Footnote:
For a description of what it is and how to establish a do-it-yourself information facility, see : "A do-it-yourself information facility to disperse some of the anxiety in the refugee camps" by D. Drucker - September 1981.
(Discussions towards establishing such a facility are currently underway)

embedded in traditional cultures, the healers often provide the "treatment of choice" in the refugee situation. The Traditional Medicine Centres are an important resource if conducted efficiently.

It is recommended that:

6. especially for the emotionally disturbed we extend the work of constructing an active collaboration and modus vivendi between traditional medical practitioner and modern Western facilities; that all assistance be given for the establishment of traditional medicine centres in the Hill Tribe camps in the north, and that such facilities be extended as appropriate to those camps where currently they are not established.

## THE FRANKLY PSYCHIATRICALLY ILL

None of the camps have a facility specially for the mentally ill. Therefore cases of necessity must be dealt with on the basis of good general medical practice and according to the available general medical facilities in each camp. It happens that from time to time and from camp to camp, medical or social service staff do arrive with some kind of psychiatric back-ground, but they are not recruited on the basis of their psychiatric background or skills, and although obviously they are pressed into service as required on an adhoc basis, there has been no specific planning or specific responsibility designated for the care of the psychiatrically ill.

However, where these patients cannot be handled by the general medical resources in the camp, there are procedures for referral and transfer to hospitals outside the camps. The procedures for permission to transfer patients from the camps are complex, time-consuming and sometimes politically delicate. The procedures for the psychiatrically ill are exactly the same as for medical cases but it is of significance that this does not seem to be widely appreciated by the Medical Co-ordinators in the camps despite the work already done to have this known and acted upon.

Psychiatric facilities in the District and Provincial hospitals for the Thai population generally are very limited also, and in practice the more disturbed and difficult refugee patients are transferred via the Lumpini Transit Camp to the Bangkok General Hospital, (where the UNHCR has a contractual agreement to receive, diagnose and treat). At the present time the refugees are being consolidated in fewer camps and there has been an increasing flow of refugees for resettlement through the transit camps. This has resulted in a very large turnover of people in the holding/transit camps. Phanat Nikhom serves as a kind of funnel or hopper and it is not surprising, therefore, given the flow and high state of excitement in the camp (compared to the camps with more static populations), that psychiatrically ill refugees are being picked up there. From Phanat Nikhom the International Committee for Migration (ICM) moves large numbers of refugees and during the routine medical examinations immediatly prior to embarkation from Thailand (when emotional tension runs high) more psychiatrically ill patients are picked up. "ICM patients" are usually sent to Samitivej Hospital for assessment only (apparently no treatment, medication or handling advice is given there) but sometimes these patients are also channelled to Bangkok General Hospital. There is pressure to have ICM patients quickly refunnelled through Phanat Nikhom again. A psychiatric breakdown, or even a lay person's psychiatric "labelling" can totally destroy both the patients' and their family's chances of resettlement and at best will result in a "one-year-hold". Our experience shows that the movement of patients from the camps through Lumpini to the Bangkok General Hospital and back again has been plaughed with problems.

It is recommended that:

7. there be a complete detailed review of the procedures and processes in moving patients from camps to hospitals. *

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Footnote: Currently underway

It is recommended that:

8. the above review (7) be followed by the preparation of a complete set of communication materials (i.e. standard letters, standard forms, flow charts and response tags etc.) in order to simplify the work of all concerned.

It is recommended that:

9. when the communication materials (8) are ready, a short Information Campaign be counted to draw attention, and familarize that concerned persons with the procedures and ways of handling these and to repromote a "system" which will continue to function despite the constant and rapid chance of personnel which charachterizes the situation in the camps.

It is recommended that:

10. the responsibilities be clearly delineated for
    (a) maintaining the paper work of the referral 'system';
    (b) providing professional guidance, support and consultation in handling the patients who might be put into the system;

    The job descriptions of the persons appropriately assigned these roles should clearly reflect the tasks which are to be performed.

PROFESSIONAL SUPPORT TO THE MANY PERSONS INVOLVED IN CARING FOR THE PSYCHIATRICALLY ILL INCLUDES THE SUPPLEMENTING AND STRENGTHENING OF WHAT MEDICAL RESOURCES WE DO HAVE IN THE CAMPS.

It is recommended that:

11. the Volags should recruit or replace nurses, so that there will be in each camp at least one nurse with training and experience in the care of the psychiatrically ill and emotionally disturbed.

    The most experienced of these nurses should be assigned stra-

tegically throughout the camps, i.e. in the larger camps (Panat Nikhom, Ban Vinai, Khao I Dang) or where there might be special need (for the boat people, Nakorn Phanom).

