

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

**A case study of mental health communication programme
delivery during mass violence in southern Thailand,
2004–2014**

**A thesis presented in partial fulfilment of the requirements
for the degree of**

Doctor of Philosophy

in

Communication

at Massey University, Manawatū, New Zealand

Aruneewan Buaniaw

2017

Copyright is owned by the Author of the thesis. Permission is given for the thesis to be downloaded or copied by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

ABSTRACT

In response to long-term mass violence in southern Thailand, the Thai government set up the 12th Mental Health Centre (the key site of this study) in 2004 for mental health healing and rehabilitation, and to provide various mental health programmes for affected groups. This case study examines how those programmes were planned, implemented, and evaluated between 2004 and 2014. The successes and challenges of mental health communication programme delivery in such a situation were also identified.

The development of Centre 12's programme reflects different but interrelated policy shifts: the reactive programme (2004–2005); the targeted groups policy (2005–2010); the general age-group targets (2011–2014); and the emerging phase of severe and complicated cases (2014 on). Key findings showed four stages in Centre 12's programme framework: planning, media/message development, implementation, and evaluation. Within these phases, Centre 12 largely focused on media/message development, reflecting the nature of the public relations work force in Thailand and concern with religion differences. Print materials were verified by experts and media were produced with cultural sensitivity. Religious-based booklets were deemed noteworthy because of the participatory process in media production, testing, and refinement.

Interpersonal and group communications were the main delivery channels. Additionally, training programmes for deliverer groups such as public health practitioners, community leaders, religious leaders, teachers, and radio DJs were crucial because these groups were trusted by local people and could reduce suspicion. Programme evaluation was a significant challenge, shown in Centre 12's difficulties measuring programme outcomes, impacts, and knowledge utilisation.

The Centre 12 case also contains some lessons in delivery in a mass violence situation: mental health communication programmes should focus on community-based approaches and coordinate with community partners, informal, flexible styles of partnership are most suitable for uncertain situations, and programme deliverers need to be concerned with cultural sensitivities. Last, leadership is an important factor for disaster management; however, organisations should set a system of recovery rather than rely on an individual leader. This case study considers wider implications for the government, campaign planners, communication and health communication scholars and practitioners, and those facing similar circumstances in the current unstable geopolitical environment.

ACKNOWLEDGEMENTS

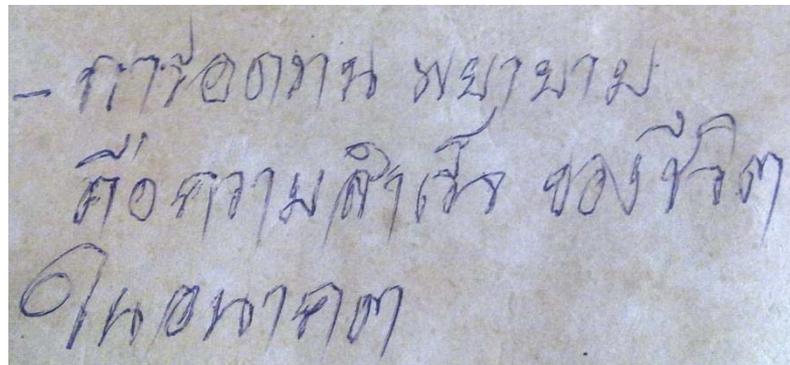
I would very much like to thank my first main supervisor, Associate Professor Dr Margie Comrie for her advice, insight, and support, both academic and personal throughout my PhD. Her patience and caring encouraged me to do my best. Second, I would like to thank my co-supervisor, Dr Susan Fountaine, her guidance was always highly helpful in shaping my thesis and strengthening my research skills. I have appreciated her professional criticism, attitude, and teaching techniques, especially when she taught me the ways to analyse and synthesise interview information. Third, thanks to Dr Niki Murray, another co-supervisor, for her insightful suggestions and her kind help when considering the details of my thesis. Last, I would like to thank my later main supervisor, Dr Rochelle Stewart-Withers for helping me complete the methodology and looking at the overall picture of my thesis. I also acknowledge my fieldwork supervisor in Thailand, Professor Dr Parichart Sthapitanonda for her advice about data collection, and her support throughout my academic life from Master to Doctoral degrees.

Thank you also to all my study participants, especially Centre 12's Director, Dr Pechdau Tohmeena, who allowed me to conduct this research and gave her fully support in data collection, and the eleven Centre staff members who work really hard to help people in the area and kindly described their work experiences, which were invaluable for my study. Special thanks to Miss Bu-nga Dulayasith for organising the interview schedules, and to Assistant Professor Dr Metta Kuning, Miss Suppavan Phungrassamee, Miss Piyathida Sinvutinon, and Miss Sunita Minsar for giving me their precious time for interviewing and expanding my knowledge about community-based practice.

I am also grateful to Prince of Songkla University (PSU), Thailand, especially to Associate Professor Imjit Lertpongsombat (Dean of Faculty of Communication Sciences, Prince of Songkla University (PSU), Pattani campus, Thailand) for allowing me leave from my work for this PhD study, and to Assistant Professor Dr Nuwan Thapthiang for her kind help checking my English writing when I applied for PhD study. I would also like to thank the Office of the Higher Education Commission, Thailand for providing me with a full doctoral scholarship, and to Miss Kamonwan Sattayayut, Minister Counsellor (Education), for her great support and being the best helper who always offers a solution to the everlasting problem of scholarship students.

I want to express my deep thanks and appreciation to my beloved husband, Treepipat, and our three children, Jaikaew, Buabucha, and Nabun, for their great support, patience, and unconditional love. Thanks to my brothers, sisters, and my best friends, who always cheers me up when I am feeling down, especially Aom, Phueng, Ning, Title, Ying, Kwang, Pêe Aied, Pêe Mam, Pêe Mink, Meaw, Aor, Pêe Dome, Pêe Dao and all of my colleagues in the Faculty of Communication Sciences, PSU, Pattani, Thailand.

Most important, I dedicate this thesis to my mother for her ongoing love and support, and to my father, who could not see this thesis completed. However, his last words encouraged me to be patient, and never give up on this marathon journey.



“Patience and endeavour are keys to succeed in life” (Tanom Nasri, my father, 1996)

August 2017

TABLE OF CONTENTS

ABSTRACT.....	i
ACKNOWLEDGEMENTS.....	iii
TABLE OF CONTENTS.....	v
LIST OF ABBREVIATIONS.....	xiii
LISTS OF TABLES.....	xv
LIST OF FIGURES.....	xvii
CHAPTER ONE: INTRODUCTION.....	1
1.1 Introducing the research problem.....	1
1.2 Significance of the study.....	2
1.3 Background of the researcher.....	3
1.4 Background to the mass violence in the three southern border provinces of Thailand.....	4
1.5 The Thai public health system.....	7
1.6 Research strategy, methods, and questions.....	9
1.7 Theoretical framework.....	10
1.8 Clarifying key terms.....	11
1.8.1 Mass violence.....	11
1.8.2 Campaign and programme.....	13
1.9 Thesis structure.....	13
1.10 Conclusion.....	14
CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK.....	15
2.1 Introduction.....	15
2.2 Public communication and public relations.....	15
2.2.1 Defining public communication.....	16
2.2.2 Public communication campaigns: A brief history.....	16
2.2.3 Perspectives on public communication campaign characteristics.....	17
2.2.4 Public communication campaigns: Major theoretical perspectives.....	18
2.2.5 Perspectives on effectiveness of public communication campaigns.....	20

While key aspects of the literature consider public communication from a social marketing perspective, the following section examines the communication approach related to the purpose and method of public communication campaigns after disasters – public relations.....21

2.2.6 Defining public relations.....21

2.2.7 Four models of public relations.....22

2.2.8 Public relations campaign and programme framework24

 2.2.8.1 Programme planning.....25

 2.2.8.2 Programme implementation.....29

 2.2.8.3 Programme evaluation31

2.3 Health communication33

 2.3.1 Models of health communication.....34

 2.3.2 Health communication: A multidisciplinary field.....37

 2.3.3 The definition and development of health communication campaigns37

 2.3.4 Health communication campaigns: Major theoretical perspectives.....39

 2.3.5 Principles of good practice in health communication campaigns.....39

 2.3.6 Health communication programme planning framework41

2.4 Development communication42

 2.4.1 Development communication: A brief history and theory.....42

 2.4.2 Perspectives on effectiveness of development communication campaigns .45

 2.4.3 Development communication campaign approaches.....45

 2.4.4 Development communication programme framework47

2.5 The value of a combined approach to campaigns.....47

2.6 Empirical studies and reviews of health and mental health communication programmes and campaigns.....50

 2.6.1 Theme 1: Mental health consequences of disasters51

 2.6.2 Theme 2: Stages of disaster and associated interventions52

 2.6.3 Theme 3: Role of government and leadership in disaster management.....54

 2.6.4 Theme 4: Role of media campaigns.....56

 2.6.5 Theme 5: Direct communication in the context of disasters.....57

 2.6.6 Theme 6: Community-based approach interventions58

 2.6.7 Theme 7: Psychosocial interventions.....59

 2.6.8 Theme 8: Cultural and social support factors60

2.6.9	Theme 9: Evaluation of mental health interventions	61
2.6.10	Theme 10: Communication partnership and community resilience	62
2.6.11	Summarising themes in empirical research.....	64
2.7	Conclusion	65
CHAPTER THREE: THE RESEARCH STRATEGY AND FIELDWORK		67
3.1	Introduction.....	67
3.2	Conceptualising case studies.....	68
3.3	Qualitative research and this study	70
3.3.1	Why qualitative research?.....	70
3.3.2	The qualitative researcher	71
3.3.3	Researcher's positionality and reflexivity in qualitative research	71
3.4	Explaining ethical research	73
3.4.1	The University ethics procedures.....	73
3.4.2	Ethics in practice	73
3.4.2.1	Demonstrating respectfulness	74
3.4.2.2	Minimising harm.....	75
3.5	Data collection methods and analysis	76
3.5.1	Interviewing	79
3.5.1.1	Research participants: The recruitment process and building relationships	81
3.5.1.2	Interview schedule	84
3.5.1.3	Informing participants.....	85
3.5.1.4	Conducting interviews	86
3.5.1.5	Terminating the interview and gaining closure	87
3.5.2	Participant observation.....	88
3.5.2.1	Selecting a setting	90
3.5.2.2	Gaining entry	90
3.5.2.3	Beginning observations.....	91
3.5.2.4	Recording observations.....	92
3.5.3	Document analysis and collateral description.....	93
3.6	Document analysis and collateral description.....	94
3.7	Conclusion	96

CHAPTER FOUR: POLICY IMPACT ON MENTAL HEALTH

COMMUNICATION PROGRAMMES97

4.1 Introduction.....	97
4.2 Policies underpinning the mental health communication programmes	100
4.2.1 Thailand’s mental health services’ responses to the mass violence	100
4.2.2 Responses at the government policy level	102
4.2.3 Responses at the practitioner level.....	105
4.3 Background of mental health centre 12: History and development.....	106
4.3.1 Coordination with the Rehabilitation Sub-Committee from 2005 to 2010	109
4.3.2 Changes after 2010.....	111
4.4 Centre staff perceptions of the impact of the violence on their work.....	114
4.5 Participants’ perception of policy content and its implications for how they work	117
4.5.1 Phase 1: Reactive programme (2004–2005)	119
4.5.2 Phase 2: Policy of targeted groups (2005–2010)	119
4.5.3 Phase 3: Policy of general age-group targets (2011–2014)	124
4.5.4 Phase 4: Emerging phase of severe and complicated cases (2014 on)	125
4.5.5 Concerns and summary of policy implications	126
4.6 Conclusion	127

CHAPTER FIVE: MENTAL HEALTH COMMUNICATION PROGRAMME DELIVERY, AND THE SUCCESSES AND CHALLENGES OF CENTRE 12’S

PROGRAMME DELIVERY129

5.1 Introduction.....	129
5.2 Key informants’ perceptions of communication programming framework	130
5.2.1 Programme planning priorities	131
5.2.2 Programme deliverers’ planning concerns.....	134
5.2.3 Media and message development	136
5.2.3.1 Media development.....	139
5.2.3.2 Media and content pre-testing.....	145
5.2.3.3 Distribution of Centre 12’s media.....	146
5.2.4 Programme implementation	147
5.2.4.1 Workshops for the deliverers group.....	147

5.2.4.2	Workshops for people directly affected by the mass violence	149
5.2.5	Programme evaluation	150
5.2.4.1	Summary of communication programme framework	154
5.3	Partnership in mental health communication programme delivery	156
5.3.1	Who is involved in Centre 12's programme delivery process?	156
5.3.1.1	Public health practitioners.....	157
5.3.1.2	Academics, special interest groups and NGOs	157
5.3.1.3	Community partners.....	158
5.3.1.4	Media networks.....	158
5.3.2	Partner group perception of the partnership role	161
5.3.2.1	The Director of the Deep South Coordination Centre (DSCC)	161
5.3.2.2	Two volunteers of Brahma Kumaris Foundation: Inner spiritual development.....	165
5.3.2.3	Staff of the Provincial Public Health Office	166
5.3.2.4	Media network: National Radio Thailand in the three southern border provinces.....	167
5.4	Participants' perception of major factors of success in mental health communication in the mass violence area	169
5.4.1	Working with networks.....	170
5.4.2	Unique nature of programme delivery	172
5.4.3	Turning crisis into the opportunity for development	173
5.4.4	Role of Centre 12's Director.....	174
5.5	Participants' perception of the factors they perceived as barriers	176
5.5.1	Barriers outside the Centre's control.....	176
5.5.2	Manageable barriers	177
5.6	Conclusion	179
CHAPTER SIX: DISCUSSION.....		183
6.1	Introduction.....	183
6.2	A multi-disciplinary approach to the study.....	183
6.3	Mental health policies and practices in response to the mass violence situation....	184
6.3.1	Government strategic policy response	184
6.3.2	Government response at the practitioner level.....	186

6.4 Centre 12’s programme planning framework	190
6.5 Centre 12’s programme planning and formative research	191
6.6 An emphasis on media/message development, testing, and refinement	195
6.7 Interpersonal communication: A key channel of Centre 12’s programme implementation	197
6.8 Centre 12’s programme evaluation	199
6.9 The challenges of mental health communication programme delivery in mass violence	202
6.10 The success factors of mental health communication programme delivery for Centre 12	206
6.11 Summary and Conclusion	211
CHAPTER SEVEN: CONCLUSIONS	215
7.1 Introduction	215
7.2 Summary of key findings	216
7.3 Limitations	218
7.4 Contributions to the field	219
7.4.1 Capturing a long-term government response	219
7.4.2 New emphasis on media/message development in programme planning	220
7.4.3 Identifying qualities for planning sustainable responses to disasters	222
7.4.3.1 Empowered individual and community potential	222
7.4.3.2 Partnership	223
7.4.4 Identifying the impact of Thai culture on public relations practice	224
7.4.5 Approaching development communication in supplementing public relations and health communication approaches	225
7.5 Implications for practice	226
7.5.1 The operational level	226
7.5.2 The delivery framework	227
7.6 Conclusion	228
REFERENCES	231

APPENDICES	255
Appendix A: Information sheets	257
Appendix B: Participant consent forms	261
Appendix C: Full interview schedule.....	263
Appendix D: Participant observation: Description of workshops during field work ..	267
Appendix E: Example of participant observation field notes	271
Appendix F: Five books of religious based media.....	275
Appendix G: Massey University Ethics Application - Responses to seven key questions posed by the Committee. (October 21, 2013)	277
Appendix H: News reporting about two violent incidents which occurred during data collection on May 24, 2014 and May 28, 2014	281
Appendix I: Details of media supporting mental health communication programmes	283
Appendix J: Example of Centre 12's programme evaluation form provided to attendees at each workshop.....	287
Appendix K: Example of questions use to evaluate programme outcomes adapted from Martin (2003)	288
Appendix L: Summary finding sheets	289

LIST OF ABBREVIATIONS

BRN	Barisan Revolusi Nasional
PULO	Pattani United Liberation Organisation
MoPH	Ministry of Public Health
DMH	Department of Mental Health
WHO	World Health Organisation
PTSD	Post-Traumatic Stress Disorder
PFA	Psychological First Aid
CBT	Cognitive Behavioural Therapy
SPR	Skills for Psychological Recovery
DCIF	Disaster Communication Intervention Framework
SBPAC	Southern Border Provinces Administration Centre
VMS	Violence-Related Mental Health Surveillance
DSCC	Deep South Coordination Centre

LISTS OF TABLES

Table 2.1 Ways of classifying publics in public relations approach.....	28
Table 2.2 Broom and Sha' (2013) Types of Public Relations Programme Evaluation	32
Table 2.3 Health communication programme planning frameworks	41
Table 2.4 Ten themes of empirical studies and reviews of mental health communication and communication programmes/campaigns in disaster contexts.....	51
Table 3.1 Links between research questions, data collection method, sources of data	78
Table 3.2 The research's participants and their positioning to this study.....	81
Table 4.1 The Centre 12 Director and staff members' demographics and work experiences	99
Table 4.2 Four Groups of Mental Health Deliverers	105
Table 4.3 The timeline of the four phases of mental health communication programme delivery between 2004 and 2014	118
Table 5.1 Examples of the major media in phases 2 and 3.....	138
Table 5.2 The analysis of two books on Healing according to Muslim Principles..	143
Table 5.3 The analysis of three books on Healing according to Buddhist Principles	144
Table 5.4 The five partner group representatives' background and work experience	160

LIST OF FIGURES

Figure 1.1. Maps of Thailand and southern region.	5
Figure 1.2. Administrative structure of Thailand’s Ministry of Public Health.....	8
Figure 2.1 Interrelationships between public relations, health communication, and development communication.	48
Figure 3.1 Mental health service delivery responding to mass violence crisis in southern Thailand.....	103
Figure 4.2 The Development of Mental Health Service Delivery Responses from 2004 to 2014.....	113
Figure 5.1 Four stages of mental health communication programme cycle within the context of the mass violence and multi-cultural society.	155

CHAPTER ONE: INTRODUCTION

1.1 Introducing the research problem

This thesis is a case study of the delivery of mental health communication programmes in the context of mass violence considered to be a national crisis within a multicultural society in southern Thailand. In dealing with this form of national crisis the Thai government developed policies to support recovery. The 12th Mental Health Centre, the site of this case study, was established to take responsibility for mental health healing and the rehabilitation of people affected by the violence.

This research covers the years between 2004, when the mass violence began, and 2014. During that time, a number of mental health communication programmes were designed and implemented. As Kreps (2014) explains “Health communication programs are essential and ubiquitous tools in the delivery of care and promotion of health” (p. 1449). This thesis makes an original contribution to health communication in the context of an ongoing violent conflict. It adds insight into the successes and challenges involved in the delivery of mental health communication programmes to people who have been exposed to violent attacks and live with stress over a long period of time.

As this study covers a period of over 10 years, it takes a holistic view of programme development and the typical framework of communication programming rather than focusing on individual programmes. This long-term focus not only adds value to the analysis through considering a lengthy time frame but usefully enables the identification of changes in response to shifts in government policy and the extent to which these are sustained over time.

The theoretical framework of this case study of Centre 12 draws from public relations, health communication, and development communication. The combination of these three approaches provides a suitable framework for exploring a mental health communication programme in a crisis situation, particularly in a developing country where community resources are limited.

The following sections outline the significance of this study, and the background to the Thai violence situation and then the Thai public health structure. The chapter then goes on to identify the research strategy and methods, before stating the research questions and giving more detail about the theoretical framework. The key terms used in this thesis are then defined. The chapter finalises by outlining the overall thesis structure.

1.2 Significance of the study

The 2013 World Health Organisation report shows mental health problems are a serious issue, estimating “that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16.3 million million between 2011 and 2030” (World Health Organization, 2013b, p. 8). Focusing on mental disorders resulting from disasters, the Department of Mental Health and Substance Abuse notes that the rates of patients diagnosed doubles after such emergencies (World Health Organization, 2011). Mental health consequences of man-made disasters cause severe damage and result in longer lasting effects than the consequences of natural disasters (Norris, Friedman, & Watson, 2002; Stratta, Cataldo, Bonanni, & Rossi, 2015).

This thesis focuses on practitioners’ experiences of planning and delivering mental health communication programmes in a long-term mass violence context. This focus fills three major gaps identified in previous literature and empirical studies about government response and mental health communication programmes (campaigns/interventions) following disasters. First, few studies on governments’ reactions to disasters consider the mental health response in the long term and within contexts of ongoing violence (Birkmann et al., 2010). Second, while numerous studies explore the mental health consequences of disaster, few studies look at the actual practice of mental health service delivery (Naturale, 2006; Stratta et al., 2015). Last, while health communication study draws on a number of disciplines and models, it lacks ‘evidence-based practice’, ‘what works or best practice in health promotion’ (Zorn, 2001), ‘concrete practices’ (Babrow & Mattson, 2003), and lessons learned from integrating multi-disciplinary approaches (Schiavo, 2007). This thesis fills these gaps by using a long-term timeframe (10 years) to study on-going mass violence and by exploring practitioners’ experiences and perspectives of their work, which document evidence-based and concrete practices. As Schiavo (2007) argued, “the experience of

practitioners as a key factor in developing theories, models, and approaches...[and] should guide and inform health communication planning and management” (p. 11).

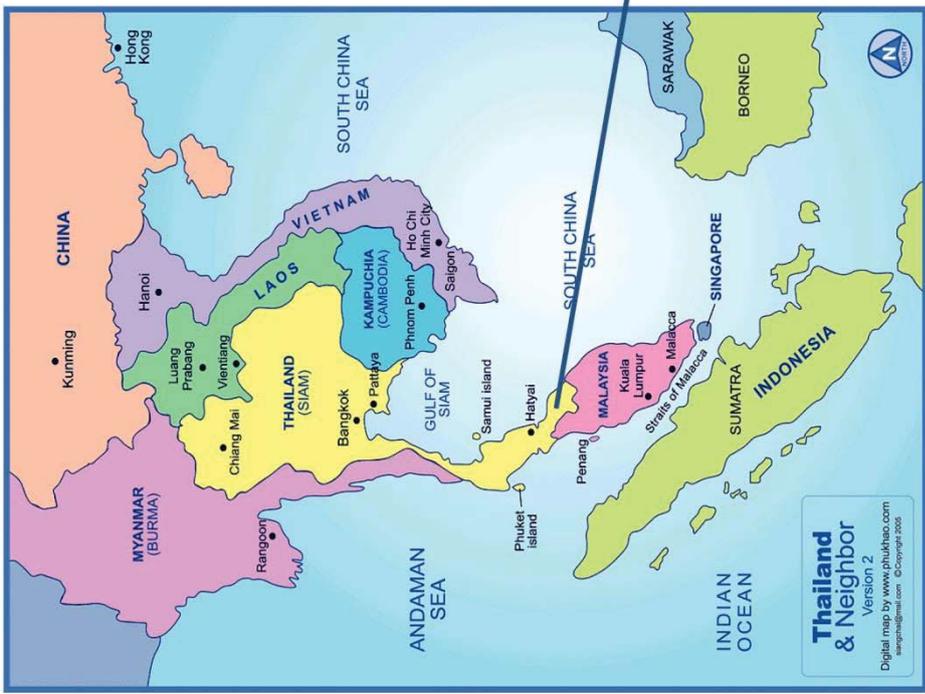
Recording deliverers’ perspectives on successful experiences and difficulties in delivering mental health communication programmes is valuable for planners charged with designing effective mental health communication programmes in the particular context of mass violence. Furthermore, knowledge gained about policy impact and programme delivery is useful to help governments target money and resources towards strategies based on evidence. Ultimately, this case study provides a deeper understanding of mental health communication programme processes, an understanding that aims to enrich campaign planning in general, as well as provide explicit guidance for those facing similar challenges within mass violence contexts and multi-cultural settings. The thesis now outlines the background to the Thai violence situation and the public health structure, and illustrates the suitability of these three approaches (public relations, health communication, and development communication) to this research.