It is recommended that:

12. a buddy-system of refugee volunteers be established to assist the medical facilities by befriending and accompanying those patients who are disoriented and wander about the camp.*

It is recommended that:

13. a social service staff member with experience of the mentally ill be assigned to reinforce the medical care and the work of the Medical Co-ordinator at Phanat Nikhom. The staff member should assist with the taking of case histories, provide documentation and descriptive material outlining the behaviour which has led to referral. The staff member should assist the families of patients, protect their resettlement status and follow through the cases to and from Chonburi hospital or Lumpini. The staff member should assist the medical co-ordinator at Lumpini with these cases. The staff member would be one of the 'core' group working with the person who had overall responsibility for the mental health programme.

It is recommended that:

14. a similar social service staff member link be established between Lumpini and Bangkok General Hospital (and, if appropriate with Samitivej Hospital). The staff member should regularly visit and assist the psychiatrists at the hospitals and the medical co-ordinator at Lumpini, and liaise closely with the Phanat Nikhom-based staff member.

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Footnote: For details of a buddy system see the Project Report. July 1981 (Discussions are underway to establish such a system)

THE VIETNAMESE "BOAT PEOPLE", WHO HAVE EXPERIENCED PARTICULARLY TRAUMATIC EXPERIENCES EN ROUTE, NEED SPECIAL PROVISIONS.

It is recommended that:

15. all efforts continue to be made to meet the boat people as soon as possible on landing and to give warm and sympathetic reassurance. Information should be given regarding the assistance that is and will be available to them. A psychiatric nurse or skilled counsellor should be added immediately to the CRS medical team.

It is recommended that:

16. an urgent attempt be made in Sikhiu (through IRFF who are the only Volag presence) and in Phanat Nikhom (for the present group of boat people) to make adequate provision so that directly or indirectly those who have experienced great trauma have the opportunity to "talk-out or "digest" and work through their emotional reactions;

TRAINING PROGRAMMES, A MATTER OF ON-THE- JOB TUTORING AND CONSULTATION

We are not ready to recommend set courses of training, although a contribution has already been made to social service workshops, conferences, and Social Service staff discussion groups. From the consultative consultation service and from other sources, however,

It is strongly recommended that:

17. systematic efforts should be made by the Consultative Counselling Service and others to write up case materials and case situations and for these to be compiled as a refugee case book.

It is also recommended that:

18. work should continue on compiling an 'annotated bibliography' and a 'reader' for training purposes.

It is also recommended that:

19. the 'core group' should assist in devising training for social service staffs on an "as needed" basis and that on-the-job consultation and tutoring should be the main method. As similar needs are recognised in a number of camps special workshops might be mounted.

LONG RANGE CONSIDERATIONS

Growing understanding of the mental health needs in the camps should lead to contributions towards formulating and reformulating wide policy and programmes. For example, we are already able to identify one area of major importance.

We observe that most resettlement arrangements are conducted on a sponsored family-by-family basis.

SUCH POLICIES ARE ANTITHETICAL TO COMMUNITY COHESION IN THE CAMPS AND BEYOND, AND LEAD TO THE DESTRUCTION OF TRADITIONAL SUPPORT SYSTEMS FOR THE "WEAKER BRETHEREN" AND THE LOSS OF CULTURAL IDENTIFICATION AND WELL-TRIED PATTERNS OF ADAPTATION.

To this extent the resettlement programme for some constitutes long term mental health pressures and far-reaching problems.

It is recommended that:

20. every effort should be made to stimulate policy and programme that will lead to resettlement (or repatriation) of communities

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Footnote: See letter to Robert Klinteberg from David Drucker 4 August 1981

rather than individually sponsored families. International agencies (UNDP, FAO, UNICEF, WHO etc.) should be encouraged increasingly to promote development projects (wtihin the context of country planning and support programmes) which are especially designed for the receiving of refugee communities.

It is our sincere wish that these recommendations will be responded to as they are intended to be, as the basis for discussion and for shaping into a detailed programme and project plan for 1982.

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4 August 1981

Dear Robert,

The Annual Conference has set my thoughts off in a number of directions. One of these relates to refugee "strategy" and if CCSDPT has not already addressed the matter raised here, perhaps it might wish to provide the forum for doing so.

The Volags are here in variety and multiplicity with familiar division of labour and concomittant fragmentation of service from the recipients' point of view. Although the diversity is one of the strengths of the voluntary principle, it is somewhat odd to see eagerly introduced into the Indo-China refugee context our familiar modern specialisations and classifications of clientele. There follows the struggle to establish our familiar services to meet our particular selection and definition of problems and our priorities as agencies. Such services are also related to Thai priorities and existing Thai institutions and resources. CCSDPT is of course in the business of pulling all our efforts into a coherent, integrated and effective programme.

At the same time, the refugees' definition of the problems and services are frequently expressed (for them!) in terms of "preserving the culture" "informal community support" "indigenous healers" "traditional leaders" and so on.

(Underlying all this there seems to be in operation the concept of services to rehabilitate the refugees, i.e. that but for somewhat arbitrary and external political, military, (economic ?) events, all was previously well and will continue to be so once the crisis is over. A sense of habilitation existed ! I have some doubts regarding the existence of such happy pre-conditions. However that maybe, it is evident that once the immediate life-preserving crisis subsides, the age-old (pre-refugee status) problems quickly re-emerge. But I digress.)