1.3 Background of the researcher

The researcher’s background is important in qualitative research as it influences data collection and interpretation (Patton, 2015). My background includes working as a lecturer in the Faculty of Communication Sciences, Prince of Songkla University, Pattani province, Thailand, where the violence erupted. During eight years of work from 2004 to 2012, I conducted several communication and health communication research projects mainly focusing on developing the potential of opinion leaders to communicate about health issues. From 2009 to 2011, I was Director of the university radio station. During that time, I met with the Director of the 12th Mental Health Centre and attended the Centre’s meetings and workshops with the deliverer groups including radio producers. I developed a relationship with Centre 12’s Director which became reciprocal when I decided to commence my PhD. My positionality as both Thai and Buddhist did not impact upon my ability to access Muslim research participants. As an insider who has lived and worked in Pattani province and has experience working between cultures, I was able to understand the everyday ways of life and navigate the participants’ religious and culture differences, in ways which would not be possible for researchers from the outside.

1.4 Background to the mass violence in the three southern border provinces of Thailand

Thailand, previously known as Siam, is located in Southeast Asia. The country has “never [been] colonized by any foreign power, unlike its South Asian and South-East Asian neighbours” (National Identity Board, 2000, p. 57). Thailand has an area of 513,115 square kilometres; its shape on the map looks like an elephant’s head with its trunk extending down into the Malay Peninsula (National Identity Board, 2000). An annual survey on July 1, 2017 revealed that Thailand had a population of about 68,302,192 people (Worldometers, 2017). More than 90% of the population is identified as Buddhist, around 5% as Muslims, and nearly 1.5% as Christians or other religions (Thailand National Statistical Office, 2010). The majority of people identify as being of Thai ethnicity, though in the north there are hill tribes of different ethnicity; and the southern provinces of Pattani, Yala, and Narathiwat are home to most of the Muslim population. This southern region has a combined population of more than 1.8 million people, with more than 80% being ethnic Malay Muslims. The overall population here makes up only 2.9% of the country’s total population (Burke, Tweedie, & Poocharoen, 2013; McCargo, 2006). Figure 1.1 shows the map of Thailand and the southern region. It also highlights Pattani province, the site of this study.

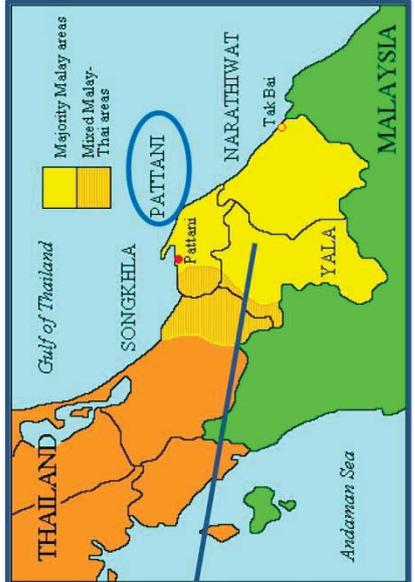


Population 1,972,896

Muslim 85.16%

Buddhist and others 14.84%

People mostly speak Patani Malay language
 (The Ministry of Interior, 2014)



Pattani, the site of this study

Figure 1.1. Maps of Thailand and southern region.

The southernmost provinces of Thailand, also known as the Deep South (Burke et al., 2013), have been the site of violent unrest since 2004. Between the 1960s and the 1980s two groups, the Barisan Revolusi Nasional (BRN), and the Pattani United Liberation Organisation (PULO), were involved in terrorist activities (McCargo, 2012; Pattani United Liberation Organisation, 2006). The BRN is a separatist movement based in northern Malaysia and operating in southern Thailand. Formed in 1963, it aims to fight for an independent Pattani state (Terrorism Research & Analysis Consortium, 2017). Similarly, PULO, established in 1968, claims its fight was against Thai colonialism and called for a free, independent Pattani. The actions of these two groups subsided in the 1980s (McCargo, 2012). However, in early 2004, mass violence incidents began again.

Many studies have tried to analyse the real cause and perpetrators of the violence (Askew, 2010; Gunaratna, Acharya, & Chua, 2005; McCargo, 2009, 2012; Melvin, 2007; Wheeler, 2014). However, Jitpiromsri and McCargo (2010), academics who live in the area and have worked on data collection and analysis of the violent incidents since 2004, argued that commonly cited reasons such as “the rise of global Islamic militancy, socio-economic grievances, or tensions among the Bangkok political elite” (p.157) overlook the core nature of the conflict. They emphasise that “The conflict in the far south is a political struggle concerning the extent to which Bangkok can exercise legitimate authority in the “Patani” region” (Jitpiromsri & McCargo, 2010, p.157).

The Deep South Watch, an organisation that works to build peace, reported that between January 2004 and April 2014, there were 14,128 violent incidents, which caused 17,005 deaths and injuries (Jitpiromsri, 2014). Regardless of efforts by all the government parties involved, the unrest has escalated in terms of both the number of incidents and the higher degree of violence. This ongoing violence has affected the people of the area in different ways. For instance, many of the Buddhist population have abandoned this land (Abuza, 2011), there are an estimated 3,000 widows and many of them struggle with psychological trauma (Tohmeena, 2013), and children suffer from anxiety and stress. Some children have had personal experiences of violence, witnessing attacks, injury, and death as almost everyday occurrences (Unicef Thailand, 2008).

Mental health problems have been a serious issue in this area since 2004 (Thongphec Sri, Prabhkri, & Chatarat, 2005). McCargo (2009) said southern Thailand’s violence impact “was usually more psychological” (p. 2). The Director of the 15th Mental Health Centre

(renamed in 2013 as the 12th Mental Health Centre) argues that mass violence impacts people's mental health and this type of violence generally results in five types of mental health disorder: major depressive disorder; suicide; post-traumatic stress disorder; generalised anxiety disorder; and drug abuse (Pusu, 2011). The Thai government responded by launching a number of mental health communication programmes to tackle the mental health results of mass violence.

It is argued that for the most sustainable recovery, the mental health rehabilitation system should be integrated into the mainstream healthcare system (McFarlane & Williams, 2012; World Health Organization, 2008). As O'Sullivan, Yonkler, Morgan, and Merritt (2003) and The Centres for Diseases Control and Prevention (CDC) (2001) stated when designing health programmes, programme planners also need to understand the setting and analyse the context that might influence the success of programme delivery. The following section outlines the structure of the public health system in Thailand.

1.5 The Thai public health system

The public health system in Thailand has been developed for more than a century. The Ministry of Public Health (MoPH) is at the core of this system, setting health policy and providing government financial support and resources. The Ministry's five missions are: setting health policy at the national level and also following up international trends; developing holistic health services for both normal and emergency cases by recognizing fundamental rights of citizens; supporting citizen participation in raising public awareness of health problems and developing their healthy behaviours; developing a quality management system in keeping with a self-sufficient economy; and setting up policy relating to health research and knowledge management (World Health Organization, 2015).

The MOPH decentralises its functions to four major administrations: Medical Services Development, the Office of the Permanent Secretary, Public Health Development, and the Public Health Supporting Services. Each administration works through further 'department-level' agencies. Figure 1.2 shows the delivery structure within each administration.

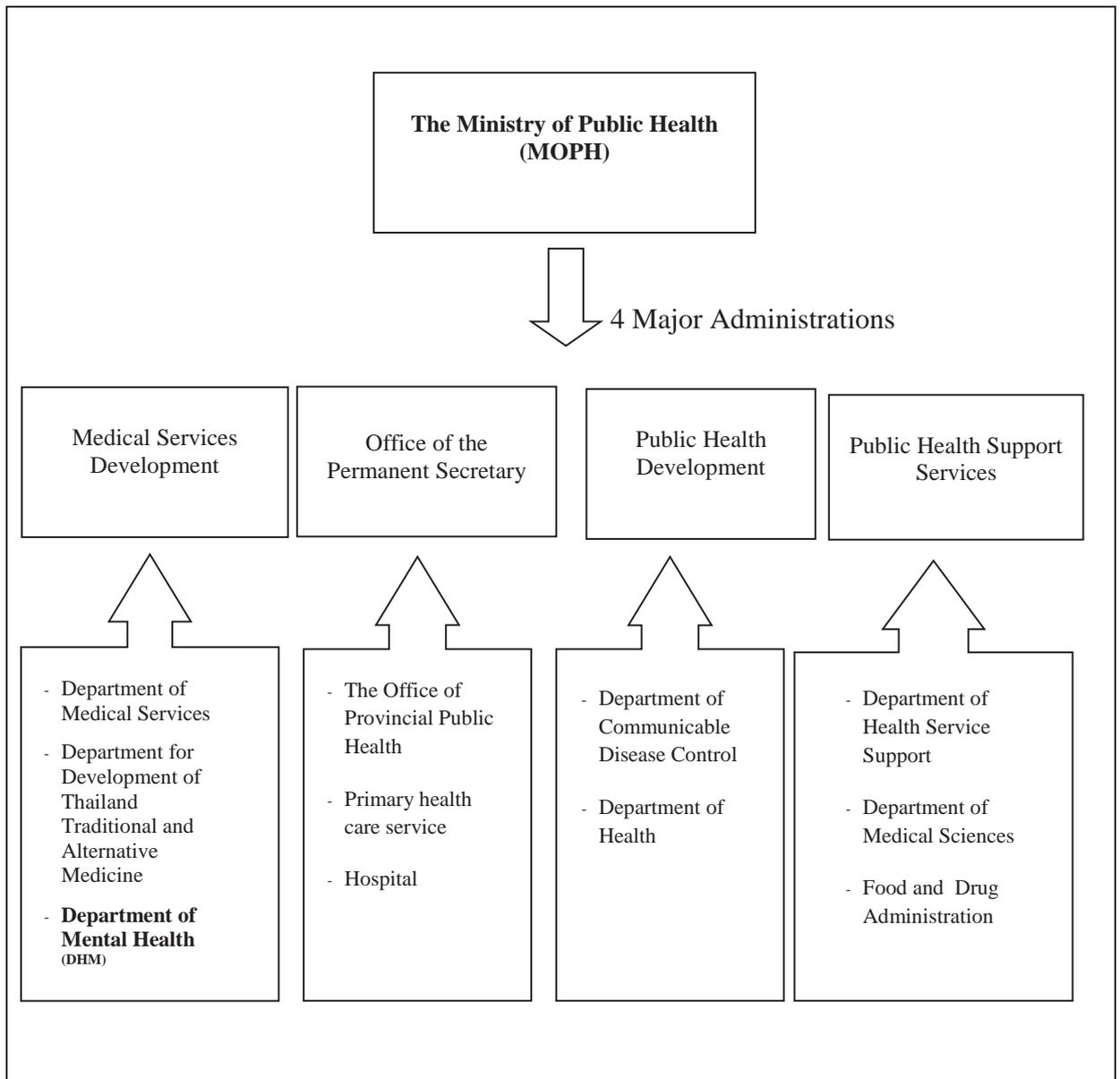


Figure 1.2. Administrative structure of Thailand’s Ministry of Public Health.

As Figure 1.2 shows, the Department of Mental Health (DMH) is one of the three departments operating under the Medical Development Group. The DMH has laid down a mental health policy that aims to promote mental health care within the community and to support people to participate in mental health programmes (Siriwanarangsana, Liknapichitkul, & Khandelwal, 2004). The DMH decentralises its duties through fifteen geographic zones. One of these sectors is Mental Health Centres. The Mental Health Centre-District 12, which is the key site of this study, is in charge of the three southern border provinces of Thailand.

1.6 Research strategy, methods, and questions

This research is concerned with communicative planning and practice through a prolonged 10-year period of mass violence. The case study approach is therefore the most appropriate research strategy, allowing for an in-depth qualitative exploration of a particular and complex case. Further, a case study has the potential to test theories, contribute knowledge, and build theories.

As this case study's focus is exploring Centre 12 staff's experiences and perceptions of their work, this study fits well within a qualitative paradigm where the purpose is to describe, explore, or explain social phenomena for gaining a deeper and richer understanding of human experience and social context (Patton, 2015; Stewart-Withers, Banks, Mcgregor, & Meo-Sewabu, 2014). Within this case study, multiple sources of evidence are employed to enable the researcher to answer the research questions. Interviews with Centre 12 staff, the director and partners, participant observation of staff planning and programme activities, and document analysis of programme collateral and policy documents provide evidence for the exploration of how mental health programmes in the mass violence area were designed and delivered from 2004 to 2014.

The aim of this study is to explore how mental health communication programmes of the 12th Mental Health Centre in response to the mass violence situation in southern Thailand from 2004 to 2014 have been designed and delivered. The five research questions are:

1. In what way did Thai government policies impact on the establishment, funding and delivery of mental health communication programmes in the mass violence situation in southern Thailand?
2. How were the mental health communication programmes responding to mass violence in southern Thailand planned?
3. How were the mental health communication programmes responding to mass violence in southern Thailand implemented?
4. How were the mental health communication programmes responding to mass violence in southern Thailand evaluated?
5. What are the effective practices and challenges of these mental health communication programmes, from the deliverers' perspective?

1.7 Theoretical framework

This thesis is a multi-disciplinary research project that draws on theories from three fields: public relations, health communication, and development communication. Given the site of the case study falls into the broad area of “crisis”, it is not surprising that the disciplinary context is wide-ranging. As long ago as the 1980s, Koselleck argued that crisis had become a key theoretical concept in all modern social and cultural sciences (Beck & Knecht, 2016), but disciplinary foundations, research traditions, and communities are fragmented and seldom linked (Schwarz, Seeger, & Auer, 2016).

The combination of these three approaches is used to illuminate understanding of mental health communication programme planning and delivery. The public relations approach, with its emphasis on the management function, planned activity, and research-based practice (Guth & Marsh, 2006) is relevant for analysing Centre 12’s programme development and programme delivery. Moreover, public relations also emphasises the development of long-term relationships, which is a core of building community resilience following disasters (Houston, Spialek, Cox, Greenwood, & First, 2015). The health communication approach is valuable for its recognition of communication techniques and strategies in health contexts (Cassata, 1980). It highlights communication strategies used to inform, influence and motivate target audiences about important health issues (U.S. Department of Health and Human Services, 2000). In particular, principles of good practice in health communication campaigns provide guidance for planners to design effective health campaigns. Last, the development communication approach applies communication research, theory, and technologies to support social development (Rogers, 1976). This framework emphasises the importance of a community-based philosophy and sustainable programmes which are key goals in disaster response (Moemeka, 1999).

These three approaches share an ultimate ideal to enhance two-way communication and participatory communication (Grunig & Hunt, 1984; Rogers, 1976; Smith, 1989). Across these fields, much of the relevant theory is normative, concerned with process and frameworks, and best practice and ideal outcomes. The shift away from a top-down, one-way communication towards normative to a two-way and symmetrical communication is a clear theme across the disciplines though the terminology and language varies. These three approaches therefore provide a suitable framework for

exploring a mental health communication programme delivery in a time of crisis, and particularly in the context of a developing country where community resources are limited.

1.8 Clarifying key terms

1.8.1 Mass violence

The thesis uses the term *mass violence* to identify the situation in the three southernmost provinces of Thailand throughout this study. When referring to the situation in southern Thailand, several scholars and researchers, both inside and outside the area, use different terms, such as ‘insurgency’ (Chalk & United, 2008; McCargo, 2009; Scupin, 2013; Wheeler, 2014), ‘violence’ and ‘violent conflict’ (Chalk & United, 2008; Jitpiromsri & Sobhonvasu, 2006; Sugunnasil, 2006), and ‘terrorism’ (Barter, 2011; Connors, 2006). Not much has been written to clarify the terms that have been used. Askew (2010) said while the term *insurgency* is generally used by academics and journalists, it has particular connotations of war and terror in the Western context. He cited the US Air Force’s definition of *insurgency* as “a violent struggle among state and non-state actors for legitimacy and/or influence over the relevant populations” (p. 119). However, Askew argued “there is no corresponding single term in the Thai vocabulary for ‘insurgency’” (Askew, 2010, p. 120). He further explained that violence in the south is complex and the term is “inadequate to define the totality of the violence. Something more than an ‘insurgency’ is going on in the current mix of violent events” (p. 121). The selection of the term *mass violence* for this research fits with the description of Turner, Yuksel, and Silove (2003) as broader attacks on communities that “emphasize the social rather than individual dimension” (p. 185). Wadsworth’s (2010) review also argued that the term *mass violence* was used in contexts where the combatants lack official status, there are no clear front lines, and civilians are the targets of random attacks to generate widespread fear. Mass violence also focuses on the action rather than the actor, reflecting southern Thailand’s situation in which “people have been reluctant to *name the problem*” (Jitpiromsri & McCargo, 2010, p. 157).

Widely found in disaster literature, the term *mass violence* refers to one of the two types of human-caused disaster (Norris, 2006), or manmade disaster (Bonanno, Brewin, Kaniasty, & La Greca, 2010; Lennart et al., 2013; NATO, 2008). The other form of

human-caused disaster is technological accidents. Murthy (2007) also used the term “mass violence” in his review of mental health impacts in ten developing countries facing long-term violence, which included Vietnam, Afghanistan, Lebanon, Palestine, and Sri Lanka.

Disaster literature is relevant to this research as it provides valuable insight into analysing mental health impacts on different populations, risk factors, and contributors to recovery. This kind of information is useful for designing appropriate mental health communication programmes for specific target audiences. However, this thesis acknowledges that those who have experienced natural disasters are different from those experiencing mass violence, especially in southern Thailand where conflicts are ongoing and people are exposed to daily violent attacks. Further, people with a strong commitment to a specific cause develop resilience to adversity and to the outcome of the violence that, according to their belief, serves their cause. Thus, ongoing violent conflicts have a different impact on mental health than natural disasters and need different communication considerations.

Some studies use the term *mass violence* together with *terrorism* (Schlegelmilch, Petkova, Martinez, & Redlener, 2017; U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services, 2004; Williams, 2007). The Office for Victims of Crime and the American Red Cross (2001) identified the difference as “Mass violence crimes may be under federal or state jurisdiction, but acts of terrorism are always federal crimes” (p. 3). However, this distinction is not applicable to Thailand, where there are no separate state and federal systems. Participants in this study spoke about the “violence” or the “crisis situation”. Interestingly, they did not use the official term “Khwam mai sangop (turbulence or disturbance)” (Askew, 2010, p. 120). It is also worth noting that while participants use the words *crisis situation*, the literature more frequently refers to *disaster*. *Crisis situation* in communication and public relations literature generally refers to organisational crises. However, disaster is widely found in the mental health literature. The choice to refer to ‘mass violence’ is further explained in Chapter Two.

1.8.2 Campaign and programme

The other key terms that need to be clarified are ‘campaign’ and ‘programme’. Smith (2013) uses a public relations perspective to clarify the theoretical difference between these two terms as follows:

A campaign is a systematic set of public relations activities, each with specific and finite purpose, sustained over a length of time and dealing with objectives associated with a particular issue. An example is a campaign to reduce accidents associated with drunk driving.

A programme is an on-going public relations activity dealing with several objectives associated with a goal. Programmes have a continuing commission within the organisation and focus on its relationship with a particular public such as an organisation’s programme in community relations or employee relations. (Smith, 2013, p. 15)

Both terms are used in this study to describe the activities of the 12th Mental Health Centre. Although the term *campaign* is generally favoured in the communication theory and literature cited, the term *programme* is also used in this study because it reflects the nature of Centre 12’s activities (such as the on-going public relations activity and focus on relationship building). More importantly, it was the term participants used when talking about their work. The term *campaign* was only used when the participants talked about launching activities in the public arena, with broad audiences (such as a mental health education campaign, on World Mental Health day, launched at a shopping mall). However, the participants did not generally distinguish between these two terms.

1.9 Thesis structure

The following chapter reviews the literature on the three communication frameworks that guide this research – public communication and public relations, health communication, and development communication. Chapter Two also examines a number of empirical studies of the mental health consequences of disasters, coping strategies, mental health communication in the disaster contexts, and their relevance to this study.

Chapter Three reviews and discusses the research methodology used in the study. It begins with a discussion of case study research and the qualitative approach. The chapter also provides details about the three methods used in the data collection: semi-structured in-depth interviews, participant observation, and document analysis. Finally, the chapter identifies data collection in fieldwork.

Chapters Four and Five provide details about the study results, which come mainly from the interviews, are supported by participant observation data and document analysis. Key findings in Chapter Four involve the Thai government's policies supporting for mental health rehabilitation, the development of the 12th Mental Health Centre, and the four interrelated phases of Centre 12's programme development, reflecting policy shifts. Chapter Five provides findings about Centre 12's programme planning, implementation, and evaluation. Results also reveal the successful factors and barriers in delivering mental health communication programmes in a mass violence context.

Chapter Six then discusses the study's findings with relation to the literature from the three key fields of public communication and public relations, health communication, and development communication.

Chapter Seven identifies the limitations of this study. The chapter then provides the study's conclusions and implications for practice.

1.10 Conclusion

This chapter introduced a general outline of the thesis. It described the background to this study and the key contextual factors of the setting, including the population and cultures of the three southern border provinces of Thailand, the mass violence situations and its impacts on the mental health of people living in the area, as well as the Thailand public health system. Gaps from previous studies on mental health communication in disaster contexts and how this thesis intends to fill those gaps were discussed. The chapter then stated clearly the research questions, outlined the theoretical frameworks, key terms used in this thesis, and an outline of the thesis structure was given. The next chapter provides further contexts through reviewing the literature and empirical studies relevant to this study and argues for the value of combining three key approaches to enable a deeper understanding of mental health communication programmes in response to Thailand's mass violence situation.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

The focus of this study is to explore how mental health communication programmes were planned, implemented, and evaluated in response to more than ten years of mass violence in southern Thailand. As a multi-disciplinary area of study, three major approaches were chosen to analyse the study findings and contribute to knowledge: public communication and public relations, health communication, and development communication.

This chapter begins by examining these three approaches in terms of their disciplines and practices, including definitions, history, framework, and major theoretical perspectives. Next, it provides a summary of the interrelationship between the three disciplines. The normative understanding of campaign/programme planning frameworks is then identified. The review concludes with 10 key themes extracted from empirical studies and reviews of health and mental health communication programmes (sometimes termed mental health interventions) in response to disaster situations, including both natural and man-made disasters, particularly war, terrorism, and violence.

2.2 Public communication and public relations

The disciplines and practices of public communication and public relations have been identified as crucial in disaster and crisis situations. Medford-Davis and Kapur (2014), who interviewed 26 communication officers of the World Health Organisation (WHO), found communication was one of the top three priority areas of disaster management. Their study summarised the role of disaster communication as preventing panic and promoting appropriate public behaviour, coordinating stakeholders, advocating for affected populations, and mobilising resources. Public communication and public relations, however, have a long history and a far wider application and role, not only in disaster management. The section below first examines public communication broadly,

followed by a discussion of the public relations approach to communication and programme planning, which is the main focus of this study.

2.2.1 Defining public communication

Public communication can be seen as “acts of communication in which knowledge is made available without restricting who may receive it” (Stappers, 1983, p. 141). This definition is clearly related to mass communication, which uses mass media channels to communicate with the public. However, Stappers argues that public communication uses more than the mass media channels, and is “public in the sense of excluding no one from its messages, it follows that any number of people can become receivers; such a group of people may or may not be called a ‘mass’, depending on the circumstances” (Stappers, 1983, p. 142).

Public communication campaigns are frequently examined through two aspects based on their intentions and their methods (Paisley, 2001; Paisley & Atkin, 2013; Rogers & Storey, 1987). Paisley and Atkin (2013) described a campaign’s intention as one group’s intention to change another group’s beliefs and behaviour. Likewise, Rice and Atkin (1989) defined public communication campaigns as “purposive attempts to inform, persuade, or motivate behaviour changes in a relatively well-defined and large audience” (p. 7). In terms of campaign methods, Rogers and Storey (1987) explained broadly that public communication campaigns use the media, messaging, and an organised set of communication activities to generate specific outcomes in a large number of individuals and during a specified period of time. Paisley and Atkin (2013) provide greater detail, saying campaigns employ different communication methods such as brochures, posters, and advertisements for a particular intention – to reform. They defined reform as “action that makes society or the lives of individuals better” (p. 23).

2.2.2 Public communication campaigns: A brief history

The topic of public communication campaigns has been explored widely in several fields, including communications, business and marketing, political studies, and health. Although the origin of public communication campaigns as an explicit method is not distinctly specified, many books and studies cite America as a primary location for the first campaign and the original background of the term “campaign” was a military intervention (Salmon & Atkin, 2003). Paisley (2001) pointed out the shift to

campaigning in social contexts was “for achieving peaceful, evolutionary social change as well as an apparatus for promoting public health and welfare” (p. 450). Paisley, in examining the historical phases of public communication campaigns in America, claims the earliest campaigns were to promote liberty and public good. Before the 18th century, public issues of concern included the abolition of slavery, the rights of women, and abstinence from alcohol. After these issues were raised by community groups, they became the main points of national agenda.

Paisley (2001) divided campaign history into three phases marked by the entry of three groups of stakeholders: associations, mass media, and government. In the period from the 18th century to the U.S. Civil War, the special-interest groups were organised as associations, groups who disagreed with policy and worked together for particular issues. After the Civil War, the associations became more powerful by using the new forms of mass media that grew exponentially in the late 19th century. At the end of the 19th century, the federal government in the U.S. acted to reduce the pressure from associations and media by passing many social laws, such as the Interstate Commerce Act, Pure Food and Drug Act, and Child Labour Act, into the Constitution. In turn, the government used the tactics of public communication campaigns to promote its own social reforms. In a revised history, Paisley and Atkin (2013) added three more groups of stakeholders of public communication campaigns: non-profit foundations (such as the Bill & Melinda Gates Foundation), trade unions, and business. Government and non-profit foundations are the main stakeholders represented in public communication activities in this study (see section 5.3).

2.2.3 Perspectives on public communication campaign characteristics

The characteristics of public communication campaigns put forward by Rogers and Storey (1987) and Rice and Atkin (2009) have been cited widely as the classical guidelines for campaign planners (e.g. Francis, Dunt, & Blood, 2002; Noar, 2006; Salmon & Atkin, 2003). The four essential characteristics of public communication campaigns are (1) the generation of specific outcomes or effects, (2) in a relatively large number of individuals, (3) usually within a specified period of time, and (4) through an organised set of communication activities (Rogers & Storey, 1987). Rice and Atkin (2009) added that campaigns are generally for non-commercial benefits, and

communication activities usually involve mass and online/interactive media, and are combined with interpersonal support.

Dorfman, Ervice, and Woodruff (2002) critiqued Rogers and Storey's (1987) idea that public communication campaigns only involve large numbers, arguing that narrow targets are also appropriate for communication campaigns. They also said the main characteristic of public communication campaigns is a strategic purpose. Based on nine campaign exemplars, Dorfman and colleagues suggested that public communication campaigns are differentiated along three axes: purpose, scope, and the level of maturity. Public communication campaigns have an element of reform or making better (as said previously by Paisley and Atkin (2013)); as a result, campaign purposes can be divided into two effects: behaviour change and policy change. These levels of change are similar to Coffman's (2002) concept of behavior change and public engagement campaigns. However, Dorfman et al. pointed out some campaigns have mixed goals, and some effective campaigns are small, with specifically directed targets and limited budget: "small in scope does not necessary mean small in effect" (p. 10). The last axis is a campaign's level of maturity. An old or long-running campaign does not mean it is more effective or more important than a short-term or a one-time event campaign (Dorfman et al., 2002).

2.2.4 Public communication campaigns: Major theoretical perspectives

Much of the theoretical perspective of public communication campaigns is pragmatically based and focused on effective campaigning (Atkin & Freimuth, 2013; Salmon & Murray-Johnson, 2013; Weiss & Tschirhart, 1994). There has been less written critiquing of the concept of campaigning itself. Two broad perspectives on public communication campaigns are the social science and marketing approaches (Atkin & Rice, 2013; Salmon, 1989). In the social science perspective, Coffman's (2002) brief overview of public communication campaign theory notes that social science theories have been applied to campaign design and evaluation. She divided campaign studies into three areas: the studies of behaviour change (such as the Theory of Reasoned Action, Social Cognitive Theory, Health Belief Model, and Stages of Change Model); public media (such as Agenda Setting, Framing Theory, and Priming); and campaign effectiveness (such as the Framework of Effective Campaigns). My study fits most closely with Coffman's third category, campaign effectiveness, because it

provides guidelines for campaign planners to design, implement, and evaluate effective campaigns.

Another viewpoint on public communication campaign theory is narrower than the perspectives addressed above. Atkin and Rice (2013) said two of the most comprehensively applicable concepts in campaign study are the Communication-Persuasion Matrix and social marketing framework (explored below). William J. McGuire's Communication-Persuasion Matrix, developed in 1981, identifies two variables used in persuasive communication: input and output variables. Input variables include source (number, unanimity, demographics, attractiveness, and credibility), message (type of appeal, type of information, inclusion/ omission, organisation, and repetitiveness), channel (modality, directness, and context), receiver (demographics, ability, personality, and life style), and destination (immediacy/delay, prevention/cessation). These input variables are similar to the elements in the classical model of communication (Berlo, 1960; Lasswell, 1948; Shannon & Weaver, 1949), which influence the response steps or output variables (such as exposure to the message, interest in message, understanding the message, and deciding to act according to the message). McGuire's model can be used as a checklist for constructing and evaluating public communication campaigns (See example of studies using McGuire's model as a framework of analysis in Dziokonski, 1977; Kelly, Sturm, Kemp, Holland, & Ferketich, 2009; Kreuter & McClure, 2004).

Social marketing also provides a practical framework for formative research, implementation, and evaluation by applying marketing principles in order to enhance behaviour changes (Mattson & Basu, 2010). These principles are similar to the public relations planning framework outlined in section 2.2.8. Several studies advise applying social marketing principles in health communication campaigns (such as Kotler & Roberto, 1989; Rogers, 1996; Snyder, 2003). Salmon (1989), however, argued that the social marketing approach, which applies principles of marketing to the ideas "deemed beneficial to society" (p. 19), should initially asked who benefited from campaigns, who defined societal problems, and what was the appropriate way to evaluate the success of social marketing. He noted that information campaigns were frequently suggested as a solution to social problems defined by elite groups (who have social resources and power). Furthermore, campaigns are focussed on changing the individual rather than changing the system, especially government-funded campaigns: "it is unusual for funds

to be disbursed to change the system rather than changing individuals responding to the system” (Salmon, 1989, p. 27). Salmon also argued that such campaigns were used as an early attempt by the government to deal with an emerging problem because they are inexpensive, easy to implement, and individuals perceive they have exercised their free will.

2.2.5 Perspectives on effectiveness of public communication campaigns

Despite the energy and planning often put into campaigns, not all are successful. A number of commonly cited factors affecting failure and success seem to have originated in two classical studies: Hyman and Sheatsley’s (1947) study, *Some Reasons Why Information Campaigns Fail*; and Mendelsohn’s (1972) study, *Some Reasons Why Information Campaigns Can Succeed*. Hyman and Sheatsley’s study emphasised campaigns cannot rely merely on “increasing the flow” to spread the information, but that campaign planners should learn the audiences’ psychological characteristics, and understand barriers such as the existence of a hard core of chronic “know-nothings”, interested people acquire the most information, people seek information congenial to prior attitudes, people interpret the same information differently, and information does not necessarily change attitudes. On the other hand, Mendelsohn critiqued Hyman and Sheatsley’s focus on psychological barriers blaming the audiences for the absence of effect. Mendelsohn’s study explored two campaigns: The National Drivers Test and A Snort History (an anti-drink-drive campaign). Mendelsohn concluded the main cause of campaign failure was audiences’ lack of the interest in contents rather than the amount of information. He argued that campaigns should be planned around the assumption that most of the audience are either only mildly interested or not at all interested in the information. Effective campaigns should set objectives explicitly, specifically, and realistically. Further, campaign planning should carefully analyse the target audiences in term of their demographic and psychological attributes, life styles, value and belief systems, and media habits. Also, campaign studies should focus on success factors, more than the failure factors. Moreover, communication campaign studies should integrate communication and social sciences research because media itself is powerless to effect behaviour change. Social science researchers could help fill this gap by determining the appropriate targets, themes, appeals, and media vehicles to reach the specific purpose of public communication campaigns.

Another effort to evaluate public communication campaign success is Rice and Paisley's (1981) five principles for a successful campaign: assessment of the needs, goals, and capabilities of target audiences; systematic campaign planning and production; continuous evaluation; complementary roles of mass media and interpersonal communication; and selection of appropriate media for target audiences. In 2001, Paisley revisited the principles and added planning, pilot testing, formative evaluation, revision, and full implementation. Similarly, Rogers and Storey (1987) claim that communication campaigns become relatively more effective when they increase their use of formative evaluation research to design campaign strategies and to pre-test the messages. The segmentation of specific audiences develops campaigns which are then reached with targeted messages.

Weiss and Tschirhart's (1994) Framework for Effective Campaigns covered the same ground. Their principles are capturing the attention of the right audiences (audience analysis), delivering an understandable and credible message (source credibility and message design), delivering a message that influences the audiences' belief or understanding, and creating social contexts that lead to the desired outcomes. All the effective principles presented in this section are useful for analysing campaign design in this study's findings.

While key aspects of the literature consider public communication from a social marketing perspective, the following section examines the communication approach related to the purpose and method of public communication campaigns after disasters – public relations.

2.2.6 Defining public relations

In 2011, Harrison wrote that “There is no single, clear, universally accepted definition of public relations” (p.5). Since then, the Public Relations Society of America (PRSA) initiated a campaign and public vote for producing a new definition, resulting in public relations being defined as “a strategic communication process that builds mutually beneficial relationship between organizations and their publics” (Public Relations Society of America, 2017). One of the key points is the PRSA's focus on ‘process’ rather than the ‘management’ function (as found in several classical definitions such as Harlow, 1977; Grunig & Hunt, 1984; and Hutton, 1999). As the PRSA noted, the term management tends to evoke a sense of control, and one-way communication.

The approach and findings of this study largely reflect this new definition, not only in its focus on strategic communication process, but also the emphasis on relationship building. As Houston et al. (2015) confirmed, the use of a public relations lens is appropriate to study the development of community resilience following disasters because of public relations' "emphasis on developing relationship and community" (p. 272).

2.2.7 Four models of public relations

While early public relations literature was empirically focused, this changed with the advent of Grunig and Hunt's (1984) four models: press agency or publicity (1850s–1900s); public information (1900s–1920s); two-way asymmetric (1920s–1960s); and two-way symmetric (1960s and 1970s). Grunig and Hunt argued that their four models reflect the development stages of public relations in North America. However, these models have been widely cited by public relations' scholars and professionals across many countries and cultures (e.g. Grunig, Grunig, Sriramesh, Yi-Hui, & Lyra, 1995; Guth & Marsh, 2006; Laskin, 2009; Turk, 1985; Waters & Jamal, 2011).

Press agency or publicity was explained by Grunig and Hunt (1984) as one-way communication in which information disseminated is "incomplete, distorted, or half-true" (p. 21). The public information model, while also one-way, provides selected information that benefits both organisations and publics such as government agencies' press releases and newsletters. The two-way asymmetric model is also persuasive in purpose. However, Grunig and Hunt described this model as "scientific persuasion" (p. 22) because practitioners apply social science research to explore publics' attitudes and behaviours and try to persuade publics to accept their messages. This two-way communication has imbalanced effects. Last, in the two-way symmetric model, PR practitioners function as mediators between organizations and publics based on mutual understanding. A major difference between the two-way asymmetric model and the two-way symmetric model is the balance of power (Grunig & Hunt, 1984). In the two-way asymmetric model, the organizations try to change public attitudes, and do not intend to change themselves. In contrast, the two-way symmetric model focuses on dialogue. Formative research and evaluation research are used to understand public perception and to explore how organisational policy might be changed to serve publics.

The four models have been the subject of much criticism, although they remain influential. Conrad (1985) proposed a “mixed-motive approach” as “one in which both parties perceive the issue from both their own and the other parties’ perspectives” (p. 311). The mixed-motive concept was applied later by Murphy (1991), who examined symmetrical public relations through game theory. Murphy found mixed motive games, in which one side integrates their own interests with what the other side wants, can reach a more acceptable solution. She claimed that the mixed-motive model “does a better job of describing the behavior of public relations practitioners in the real world than does a purely symmetrical model” (p. 312). Similarly in 1993, Leichty and Springston critiqued the unclear boundary between two-way asymmetric and two-way symmetric models. They also disagree with the idea that one public relations model is best across all situations. They suggested that an organization should target their publics and interact with them differently depending on each situation.

In 1995, the four models were examined at the international level by Grunig, Grunig, Sriramesh, Huang, and Lyra, who found press agency and public information models were widely used, although practitioners (especially in India and Greece) recognised that the two-way symmetric communication was the ideal. The four models were applied differently depending on the purposes, for instance, when organisations want to build a positive image, they use press agency. Interestingly, there was evidence of changing PR models in Taiwan when dealing with a nuclear power crisis. Press agency was used by the government to provide highly technical but one-sided information supporting the construction of three nuclear plants. Then, public information was used to educate the public on nuclear information after the activists appeared to protest the new nuclear plant project. Last, the two-way asymmetrical model was used to conduct audience analysis research and institute more participative campaigns, but these campaigns were more persuasive than negotiating equally. At the end, the new project was not approved; however, Taiwan became a case study for adapting the model of public relations most suitable to context (Grunig et al., 1995; Leichty & Springston, 1993).

In relation to public relations models in Thailand, Ekachai and Komolsevin (2004) and (Srisai, 2011) said Thai PR practice was mainly influenced by U.S. principles. Sriramesh (2004) noted that one reason for this was that Asian students mostly graduated from American universities. Ekachai and Komolsevin (1996), applying

Grunig and Hunt's (1984) four models of public relations to study the roles of Thai PR practitioners, found press-agentry and public-information models were dominant in both the government and private sectors. Government organisations relied heavily on public relations to disseminate rural development policies; "development-related public relations involved primarily one-way asymmetric communication with transmission of one-sided messages" (Ekachai & Komolsevin, 1996, p. 159). Furthermore, the communication-technician role was prevalent among Thai practitioners, and measurement of success and failure largely relied on the amount of media produced and media dissemination statistics.

Although Thai PR practitioners rely mainly on the U.S. approaches, Thai culture plays a crucial role in their practice (Sriramesh, 2004; Srisai, 2011). Saang Kwaam Pratabjai (impression building) is key in the Thai PR practice of managing relationships with stakeholders. Eight main aspects of Thai culture influence impression building (Srisai, 2011), for instance, "relationship orientation" such as doing good deeds, favours or help for others, is then returned with some kind of benefit, favour, friendship, or respect from the receivers. Community-based relationships are also emphasised because Thais live in a collective culture, rely on the groups to which they belong, and opinion leaders are key communicators in Thai rural areas. Furthermore, Thai characteristics such as being flexible, adjustable, joyful behaviour and having fun also influence PR practice. Other aspects include the hierarchical structure, Buddhist orientation, and respect for the Monarchy. Chapter 5.2.2 will show how cultural aspects influence this study's participants.

2.2.8 Public relations campaign and programme framework

As highlighted earlier (in 2.2.6), public relations is a strategic management function. Public relations practitioners need to design public relations campaigns strategically to achieve campaign missions and goals (Atkin & Freimuth, 2013; Austin & Pinkleton, 2015; Wilson, 2001). Several campaign frameworks have been generated as guidelines for public relations practitioners. For instance, Marston's (1979) RACE model stands for research, action planning, communication, and evaluation, and Kendall's (1996) RAISE model means research, adaptation, implementation, strategy, and evaluation. Hendrix (1998) also developed the ROPE model (research, objectives, programming, and evaluation). Last, Crifasi (2000) offered the ROSIE model, which attempts

to combine those previous frameworks (for research, objectives, strategies, implementation, and evaluation). As can be seen, each framework embraced similar elements, especially starting planning with research, which in some models also includes strategy and objective planning; which was then followed by the implementation of various communication activities. The broad framework concludes with programme evaluation, which may also be a basis of a new improved programme. The following section further discusses the three broad processes: programme planning, programme implementation, and programme evaluation.

2.2.8.1 Programme planning

Three important components of effective programme planning are discussed below, including research, setting programme goals and objectives, and identifying stakeholders.

Research

In the public relations campaign planning literature, research is described as an essential element influencing the success of programme implementation (Austin & Pinkleton, 2015; Bowen, 2003; Harrison, 2011; Kirby, 2009; Syed, Khadka, Khan, & Wall, 2008; Walker, 1994). Bowen et al. (2010) stressed that formative research helps practitioners to segment publics, tailor communication for specific publics, and build relationships with those interested in campaigns. Research was also identified earlier in section 2.2.8 as a main element in two-way asymmetrical and two-way symmetrical models of public relations.

Dozier and Repper (1992) divided public relations research into two types: environmental scanning and evaluation research. Information from environmental scanning research (termed front-end research by Stacks, 2002), used to explore problems and as a baseline for programme evaluation research, is usually gathered through focus groups, surveys, and interviews. Focus groups are ideally suited to environmental scanning and are useful “to pre-test attitude” (Harrison, 2011, p. 316) because they allow flexibility for open-ended discussion and are also inexpensive, quick, and easy to repeat. Further advantages of focus groups are supporting interaction between participants and allowing a large amount of data to be collected (DiStaso & Stacks, 2010). However, concerns include the moderator’s ability to lead and observe

the participants, and the small sample size and limited sampling strategies, which mean it is difficult to generalise to the wider public (DiStaso & Stacks, 2010). Questionnaire surveys and interviews are also recommended for environment scanning; however, survey researchers should select “the specifics public or a broad cross section of many publics” (Dozier & Repper, 1992, p. 187).

Grunig (2006) noted that, after his publication on the four models in 1984 (Grunig & Hunt, 1984), research became important in programme planning not only because it is a crucial component in the two-way asymmetrical and two-way symmetrical models, but because strategic management also became a focus of public relations and other kind of management.

In practice, there have been a number of studies about the actual nature and extent of research used by practitioners. Judd (1990) conducted surveys with PR practitioners in the U.S. and found those practitioners who valued research highly were more likely to conduct research. The most popular techniques were in-depth interviews or focus groups, formal clipping analysis, and formal public opinion surveys. In contrast, Dozier (1990) found informal research, such as face-to-face communication or phone conversation and the ‘mixed approach’ (such as clip file content analysis), was used most frequently by PR practitioners. Scientific research, such as surveys and focus groups, was used least frequently because of its complexity. However, Walker (1994) analysed 124 campaign documents in the collections of Australia’s Golden Target Award between 1991 and 1992 and interviewed 20 award-winning PR practitioners. She found surveying was the most favoured method, followed by interviews and discussions, and secondary analysis. Informal research was favoured because it was cheap and quick. Findings from Walker’s interviews highlighted two problems of using research for PR practitioners: first, practitioners did not recognise their practice as research, as they felt it was their routine job; second, while research was actually undertaken, the narrow scientific definition of research might not describe it. Later, DiStaso and Stacks (2010) also analysed the use of research by PR practitioners from 1999 to 2008 (through America’s 167 Silver Anvil Award winners). Their study found secondary research, which they defined as using existing resources, such as online databases for information or data related to a particular need or strategy, was used most frequently, followed by surveys, interviews, and focus groups. The study also showed

that after 2004, while there were fewer focus groups and surveys interviews and secondary research were dramatically increased.

It is noteworthy that most of the studies above, generally well-resourced exemplars, such as award-winning campaigns, relied largely on Grunig's (2002) excellent model, which prioritised formative research. On the other hand, many studies also pointed out the difficulties of conducting programme research. While robust research is perceived as an important factor of successful public communication programmes, little of it is undertaken (Harrison, 2011; Macnamara, 2008; Walker, 1994). This applies both to the private sector and to government organisation. Hiebert and Devine (1985) conducted an in-depth survey of government information officers in the U.S. and found a low level of research and evaluation was conducted: "approximately 80% never or rarely conduct formal public opinion surveys and almost 76% never or rarely conduct formal readership surveys of their published material" (Hiebert & Devine, 1985, p. 49). Newspaper clipping and analysis were the most popular methods of research. Similarly, Yun's (2006) survey of public diplomacy practices and management of 113 embassies in Washington D.C. found respondents reported they used "little" or only "some" degrees of research (p. 304).