I see that the resettlement process seems to be based firmly on a family-by-family approach. It tends to be a nuclear rather than

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extended family we have in mind, (certainly one-wife-at-atime please!), and there is the requirement and expectation that someone somewhere in the accepting country will take sponsorship responsibility for the family. (perhaps someone can tell us how this actually works out and what it involves in reality at the receiving end). Associated with this selection procedure is the complaint (with political colouring) that "the cream" of the refugees is being skimmed and "the debris" left behind for the country of first refuge to deal with....

These are the signals I have been reading, newly arrived, as I am, on the scene.

Could we (have we?) explored the possibilities and implications of an overall approach which will begin by actively clustering families together into community entities (perhaps in units of 400 persons-a jumbo-jet load!) The make-up of such communities will, of course, be determined in part by self-selection in the camps, but efforts would be made to encourage each community to embrace and support a 'quota' of 'problem cases' 'misfits' (in the community and in the services sense).

Instead of families, we could then think in terms of small communities; they could be processed as communities, and provision made for such communities here and in the countries of reception. The 'community' (and we) should begin to think and plan around its communal fate over the long run and not as a staging post for individuals or small numbers of family members who are to be thrust into a devil-take-the-hindmost society. (Although alas, much of our would is of this kind, rugged individualism is not ordinarily the philosophy of community service-oriented voluntary organisations). In any case, there is evidence to suggest that refugee and migrant families in the early years tend to seek each other out and recluster, so making the famous "melting pot" very lumpy. (In the U.S. anyway, this ethnic lumpiness continues after a couple of centuries of migration, active Americanisation and national aspiration).

Of course, for some unfortunate individuals or small groups in some situations, special provision may be appropriate from time to time. It might mean them leaving the newly established community group. However, the community approach might be supportive and necessary at the 'newly refugeed' end of events and should continue long after in the resettlement setting.

Such a community settlement process is likely to facilitate efforts that are necessary at the receiving end of resettlement. Community support and a sense of group belonging can exist for as long as it is needed and until its members (or their more easily acculturated children) are ready to strike out on their own in the new culture. They might well derive strength and assurance from the sense of having a "home-group" - an "ethnically comfortable group" to fall back upon.

The point is that the problems and the opportunities which the situation poses ought rationally to be thought about in the perspective of, say, two generations. Refugees and Migrants are not a passing phenomenon but a large-scale and on-going process in a modern world where the land is no longer the dominant determinant of communities, and nations and geographical boundaries are unstable.

I think it is worth thinking about and planning this kind of community approach now, rather than continuing (as I see it) to go from one refugee disaster to another on a predominately ad-hoc basis. Such an approach might also provide the perspective and the framework for making the best possible long-range use of the very mobile personnel and the relatively short-term and varied efforts of Volags. Perhaps there is already significant experience of this kind of community movement we can learn from ?

Initial discussion among ourselves, some such unified strategy committment among Volags, modification of policy, process and provision of receiving nations, and some international leadership and persuasion; seem to be on this agenda.

I'd be pleased to elaborate and to help plan developments in this direction if you think that this is a constructive and realistic way to go. Your comments would be much appreciated.

Sincerely yours,

David Drucker
Project Administrator

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17 August 1981

Dear Dr. Townsend,

The CCSDPT medical subcommittee meeting on Thursday 6 August 1981 stressed the importance of promoting simple positive health behaviour and providing primary health care understanding and practices for the refugees to take with them wherever they might go. I linked this to the discussion about the absence of medical cards and the problems that arose when there were no records available regarding immunisations and so on.

It was not that the cards disintegrated (plastic envelopes help) or that they were accidently mislaid (in Bangladesh, circa smallpox, a hook was provided to hang the card on the doorpost of each hut). It was whispered to me that refugees were suspicious of what was on the card and did not want to be labelled and identified that way. Alas for mutual trust and understanding!

Could the problem(s) be tackled along the following lines?

1) Identify and spell out in lay terms the items needed to be recorded on such a card.

2) Promote a competition among the refugees to design such a card - pictures not words!

3) Prizes for the best design - adults, school children (2 age groups?)

4) Exhibit best (say 25?) designs.

5) Formal prize giving 1-2-3.

6) Simple production of cards.

7) Distribute and use.

8) Have copies displayed everywhere.

Such a 'game' would hit many targets at once:- widespread information about contact and purpose of cards, making them easily understood by the refugees (medical staff could also understand the pictures!); provide a take-off point for more focussed health education (why immunisation, etc); give some purposeful and interesting activity to the refugees and their children; bring some fun into the usual solemn medical field; give recognition to those who do a nice social service job; etc, etc.