In summary, the day-to-day planning research and activities of communication practitioners do not appear to reach the threshold for effective practice that is advised in the literature (Harrison, 2011; Macnamara, 2008; Walker, 1994). In this context, the Centre 12 case study provides an unusual insight into the long-term communication practice of a particular government institution.

Goals and objectives

While goals provide the directions and overall outcomes, objectives provide specific and measurable outcomes to meet the goals (Bowen et al., 2010; Cutlip, Center, & Broom, 2006). Cutlip et al. (2006) suggested considering four elements in setting objectives: target publics, change outcomes (knowledge, opinion, and behaviour), measurement, and target date. Another perspective comes from Harrison (2011) who proposed an acronym 'SMART' (Specific, Measurable, Agreed, Realistic/Relevant, and Timed), which he said is widely used around the world for designing programmes' objectives. One of the common pitfalls in setting public relations programme objectives is describing activities rather than outcomes (Bowen et al., 2010; Broom & Sha, 2013),

for instance, “To mail out 12 monthly issues of... or To inform people about...” (Broom & Sha, 2013, p. 272). To avoid this problem, practitioners need to ask themselves, “Is this an impact we need to achieve in a target public?” (Broom & Sha, 2013, p. 272). Bowen et al. argued that outcome objectives (or results objectives; Harrison 2011), are the most important because they reflect the changing behaviour of the programmes’ audiences.

Identification of publics and stakeholders

The terms ‘public’ and ‘stakeholder’ are often used synonymously (Grunig & Repper, 1992), although they are different concepts (Harrison, 2011). A public is defined as “a loosely structured system whose members detect the same problem or issue, interact either face to face or through mediated channels, and behave as though they were one body” (Grunig & Hunt, 1984, p. 114). Based on this definition, publics are those affected by a problem; however, their interaction to the problem depends on the level of interest. Table 2.1 below clarifies types of publics in public relation studies.

Table 2.1 *Ways of classifying publics in public relations approach*

Ways of classifying publics	Authors and Studies
Latent publics, aware publics, and active publics	Grunig and Repper (1992)
All-issue publics, apathetic publics, single-issue publics, and hot-issue publics	Grunig and Repper (1992)
Active publics, aroused publics, aware publics, and inactive publics	Hallahan (2001)
Primary publics, intervening publics, and special publics	Center, Jackson, Smith, and Stansberry (2014)

Public relations programme planners should figure out a programme’s “target publics”. As Broom and Sha (2013) explained, “Effective reification of target publics requires an understanding of “publics” both as they arise in response to specific situations and as they identify with specific groups across situations” (p. 267).

Grunig and Repper cited Friedman's (1984, p. 25) definition of stakeholders as, "the group or individuals with whom the organisation interacts or has interdependencies and any individual or group who can affect or is affected by the actions, decisions, practices or goals of the organisations". Based on this definition, stakeholders are part of the organisation. Broom and Sha (2013) suggested that public relations practitioners need to analyse stakeholders when designing programmes because different groups of stakeholders are related to organisations. Further, they noted "not all those identified as stakeholders in a situation necessarily become target publics for the program designed to address a particular problem" (Broom & Sha, 2013, p. 246).

2.2.8.2 Programme implementation

To be effective in the implementation process, practitioners need to understand why and how the plan can be implemented. Harrison (2011) claimed understanding public relations theories and principles is important because theories drive good practice. He provided examples such as the broad communication process (sender/message/channel/and receiver) and the revised communication models; interpersonal communication (transactional process); motivation, e.g. Maslow's Hierarchy of Needs; and principles of influence, e.g. persuasive communication. These theories are useful for this study because they provide the basis of crafting communication, especially interpersonal communication, which is widely used in disaster contexts. This section, however, concentrates largely on programme implementation or delivery, and includes media design and production, media selection, communication tactics, and channels of communication necessary to accomplish programme objectives.

Strategy refers to "the overall concept, approach, or general plan for the programme designed to achieve an objective and tactics refer to the actual events, media, and methods used to implement the strategy" (Broom & Sha, 2013, p. 273). However, Harrison (2011) noted that practitioners mostly use 'action' or 'action steps' rather than the academic word, 'tactics'. As Broom and Sha's (2013) summarisation, "strategy is selected to achieve a particular outcome, and tactics are how the strategy gets implemented" (p. 273). Communication strategies focus on two components: messages and channels.

Harrison (2011) argued that the main message of a campaign should be clear and concise, and guide all communication practices in the implementation process, an assessment that agreed with Gregory (2006), who maintained that the message is the key component of an effective communication campaign. In message design, the campaign planner should think about message components such as format, tone, context, timing, and repetition. However, the limitation of message design is focusing on one-way communication (Gregory, 2006). Gregory claimed dialogue was more effective communication, but that it is difficult to evaluate the success of dialogue except through examining the quality of the relationship.

In message delivery, channel selection is crucial to successful programme implementation. Broom and Sha (2013) believed mass media are effective when programmes aim to change knowledge, and both mass media and interpersonal channels can impact on attitude change. Interpersonal communication, especially with family and friends, is effective for programmes that focus on behaviour change. Bowen et al. (2010) uses the public relations terms *intervening publics* or *influentials* to identify people who pass information on to the key publics and act as opinion leaders. Similarly, Broom and Sha (2013) and Weimann (1991) also emphasised that opinion leaders or influentials are those who can influence the knowledge, attitudes, and behaviours of other people. Kreuter and McClure (2004) suggested senders who were perceived as expert and trustworthy were more persuasive sources. In focusing on disaster situations, Abeldaño and Fernández (2016) reviewed psychosocial interventions and found that when resources are limited group assistance and workshops inclusive of interpersonal communication are common and effective types of intervention for coping with mental health problems.

Regarding mass media channels of programme implementation, this section focuses on radio and print media, the main channel used by participants in this study. Radio has been described as an effective channel in delivering mental health messages (Birowo, 2010; Ewart & Dekker, 2013; Perez-Lugo, 2004; Shaw, Hibino, & Matsuura, 2012) in crisis situations because it provides “instant and in-depth reporting and portability” (Moody, 2009, p. 162) and emotional support for reducing stress. Print material was also shown as an effective supporting tool for health programme implementation (Ben-Gershon, Grinshpoon, & Ponizovsky, 2005; Paul, Redman, & Sanson-Fisher, 2003). Print media, especially pamphlets and booklets, are valuable as they offer detailed

messages, supplement personal communication, and are attractive, colourful, and easy to reproduce (Aronoff & Baskin, 1983). Similarly, Paul, Redman, and Sanson-Fisher (1998) said print materials are widely used in public health education, though there is little investigation into the costs and processes involved in developing the material and their effectiveness in practice. Paul et al. interviewed 21 agencies in New South Wales and found only one-fifth of 183 health education pamphlets were produced by consulting the target group members and one-fifth were pre-tested by using focus groups.

Bowen et al. (2010) argued that once messaging and communication channels were determined, two components need to be further developed: the planning calendar and budget estimation. However, in a crisis situation (as is the focus of this study), Cutlip et al. (2006) identified three types of planning scenario commonly used in organisations: planning for immediate crises; planning for emerging crises; and planning for sustained crises. For immediate crises, when an unexpected situation suddenly occurs, public relations practitioners have no time for research and planning, but react to the crises with a general plan for avoiding confusion, conflict, and delay. Second, for emerging crises, although practitioners have more time to research and plan, the crisis might erupt suddenly. The organisation therefore needs to take action before the situation becomes critical. Last, sustained crises are those that persist for months or years, for which strategies for long-term problem solving need to be developed.

2.2.8.3 Programme evaluation

Evaluation is essential to prove the effectiveness of public relations programming and is an integral part of planning research (see section 2.2.9.1). “Lack of evaluation was referred to as ‘the great tragedy as clients and practitioners don’t get the impact of their own work’” (Walker, 1994, p. 151). Gregory (2006) identified the following principles that help evaluation: setting SMART objectives; merging evaluation from the start; using on-going monitoring evaluation; training research methods or including a specialist in the team; and evaluating processes. Table 2.2 below identifies types of programme evaluation and related issues by Broom and Sha (2013) adapted from Cutlip, Center and Broom (2006).

Table 2.2 *Broom and Sha' (2013) Types of Public Relations Programme Evaluation*

Types of PR programme evaluation	Objectives	Components for evaluation issues
Preparation or inputs evaluation	Assess the quality and adequacy of information	<ul style="list-style-type: none"> - Background information used to plan programmes - Programme content - Presentation quality (the production of messages and events)
Implementation evaluation or outputs evaluation	Explore progress when the programme is being implemented	<ul style="list-style-type: none"> - Distribution (number of messages and events produced) - Placement (number of messages in media) - Potential audience (number of people exposed to message and event content) - Attentive audience (number of people who attend to message and event)
Impact or outcomes evaluation	Look at the consequences of the programme and whether it does accomplish its objectives and goals	<ul style="list-style-type: none"> - Knowledge gain - Opinion change - Attitude change - Behaviour change - Repeated behaviour - Social and cultural change

Although programme evaluation is very important, it is challenging for public relations practitioners. As mentioned earlier, Walker's (1994) investigation of PR practitioners' attitudes toward outcome measurement found funding and time were the most important barriers. Some practitioners mentioned public relations and marketing activities were combined and it was "too difficult to prove the effect of public relations" (Walker, 1994, p. 151). Finally, difficulties were dependent on types of campaign and objectives: "It was claimed that exposure to a campaign or message can be measured easily, as could its impact, whether a goal is achieved or a problem solved" (p. 151). However, measuring attitudinal, societal, or cultural change was more difficult. Walker also raised the problem of effective campaign evaluation, "a public awareness campaign measured

its success by evaluation forms following each marketing workshop, feedback from workshop participants, increase in market share, and media coverage because it is easy (see also Kreps, 2014). A large number of practitioners simply provided a listing of the media they reached and did not attempt to evaluate the campaign's significance" (p. 148). Watson and Simmons's (2004) longitudinal study found PR practitioners in Australia had increased research and evaluation. However, they focused on outputs such as volume of communication, rather than outcomes, especially behavioural change. (For more on the predominance of output evaluation see also Broom & Sha, 2013; Kabucua et al., 2016; Kreps, 2014; Sixsmith, Fox, Doyle, & Barry, 2014; and U.S. Department of Health and Human Services Centers for Disease Control and Prevention, Office of the Director, & Office of Strategy and Innovation, 2011). In the Thai context, programme evaluation was also rare because of a lack of funds and personnel (Ekachai & Komolsevin, 1996, 2004).

Having discussed public communication and public relations theories and campaigns, this chapter now turns to the other two approaches informing this research: health communication and development communication.

2.3 Health communication

The study of communication and health has developed within the last four decades (Kreps, Bonaguro, & Query, 1998; Parrott, 2004; Rogers, 1994, 1996; Thompson, 2003), and different definitions of health communication have evolved. Rogers (1996) defined health communication broadly, by focusing on content, as "any type of human communication whose content is concerned with health" (p. 15). Other definitions have tried to be more specific by focusing on the health care context. For instance, Cassata (1980, p. 584) stated that health communication is "the study of communication parameters (levels, functions, and methodologies) applied in health situations/context". Likewise, the United States Department of Health and Human Services (2000, p. 11) defines health communication by focusing on the purposes and use of communication strategies in health contexts:

the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community.

Ratzan, Payne, and Bishop's (1996) overview of the definitions of health communication categorised them in two approaches: the Communication-Levels Approach and the Operational Approach. The Communication-Levels Approach includes studies that focus on the level of communication, normally divided into intrapersonal, interpersonal, small group, organizational, mass, and public communication. Among these levels of communication, Ratzan et al. (1996) claimed that interpersonal communication, followed by mass communication, have received most attention. The Operational Approach focuses on two characteristics of communication: context and topic of communication. Context is the situational or environment factors that affect the communication act, such as the studies in health care processes or health delivery systems. The topic of communication focuses on the health issue being addressed. All these definitions provide an initial understanding of health communication components and imply the general ideas being pursued in health communication studies. In relation to health communication campaigns, the focus of this study, Maibach (2002) said that a health communication campaign is one of the communication interventions developed for improving health outcomes.

2.3.1 Models of health communication

Ratzan et al.'s (1996) multi-methodological analysis, *The Status and Scope of Health Communication*, gives the historical backdrop of health communication studies. They discussed evidence of a relationship between communication and health that, they claimed, started in ancient Greece with a focus on communication flow from the powerful physician to the passive patient. This idea is similar to Smith's (1989), who mentioned health and communication was initially based on a 'Traditional Medical Model' that emphasised the doctor as active and in control while the patient is passive. This idea still affects health communication study, which widely focuses on doctor-patient or provider-client communications. Many studies align with this model, as shown in Kreps and Bonaguro (2009).

Within the paradigm of the traditional medical model, Smith (1989) further pointed out assumptions, such as the idea of the authority figure of the doctor controlling the communication process and being responsible for the audience's behaviour and being the person who evaluated the patient's satisfaction. As a result of perceived limitations, the traditional medical model was modified in the second approach, described by Smith as the 'Psychosocial Model of Medicine'. This suggests the doctor should try to understand the patient's psychological and sociological factors influencing his or her health. Although the doctor still has a powerful authority, social science variables are more greatly integrated in this approach, such as the patient's environment, cultural patterns, information learned, and health beliefs. From the psychosocial perspective, the patient becomes an active participant in the communication process. Smith's most recent model is the 'Participative Model of Health Communication', which advocates encouraging the patient's participation in healthcare and exploring what the patient really wants through two-way communication with a more balanced power of control. This approach is very useful for both physician and patient. However, Smith argued, the major challenge for health communication study is investigating "the problems and applications in the participative model" (Smith, 1989, p. 20). For health professionals wanting to use the model, the conditions under which people adopt it and the impacts of participation on health status still need to be examined. Positive support for this approach has appeared in numbers of studies and books that focus on patient participation in health care contexts, for example, Collins (2007), Greenfield, Kaplan, and Ware (1985), Lau (2002), and Solbjør, Rise, Westerlund, and Steinsbekk (2013). These three models of health communication will be used to analyse the nature of Centre 12's service delivery.

Kreps et al. (1998) provided another starting point in understanding the field of health communication by claiming it was an applied discipline that began in the 1950s, integrating the communication discipline and the social sciences and including psychological and sociological perspectives in order to explore communication in the health care context. Kreps et al. (1998) further identified two major branches in health communication studies: health care delivery and health promotion. This study relies largely on the health promotion branch, aiming to study the persuasive use of communication messages and media to promote health. Research here includes the study of "the development, implementation and evaluation of persuasive health

communication campaigns to prevent major health risks and promote public health” (Kreps et al., 1998, p. 3). Many health promotion studies are focused on evaluating mass media in disseminating health information. Finnegan and Viswanath (1989) argued that the idea of health promotion tended to be limited to mass-mediated campaigns. They pointed out that the mass media approach was very narrow, and health promotion should expand to combine those communication activities that affect individuals’ decisions, social and cultural conditions, and public policy initiatives to support healthier behaviour in society. Therefore, health promotion should bring influence at both individual (beliefs, attitudes, and behaviour) and community levels. Although Kreps et al. (1998) described the health care delivery branch and health promotion branch as separate fields of study, in practice the two have merged. It is important, in fact, that health promotion is coordinated with the health care delivery system.

Scholarly research in health communication is usually estimated to have first appeared in 1977 (Ratzan et al., 1996). Since then the number of research studies and books on health communication have grown significantly. One of the pioneer studies is Rogers’ (1996) identification of five key lessons learned from the past 25 years of health communication studies. The lessons, particularly about well-designed campaigns, using appropriate persuasive strategies, audience segmentation and message design, are later considered in analysing Centre 12’s mental health communication programmes.

The scope of health communication research broadened in the 10 years from 1996, according to Freimuth, Massett, and Meltzer (2006), in a descriptive analysis of 321 research articles published between 1996 and 2006, of generally successful programmes about smoking, HIV/AIDS, and cancer. The authors noted that most of the studies used quantitative rather than qualitative survey methods and mostly analysed communication components and communication interventions (*ibid*). Communication components in the study included the analysis of audience characteristics, message characteristics, content description, and communication channels, with more than half the studies analysing the impact of mass communication channels use. Freimuth et al. (2006) noted that only a few studies focused on interpersonal channels and new communication technologies. While new technologies are little evidenced in this case study, findings have the potential to add knowledge about interpersonal communication in health communication.

2.3.2 Health communication: A multidisciplinary field

Health communication is described as a multidisciplinary field of study (Bernhardt, 2004; Cassata, 1980; Kreps & Bonaguro, 2009; Parrott, 2004), drawing on the knowledge-bases developed in the biological, psychological, social, and cultural sciences (Cassata, 1980). Cassata further argued that communication has played a key role in synthesizing theoretical and practical principles from these disciplines and applying them in the health setting. Bernhardt (2004) also identified numerous disciplines contributing to public health communication, including mass and speech communication, health education, marketing, journalism, public relations, psychology, informatics, and epidemiology. Zorn (2001) believed that more health communication study was required for “evidence-based practice, outcome assessment, and ‘what works’ or ‘best practices’ in health promotion” (p. 149). Zorn’s idea is similar to that of Babrow and Mattson (2003) who, while stressing the importance of health communication research into “concrete practices” (p. 37), queried the exact meaning of the term. Babrow and Mattson cite other authors who say that health communication should emphasize doing over theorizing, but they place greater emphasis on Craig (1989), who stated that health communication theory is meaningless if it does not apply practically to health and illness. Schiavo’s (2007) chapter on health communication in the 21st century argued that as health communication draws on a number of disciplines and models, the lessons learned from integrating multi-disciplinary approaches should be explored, as it is “the experience of practitioners as a key factor in developing theories, models, and approaches that should guide and inform health communication planning and management” (p. 11).

2.3.3 The definition and development of health communication campaigns

Health communication campaigns are a subset of public health communication (Logan, 2008). Logan, quoting Atkin (2001) and Piotrow and Kincaid (2001) provides a definition of health communication campaigns: “Health communication campaigns are either informative or persuasive”. This idea was explained by discussing health campaign intentions, which include changing awareness or basic knowledge (cognitive dimension) about a disease or condition, changing attitudes (affect dimension) or ability to cope with a disease or condition, or changing behaviour to take a specific action. Similarly, Snyder (2001), in a meta-analysis of 48 social science-based health

communication campaigns, found that most campaigns either attempt to persuade people to stop an existing health behaviour or to initiate and promote a new therapeutic behaviour.

Noar's (2006) retrospective of health campaigns used Rogers and Storey's (1987) history of mass media campaigns in the United States to divide health communication campaigns into four eras, beginning in the 1940s to 1950s with *an era of minimal effects*, because many large-scale campaigns failed in this time and the causes of those failures were questioned. He termed the time between the 1960s and 1970s *a campaign can succeed era*. In this stage, there were widespread studies focusing on effectiveness principles of campaigns. Prevention campaigns emerged, especially the Stanford 3-city Heart Disease Prevention Program (SHDPP), launched in 1971. Rogers (1996) claimed this era saw the rise of health communication study. The third era, which covers the period of 1980s to 1990s, has been described as *moderate effects*. In this era, many scholars learned more about how campaigns work and focused on effectiveness and limitations, especially of mass media campaigns. As a result, there were plenty of cases of campaign success and failure. The last era, between 1996 and 2005, was called *a conditional effects era*: "we have not necessarily discovered the new principles of campaigns design, but rather have seen many principles that were formalized in previous eras *effectively* and *creatively* put into action" (p. 22). Noar's (2006) study not only provided the historical background of health campaigns, but also suggested the future directions of health campaign research in the 10 years between 2006 and 2016. He claimed the conditional effects era would continue, and campaign scholars should pay more attention to the meta-analysis of campaign literature that examined the principles of success, then develop those principles as a template for campaign planners and eventually campaign theory. Noar, arguing that unique and creative message design strategies need to be developed in campaign studies, advocated more studies of health communication campaign evaluations.

Dutta and de Souza (2008) provided another perspective of health campaigning by examining it through the lens of development communication, arguing that health campaigns "were conceptualized and implemented under the umbrella of development communication" (p. 326). They divided health campaigning into two frameworks: the dominant framework and the reflexive modernity framework. (For further details about the development communication approach see section 2.4.1). Dutta and Rebecca said

the dominant framework of the 1950s and 1960s focused largely on changing society to become “modern”. The western innovations disseminated to “Southern nations” (p. 327), included immunisations, sterilisation, and family-planning programmes. A one-way flow of communication from the centre to the periphery, especially through mass media, was mainly used in this framework. Later, the dominant framework for health was widely analysed for its application especially in developing countries where local cultures are highly important for making health decisions. The reflexive modernity framework was proposed by the authors as a tool to improve health campaigns and adapted to the cultural context. Additionally, interpersonal communication and dialogue were suggested in health campaign implementation (Dutta & Rebecca, 2008). Evidence of Centre 12’s community-based programmes reflecting Dutta and Rebecca’s reflexive modernity framework is shown in results Chapter 4.5.2 and 5.2.1.

2.3.4 Health communication campaigns: Major theoretical perspectives

Health communication campaign research studies are “a hybrid of social science and clinical intervention approaches” (Logan, 2008, p. 78). Logan described four conceptual frameworks that contribute to health communication campaign research. The first framework is the McGuire model, which focuses on five potential health communication barriers: source-based, message-based, channel-based, receiver-based, and destination-based (see 2.2.4). The second framework is the sociocultural dimension, which focuses on audience receptivity to health campaign messages, and includes three widely used sociocultural oriented perspectives: social influences, cognitive behavioural perspectives, and life skill perspectives. The third major framework is the cognitive approach, which includes the theory of reasoned action, the health belief model, and the extended parallel process model. The last framework was proposed by Cappella (2006) who added four more theoretical approaches: 1) behaviour-change theories; 2) information processing; 3) message effects; and 4) systemic factors (which includes the sociocultural dimension). As this study focuses on how campaigns are designed and delivered based on the campaign planners’ perspective, McGuire’s framework is the most applicable for exploring the research questions.

2.3.5 Principles of good practice in health communication campaigns

Maibach (2002) suggested four principles for effective public health communication: know your audience; focus on the right objective; determine what information is of

greatest value; and convey simple, clear messages, many times, and through many sources. Noar's (2006) review of campaign literature between 1996 and 2005 summarised the following major principles of effective campaign design: conduct formative research; use theory as a conceptual foundation for the campaign; segment audience; use a message design approach; place messages in channels widely viewed by the target audiences; conduct process evaluation; and use a sensitive outcome evaluation design. Similarly, Schiavo (2007) highlighted the key characteristics of effective health communication: audience-centred, research-based, multidisciplinary, strategic, process-oriented, cost-effective, creative in support of strategy, audience and media specific, relationship building, and aimed at behavioural or social change.