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approach

This kind of ~~approval~~ is in line with a community approach which puts more and more matters into the hands of the refugees themselves. Especially it denystifies activity and increases the flow of information - a matter which I have discussed previously with Robert Klinteberg.

(Somewhat related to this design competition is the idea of a comic-strip "guide to resettlement". Once again the refugees doing the work themselves. But perhaps that's a more touchy non-medical story!)

What do you think?

Best wishes.

David Drucker

September 1981

# A do-it-yourself information facility to disperse some of the tensions and generalised anxiety in the refugee camps.

D. DRUCKER
Mental Health Consultant
c/o UNHCR
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There is reported to be a great deal of anxiety and depressive reaction which drains the psychological energy of the refugees in the camps. Just one of the causes seems to be the lack of flow of authoritative information which is available to the refugees. Where information is in short supply rumour fills the vacuum. Of course there are some questions for which no proper information is available anywhere but even in that kind of situation authoritative information that "no such authentic information exists and all else is rumour founded on no reliable fact or source", could be of some value. Much information resides within different organisations and agencies and is held by various personnel but is neither provided to the refugees nor do the refugees have a way to gain access to it. Officials and there offices (along with much else) create perhaps unwittingly frontiers across which the refugees do not cross. Rumour (and some sound information too for that matter) travels along informal networks. There is perhaps a common perverse pleasure in conveying bad news rather than good and much of this occurs in natural gossip.

It occurs to me that it might prove very useful in relieving the refugees from the burden of rumour and at the same time providing them with useful things to do, think about, and plan for, if we could assist in strengthening the informal information network, link it to the more organised and formal network, and tackle head on some of the rumour and destructive gaps in information. One would hope that a genuine partnership style of relationships between the refugees and the helping services would emerge also.

The refugees should themselves become an important resource for disseminating information (both ways) and run there own information facility.

The 'facility' needs no special accomodation just somewhere to sit and a sign declaring that all questions about anything are welcome here. Here, should be a central meeting place, in a market at a restaurant or anywhere people ordinarily congregate with time to spare, and preferably should be manned when people are ordinarily at leisure, evenings, festivals

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and so on.

A group of information workers should be organised on a rota basis and their major skills should be in good listening and encouraging others to speak and to be at ease. Some simple questions can be common-sense answered simply (Although common sense is not as common as many of us like to believe.) Many questions will involve providing information about resources within the camp and making or encouraging referral.

But a record should be kept by the worker of all questions that come to them. Especially in the refugee situation the people are geographically captive, they have time on their hands and should therefore fairly easily be persuaded to return in a specified short time when some kind of answer or response will be ready for them.

The workers should meet on a regular basis with the Volag partners of the information facility and carefully consider the appropriate resource for getting answers to the specific questions and the nature of the response to be given to the 'client'. The information workers are not to attempt counselling, or therapeutics of any kind although of course information about resources for such service can be offered as appropriate.

From the list of questions as they are accumulated one will soon be able to identify the comman occurence questions and begin to build some kind of card index resource for "looking-up" some of the information. The cards could indicate ways for the worker to proceed in getting specific information to general type questions (i.e. What has happened to my application for.....) One would also soon discern those areas where perhaps special campaigns to provide certain types of information would be appropriate and rewarding. Two or three such possibilities come quickly to mind.

1. <u>Tours of the Camp for Refugees</u>

Refugees are told about camp facilities usually in one big talk when they arrive and are in poor shape to hear or understand all the information about the various unfamiliar services and appropriate procedures for doing things.

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Why not regular camp "tours" with tour leaders on a pre-arranged basis taking groups round the facilities, explaining them, introducing, encouraging questions and so on...? May be with a few picture leaflets just like any tourist agency might provide. But in this case a series of "this is your camp, how best to use it and contribute to its life" as the focus!

2. Demystifying Medical Records/Health Education

See Memo to Dr. Amos Townsend CCSDPT (enclosed)

3. Resettlement (Comic-Strip)

Organise the refugees who are involved in resettlement into producing a'comic-strip' with lots of humour, as a guide to resettlement procedures, drawn from their own experience and any information we can reliably give them. Include in the comic-strip all the misconceptions and the consequences of making some of the mistakes. If the resettlement people can be encouraged to react to the early 'draft' of the comic-strip that would be fine and in any event the positive and reasonable reasons for things being done the way they are should be emphasised. Even some of the seemingly unreasonable things could be incorporated in an amusing way. It is to be hoped that the first issue of such a comic-book will be improved upon as its usefulness (or otherwise) becomes apparent.

These are just my off-the-cuff examples - the questions as they come to the information facility should suggest many more and should lead to serious projects for the refugees to tackle themselves, mainly in their own way. It is their responsibility (we the Volags are only there as a resource for them). However,one would hope a light and lets have some fun, approach would be the style of doing serious things.

An information facility of this do-it-yourself kind should need little or no initial funding. (Later, specific campaigns, production of materials etc. would need an appropriate but modest budget.) What is needed is a community organisation approach with a worker who has the

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responsibility of setting up such a facility and able to stick with it stimulating the activity and being sensitive to the enthusiasms and loss of interest which characterise any volunteer project. Recruitment of volunteers, working out procedures and processes, establishing a rota, arranging for pairing the volunteers to support each other, making sure new recruitment takes place as workers drop out, doing a great deal of 'finding out' which the refugees are in no position to do for themselves are some of the major tasks.

Training for such workersshould be of an arising-from-the-job case-by-case basis. The facility will need some camp publicity to get started but should be generally low-profile and thought of as "a friendly place where our own kind will help us find out what we need to know".

A flow of information to the refugees and a source for keeping one's finger on the pulse of what is currently of concern to them which are the objectives of such a facility should go some way towards dispersing some of the tensions and anxieties in the camps.

October 1981

# A Consultative Counselling Service

# for the

# Indo-Chinese Refugee Camps

D. DRUCKER
UNHCR/SOM
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INTRODUCTION

There are many Volags in the refugee camps and they tend to provide service vertically - medical, educational, vocational, youth, rehabilitation, unaccompanied minors, widows, tracing etc. Those most skilled in the interpersonal processes/* and most able to do the counselling (with individuals, families, small groups or the community organizations such as section leaders and so on) are at any one time scattered somewhat at random throughout the agencies and the location of the most experienced persons changes constantly because of the rapid and constant turnover of social service staff. Great fluidity is inherent in the very nature of the refugee situation, which requires agencies to plan and budget for emergency needs and the completely uncertain time frames beyond that. It is inevitable that commitment to (and from) personnel must be short and somewhat expedient.

There are ways to work within these constraints and to maximize the effectiveness of the agency inputs and of the available staff. The Volags do meet in the camps at formal and informal meetings and there is no question that much consultation takes place between Volag staffs on a spontaneous basis. I would like to suggest a way of concentrating such processes on an ongoing and stabilizing basis, given the current refugee situation here in Thailand. For want of any other label it might be called a Consultative Counselling Service ? (CCS?)

The Volags, the UNHCR Field Officer and (unless inappropriate) the refugee leadership by consensus should select (say) four to six staff members who will constitute the CCS. The staff members selected from those already working within each camp would in effect be secunded for (say) at least one day a week to the CCS. The CCS would perhaps best meet in the UNHCR premises in order to symbolize that for that day, each member does not represent, nor is a delegate from, his particular parent agency but has been selected on the basis of his excellence in terms of his/her recognized operational skills and experience of that camp. Only the status of being recognized by one's peers as capable and ready to do a competent job in the counselling field and in the camp situation should be involved

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/* (which we might call horizontal because the skills are common although the clientele is targeted vertically)

here. Status inside or between agencies should be totally irrelevant. As the staff of the agencies and as the situation changed and the individual members of the CCS departed or were not available, they would be replaced by a "reserve" or by a relatively new arrival who had the necessary and acknowledged talents. The CCS member, for the day he functioned as such, would consider his only allegiances to be the CCS, to the refugees and to his social service colleagues generally throughout the camp.

The CCS would invite referral of "cases" from all agencies and sources and bring material from their own agencies for "consultation". Consultation would be focused upon narrative description and information about "cases". The case would be in relation to an individual, family, group or community situation, submitted from any agency or person within the camp. With the data available and with any clarification or elaboration that could easily or swiftly be obtained, the consultative group would do its best to provide from its joint deliberations an agreed "diagnostic statement".

The diagnostic statement would indicate what was thought to be the nature of the problems involved and the relative and inter-related importance of these. Such an analysis would be the basis for working out a consensus embodied in a "treatment or work plan".

The treatment plan should be 100 per cent practical, in the sense that provision, skills, personnel etc. actually existed in the camp now and that camp conditions and regulations permitted what was being recommended. The treatment plan would indicate exactly which agency service or person would be approached to do what, and who would be designated to accept over-all responsibility to follow-through on that case and to report back to the consultative service for review after a specified period of time.

Of course, although the consultative group would need to discipline itself to always provide a what-should-be-done-now plan and to avoid philosophic debate or polemic, it should be alert to those elements and factors in the case which indicate and illustrate that wider matters concerning policy, programme, or information gathering need to be considered

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and long-range action is necessary or desirable in the camp. The consultative group would then pass on such observations to the appropriate body (Field Officer, Section Leaders, Medical Co-ordinator, CCSDPT, Volags or Social Service Co-ordinator/*) for response and possible action.

The "cases", the "diagnostic statement", the "treatment plan", and later the "review", "revised treatment plan" or "conclusion" (closing the case) should be written up briefly and concisely and distributed appropriately. The collected cases would constitute a very important "case book" of problems and their solution (one hopes) in refugee camps. (This is material which if very, very difficult to obtain, if it is actually documented anywhere at all!) The CCS is likely to find that such deliberations and careful documentation will serve as a professional model for others in the camp to aspire to, and certainly the experience of such consultative process and the material are the stuff of which good in-service training programmes are made. It would be excellent if such a CCS process could be got under way and provided the material and subject matter for inter-camp or regional training workshops (as for example the one to be held in Bangkok in December). A CCS would also provide support and encouragement to those coming from such workshops to exercise their newly learned skills within a framework rather than, as is often the case, in situations where trainees are sent to apply their learning on a "sink or swim on your own" basis.