In the Thai context, only one study focusses on health communication campaign design. Sthapitanonda and Gundpai's (2013) *Identifying Key Factors for the Successful Implementation of Health Communication Campaigns: A Study Based on In-depth Interviews with Key Campaigners*, aimed to explore key factors for the successful implementation of health communication campaigns from the campaign designers' perspective. This study was based on three campaigns judged to be the most significant health campaigns in Thailand: anti-AIDS campaigns, anti-drug campaigns, and anti-tobacco campaigns. In-depth interviewing with key campaigners operating in a health-related context was used as a research method. This study found several keys factors to success: campaign organisation: various partners, a sense of belonging to the campaign, and 'no enemy' strategy (maintain a good relationship with stakeholders); content/message: a variety of useful content, the presentation of concrete examples, observable results in a short period of time, situation-related and media-related information, and pre-test before real action; audience: perceiving target groups as their partners, and spokespeople from the target groups; mass media: setting the media agenda, perceiving the media as part of the process, and developing a close relationship with the media; management: close cooperation, flexibility in implementation, continuity, strategic and systematic planning, and information management systems; and environmental considerations: positive relationships with politicians, and a supportive international agenda. The understanding of campaigning in the Thai context is particularly useful for analysing success factors of health communication campaigns in this study.

2.3.6 Health communication programme planning framework

Table 2.3 below identifies several health communication programme planning frameworks from 1980 through to 2007. All the frameworks are based on the U.S. context and most of them are driven by the U.S.'s health policy.

Table 2.3 *Health communication programme planning frameworks*

Studies	Health communication programmes processes
Arkin and National Cancer Inst (1989)	<ul style="list-style-type: none"> • Planning and strategy development • Developing and pretesting concepts, messages, and materials • Implementing the programme • Assessing effectiveness and making refinements
The Centres for Diseases Control and Prevention (CDC) (2001)	<ul style="list-style-type: none"> • Define the problem • Set communication objectives • Segment target audiences • Develop and pre-test message concepts • Select communication channels • Design messages • Implement programmes • Evaluate outcome and impact
Coffman (2002)	<ul style="list-style-type: none"> • Campaign planning (considering goals/desired results, target audience, desire actions/behaviours, communication strategies, messages, and communication vehicles) • Campaign evaluation (outputs, process, and impact)
O'Sullivan et al. (2003)	<ul style="list-style-type: none"> • Analysis of the situation • Design communication strategy • Managing or implementing plan • Evaluation
Schiavo (2007)	<ul style="list-style-type: none"> • Planning (research and audience-based, structured approached, and strategic process) • Implementation and monitoring (programme delivery, monitoring results and audience feedback) • Evaluation, feedback, and refinement (start during planning and continuing in every part of communication process)

As can be seen, these frameworks identify similar elements in the programme development and implementation processes. The frameworks are also similar to public relations programme planning frameworks, with research and planning at the first stage, followed by managing and delivering plans and evaluation. In particular, this study most aligns with O’Sullivan et al.’s (2003) framework, including situation analysis (listen to the audiences; assess existing program policies, resources, draw up action plan), development message and materials (pretesting, revision, and production), implementation, and evaluation. The following section identifies the last approach has been used to analyse this study’s results, development communication.

2.4 Development communication

There are several definitions of development communication (Servaes, 2008). Rogers and Hart (2002) said “development communication is the study of social change brought about by the application of communication research, theory, and technologies to bring about development” (p. 9). Fraser and Villet (1994) stated that the planned use of communication techniques, activities and media is a fundamental requirement for appropriate and sustainable development because communication is a powerful tool supporting the exchange of ideas among all sectors of society and lead to the greater involvement in social development.

Moemeka (1999) reviewed the background of the development communication approach and broadly defined development communication as “the use of communication techniques, technology, principles and practices in the development process” (p. 12). Under definitions of development communication, communication is the *exchange* of ideas and opinions to create understanding rather than merely *transmitting* information. As Moemeka said, development communication creates the environment of participation, understanding, and positive change. Based on these definitions and concepts, development communication is applicable to this study as this approach aspires to sustainable development, which is also identified as a key goal in disaster response.

2.4.1 Development communication: A brief history and theory

Rogers’s (1976) widely cited paper *Communication and development: The passing of the dominant paradigm* described the original concept of communication in

development and then offered an alternative concept. In the *Dominant Paradigm* (in the 1960s), the concept of development in western countries, especially Europe and the United States, was centered on the rate of economic growth. Industrialization and technology were seen as keys to development. As a result, introducing technology and mass media to people in less developed countries was assumed as the way to change them from traditional to modern. However, this paradigm was later widely criticised as being too focused on economic factors and income while paying little attention to quality of life. Furthermore, technological dissemination from rich to developing countries has caused problems that make developing countries weaker and more dependent.

The dominant paradigm shifted in the late 1960s and the 1970s. Rogers (1976) proposed alternative pathways to development that focused on the equality of distribution of information and socioeconomic benefits. The *Alternative Paradigm* of development focuses on decentralization, self-reliance, and independence in development, with emphasis on the potential of local resources, and the integration of tradition and cultures. Communication also changed. Mass media was recognised as causing indirect effects (e.g. increasing knowledge gap between receivers of high and low socioeconomic status) rather than the direct and powerful effects intended (such as changing people's knowledge, attitudes, and behaviour). In the alternative paradigm, Rogers suggested a new concept of development communication, focusing on self-development in which the roles of communication are completely different from the top-down development approach. For instance, using mass media to provide technical information about development problems, possibilities, and appropriate innovations based on local people's requests and expressed needs.

Rogers's two paradigms were used by many scholars and referred to the initial *Diffusion approach* and the later *Participatory Communication approach* (Gumucio-Dagron, 2008; Morris, 2003; Servaes & Malikhao, 2008). Servaes and Malikhao (2008), for instance, believed the diffusion model focuses on providing new ideas and information for behavioral change and relies on the vertical process of information from campaign deliverers to target audiences. They argued the participatory model emerged as a reaction to the diffusion model, and that development communication is not a vertical or top-down process but rather a horizontal process of information exchange and interaction. In this approach, dialogue is highlighted as a catalyst for individual and

community empowerment. This new approach is based on the idea of respecting the cultural identity of local communities and democratisation and participation at all levels. Participatory communication later became an important approach used in this field of study. Servaes and Malikhao (2008) were concerned about the participatory communication approach saying it might still be perceived as a “paternalistic or social marketing strategy” (p. 13). However, they added “it at least distinguishes between policy and planning-making at micro and macro levels” (p. 14).

In relation to conflict situation, development communication theory has been used as a basic framework to analyse the role of media and communication in post-conflict context. As the World Bank’s (2008) review of communication in post-conflict or transitional environments identified, development communication (termed as communication for development in the review) is appropriate to analyse this situation because it focuses on “community-based activities that support long-term development” (p. 9). Hoffmann (2014) also suggested the development communication approach can be used to explain roles of mass media in conflict situations and building peace. An example study supporting Hoffmann’s idea is that of Curtis (2000), which analysed local radio in post-conflict for peace building projects in Rwanda and Bosnia. She found local media can be an effective instrument to foster community participation, dialogue, sustainability, and community empowerment. All are also key elements in the participatory communication model of development.

Gumucio-Dagron (2008), however, identified some gaps in participatory communication studies arguing, it “has often very little ‘sync’ with what is actually happening on the ground” (p. 71). In other words, it is not truly participatory, for example, while most research was conducted in western countries, the subjects of research are located in developing countries. Researchers have spent only short periods of time in fieldwork, and little research involved local researchers who could provide deeper insight into the overall context. Morris’s (2003) study of 44 health campaigns conducted in the developing countries in Africa, Latin America, and Asia analysed and compared those campaigns’ approaches. She concluded that development campaigns should combine the diffusion and the participatory approaches. Writers in public relations and health communication also talk about the mixture of these two approaches and this combination is reflected in this study’s findings (see section 4.5.2)

2.4.2 Perspectives on effectiveness of development communication campaigns

Snyder's (2003) review of the effectiveness of development communication campaigns from a variety of studies and contexts found only a limited number of studies have examined campaign effectiveness. However, her study showed mediated campaigns could produce small effects, "with an average increase of 7 to 10 percentage points in the desired behavior" (p. 179). Additionally, campaigns aiming to promote new behaviour have slightly larger effects than campaigns for changing and preventing the existing behaviour. Additionally, short-term media campaigns are effective and encourage people to seek more information. Snyder's review also suggested that an entertainment-education approach may be cost-effective as shown in radio drama programmes in Zimbabwe, Gambia, and Tanzania, which increased the rate of family planning (Piotrow et al., 1992; Rogers et al., 1999; Valente, Kim, Lettenmaier, Glass, & Dibba, 1994). However, the effectiveness of development communication campaigns was difficult to measure:

many problems have declined since development programs have focused on them, but there is no way to separate the impact of communication campaigns from other development activities and from other influences. (Snyder, 2003, p. 180)

Snyder said the average reach of development campaigns is also difficult to gauge and the effectiveness varies depending on type of channels and media used.

2.4.3 Development communication campaign approaches

Snyder (2003) explained broadly that the main purpose of development communication campaigns is "developing a country or a population" (p. 167). The concept of development varies from time to time, which directly affects development communication campaign practices. However, she identified two communication activities for social change: communication channel enhancement, and information provision. Channel enhancement focuses on improving communication infrastructure, such as increasing the availability of information technologies, supporting knowledge, and communication skills, and organising networks to increase information flow. Information provision includes the use of communication campaigns, curriculum, and training programmes. Snyder summarised several major approaches applied in

development campaigns. Three approaches relevant to this study – formative research, participatory campaigns, and organisational improvements – are explored below.

Formative research

Snyder (2003) defined formative research as “research conducted during the planning stage of a campaign with the goal of creating a better campaign” (p. 170). The advantages of conducting formative research are helping to segment target audiences, making decisions on a campaign’s focus, designing the main messages and channels, and pre-testing messages and programmes. However, she also claimed that formative research is not always done for several reasons, for example, campaign planners feeling they already know the audience, campaign materials having already been produced, and time is limited (Snyder, 2003).

Participatory campaigns

The participatory approach to development aims to involve those people affected by the campaigns. Snyder (2003) clarified five types of people or groups who could participate in development campaigns: 1) representative participants (such as local leaders, for gaining support and advice); 2) local experts (such as local organisations, for funding and being a partnership in campaign design, implementation, and evaluation); 3) academics (for conducting formative research and using results to refine the campaign); 4) local outreach worker (for building relationships and communicating with target audiences as they are usually similar to the targets); and 5) government agencies (for linking local problems to decision makers). Lastly, Snyder summarised the potential of participatory programmes: empowering target audiences and supporting democracy.

Organisational improvements

In the last 20 years, organisational improvements have become an increasing focus for campaign planners (Snyder, 2003). This increase in focus is linked to the challenges faced by development campaigns, such as lack of campaign evaluation and the fact that many campaigns were supported by people outside the community and therefore ended when the project ended. As a result, improving the capability of local organisations was seen by programme deliverers as important for enhancing sustainable programmes. Several strategies were used in this approach. For instance, staff development and training (through short courses or workshops in the targeted country or abroad),

campaign management, coordination of service delivery, and coordination with multiple partners (suggested for dealing with scarce resources and when many organisations have worked on the same problem). Snyder (2003) described coordinating with multiple partnerships as, “Organisations can be joined through horizontal partnership to share resources or coordinate outreach to different groups, vertical hierarchy, or combinations of both” (p. 175).

2.4.4 Development communication programme framework

In a similar approach to public relations and health communication, UNICEF - Programme Division (2014) described the key steps in a development communication planning programme as research and analysis, setting communication objectives, creative strategy and materials development, implementation and monitoring and evaluation. Further discussion of the links between these different approaches occurs in the next section.

2.5 The value of a combined approach to campaigns

Sections 2.2–2.4.4 have examined disciplines and practices of the three approaches – public relations; health communication; and development communication. This section summarises the interrelationship between these three disciplines and identifies the value of this combination in contributing a multi-disciplinary framework to analyse communication practices and communication programmes in the long-term disaster context. Figure 2.1 summarises the focus of each approach and the interrelationships between them. All approaches advocate the ideal of two-way communication and dialogue.

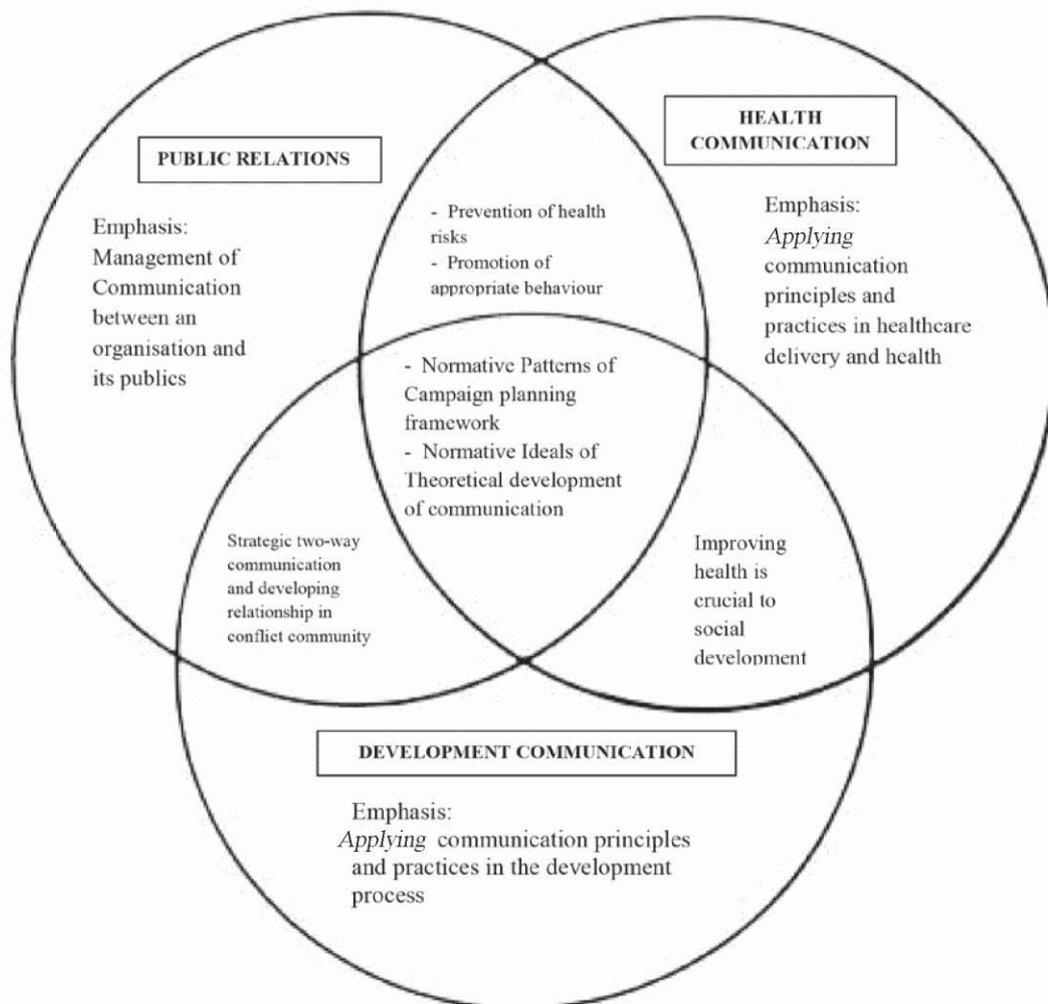


Figure 2.1 Interrelationships between public relations, health communication, and development communication.

As seen in Figure 2.1, these three approaches are relevant to this study as evidence in this review shows they have been used to analyse communication activities in conflict contexts. The public relations approach focuses on management of communication, identified as the process of planning, implementation, and evaluation of an organisation's communication with its internal and external publics (Grunig & Hunt, 1984). Thus, public relations can be used to analyse Centre 12's programme development, programme delivery, and the coordination among partners.

In particular, Houston et al. (2015) said the public relations lens is appropriate for the study of developing community resilience following disasters because public relations puts an “emphasis on developing relationship and community” (p. 272). Similarly, the health communication approach is also applicable, especially in the health promotion branch (Kreps et al., 1998), which focuses on the development, implementation, and evaluation of communication activities to prevent health risks and promote public health. Last, development communication, especially the participatory model (Rogers, 1976), identifies the concept of the community-based approach, including participatory communication, community empowerment, cultural concerns, partnership and sustainability development. These key aspects of development communication are also discussed in psychosocial interventions for long-term disaster response (see section 2.6.6 and 2.6.7). Furthermore, development communication is usually used to explore situation outside the developed countries. This approach is therefore suitable for this study which aims to explore the experiences of Centre 12’s communication practices and contribute to area-based knowledge rather than adopting Western theories (which are generally the basis of public relations and health communication studies).

The previous paragraph identified the strength of each approach and how they could apply to analyse Centre 12’s programme delivery. In particular, the overlapping of these three approaches is also considered and is the main focus of this research. As shown in Figure 2.1 above, these three approaches have two shared similarities: normative patterns of campaign planning framework, and normative ideals of communication model.

First, reviewing the literature from public relations, health communication, and development communication shows three major stages in the programme planning framework – planning, implementation, and evaluation. Research was highlighted at the first step of programme planning by all three approaches. Public relations uses research for scanning environments and for evaluation of programmes (Dozier & Repper, 1992). Similarly, in health communication, research is first used to review background information in order to define problems (The Centres for Diseases Control and Prevention (CDC), 2001), while in development communication, research is identified broadly as research and analysis of socio-behavioural characteristics of the target audiences (UNICEF - Programme Division, 2014). In terms of programme implementation, all three approaches use similar communication channels that vary

according to the particular purpose. All three approaches stress the importance of strategic planning and selecting communication channels that need to suit the audiences (Noar, 2006; Rice & Paisley, 1981; Schiavo, 2007; Snyder, 2003). Finally, they all highlight the importance of evaluation, which, from the outset, needs to be properly researched and designed to be able to measure the outcomes of campaigns. All approaches also recognise the difficulty of conducting effective evaluation.

Second, all three approaches trace a linear theoretical development of communication from initial one-way and top-down communication activity. For instance, in public relations, this is referred to as the models of press agency and public information. In health communication, it is referred to as the traditional medical model, and in development communication, as the diffusion model. Public relations and health communication theories then suggested an intermediate development in communication. This, in public relations, is termed the two-way asymmetric model and in health communication, the psychosocial model of medicine. Finally, all three approaches discuss the importance of dialogue and participation as a highly effective communication model. In public relations, this is termed the two-way symmetric model, in health communication, the participative model, and in development communication, the participatory model. While all approaches see the participative, dialogue model as superior, each discipline acknowledges the difficulty of true participative communication and that in practice those delivering campaigns frequently combine those processes of vertical or top down communication with horizontal processes of communication.

2.6 Empirical studies and reviews of health and mental health communication programmes and campaigns

As this study focuses on the impact of government policies on mental health communication programme delivery in responding to the long-term mass violence in southern Thailand, this section outlines empirical studies and reviews of health and mental health communication programmes and campaigns undertaken in a similar context. Based on a wide-ranging search of mental health communication in response to disasters, relevant studies and reviews have been categorised by the researcher into 10 major themes as shown in Table 2.4. Many of these themes are revisited in Chapter 5.

Table 2.4 *Ten themes of empirical studies and reviews of mental health communication and communication programmes/campaigns in disaster contexts*

Themes
1. Mental health consequences of disasters
2. Stages of disaster and associated interventions
3. Role of government and leadership in disaster management
4. Role of media campaigns
5. Direct communication in the context of disasters
6. Community-based approach interventions
7. Psychosocial interventions
8. Cultural and social support factors
9. Evaluation of mental health interventions
10. Communication partnership and community resilience

2.6.1 Theme 1: Mental health consequences of disasters

A large number of studies and reviews show the psychological impact of both man-made and natural disasters (see for instance, Lipinski, Liu, & Wong, 2016; Stratta et al., 2015; Thongphecstri et al., 2005). Murthy and Lakshminarayana's (2006) surveys from 10 countries showed post-traumatic stress disorder (PTSD) is the major psychological consequence following disaster (see also DiMaggio & Galea, 2006; García-Vera, Sanz, & Gutiérrez, 2016; Udomratn, 2008). The other symptoms found by Murthy and Lakshminarayana include depression, anxiety, and alcohol and drug misuse. Surveys also show that women were more affected by the disaster than men, and girls more than boys, which is similar to Norris et al.'s (2002) empirical review of 160 disaster victims from 29 countries that concluded females were more likely to be impaired than males, youth more than adults, and victims who experienced mass violence (e.g. terrorism, shooting sprees) more than those experiencing natural disasters.

In the Thai context, three surveys of Tsunami survivors in 2004 (Thienkrua et al., 2006; Tuicomepee & Romano, 2008; Van Griensven et al., 2006) show the prevalence of PTSD, anxiety, and depression in children and adults. Behavioural problems resulting

from PTSD symptoms included aggression, bed wetting, nightmares, difficulty concentrating, and obsessive thoughts.

Thienkrua et al. (2006) stated that children who had experienced extreme panic or fear had a nine times higher risk for PTSD symptoms than those who had not experienced the tsunami. For adults, the loss of livelihood was found to be the main risk factor for PTSD and depression. Depression symptoms were found more in adults than children. Thienkrua et al. (2006) therefore suggested different approaches of mental health interventions: “children may benefit from therapeutic interventions, while for adults, contextual interventions aimed at the restoration of livelihood may be more appropriate” (p. 558). Further, they found the degree of trauma was related to the level of damage and loss experienced. Similarly, Felton (2004), commenting on the 9 /11 attack said, “the rates of initial distress and also subsequent recovery were highest for those in close proximity to the attacks”. Finally, in a finding especially relevant to the Thai situation, McDonald (2007) argued that in long-term conflict, victims may cope better if the violent conflict seems reasonable and justified. However, if the purpose of violent conflict is less clear, it might result in increased substance misuse, breakdown in relationships, and increasing risk of suicide.

Cohen (2002) divided survivors of disasters into five groups based on their level of physical impact: primary survivors (experienced maximum exposure to the traumatic event); secondary survivors (close relatives of primary victims); third-level survivors (rescue and recovery personnel); fourth-level victims (others in the community); and fifth-level victims (individuals experiencing distress after seeing or hearing media reports). Of particular relevance to this study are her categories of second- and third-level survivors. Cohen’s review said rescue professionals and care givers might develop ‘burnout syndrome’ (p. 151) because they have been exposed to numerous painful experiences. NATO’s (2008) disaster response guidelines suggest reducing healthcare staff uncertainty by providing team support from colleagues and managers and informing them clearly about work plans and their anticipated roles.