To the argument that staff members spending a day away would seriously reduce the effectiveness of the individual agency, it must be answered that <u>some</u> of the agency's cases will become a focus of the CCS deliberations and that the time spent in this way will effectively be concerned and deal with some of the demands ordinarily made upon the agency, and the most experienced counsellors from a number of other agencies will be adding their skills to the tasks. It can be expected that the quality of the work will be improved for <u>all</u> the agencies and this might well reduce over-all demand from the refugees. The improved <u>operational</u> (day-to-day detailed work) collaboration (co-labour-action) between the agencies

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/* The subject of a further discussion paper presently under preparation.

and the increased sense of professional belonging, identity and unity should all more than compensate for the loss of an every-day on-the-agency-focused-work presence.

I would be glad to learn whether a camp would like to organize such a CCS. I would be very happy to be involved in its launching and establishment and to know of some of the snags. Eventually we should learn whether in practice it makes a real contribution or is just another bright idea but without practical merit, and therefore to be discarded. I do believe, however, that some such arrangement would strengthen our capacity to meet the over-all needs of the refugees and to allow us to pick up successfully the difficult not-anyone's - specific-responsibility situations (the mentally ill and emotionally disturbed, for example) and contribute to the effective over-all planning for the present (and the future, unfortunately) refugee situations.

David Drucker

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4 August 1981

Dear Robert,

The Annual Conference has set my thoughts off in a number of directions. One of these relates to refugee "strategy" and if CCSDPT has not already addressed the matter raised here, perhaps it might wish to provide the forum for doing so.

The Volags are here in variety and multiplicity with familiar division of labour and concomittant fragmentation of service from the recipients' point of view. Although the diversity is one of the strengths of the voluntary principle, it is somewhat odd to see eagerly introduced into the Indo-China refugee context our familiar modern specialisations and classifications of clientele. There follows the struggle to establish our familiar services to meet our particular selection and definition of problems and our priorities as agencies. Such services are also related to Thai priorities and existing Thai institutions and resources. CCSDPT is of course in the business of pulling all our efforts into a coherent, integrated and effective programme.

At the same time, the refugees' definition of the problems and services are frequently expressed (for them!) in terms of "preserving the culture" "informal community support" "indigenous healers" "traditional leaders" and so on.

(Underlying all this there seems to be in operation the concept of services to rehabilitate the refugees, i.e. that but for somewhat arbitrary and external political, military, (economic ?) events, all was previously well and will continue to be so once the crisis is over. A sense of habilitation existed ! I have some doubts regarding the existence of such happy pre-conditions. However that maybe, it is evident that once the immediate life-preserving crisis subsides, the age-old (pre-refugee status) problems quickly re-emerge. But I digress.)

I see that the resettlement process seems to be based firmly on a family-by-family approach. It tends to be a nuclear rather than

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extended family we have in mind, (certainly one-wife-at-atime please!), and there is the requirement and expectation that someone somewhere in the accepting country will take sponsorship responsibility for the family. (perhaps someone can tell us how this actually works out and what it involves in reality at the receiving end). Associated with this selection procedure is the complaint (with political colouring) that "the cream" of the refugees is being skimmed and "the debris" left behind for the country of first refuge to deal with....

These are the signals I have been reading, newly arrived, as I am, on the scene.

Could we (have we?) explored the possibilities and implications of an overall approach which will begin by actively clustering families together into community entities (perhaps in units of 400 persons-a jumbo-jet load!) The make-up of such communities will, of course, be determined in part by self-selection in the camps, but efforts would be made to encourage each community to embrace and support a 'quota' of 'problem cases' 'misfits' (in the community and in the services sense).

Instead of families, we could then think in terms of small communities; they could be processed as communities, and provision made for such communities here and in the countries of reception. The 'community' (and we) should begin to think and plan around its communal fate over the long run and not as a staging post for individuals or small numbers of family members who are to be thrust into a devil-take-the-hindmost society. (Although alas, much of our would is of this kind, rugged individualism is not ordinarily the philosophy of community service-oriented voluntary organisations). In any case, there is evidence to suggest that refugee and migrant families in the early years tend to seek each other out and recluster, so making the famous "melting pot" very lumpy. (In the U.S. anyway, this ethnic lumpiness continues after a couple of centuries of migration, active Americanisation and national aspiration).

Of course, for some unfortunate individuals or small groups in some situations, special provision may be appropriate from time to time. It might mean them leaving the newly established community group. However, the community approach might be supportive and necessary at the 'newly refugeed' end of events and should continue long after in the resettlement setting.

Such a community settlement process is likely to facilitate efforts that are necessary at the receiving end of resettlement. Community support and a sense of group belonging can exist for as long as it is needed and until its members (or their more easily acculturated children) are ready to strike out on their own in the new culture. They might well derive strength and assurance from the sense of having a "home-group" - an "ethnically comfortable group" to fall back upon.

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The point is that the problems and the opportunities which the situation poses ought rationally to be thought about in the perspective of, say, two generations. Refugees and Migrants are not a passing phenomenon but a large-scale and on-going process in a modern world where the land is no longer the dominant determinant of communities, and nations and geographical boundaries are unstable.

I think it is worth thinking about and planning this kind of community approach now, rather than continuing (as I see it) to go from one refugee disaster to another on a predominately ad-hoc basis. Such an approach might also provide the perspective and the framework for making the best possible long-range use of the very mobile personnel and the relatively short-term and varied efforts of Volags. Perhaps there is already significant experience of this kind of community movement we can learn from ?

Initial discussion among ourselves, some such unified strategy committment among Volags, modification of policy, process and provision of receiving nations, and some international leadership and persuasion; seem to be on this agenda.

I'd be pleased to elaborate and to help plan developments in this direction if you think that this is a constructive and realistic way to go. Your comments would be much appreciated.

Sincerely yours,

David Drucker
Project Administrator

/pp

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17 August 1981

Dear Dr. Townsend,

The CCSDPT medical subcommittee meeting on Thursday 6 August 1981 stressed the importance of promoting simple positive health behaviour and providing primary health care understanding and practices for the refugees to take with them wherever they might go. I linked this to the discussion about the absence of medical cards and the problems that arose when there were no records available regarding immunisations and so on.

It was not that the cards disintegrated (plastic envelopes help) or that they were accidently mislaid (in Bangladesh, circa smallpox, a hook was provided to hang the card on the doorpost of each hut). It was whispered to me that refugees were suspicious of what was on the card and did not want to be labelled and identified that way. Alas for mutual trust and understanding!

Could the problem(s) be tackled along the following lines?

1) Identify and spell out in lay terms the items needed to be recorded on such a card.

2) Promote a competition among the refugees to design such a card - pictures not words!

3) Prizes for the best design - adults, school children (2 age groups?)

4) Exhibit best (say 25?) designs.

5) Formal prize giving 1-2-3.

6) Simple production of cards.

7) Distribute and use.

8) Have copies displayed everywhere.

Such a 'game' would hit many targets at once:- widespread information about contact and purpose of cards, making them easily understood by the refugees (medical staff could also understand the pictures!); provide a take-off point for more focussed health education (why immunisation, etc); give some purposeful and interesting activity to the refugees and their children; bring some fun into the usual solemn medical field; give recognition to those who do a nice social service job; etc, etc.

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approach

This kind of ~~approval~~ is in line with a community approach which puts more and more matters into the hands of the refugees themselves. Especially it denystifies activity and increases the flow of information - a matter which I have discussed previously with Robert Klinteberg.

(Somewhat related to this design competition is the idea of a comic-strip "guide to resettlement". Once again the refugees doing the work themselves. But perhaps that's a more touchy non-medical story!)

What do you think?

Best wishes.

David Drucker

Notes for a file

Meeting at Panat Nikom. Tuesday 8 September 09.30 a.m. initiated by Mr. D. Drucker c/o UNHCR.

Subject Care of the Psychiatrically disturbed and the Mental Health problems of the refugees.

Present Dr. Rangaraj, UNHCR Health Co-ordinator
Ms. Nellie Chan, UNHCR
Dr. Serrano, Medical Co-ordinator, CRS
Dr. Chetty (Lumpini), CRS
Dr. Shivarani (Panat), CRS
Dr. Chitporn, Medical Co-ordinator, COERR
Dr. Wason (Panat), COERR
Ms. Susan Walker, Co-ordinator, ARC
Dr. Coleen O'Keefe (Panat), ARC
Ms. Megan Murray, ICM

Mr. Drucker introduced the meeting, the purpose of which was to identify, clarify and try to resolve some of the problems which arise from the refering and handling of patients and to meet the needs which are surfacing in the camps.

DISCONTINUITIES

Dr. Wason (COERR) gave an example of a patient who had "escaped"..... said "to have gone away in an ICM transport".

Dr. Chetty informed us that the patient (and his brother)were currently in Bangkok General.

Ms. Murry said the patient was on a large list (hundreds) of refugees to be transported to Lumpini and they had no way of knowing that one of this large group had left the hospital to join the movement. The psychological problems had probably been reidentified at the ICM medical examination which is standard procedure for all refugees moving out of Thailand.

The above is an unusual situation but in some respects well illustrates the difficulties of keeping a check on what happens to patients who come to Panat go to the OPD (CRS) onto the hospital (COERR) thence to the District Hospital at Chonburi, and then back to Bangkok General and again returned with treatment (and/or social) recommendations.