2.6.2 Theme 2: Stages of disaster and associated interventions

Mental health interventions should be designed and implemented in response to the different stages of disaster (Abeldaño & Fernández, 2016; Stratta et al., 2015; Vernberg, 2002). Watson, Brymer, and Bonanno (2011) reviewed interventions in response to two

timeframes: the early stage of disaster and mid to long-term, noting that there is very limited intervention up to one month following the disaster (see also Gray & Litz, 2005). Gray and Litz found psychological interventions (rather than psychosocial interventions) were more characteristic of the early phase, for instance, a psychological debriefing in which trained counsellors explore facts, thoughts, and the reactions of survivors after passing the critical situation. However, this debriefing approach has been criticised because it does not reduce mental distress and decrease PTSD, but rather can be seen to increase the risk of subsequent psychological disorders (Gurwitch, Sitterle, Young, & Pfefferbaum, 2002; Wessely, 2006). Psychological First Aid (PFA) is another intervention used at this early stage and was highlighted as an effective intervention (Gurwitch et al., 2002; Watson et al., 2011; Wessely, 2006). Vernberg (2002) described PFA by citing the American Red Cross training materials as: providing direct, instrumental assistance for problem solving and practical needs; offering assistance in evaluating information and developing a plan for the immediate future; activating social support systems, including family and community networks; and providing factual information about the disaster and typical reactions of adults and children who have experienced similar circumstances. However, there has been no systematic study of the impact of PFA (Watson et al., 2011).

In relation to mid- to long-term conflict, Watson et al. (2011) reviewed two psychosocial interventions widely applied in disaster situations: Cognitive Behavioural Therapy (CBT) (for CBT's functions and implementations see Duffy and Gillespie (2009)) and Skills for Psychological Recovery (SPR). SPR or a problem-solving approach is particularly relevant to this study as it was used by the psychologists when gathering information and prioritizing assistance, building problem-solving skills, promoting positive activities, and rebuilding healthy social connections (Berkowitz et al., 2010; Forbes et al., 2010).

Hobfoll et al. (2007) identified five essential elements of immediate and mid-term trauma interventions: a sense of safety, promoting calm, promoting a sense of self-efficacy and community efficacy, promoting connectedness, and promoting hope. Watson et al. claimed this is a valuable framework that has influenced subsequent psychiatric study.

In relation to a post-conflict situation, Ghosh, Mohit, and Murthy (2004b) reviewed mental health promotion in long-term post-conflict situations in the Eastern Mediterranean Region and suggested that interventions in the post-conflict phase should focus on a community-oriented approach rather than on individuals. Six levels of interventions for recovery were identified in the review: increasing resilience in populations; increasing family support-focused interventions; encouraging community solidarity and traditional methods of support; increasing the variety of media or channels used in promoting mental health messages; integrating mental health caring skills into general practice and services; and disseminating correct information about available help through mass media. These findings are similar to Stratta's (2015) suggestions that post-disaster interventions should focus on building resilience in both individuals and communities. Ghosh et al. (2004) and Stratta et al.'s (2015) interventions are directly relevant to this study as they reflect some of the aims of Centre 12, for instance, "promoting, protecting, and developing community mental health for enhancing the mental health of people" (Mental Health Centre 15, 2012).

Houston's (2012) "Disaster Communication Intervention Framework" (DCIF) identified interventions to cover the three phases of disaster: pre-event (preparedness), events (response), and post-events (recovery). For instance, in the response phase, interventions should aim to promote wellness, coping, recovery, and resilience. Communication activities to achieve these objectives include providing information about the event and disaster response to reduce uncertainty, monitoring media and providing corrections to disseminated information, and connecting people with social support and community resources. Additionally, Houston's (2012) three phases of DCIF are somewhat similar to Srivastava's (2010) four phases of disaster response: rescue; relief; rehabilitation; and rebuilding. Srivastava's (2010) four phases and Houston's (2012) three phases of disaster response are useful for this case study.

2.6.3 Theme 3: Role of government and leadership in disaster management

In responding to disasters, the national government generally has the prime responsibility for recovery. Birkmann et al. (2010) examined the role of the Sri Lanka government in responding to the 2004 tsunami in providing "windows of opportunity" (p. 639) to reform institutional structures. As they said, the main strategy in the recovery phase was to increase community resilience by establishing a buffer zone and

resettlement; developing tsunami early warning systems; and creating new organizations and institutions (such as the Disaster Management Centre). After Thailand's 2004 tsunami, the Department of Mental Health established a central mental health operation centre for mental health recovery, and set up mobile mental health teams to deliver mental health services in the affected communities (Visanuyothin, Chakrabhand, & Bhugra, 2006). In the case of the terrorist attacks on the World Trade Centre in 2001, the US government instituted "Project Liberty", a crisis counselling programme for mental health recovery. Surveys found this programme was judged successful in reaching out to many diverse communities, "over 1.2 million New Yorkers have received one or more face-to-face counselling and/or public education services through Project Liberty" (Felton, 2004, p. 148). In the 9/11 terrorist attacks, mental health interventions in response to the terrorist attacks were created, such as the Federal Collaboration Model, data collection processes and procedures, public educational materials, and curricula and training for thousands of mental health workers. Based on positive evaluation, the U.S. government later provided more funds for continuing recovery activities.

Leadership, whether by government or NGOs, is an essential element of disaster management. Cuny (2000) defined leadership in disaster management as "the process of influencing the activities of others in effective efforts toward achievement of specified goals" (p. 70), focusing on working with others rather than on commanding. A leader will use coercion, reward, position, knowledge, and admiration depending on the circumstances, but, most important, leaders should also be influenced by followers as this will establish more interaction and respect (Cuny, 2000). Further, Cuny described four styles of leadership (directive, supportive, participative, and achievement-oriented), noting that the directive style might be appropriate in an emergency or crisis situation but "supportive leadership has its most positive effect on satisfaction for subordinates who work on stressful and frustrating jobs" (p. 72). Two factors that have the most impact on a leader's ability to lead are self-confidence and professional competence (experience and understanding the tasks). According to Demiroz and Kapucu (2016), under challenging and stressful conditions, leaders are expected to respond to the threats and uncertainties, and manage the incidents successfully. Demiroz and Kapucu's exploration of leadership competencies in managing catastrophes are somewhat congruent with Cuny's. They argued that key competencies are the ability to cooperate

with other stakeholders, flexibility in decision making and operations, adaptability to disaster conditions, and effective communication with other stakeholders and the public. However, Demiroz and Kapucu concluded, “the most effective leadership is symbolic of a high level of coordination amongst different responders in government, non-profit, and private sectors” (p. 95).

Several of these key competencies of leadership are very similar to the characteristics of effective leadership found in the Thai context. Selvarajah, Meyer, and Donovan (2013), surveying over 400 Thai managers, revealed that cultural context significantly influences their leadership. As with leadership in other Southeast Asian countries, the Thai leaders saw constructing a harmonious environment as the most important factor of excellent leadership, reflecting the Thai culture, which is generally compromise and avoids uncertainty. In disaster context, Peltz et al. (2006) explored leadership in response to Thailand’s 2004 tsunami disaster and found several roles of effective leadership, including prompt action, encouraging staff and providing critical aid in manpower and equipment, cooperating with all relevant agencies, using earlier experience to manage disaster response, and paying attention to the needs of staff members. These roles are similar to the concept of ‘authentic leadership’ in public relations, defined as leaders who use self-knowledge and self-image to enhance their leadership, openly sharing information and expression with others, analysing relevant data before making decision, and using internal moral standards and values to make decision (Amornpipata & Sorodb, 2017; Men & Stacks, 2014). In contrast, Peltz et al. said less effective leadership in disaster situations was shown by a lack of information about the disaster response and a feeling that the situation was not being controlled.

2.6.4 Theme 4: Role of media campaigns

A number of empirical studies show mass media campaigning is effective in educating the public about mental health consequences of disaster and accessing help (e.g. Beaudoin, 2008, 2009; Frank et al., 2006). This is especially the case in response to short-term and large-scale disasters such as the World Trade attack on September 11 (Bradley, McFarland, & Clarke, 2014; Felton, 2004; Frank et al., 2006; Rudenstine, Galea, Ahern, Felton, & Vlahov, 2003; Stein et al., 2004). As mentioned above, one month following the attack, Project Liberty was set up as a cooperative centre for free mental health counselling, providing public education programmes for people suffering

short-term mental health impacts and intensive interventions for severely impacted individuals (especially those living in New York). For people in general, information about traumatic stress symptoms and positive coping strategies was disseminated by mental health workers who were trained in disaster mental health counselling. Media campaigns were mainly used to raise public awareness of how to access services and to establish a positive public image for the programme through television, radio advertising, online, and print media. The advertisements used celebrities and different content designed to reach differing demographic audiences. Felton argued media campaigns have the power to inform the public about mental health response efforts and how to get help (as shown in Frank et al., 2006; Rudenstine et al., 2003). Similarly, mass media campaigns improved PTSD and prevented behavioural problems in African-American women who were the target audience of a mental health recovery programme following Hurricane Katrina in New Orleans (Beaudoin, 2009). Houston, First, Spialek, Sorenson, and Koch (2016) confirmed that media campaigns are well suited for promoting the adoption of new coping and resilience behaviours across the different phases of disaster. Of relevance to this research, a number of studies illustrated the role of community radio in disaster situations (e.g. Birowo, 2010; Ewart & Dekker, 2013; Moody, 2009; Romo-Murphy, James, & Adams, 2011; Shaw et al., 2012). Ewart and Dekker's (2013) findings reveal talkback radio programming was effective in supporting community formation, enhancing active networking, and building community resilience. Similarly, in the impact phase, radio was effective in providing emotional support to reduce negative effects following Hurricane Georges in Puerto Rico in 1998 (Perez-Lugo, 2004).

2.6.5 Theme 5: Direct communication in the context of disasters

Many studies report that people exposed to disasters do not seek mental health care or use available services (for instance, Morrison, 2012; Stein et al., 2004; Stratta et al., 2015; Watson et al., 2011). One of the reasons for this is that people who have experienced a disaster might think PTSD and depression are common symptoms, and believe they do not require treatment (Stratta et al., 2015). It is seen as important, therefore, that mental health professionals seek communication strategies and tactics to deliver mental health services and programmes directly to victims (Butler, Panzer, & Goldfrank, 2003). Both Naturale (2006) and Stratta et al. (2015) said that while many studies and reviews focus on psychological impacts after disaster, few studies have paid

attention to service delivery. Particularly lacking is evidence-based research that enhances understanding of the best practice in clinical outcomes and outreach strategies.

However, Heath (2001) discussed other outreach interventions that also targeted a large population, but had a limited budget. He mentioned mailing (including an informational brochure about available treatment services) and direct telephone contact for Vietnam War veterans. In addition to mass media channels, many campaigns also include interpersonal communication strategies, especially those campaigns aimed at connecting individuals to interpersonal services, fostering social connections, and examining attitude change (Francis et al., 2002; Houston et al., 2016). Further, Bradley, McFarland, and Clarke's (2014) review of 27 studies on the effects of risk communication interventions during three stages of the disaster cycle show different types of communication channels used in each stage. In the mitigation and preparedness stage, face-to-face group participation, telephone, and several communication channels were used. In the response phase, multi-channel information campaigns and school-based education programmes dominated. In the recovery phase, media campaigns were mainly used to encourage people to access help and educate them about healthy behaviors following disasters. Multi-channel campaigns and activities were used in this phase, such as face-to-face communication, group communication, and school-based campaigns.

2.6.6 Theme 6: Community-based approach interventions

The existing studies about mental health interventions in response to long-term disasters with limited resources highlighted community-based approaches (Griffith et al., 2005; Stratta et al., 2015). Ghosh et al. (2004) argued that interventions in the recovery phase should focus on a community-oriented approach rather than on individuals. Similarly, Watson et al. (2011) emphasised that post-disaster psychosocial interventions should create a network of stakeholders and be concerned with culturally and regionally appropriate responses. Several studies have clearly shown cultural sensitivity is essential in designing mental health interventions in the recovery phase. For instance, positive outcomes have been found in strengthening family ties, friendships, and religious faiths in Eastern Uganda (Muhwezi et al., 2014); family-based intervention (family psycho-education and family group treatment) in Kosovar (Griffith et al., 2005); cultural adaptation of psychological therapy in Israel and Uganda (Ben-Gershon et al.,

2005; Hall et al., 2014); traditional healers in Southern Mozambique (Honwana, 1997); a community reflection group in Guatemala (Berliner, Dominguez, Kjaerulf, & Mikkelsen, 2006); and yoga practice for managing stress following a natural disaster in the Andaman Islands (Telles, Naveen, & Dash, 2007).

A psychological training programme in Uganda illustrates the successful adoption of local culture into public health service. Hall et al. (2004) examined the successful collaboration between Western and third world countries, as mental health professionals in Uganda were trained by a UK organisation and learnt Western knowledge. However, the effectiveness of their practices resulted from adapting Western knowledge to Ugandan culture. Examples of the adaptations of psychological therapy are using trained interpreters and local staff who can speak local languages, using local leaders and community members to encourage treatment, and acknowledging traditional beliefs and working closely with the traditional and spiritual healers. Ugandan practitioners used thought records, and mood and activity diaries with those unable to read or write and used local staff who could speak local languages to communicate the psychological terms by using proverbs and local metaphors.

In contrast, Rabiei, Nakhaee, and Pourhosseini (2014) interviewed 26 experts in disaster management in Iran and summarised the following problems and weaknesses of healthcare community workers: rescuers' unfamiliarity with the basic principles of psychosocial support; shortage of relevant experts and inadequate training; attention not paid to the needs of specific groups; weaknesses in organizational communications; discontinuation of psychological support after disaster; unfamiliarity with the native language and culture of the disaster area; little attention paid by media to psychological principles in broadcasting news; and people's long-term dependence on governmental aid. Additionally, in relation to government aid, disaster response services have to integrate into mainstream delivery structures because the services have to be continued even after government funds are withdrawn (McFarlane & Williams, 2012). Henderson, Berliner, and Elsass's (2016) review of disaster intervention studies concluded that more evidence from research into community-based interventions was needed.

2.6.7 Theme 7: Psychosocial interventions

Psychosocial interventions that combine human capacity, social and ecology, and cultures/values (Galappatti, 2003 cited in the Psychosocial Working Group (PWG) in

America) are also widely used in disaster situations. A recent study by Abeldaño and Fernández (2016) reviewed 52 published articles on psychosocial interventions in disaster situations from 1980 to 2004. Four types of interventions were identified, each relevant to this study: interventions based on time (such as before, during, and after disaster); types of disaster (natural and man-made); spheres or levels of action (the integration of various sectors to solve the needs of affected communities; and person-centred (the empowerment of family and community levels and enhancing community participation).

Another perspective is provided by Wells, Miranda, Bruce, Alegria, and Wallerstein (2004), who emphasised that community intervention strategies, in the form of public health or community development interventions, have to be applied in mental health services. Their study suggested that public health interventions aim to reduce health risks. These should integrate with social sciences theories such as the theory of planned behaviour, the health belief model, social change theories, and communication campaigns that combine media and local-based strategies (for instance, individual counselling, home visitations, group sessions, telephone, internet or print material). Wells et al. (2004) said media-based interventions can improve access and change attitude, but local-based interventions can change individual behaviour. They said community development interventions aim to increase the capacity and resources of communities. Strategic approaches in this category include media advocacy, participatory community interventions (the partnership model), and evaluations of practice-based quality improvement interventions.

NATO (2008) has also provided guidelines for designing, delivering, and managing psychosocial services for people involved in major incidents, conflict, disasters, and terrorism. NATO's guidelines described four groups of people who need different levels of recovery interventions: resistant people who show transient distress; resilient people; people who have more sustained or persistent distress associated with dysfunction and/or impairment; and people who develop a mental disorder.

2.6.8 Theme 8: Cultural and social support factors

Several studies are relevant in identifying cultural (religious and family) and social supports as the main coping strategies after disasters (McDonald, 2007; Murthy & Lakshminarayana, 2006; Tuicomepee & Romano, 2008). Thielman (2004) studied

psychiatric consequences after the bombing of the U.S. embassy in Kenya, and found religion, prayer, and faith in God were of most help in coping with stress, followed by family support. In the Thai situation, Tuicomepee and Romano (2008) said that Thai adolescent survivor's families also played a key role in helping them cope. They concluded that strong functioning family and supportive community networks can protect youth from behavior problems. Counselling programmes also used peers, teachers, classmates, and mental health providers to help decrease distress, and recreational activities, such as art, to help children recover from trauma. Importantly, Tuicomepee and Romano said using psycho-educational interventions such as programmes and workshops to educate parents, teachers, and other community partners about psychological consequences after disasters were the ways to prevent or reduce mental health problems. In contrast, the breakdown of protective networks in the community can lead to the lack of social support and increase mental health problems. This is especially seen in Cambodia where mental health recovery from the country's civil war was difficult because village chiefs, elders, and traditional healers (monks, mediums, and traditional birth attendants) had lost their roles in maintaining the mental health of communities (Murthy & Lakshminarayana, 2006).

Psycho-education was mentioned earlier as an important supportive factor in disaster situations. Houston et al. (2016) described the advantage of psycho-education as it focuses on information or an education approach (such as disaster reactions, coping and resilience strategies) and provides opportunities for disaster assistance and service to avoid some of the stigma associated with traditional mental health services. Psycho-educational information can be disseminated in a variety of formats including printed advertisements, online, and social media, and through interpersonal communication (both mental health professionals and other service providers). These factors appear in this case study and are discussed in Chapter 5.

2.6.9 Theme 9: Evaluation of mental health interventions

As mentioned previously (in section 2.2.8.3), programme evaluation is very important; however, it is challenging in practice for many reasons, such as funding, time, and the difficulty of measuring the effectiveness of public communication programmes (Walker, 1994). Ben-Gershon et al.'s (2005) study of a mental health unit responding to terrorist attacks in Israel found no systematic data to evaluate the effectiveness of

interventions (see also Baingana, Bannon, & Thomas, 2005). This difficulty is also reflected in Dumesnil and Verger's (2009) review of 15 depression and suicide awareness programmes published between 1987 and 2007. Four categories of public awareness programmes about depression and suicide included short media campaigns to long-term local or community programmes. Findings revealed the programmes provided a moderate improvement in public knowledge about depression and suicide, but most programme evaluations did not assess attitude change. Furthermore, no study has clearly demonstrated that programmes help to increase the numbers seeking mental health support or to decrease suicide behaviour. Similarly, Frank et al.'s (2006) examination of media campaigns in post-September 11 New York found that the campaign planners evaluated the types and numbers of media produced, numbers of people accessing media, and numbers of phone calls. They concluded that although media outlets are effective in encouraging individuals to seek mental health services, it is necessary to evaluate the impact of multimedia-based campaigns in order to justify media-spending decisions.

Overall, the literature shows that not only is evaluation of mass media challenging, the evaluation of supporting media is even more limited in practice. Houston et al. (2016) "most strongly noted the lack of evaluation studies and evaluation frameworks for disaster preparedness educational products" (p. 54). Much disaster preparedness has taken place, and many psycho-education materials have been developed, but there is a lack of evaluation. For instance, there is no evidence of what formats, messages, or campaign strategies are effective and cost-effective; yet "without evaluation research, the field cannot transition to using evidence-based public child and family disaster communication messages and campaigns" (pp. 54–55).

2.6.10 Theme 10: Communication partnership and community resilience

As mentioned earlier, most people affected by disaster do not seek help at service centres. As a result, outreach service is important and mental health professionals need partnerships for service delivery. Dowling, Powell, and Glendinning's (2004) review of partnership in healthcare service delivery defines partnership as joint working and cooperating to achieve a common goal that involves creating new organisational structures and processes and sharing information, risks, and rewards. Partnership in planning and implementing prevention programmes should combine two main

stakeholders: the experts referred to as outsiders or the formal sector and those vulnerable to the problems (insiders or the informal sector) (Nelson, Amio, Prilleltensky, & Nickels, 2000). Also relevant to this study's approach to partnership are the steps suggested by Nelson et al. for developing effective community-based work: creating partnerships; clarifying values and vision; merging the strengths of partners; developing programme; and researching and evaluating the programme. Additionally, Nelson et al. found most of health prevention programme literature focuses on the developing and planning, implementation, and evaluation of the programme, and ignores the steps that develop the partnership, which is crucial to success. Further, when evaluating the success of partnerships, Dowling et al. (2004) said most studies restrict themselves to evaluating process (whether the partnership is working and the relationship) rather than outcomes (benefits from the partnership).

Partnerships instituted by formal sectors have been mentioned in many studies. For instance, Dumesnil and Verger's (2009) review of public awareness campaign about depression and suicide described gatekeeper training programmes conducted by training opinion leaders such as spiritual providers, school personnel, parents, and community religious professionals to deliver mental health awareness messages. Such programmes and workshops were instituted in the Maldives tsunami disaster to educate teachers to provide psychological support for students (Ibrahim & Hameed, 2006). Similarly, in Thailand, parents and teachers were trained in ways to prevent or reduce youth behaviour problems (Tuicomepee & Romano, 2008). Children's programmes are sustainable if teachers design courses that provide information not only about potential psychological and behavioural problems following a disaster but also about the way to access counselling. Tuicomepee and Romano also recommended "religious leaders, indigenous healers, health professionals, and mental health providers, as partners, can educate the public about youth behavioural problems and resources to assist parents and other caregivers" (p. 139). Lessons learned from several studies reveal communication challenges and ineffective coordination with partners were barriers in mental health communication programmes (e.g. Col, 2007; Hall et al., 2014; International Federation of Red Cross and Red Crescent Societies, 2000; Lee & Fleming, 2015; Srivastava, 2010).

Partnership in practice is not easy, especially in disaster contexts. Martin, Nolte, and Vitolo's (2016) Four Cs framework (deriving from partnership literature:

communication, cooperation, coordination, and collaboration) was tested by interviewing those responding to the 2010 Haiti earthquake. Martin et al. said poor international partnering was revealed as an important obstacle to successful disaster response. Because the Four Cs range from informal and low-risk activities to formal, embedded, risky, and costly activities of the partnering continuum (collaboration), they can be used by any disaster response organisation. Martin et al. also suggested that different types of organisations might be good at different partnering activities; for instance, NGOs might be good at communicating and cooperating, while government agencies and military might be excellent in coordinating and collaborating.

Community resilience has been mentioned widely as a sustainable goal of long-term disaster recovery. Norris, Stevens, Pfefferbaum, Wyche, and Pfefferbaum (2008) reviewed several concepts and definitions of resilience and summarised it as “a process linking a set of adaptive capacities to a positive trajectory of functioning and adaptation after a disturbance” (p. 130). Resilience not only focuses on outcomes (adaptation), but also on process (adaptive capacities) (Norris et al., 2008). Houston et al. (2015) cited Pfefferbaum and Klomp (2013, p. 279) saying that community resilience involves more than a collection of resilient individuals, “it emerges from collective activity in which individuals join together in efforts that foster response and recovery for the whole”. Norris et al. (2008) proposed a community resilience model of four major components: economic development, social capital, information and communication, and community. In summary, partnership and community resilience are crucial to programme success, and participants in this study talked frequently about building and maintaining partnership.