UNHCR says that the missing patient would have been located on the normal movement list in this case. But the general rule is that the Medical Co-ordinator (now Dr. Shivarani) should be kept informed of all transfers (or missing) patients.

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Transfer of Patients

Generally the procedures for transfer of cases where the medical facilities at the camp cannot meet the need are the same for psychiatric cases as for medical cases.

The procedures are laid down for routine referral, urgent cases, and life and death situations. These procedures were underlined by Dr. RANGARAJ who stressed that the responsibility rested firmly with the camp Medical Co-ordinator to put the procedures into operation.

Collaboration

Mr. Drucker reported that in the interest of making sure that the various administrative and organisational gaps do not effect patient care and resettlement there had been a very cordial meeting with Dr. Thamrong at Bangkok General and regular meetings and review of cases would now take place between Dr. Thamrong and Dr. Chetty of Lumpini. We would also try to meet will the psychiatrist who comes once a week to Chonburi. Dr. Chitporn said he would assist in making the introductions.

Transportation on Transfer

The responsibility for actual transportation for patients rested with the camp Medical Co-ordinator although in practice it seems that COERR usually successfully provides the transportation at Panat. COERR also arranged for referral to Chonburi hospital but informed the Medical Co-ordinator.

Dr. RANGARAJ explained the problems that UNHCR had to deal with in arranging transfer of patients with the authorities in Bangkok, and how the Medical Co-ordinator could help with proper documentation.

MEDICATION

Arrangements had now been agreed for providing patients with medication following upon their discharge from Bangkok General and return to the camp. This would be handled by Dr. Chetty on request from the camp Medical Co-ordinator. (see memo).

Psychiatric 'LABELLING'

The resettlement problems which arose when psychiatric 'labels' appeared on the refugees records were discussed. This too had been the subject of a memorandum (see enclosed) and had been verbally presented to the CCSDPT September medical sub-committee meeting.

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CLUSTERING

The process of handling the needs and possible resettlement of the handicapped (psychiatric/physical) were re-outlined. It was clarified that there was no intention of providing a specialised psychiatric facility at Phanat and bringing all such patients there. We were interested in being as much help as possible to the medical facilities in handling the cases that are in the camp.

BUDDY SYSTEM

In order to relieve the burder on the in-patient staff who deal with wandering and disoriented patients, the idea of a buddy system organised from among the refugees was outlined. This was very much welcomed by Dr. Chitporn (COERR) who thought that such an arrangement was also needed in the Northern camps. Mr. Drucker will explore this latter possibility with COERR. Meanwhile CRS thought that the buddy system should be introduced at Panat and the meeting was informed that Fra Comolly (CRS) had shown great interest in launching such a project. The UNHCR Mental Health Consultants would be glad to offer support in getting this started. The system should be designed patient by patient and might possibly be extended to out-patients later.

Dr. Rangaraj thought that recruitment of a psychiatric nurse night well be a good way of strengthening the overall capability of handling the situation under review.

NOTIFICATION OF REJECTION FOR RESETTLEMENT

It was said that difficulties arise due to the delay in transmitting decisions of rejection. There is then great delay in resubmitting to other countries. It was asked whether the appropriate representation could be made to embassies and the information channels to improve this situation.

WOMEN ARRIVING FROM SONGKHLA

Ms. Nellie Chan raised the question of the recent arrivals from the Songkhla camp which has been officially closed.

There was much concern for the women who had lost families and who had been subject to attack and rape.

The view was expressed that it was not desirable to emphasise these women's "difference" from other refugees, and it was better to as quickly as possible prepare them for normal resettlement arrangements. Some of these women however are rejected by their own community and it is known that the longer the trauma goes unrelieved the worse might be the long range implications.

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There was agreement that there was a special need, and that there should be some special protection provided until the women were ready to use their normal adaption abilities, but judgement should be made so that dependency is not prolonged longer than necessary. Although there was agreement regarding the need, and the urgency of setting up some provision, there was no general agreement on the nature and detail of such provision. Sister Leona (CRS) had submitted a proposal and Save the Children Foundation were preparing a proposal also. As the Vietnamese refugees were now on both sides of the camp (Transit and Holding) the question of one, two, or a combined service/facility remains open to discussion. When the proposals are available it was thought that perhaps a special meeting should consider the matter. The interested parties, the agencies, the mental helath consultants, John Williamson, UNHCR, should come together and decide the way to go.

GENERAL

Those present were invited again to call upon the services of the UNHCR Mental Health Consultants as required. It was announced that Linda Barnes who had been working as medical/psychiatric social worker would be coming to Panat soon and can be expected to be of assistance in relation to some of the matters we have been discussing. Jan Williamson would be helping to strengthen the Panat - Lumpini - Bangkok General connections.

There was an expression that the meeting had proved to be a useful occassion and as one when matters of mutual concern arose, collaboration would be enhanced by meetings of this kind.