2.6.11 Summarising themes in empirical research

This review identified 10 interrelated themes in empirical studies of health and mental health communication programmes and campaigns that focus on disaster contexts. Some themes related to the nature of disaster situations such as the mental health consequences of both natural and man-made disasters, which involved a number of symptoms that occur for both victims and rescue professionals, such as nightmares, anxiety, and post-traumatic stress disorder. This review also explored the role of government and leadership in disaster, as they are the core of disaster recovery. While disasters have caused vast damage, they also provide opportunities for governments to

set up new systems, new organisations, and new regulations. Communication channels, both mass media, especially talkback radio, and interpersonal communication, were also identified as effective in disaster situations.

Several themes are related to disaster response interventions, for instance, psycho-social interventions, community-based approach interventions, and cultural and social support factors. Most of the reviews reveal psychological intervention was used in the early stages of a disaster, while psychosocial intervention and community-based approaches were used both during mid- to long-term disaster stages, and in post-disaster situations. These themes reflect the effectiveness of using both a social and cultural approach in mental health rehabilitation. However, evaluation of the impact of these interventions was highlighted as an essential challenge in disaster studies. For sustainable recovery, community partners, such as opinion leaders, community religious, and school personnel, need to be involved in disaster response and aim to build community resilience.

2.7 Conclusion

This review covers the definition, origin, and main theories underpinning public communication and public relations, health communication, and development communication. It stresses the main similarities between these three approaches, particularly the movement from top-down and one-way to the normative two-way flow of communication. The review outlines the three main steps of the programme planning framework: research and planning, implementation, and evaluation. Literature across all three approaches identifies similar research and planning processes and the difficulty practitioners have faced in conducting effective formative research. There is also consensus about the value of implementing a variety of strategies and tactics when delivering communication programmes, especially in the specific context of mass violence. These strategies and tactics however, use a typical mix of communication channels. Finally, the evaluation stage presented similar challenges for practitioners in all three communication areas in relation to time, budget, and the difficulty of evaluating programme outcomes and impacts.

The chapter concluded with a review of the empirical studies of health and mental health communication programmes and campaigns, focusing on disaster contexts,

categorised into 10 major themes. These themes were mental health consequences of disasters; stages of disaster and associated interventions; role of government and leadership in disaster management; role of media campaigns; direct communication in the context of disasters; community-based approach interventions; psychosocial interventions; cultural and social support factors; evaluation of mental health interventions; and communication partnership and community resilience.

Theoretical frameworks and empirical studies in this review have been used as a basis for understanding mental health communication programmes in response to a long-term and on-going mass violence situation. The three main communication approaches outlined here (public communication and public relations, health communication, and development communication) will be used to analyse and discuss Centre 12's practices. A number of empirical studies on government responses and coping strategies for victims of disasters are relevant to Centre 12. Centre 12's experiences can extend literature on public health communication in response to long-term disasters.

This literature review also underpins the methodology explored in Chapter 3 and informs the discussion of the results in Chapter 6. The chapter which now follows outlines the research design and fieldwork.

CHAPTER THREE: THE RESEARCH STRATEGY AND FIELDWORK

3.1 Introduction

This research is a case study of the communication practices of the 12th Mental Health Centre in response to the mass violence situation in southern Thailand from 2004 to 2014. The aim of the study is to explore how mental health communication programmes in the mass violence area were designed and delivered. Five research questions are asked:

1. In what way did Thai government policies impact on the establishment, funding, and delivery of mental health communication programmes during the mass violence situation in southern Thailand?
2. How were the mental health communication programmes responding to mass violence in southern Thailand planned?
3. How were the mental health communication programmes implemented?
4. How were the mental health communication programmes evaluated?
5. What are the effective practices and challenges of these mental health communication programmes, from the deliverers' perspective?

This chapter describes the fieldwork experience and outlines the research strategies used to collect and make sense of the data. The chapter is presented as two parts: *part one* focuses on the design of the research (planning); *part two* focuses on undertaking the research (the fieldwork). *Part one* begins by describing the principles of case studies and why a case study approach to the research was appropriate. As this exploratory study lends itself to a qualitative research paradigm, a brief explanation is given, describing, in particular, the role of the qualitative researcher as both an instrument in qualitative inquiry and a co-constructor of knowledge. Important concepts of positionality, reflexivity, and subjectivity are therefore described. Finally, procedural ethics and ethics in the field are discussed.

Part two begins by outlining the methods used for data collection. Data was collected through semi-structured interviews, participant observation, and document analysis with collateral description. In taking a mixed method approach to data collection, a deeper, richer, more rounded picture is revealed. This fits well with Yin (2009) who argues for the importance of case study research using mixed methods in data collection. Moreover, “by using a combination of observations, interviewing, and document analysis, the fieldworker is able to use different data sources to validate and cross check findings” which enables “triangulation” (Patton, 2002, p. 306). Patton (2002) advocates the importance of triangulation. Rigour in the process also ensures that the findings are trustworthy and credible (Stewart-Withers et al., 2014). To demonstrate rigour, the data collection methods, their core principles, and how each method was applied in practice are discussed. Qualitative research tends to be an iterative process, with data collection and analysis occurring simultaneously; therefore, how the researcher shifted back and forth in terms of collection and analysis is also described.

Part One: Research Design

3.2 Conceptualising case studies

In exploring the practices of the 12th Mental Health Centre, specifically how mental health communication programmes were planned, implemented, and evaluated, and how contextual factors influenced the structure and the delivery process of mental health services, a qualitative case study approach was applied. A case study is defined as “the study of the particularity and the complexity of a single case, coming to understand its activities within important circumstances” (Stake, 1995, p. xi). A case study approach fits when a case is very interesting and the researcher wishes to explore the interaction between the case and its context. Yin (2009) defines a case study as an empirical study that investigates in depth the real-life context – particularly helpful when the boundaries between context and phenomenon are not clear. The focus of my research is thus congruent with Yin’s three broad considerations when choosing whether to use a case study design: that: 1) the researcher wants to answer “how” or “why” questions; 2) the researcher has no control over and access to actual behavioural events; and 3) the study focuses on contemporary events. This research method is also in keeping with Stake’s (1995) suggestion that a case study can be a person, a group, or a “specific, complex, and functioning thing” (p. 2). The phenomenon of interest in this

study is *'mental health communication programmes of the 12th Mental Health Centre'* (specific and complex condition) in *'response to the mass violence situation in southern Thailand'* (specific function).

Yin (2009) describes two advantages of the single case. First, a single case can be used for testing theories, contributing to knowledge, and building theories. Second, a case study can represent an extreme or unique case. The mental health practices of the 12th Mental Health Centre were designed in response to the specific context of the mass violence situation in southern Thailand. These practices provide the basis for an empirical study based on this context that then permits an opportunity to test and build theory, or, as suggested by Rowley (2002), to be a pilot for further multiple case studies.

The conceptual structure of a case study should be organised around issues rather than just information or questions: "the issues as organizers for a case study serve to deepen understanding of the specific case" (Stakes, 1995, p.440). The issue in this study is the communication programmes of the 12th Mental Health Centre in response to the mass violence situation in southern Thailand from 2004 to 2014 – exploring also how mental health communication programmes have been designed and delivered – and then drawing some conclusions that might be useful for the many other regions around the world where conflict occurs.

Stake (1995) distinguished three types of case studies: intrinsic, instrumental, and collective. An 'intrinsic' case study focuses on a particular case that is interesting and essential in itself. An 'instrumental' case is also study of a particular case; however, that case is used as an instrument to understand something else. Last, a 'collective' case study examines several instrumental cases and the coordination between the individual studies. My study combines the intrinsic and instrumental cases by concentrating particularly on Centre 12's mental health communication programmes (intrinsic). Those programmes were used to understand the typical framework of communication programming in response to mass violence contexts (instrumental).

In collecting quality case study evidence, Yin (2009) argues for adherence to three principles. First, that multiple sources of evidence be acquired and used for the creation of a case study database, and that there be linkages in terms of the chain of evidence. Second, the case study evidence comes from some combination of six sources, i.e.

documents, archival records, interviews, direct observation, participant-observation, and physical artefacts. Third, while two or more methods should always be employed in case study research, Yin (2009) remains emphatic that interviews are the most important means for gathering information. In this study, three methods were used for data collection: document analysis, interviews, and participant observation. Interviewing was the major data collection method used in the study. The data collection methods used will be further explained in sections 3.5.1, 3.5.2, and 3.5.3.

3.3 Qualitative research and this study

This case study explores communication strategies used in designing and delivering mental health communication programmes in a mass violence situation, with a particular focus on the deliverers' perspectives. It fits well within a qualitative paradigm where the purpose is to unearth deep, detailed information to help understand human experience and social context (Denzin & Lincoln, 1994 ; Mason, 2002; Patton, 2015).

3.3.1 Why qualitative research?

To belong to the qualitative paradigm, the research must 1) take place in the natural world, 2) use multiple methods that are interactive and humanistic, 3) focus on context, 4) be emergent rather than tightly prefigured, and 5) be fundamentally interpretive (Marshall & Rossman, 2016). Qualitative researchers therefore study things in their natural setting and try to interpret phenomena in terms of the meaning people bring to them. A qualitative approach should be used to “describe, explore, or explain social phenomena...that [takes] place in a naturalistic setting” to gain a deeper, richer, better understanding of, and gaining insight into, an issue (Stewart-Withers et al., 2014 see also Jensen, 2002, p. 236).

While both qualitative and quantitative approaches apply ‘scientific’ procedures, qualitative research is more concerned with the study of processes and meanings, while quantitative research aims to measure and analyse the relationship between variables in terms of quantity, intensity, or frequency (Denzin & Lincoln, 1994). These approaches thus produce different outcomes and answer different sets of questions, from which different sets of data emerge: “qualitative research is about generating and building up theory as opposed to being hypothesis-driven, it works in an inductive manner (from the

specific to the general) rather than deductive (moving down from the general to the particular)” (Stewart-Withers et al., 2014, p. 59).

3.3.2 The qualitative researcher

Considering the above, three features of qualitative research are deeply relevant to this study: the “concept of meaning” (Jensen, 2002, p. 236), which acknowledges that human beings experience every event in their lives as meaningful; the importance of gaining deep knowledge and insight into the participant’s perspective, i.e. considering the emic perspective (analysis through the insider perspective); the need to be concerned with the view of the researcher; reflecting in terms of the etic perspective (analysis through the outsider or observer perspective) (Jensen, 2002).

3.3.3 Researcher’s positionality and reflexivity in qualitative research

This research combines elements of both emic and etic approaches. With my previous experience of working and researching in the mass violence area for 8 years, I understand the participants’ way of life and cultures. Being an insider brings benefits, one of which is that it can increase participants’ willingness to engage in the research (Marshall & Rossman, 2016). However, mental health communication in a mass violence crisis is a sensitive issue and communication processes are mostly conducted by health professionals. As a non-health professional, I also take the role of outsider when observing and looking to make sense of the participants’ activities. The challenge for the researcher who combines emic and etic viewpoints is “to become capable of understanding the setting as an insider while describing it to and for outsiders” (Patton, 2015, p. 338). (For further specifics about my role as the participant observer, see section 3.5.2.). Finally, in reflecting on my insider-outsider status, I am also demonstrating reflexivity and considering my positionality.

The researcher is the core instrument of qualitative inquiry (Lincoln & Guba, 1985; Marshall & Rossman, 2016; Stewart-Withers et al., 2014). The researcher’s background can influence data collection and interpretation. As Patton (2015, p. 3) states, “your background, experience, training, skills, interpersonal competence, capacity for empathy, cross-cultural sensitivity, and how you, as a person, engage in fieldwork and analysis—these things undergird the credibility of your findings”. While the quality of research relies heavily on researchers’ points of view, researchers need to be aware of

personal values and biases and should aim to pass on the participants' reflections rather than their own judgments. Stewart-Withers et al. (2014) argue that a qualitative researcher should be an active learner, paying attention to "people's local realities, and genuinely hearing the voices of those telling the story" (p.61). This study, therefore, acknowledges the impact of the researcher on the research process. In attempting to ensure that the research findings truly reflect the participants' views, I recognise also the importance of understanding my positionality and behaving reflexively.

Recognising positionality is very important when undertaking qualitative research. Stewart-Withers et al. (2014) suggest when thinking about one's positionality one needs to think through "gender, religious, class, sexual orientation, race or ethnicity, or other more personal attributes such as age, life experiences or history" (p. 62) and also consider how this positionality may influence the participants' relationship with the researcher, their responses, and thus the data. Positionality is not necessarily a weakness of qualitative research as long as the researcher is aware of its influence on the research process. In this study, I acknowledge my background as a university lecturer and communication researcher to be a factor that might affect the participants' feelings and their reflection responses. For instance, in Thai culture, university lecturers are seen as of high status. To counter this impact of my assumed higher status, I explained to all the participants that the study of mental health issues was new for me and that I am a student who wanted to learn from *their* experiences. Yet in keeping with the need for transparent, open, and ethical data collection, participants did need to be aware of my university position. The tactics used to try to reduce any potential impact will be outlined later in the chapter.

The researcher-based approach of qualitative research can raise questions about the validity and reliability of a study. That said, what qualitative researchers are really interested in is process and requirements of the researcher to behave reflexively. Sultana (2007) describes reflexivity as the process of "reflecting on self, process, and representation, and critically examining power relations and politics in the research process, and researcher accountability in data collection and interpretation" (p. 376). Reflexivity means the research can be deemed credible and trustworthy (hence reliable and valid). Using field notes or diaries to record ideas and experiences from the field promotes reflexivity (Stewart-Withers et al., 2014). In this study, personal reflexive notes were made after interviews and as part of participant observations (see section

3.5.2.4). Recording observations and part of the evidence file are provided in Appendix E. Finally, behaving reflexively and thinking about one's position and impact on the research is in a sense behaving ethically. This next section explores ethics in research in more detail.

3.4 Explaining ethical research

This study was conducted in a mass violence area. Contexts such as this compromise people's rights as human beings to go about their daily lives safely and with dignity. Because of this I was mindful that my research caused no harm and promoted participants' rights to privacy, to be fully informed, and to feel they had been treated with respect. These were even more important, given my participants were located within a multi-cultural setting and held different religious, cultural, and lifestyle beliefs. This research was guided by and complied with Massey University Human Ethics Committee requirements. Additionally, I considered a number of long-standing ethical principles defined by Marshall and Rossman (2016) as beneficence and justice. Before I discuss how various principles were applied in practice, I outline briefly the Massey University institutional ethics process and aspects I was asked to consider.

3.4.1 The University ethics procedures

After gaining approval to undertake research via a permission letter from Centre 12's Director, I looked to apply for University ethics approval. This study, Human Ethics Application no. 13/73, was considered on Thursday October 10, 2013. The ethics committee asked for consideration in seven areas before granting approval: interview location, participant recruitment, participant observer's role and expectations, photograph usage, participants' opportunity to review transcription, the risk of harm to the researcher and the risk to Centre 12 if participants spoke in a negative light about the Centre's policies, strategies, and communication (See Appendix G for my answers to those questions; Appendix 1 and 2 contain copies of the information sheets and consent forms).

3.4.2 Ethics in practice

The major ethical principles as espoused in the University Code are:

- respect for persons;

- minimisation of harm to participants, researchers, institutions and groups;
- informed and voluntary consent;
- respect for privacy and confidentiality;
- the avoidance of unnecessary deception;
- avoidance of conflict of interest;
- social and cultural sensitivity to the age, gender, culture, religion, social class of the participants; and social justice (MUHEC, 2015).

While careful consideration was given to all principles I refer specifically to the ways I sought to show respectfulness and minimise harm, which also encapsulates other principles.

3.4.2.1 Demonstrating respectfulness

Marshall and Rossman's (2016) ideals of respectfulness refer to the fact that: "We do not use the people who participate in our studies as a means to an end (often our own) and that we do respect their privacy, their anonymity, and the right to participate—or not—with their free consent" (p. 52). Hence the study information sheets were given to 17 participants (the Director of the 12th Mental Health Centre, 11 Centre staff, and 5 partner group representatives) when I first met them. After giving them the opportunity to ask questions, I emphasised that taking part in this study was entirely their own choice and would not affect their jobs in any way and they would be free to withdraw from the study at any stage.

I was able to enhance the ethical elements of the study when I later returned to Thailand and presented the draft findings to participants in a face-to-face situation, demonstrating my respect for their contribution. This review of the findings by the study's participants also improved the accuracy and the overall quality of this study and links to my earlier point about the importance of process. This also supports the understanding that in qualitative research there are multiple truths, and knowledge is co-constructed between the researcher and the participants, that research is an iterative process (Stewart-Withers et al., 2014), and it is important that the participants feel listened to and genuinely heard.

Interviews were conducted where and when the participants felt comfortable, as will be described in section 3.5.1.4. For the Centre 12's staff, most of the interviews were conducted at the Centre's meeting room, which the participants preferred as they felt it

was safer in terms of privacy. I mainly used Thai language in the interviewing. Although Malayu-Pattani and Yawi language are used in daily life, all the participants could also speak Thai. When I asked them whether they wanted to use Malayu-Pattani or Yawi language because I could provide a translator, all participants said they preferred to use Thai.

Respect for social and cultural sensitivity is also important in qualitative data collection. As Patton (2015) emphasises, “Sensitivity to context is central in qualitative inquiry and analysis” (p. 9). As the participants include Buddhists and Muslims, I listened to and observed their social behaviours, beliefs, opinions, and knowledge without criticism, particularly, in relation to ideas about religions and cultural beliefs. Furthermore, I built rapport with the participants by using family-oriented terms. I referred to myself as “Pêe” (a Thai word meaning the elder sister in the family) and I referred to the Centre’s staff as “Nóng” (equivalent to a younger sibling). Most of the study’s participants were Muslim, so I was careful not to make appointments in their prayer time or on a Friday afternoon when Muslim males go to perform religious activities at the mosque. I also did not discuss or make any comparison between Buddhists and Muslims.

3.4.2.2 Minimising harm

There were possible risks for participants and for myself as the researcher. The participants were both Buddhist and Muslim, but because I have lived in the area for 8 years, I understood and respected their differences, reducing chances of individual harm, primarily emotional or spiritual. As the research setting was in the mass violence area I had prior discussions with my supervisors where they were reassured that violence is not an everyday occurrence and, for the most part, daily life carries on. Further, this was my former work place and I was relatively well-placed to understand and manage risk. In case of any potential risks, however, I understood I would put my safety over and above data collection by respectfully cancelling or postponing appointments, or by leaving the risky situation or area. Given that the research might provoke emotion as participants were talking about personal experiences I was also careful to support any participants if they became distressed by stopping the interview, directing them to support, and continuing only if they felt they were able to.

Two violent incidents occurred while I collected data. The first incident was bombing around the city at night time on May 24, 2014. It was claimed to be the most violent

incident in the 10 years of the on-going crisis because more than ten bombs exploded in the city in the same time. I left the area in the morning because there was no water and electricity in town. I contacted Centre 12's Director and staff, asking about their safety and their plans to deal with the violence. They told me that they were preparing to visit people in some areas in the next few days. I had to check news reports all the time and confirmed the situation from people in the area. Two days later, I went back into the research setting and prepared to go to a hospital recommended by the Centre 12's staff as their partner group. Unfortunately, a motorcycle bomb exploded in front of the hospital in the early morning (for news reports about this violent incident see Appendix H). I discussed these situations with my supervisor and changed my plans. My data collection plan was delayed because staff were busy responding to the crisis. More important, for safety's sake, the partner group participant was changed from the hospital to the Provincial Public Health Office, the core organization that controls and supervises hospitals in the province but is less directly involved as a partner with Centre 12.

Part Two: Doing the Research

3.5 Data collection methods and analysis

Lincoln and Guba (1985) divided data collection methods in qualitative research into two categories: data collection from non-human sources such as documents and records; and data collection from human sources, through interview and observation methods. This study drew on three methods from these two categories: semi-structured interviews, participant observation, and document analysis. Using multiple methods allows for triangulation of the data and ensures trustworthiness and credibility (Carter, Bryant-Lukosius, DiCenso, Blythe, & Neville, 2014; Patton, 1999). Using multiple methods, multiple sources, and multiple participants, and taking my findings back to participants for corroboration, were two important ways in which I practised triangulation.

As mentioned above, interviewing was the main method used for data collection. My role as participant observer provided further insight into the communication practices. A variety of documents and records (such as annual reports, project reports, evaluation

sheets) and media (such as booklets) produced in response to the mass violence crisis, were also accessed. These were used to help answer Research Question 1.

Semi-structured interviews and participant observation with some document assessment were used to explore research questions 2 to 4. The semi-structured interviews were also used to answer research question five. Table 3.1 provides a summary of methods used to answer the five research questions, with the most relevant method for each research questions

Table 3.1 *Links between research questions, data collection method, sources of data*

Research question	Method
1. In what way did Thai government policies impact on the establishment, funding, and delivery of mental health communication programmes during the mass violence situation in southern Thailand?	1. Document analysis of records and annual reports 2. Document analysis of media and collaterals 3. Semi-structured interviews
2. How were the mental health communication programmes responding to mass violence in southern Thailand planned?	1. Semi-structured interviews 2. Participant Observations 3. Document analysis of media and collaterals and annual reports
3. How were the mental health communication programmes implemented?	1. Semi-structured interviews 2. Participant Observations 3. Document analysis of media and collaterals and annual reports
4. How were the mental health communication programmes evaluated?	1. Semi-structured interviews 2. Participant Observations 3. Document analysis of media and collaterals and annual reports
5. What are the effective practices and challenges of these mental health communication programmes, from the deliverers' perspective?	1. Semi-structured interviews

The following sections focus on the three methods (interviewing, participant observation, and document analysis and collateral description), explaining how these methods were applied in this study.

3.5.1 Interviewing

Interviews and data collection

Interviewing is the main method used for data collection. The interview has been defined broadly as “a conversation with a purpose” (Lincoln & Guba, 1985, p. 268). Similarly, DeMarrais and Lapan (2004) see interviewing as “a process in which a researcher and participant engage in a conversation focused on questions related to a research study” (p. 55). The most common type of interview is the face-to-face type (Berg, 2009).

The effectiveness of the interview technique depends on three conditions: the interview structure, the degree of openness, and the quality of the relationship between the interviewer and respondent (Lincoln & Guba, 1985). Fontana and Frey (1994) grouped interview techniques into structured and unstructured categories. While the questions of a structured interview are pre-established, with a limited set of response categories, an unstructured interview has only a list of topics or issues as an interview guide. Moreover, unstructured questions are informal and usually open-ended. As a result, some scholars refer to unstructured interviewing as open-ended interviewing (Patton, 2002). In a more nuanced explanation, Berg (2009) also identified the semi-structured interview, which is what I chose for my study.

The semi-structured interview combines both a structured set of questions and the open-ended format of the unstructured interview. Mason (2002) summarised four core features of semi-structured interviews: the interactional exchange of dialogue (which could be by one-to-one interview, group interview, or interview through telephone or internet); the informal style of conversation or discussion; the thematic or topic-centered set of questions (which can be altered flexibly); and the construction of data and knowledge through dialogue or interaction during the interview. Similarly, Bryman and Bell (2011) suggest semi-structured interview questions are more general in their frame of reference than those typically found in a structured interview and the “interviewer usually has some latitude to ask further questions in response to what are seen as significant replies” (p. 205).

The five steps of the interview process defined by Lincoln and Guba (1985) guide this study. The first step decides who to interview. The second step involves organising

interview questions, deciding the interviewer's role and level of formality, and confirming place and time of the interview. The third step is informing the interviewees about the nature and purpose of the interview. The fourth step is pacing the interview and keeping it productive. The final step is terminating the interview and gaining closure. At this last stage, the interviewer looks to summarise the overall ideas with the interviewee to check for correct understanding and to add more information if required.

Interviews and data analysis

Patton (2002) suggested that an effective interview question should “yield in-depth responses about people's experiences, perceptions, opinions, feelings, and knowledge” (p. 4). He added that the data should consist of “verbatim quotations which can be used for data interpretation” (p. 4). Glesne (2005) described data analysis in qualitative research as an organising of all the evidence to make sense of what we have learned. She advises, “you must categorize, synthesize, search for patterns, and interpret data you have collected” (p. 147). Moreover, Glesne also claimed that the most widely used means of data analysis in the sociological tradition is thematic analysis, defined as “a process that involves coding and then segregating the data by codes into data clumps for further analysis and description” (ibid, p. 147). In this research, the thematic approach was used to analyse interview data.

Limitations of interviews

Denzin (1989) describes interviewing as an excellent way to discover the meanings and interpretations people give to their experiences. However, this method also has some limitations. As Seidman (2006) states, it takes a great deal of time and energy. Similarly, Stewart-Withers et al. (2014) identify the difficulty of recording data in interviewing, while the researcher has also to be actively listening. Audio recording and then transcribing or summarising takes time. Kvale and Brinkmann (2009) suggest unacknowledged researchers' bias may cause invalid results. This research acknowledges my positionality and potential bias, and employs triangulation, to offset this risk. Recognizing and acknowledging the perspective of the researcher can in fact contribute to new knowledge. The following section outlines how Lincoln and Guba's (1985) five steps of interviewing were applied and discusses sampling approach and size.

3.5.1.1 Research participants: The recruitment process and building relationships

Once the study topic was selected, the 12th Mental Health Centre was chosen as the fieldwork site and the Centre's Director and staff members became the key informants of this study. In total, 17 participants were interviewed. Table 3.2 below shows the research participants and their positioning in relation to this study. Although all staff members gave permission for their names to appear in the thesis, this study omits individual names (except that of Centre 12's Director and an academic partner representative) because of ethical considerations and the safety issues involved in Thailand's political climate. As a result, participants are referred to by numbers, which follow the interview order.

Table 3.2 *The research's participants and their positioning to this study*

<i>Participants</i>	<i>Positioned with</i>
1. Director	The 12 th Mental Health Centre
2. Centre Staff Member No 1	The 12 th Mental Health Centre
3. Centre Staff Member No 2	The 12 th Mental Health Centre
4. Centre Staff Member No 3	The 12 th Mental Health Centre
5. Centre Staff Member No 4	The 12 th Mental Health Centre
6. Centre Staff Member No 5	The 12 th Mental Health Centre
7. Centre Staff Member No 6	The 12 th Mental Health Centre
8. Centre Staff Member No 7	The 12 th Mental Health Centre
9. Centre Staff Member No 8	The 12 th Mental Health Centre
10. Centre Staff Member No 9	The 12 th Mental Health Centre
11. Centre Staff Member No 10	The 12 th Mental Health Centre
12. Centre Staff Member No 11	The 12 th Mental Health Centre
13. Academic	The Director of the Deep South Coordination Centre
14. Special Interest Group 1	Volunteer of Brahma Kumaris Foundation
15. Special Interest Group 2	Volunteer of Brahma Kumaris Foundation
16. Health Network	Senior staff of the Provincial Public Health Office
17. Media Network	Radio broadcaster of the National Radio Thailand in the three southern border provinces

The strategies I used to access the participants were: establishing contact with the Centre 12's Director, introducing myself to the Centre's staff, and investigating the partner group representatives.

Step 1: Establishing contact with the Director

With my previous experience of working and researching health communication in Thailand, I had met the Director on earlier occasions, which I thought would be useful when I introduced myself in relation to the study. First, I wanted to find the Director's mobile phone number. Although in Thailand, as in other countries, the common way of contacting officials is through their offices, I thought it would be more effective to call the Director's personal number, to establish immediate contact and remind her about our previous meeting. Fortunately, one of my friends at the Provincial Non-Formal Education Centre had worked with Centre 12 and also worked closely with the Director for a long time. After I described the research to her, my friend gave me the number and told me she would call the Director to tell her about the study. My friend also offered to go to the Centre and help me find basic information about its activities and media production.

I then called the Director in November 2013, introduced myself as a university lecturer at the Faculty of Communication Sciences, Prince of Songkla University, Pattani, now a PhD student at Massey University, New Zealand, and referred to our earlier meeting several years ago. The Director said she remembered me and referred to my friend who had already talked to her. My personal work background and experience, combined with my friend's recommendation, thus helped me build a faster rapport. After explaining the study briefly, I asked her permission to undertake the research. The Director said she was happy to support my study as it would be useful for her Centre and the Department of Mental Health. A few days later, I e-mailed an official permission letter to the Director, who signed it, thus allowing me access to the Centre and its staff. Additionally, she gave me contact details of a staff member to help me find the Centre's documents and media outputs.

Step 2: Introducing myself to the Centre's staff

In approaching Centre 12's staff, I firstly e-mailed the staff member mentioned above. She confirmed she was happy to help and would tell the other staff about my study.

Back in NZ, I applied for University ethics approval and went through the PhD confirmation process.¹

Four months later, I began data collection in the field, which was carried out between 25 April and 15 June 2014. On arriving in Pattani on 26 April, I first made an appointment with Centre 12's Director. While most of the staff were busy preparing for a meeting, the Director introduced me to Miss Bu-nga Dulayasith, a social worker at the Centre who offered to coordinate interview times with the other staff and was a major support for me in my study. At this stage, I had permission to come to the Centre any time to interview the staff and observe the Centre's activities.

To become a trusted interviewer with the Centre's staff who did not know me and who were very busy, my strategy was to visit the Centre regularly and join in their activities as often as I could. Accordingly, I went to the Centre 12 for 25 days in the 2 months of data collection. Apart from visiting the Centre, I also interviewed partner groups and participated in workshops.

In the first 2 weeks of field work, I started by observing Centre 12's work environment and the relationship between the staff members. I talked with the staff members on general topics such as weather and their health and looked at the printed media on the official bulletin board and asked about content and design. All staff members, except the Director and the deputy, worked in one large office. Each had a small personal space for their desk. I also observed the mix of formal and informal verbal communication among the staff and between the Director and staff.

At the end of week two, Miss Dulayasith invited me to observe Centre 12's workshop for those working with young children. This allowed me to see and talk closely with the staff members who took responsibility for the workshop. In week three, Miss Dulayasith started to help me arrange the interviews. It was difficult at the beginning because the staff timetables were unstable. After three appointments were postponed, Bu-nga said she did not want me to waste my time so instead of making appointments ahead of time, she made arrangements at the beginning of each day and phoned me. However, progress was slow as the participants were still busy. Then, in week four, I

¹ The confirmation process is one of the milestones, checks, and balances, students need in order to move from having provisional PhD registration to full registration at Massey University. If the student does not successfully complete this process, which shows they have done the required work in the first year and are intellectually capable, they are no longer able to continue with the PhD.

went to observe another workshop that was attended by most of the staff. Those two days provided a good chance for me to meet most of them again as I took the role of participant observer. As two bombings occurred in week five, I had to leave the area for 4 days as my accommodation was not protected and there was no electricity and water. After the area was confirmed as safe, I returned. Surprisingly, in weeks six and seven it was easy to obtain interview appointments. A participant confirmed staff had more time after completing the workshops. Also, as the crisis was continuing, most staff stayed at the Centre because they were preparing to provide more mental health rehabilitation programmes in the local community in response to the latest violence. By May 30, 2014, eleven staff members were interviewed. I interviewed the Director last, on June 4, 2014, as I believe that if she had been the first interviewee and then introduced me to the staff, they may have felt a greater obligation to take part in the study.

Step 3: Investigating the partner group representatives

All Centre staff, including the Director, were asked to recommend partner groups who I could interview about their work on mental health issues and their relationship with the 12th Mental Health Centre. This process, known as the snowball technique, is described by Bryman and Bell (2007) as “the researcher makes initial contact with a small group of people who are relevant to the research topic and then uses these to establish contacts with others” (p. 192). Many people and groups were recommended to me. However, five people from four partner groups were finally selected for the study, based on the high number of recommendations and the fact they were accessible (see details about these five partner group representatives in Chapter 5 at 5.3.1).

3.5.1.2 Interview schedule

In this study, the overall research questions were divided into three overlapping categories for the three groups of participants: 11 questions for the Director of the 12th Mental Health Centre; 22 questions for the Centre staff; and 10 questions for the community-based partner groups. The questions were designed after reviewing relevant literature on health communication, public relations, and communication campaigns. Additional questions arose after reading documents from the Centre’s official website (<http://www.mhc12.go.th/index.php/en/>), news reports about Centre 12’s activities, and the Director’s media interviews on mental health issues in southern Thailand.

When setting up the interviews, I introduced myself as a researcher and PhD student in Communication at Massey University. Several participants were interested in my study and asked for more information about studying abroad and especially doing research in the English language, my status, and my family. I shared my personal information and I believed these conversations built up the feeling of intimacy (as suggested by Sultana, 2007). Further, I told the interviewees that while I had an interview schedule as a guideline, the questions were flexible and discussion informal as I would like to learn from their experiences. I asked them to feel free to tell their stories fully.

Confirming time and place of interviews differed from my initial planning. I had thought the participants might choose interview venues out of their office and perhaps outside their work hours (as recommended by Rice and Ezzy, 1999). However, Centre 12's staff were very busy and their schedules were changing unexpectedly as new meetings were set up, sometimes outside normal working hours. Therefore, interviewees preferred to be interviewed in the Centre 12's meeting room, which they found convenient. As mentioned previously, the Centre's office was also safer than a public place because of the possibilities of bombing and shooting.

One long-term staff member was on maternity leave but wanted to participate. I interviewed her in the ground floor of her apartment building. For the five partner group representatives, two interviews were held at their offices, one was conducted before a community-based meeting started (and continued in the van while returning from the meeting), another interview was conducted at the coffee shop in Prince of Songkla University, and, as noted above, one interview was conducted online.

3.5.1.3 Informing participants

Before interviewing, each participant was informed about the study's objectives and received the information sheet in Appendix 1. If they decided to take part in the study, a participant consent form (in Appendix B) was provided. Participants were asked if interviews could be recorded, if their activities with others could be observed, if photographs could be taken and shown to them for selecting, and if their name could be used in this study. They were also informed transcripts would be returned to them for checking and, if they wished, their interviews could be presented anonymously. Except for one representative from the Brahma Kumaris Foundation who wished to remain anonymous, most participants agreed to all requests.

3.5.1.4 Conducting interviews

In conducting interviews, I combined Patton's (2002) and Berg's (2009) ideas for designing question order. Patton (2002) proposed "The Matrix Listing Question", which includes five types of question: emotion or feeling questions (experience), knowledge questions (specific factual), sensory questions (things one might see or observe), opinion or value questions (individual thoughts of something or some experience), and background or demographic questions. Berg (2009) suggested starting with easy, non-threatening questions, then some important questions for the research topic (non-sensitive questions), before asking important or sensitive questions, and moving to the next topic.

My interviews began with a request for interviewees' demographic details, including their education and previous work experience, followed by an overall description of their job. Questions then focused on activities or specific experiences, with opinions, values, and work evaluation last. The core interview questions addressed how interviewees planned, implemented, and evaluated their mental health communication programmes. (For the full interview questions see Appendix C).

As this study focused on the participants' experiences on the job, reflections focused more on factual details than on emotional responses. The participants were professionals and familiar with the research process, so their answers were straightforward. Answers about work experience were detailed. However, participants were more careful in expressing their opinions or feelings about the context in which they undertook their work. This might reflect the limitations of interviewing in the workplace and in a tight time-frame. Alternatively, it might be the result of conducting research in a crisis area. Participants might have become tired of the violence and not want to discuss it, or because of sensitive circumstances, might have felt cautious of the researcher and therefore were careful expressing feelings and opinions.

However, the interviewees appeared to be confident in their answers and happy discussing professional activities and asking questions when they were unsure. For example, a staff member asked me what kind of communication I expected, interpersonal communication or mass communication, and one of the partner group representatives asked me "How would you define mental health?" when I asked her to explain her work on mental health.

I made some adjustments during interviewing. First, I soon understood that the language used in the questions was academic and difficult to understand. Consequently, I changed “What kind of sources do you use to reach your target groups?” to “Who were the people chosen to communicate with about mental health issues, and why; Did you use the same person for every group?”

A second change came when one participant asked me whether her friend who had worked with her in the same position could be interviewed at the same time because she might forget some important points and her friend could provide that information. Then, two other staff members also asked to be interviewed together with their co-workers. In total, I did interviews with three pairs of participants. However, I frequently repeated key questions to each of them separately.

Interviews with partner group participants differed slightly. I knew most of them from my previous experience working as the Director of Prince of Songkla University’s radio station. Thus, after I called them, they checked their schedules and arranged the interview times and place. Two interviews were conducted at their offices, one interview ran before and after a community-based meeting, and another interview was conducted at the coffee shop in the University.

The average length of an interview was about 60 minutes. The minimum time was a 19-minute interview with a staff member who had only been with the Centre for 2 weeks and the maximum time was a 90-minute interview with a staff member who had been with the Centre since it was set up. All interviews were transcribed and translated from Thai to English by the researcher, with support from supervisors. Additional support came from Centre 12 who helped with the technical terms.

3.5.1.5 Terminating the interview and gaining closure

After participants answered key interview questions, I generally summarised their responses to ensure my understanding was correct. For instance, one participant described her previous experiences and why she was seconded by the Department of Mental Health to work in Centre 12. I summarised, “You thought your previous experiences of working in the crisis area was a benefit for work in this area?” She said “Yes, although they were different types of crisis, but my view of seeing things was deeper than the other staff”. At the end of each interview, interviewees were reminded

of their right to review the transcriptions. I also asked for their cell phone numbers or email address and for permission to contact them again if I needed more information.

3.5.2 Participant observation

This study employed participant observation to refine the picture of mental health communication programme planning, delivery, and evaluation in the activities of the 12th Mental Health Centre and partner groups. Observation is described as a naturalistic inquiry that takes place in the setting (e.g. Bryman & Bell, 2007; Marshall & Rossman, 2016; Mason, 2002) and there are many terms for describing field-based observations, such as participant observation, fieldwork, qualitative observation, direct observation, and field research (Patton, 2002). However, participant observation is different from direct observation, as pointed out by Guest, Namey, and Mitchell (2013, p. 78) who quoted John Whiting's comparison that "An observer is under the bed. A participant observer is in it". Guest et al. (2013) further defined participant observation as a method in which the researcher participates in the daily life of the people under study to observe things that happen, listens to what they say, and questions them over a length of time. This is similar to Patton's (2002) definition of observation as "fieldwork descriptions of activities, behaviours, actions, conversations, interpersonal interactions, organizational or community processes, or any other aspect of observable human experience" (p. 4). From these definitions, Adler and Adler's (1994) summary of the scope of observation covers the whole picture. They concluded that observation "occurs in the natural context of occurrence, among the actors who would naturally be participating in the interaction, and follows the natural stream of everyday life" (p. 378).

Many scholars acknowledge the advantages of participant observation. Lincoln and Guba (1985) for instance, argued that participant observation "allows the inquirer to see the world as his subjects see it, to live in their time frames, to capture the phenomenon in and on its own terms, and to grasp culture in its own natural, ongoing environment" (p. 273). Similarly, Patton (2002) identified three advantages of participant observation: understanding and capturing context surrounding participants, which is essential to a holistic perspective; direct experience of a setting and people in that setting allows an observer to be more open and discovery-oriented; and there is an opportunity to see things that may routinely escape awareness among the people in the setting.

However, there are important limitations of participant observation. Mason (2002), for instance, provided a broad view of ethical concerns related to participant observation. They were critiques about the covert and overt role of the investigator, the way in which the observers build and maintain relationships with the participants, and the question of gaining informed consent. Additionally, Adler and Adler (1994) pointed out that the invasion of privacy is a limitation of the observation method. Likewise, Bryman and Bell (2011, pp. 496-497) argued that participant observation is “intrusive in terms of the amount of people’s time taken up when it is in organisational settings. In work organizations, there is a risk that the rhythms of work lives will be disrupted”. In this study, observation also took place in the work place; I acknowledged this concern and aimed to be very careful in my observation and not disturb the participants’ working circumstances.

Frey, Botan, and Kreps (2000), who used the participant observation method in their communication research, suggested three interrelated aspects of applying observation. The first was participant-focused, which studies the communication behaviour of a particular *group of people* to see what is going on in their everyday life experiences. The second was research setting-focused, which tries to understand communication among people within the particular *setting* to see how the setting affects the communication. The final aspect was a focus on communication acts, which studies communication designed for particular purposes and includes responses of the receivers. My study combines these three aspects as it aims to explore how mental health communication programmes are designed and delivered (communication acts) from the deliverers’ perspective (participant-focused) and in the specific context of the mass violence situation (setting-focused). Based on this framework, my mission in the field was observing what participants do, how they do it, and in what circumstances. My observation was made overtly as I told the participants at the early stage of the observations that I was a researcher who was studying mental health communication at the 12th Mental Health Centre.

Adler and Adler (1994) quoted Gold’s (1958) four modes of the classic typology of research roles in observation: “the complete participant, the participant-as-observer, the observer-as-participant, and the complete observer” (p. 379). The complete participant was described as an observer who is involved in the setting but covert in their role as researcher. With the participant-as-observer, in contrast, the people know they are being

studied while the researcher is involved as much as possible in the setting. With the observer-as-participant, the researcher is primarily an observer and may act like people in the setting but does not participate actively in the activities. The last role is the complete observer. In this role, the researchers are full-covert observers. They do not interact with people in the setting because they want to observe without influencing the participants. Gold (1958) claimed few researchers adopt this role because it reduces the perspective of insider. In this study, I took the participant-as-observer role. The participants were informed about my role as the researcher and they realized that they were observed and I participated in activities provided in the meetings or workshops. In this mode, I could take the role of insider while remaining an outsider. As Guba and Lincoln (1981) described, “in a real sense it permits the observer to use *himself* as a data source; an observation allows the observer to build on tacit knowledge, both his own and that of members of the group” (p. 193).

After participant observation was selected as an appropriate method of data gathering in this study, I applied Adler and Adler’s (1994) observation processes as a guideline to developing the study. The four steps of this study’s observation were: selecting a setting, gaining entry, beginning observations, and recording observations and analysing data. The following sections clarify how these four processes were applied in this study.

3.5.2.1 Selecting a setting

The research site was the 12th Mental Health Centre in Pattani province, Thailand. The observation process was initially planned to take place at Centre 12’s office, especially during staff meetings to plan mental health programmes and activities and workshops. In practice, participant observation occurred not only in the Centre’s office, but also in the school, the university, the Sub-District Administrative Organization office, and a hotel.

3.5.2.2 Gaining entry

Early days in the field are the most anxious because of many unknown situations but also exciting with new learning experiences (Glesne, 2005). The first day of gaining entry to the field was exciting. I met the Centre’s Director (as described earlier in section 3.5.1.1) and Miss Bu-nga Dulayasit, a social worker staff member. The director served as a gate keeper for me in this study (Bernard, 1994). While observing the

Centre work environment, I began an easy opening conversation with the Director by talking about the study's participants. The director made suggestions about the recruitment process, including dividing the potential participants into two groups: people who have worked in the healthcare sector, and those who have worked outside the healthcare sector. The Director's idea was helpful in allowing me to compare participants' roles, strengths, and weaknesses. I asked her permission to observe the staff activities and workshops. She allowed me to observe all events except the Centre's meeting with a group representing the opponents of the Thai government. In total, my first entrance to the field consisted of about 1 hour talking and then 30 minutes to observe and record the setting and context.

3.5.2.3 Beginning observations

Participant observation in practice differed from my initial planning. When I began observation most of the activities were already planned. As a result, I did not have a chance to participate in the programme planning; however, I added questions about the planning process into the interview instead. I was invited to participate in the first workshop at the end of week two, which benefited me later as I was recognised by most of the staff as a researcher who participated in their workshop.

My role as participant observer in this study occurred on four occasions: two workshops organised by the Centre, and one meeting and one workshop organised by the partner group representing spiritual development. For the first two workshops, the participants were mostly public health staff and government officials, while the other two activities were for people affected directly by the mass violence situation. The following four paragraphs explain broadly the four participant observations. For further details on each observation see Appendix D.

My first observation period was a 3-day workshop organised by the Centre. "Guidelines for helping and supporting IQ and EQ² for pre-school children and childhood" was held on May 6–8, 2014. This workshop was developed because the National Statistical Office had found that children in Pattani province had a very low IQ and EQ level compared with the rest of Thailand, possibly as a result of the mass violence situation. This workshop aimed to explain IQ and EQ and how to develop the IQ and EQ of

² IQ means intellectual intelligence and EQ means emotional intelligence

children from 6 to 11 years old. The workshop attendees were teachers, parents, and staff of the Sub-District Health Promotion Hospital in Pattani province.

The second observation period was Centre 12's workshop, "Developing a clinical prototype for treating mental health of people affected by the crisis", on May 19–20, 2014 at CS Pattani hotel. Attendees included public health officers, local government officers, religious leaders, and community leaders of the three areas (one district in each of the three provinces). This workshop aimed to disseminate and invite feedback on the, "clinical prototype", which Centre 12 had developed and wanted to apply in the selected areas.

The third observation period was a workshop organised by the partner spiritual development group. "The potential development of volunteering women" workshop was launched on May 29, 2014 at the meeting room in Prince of Songkhla University. The workshop attendees had been widowed as a result of the violence. This workshop aimed to share the experiences of widows who had overcome the crisis in their lives.

The last observation period was on June 3, 2014. I was invited to a meeting in the Khao Tum Sub-District, located on the border between the Pattani and Yala provinces. This area was subjected to a high percentage of violent incidents, and government officials and citizens were keen to launch a mental health rehabilitation programme for children. As a result, they invited the two representatives from the spiritual development group to design a programme.

3.5.2.4 Recording observations

Lincoln and Guba (1985) described various modes of data recording such as field notes or diaries, context maps, entries according to some taxonomy or category system, rating scales, and checklists. This study selected field notes as the major way to collect data, as they were the easiest way to expand an idea when observing (Lincoln and Guba, 1985). This method is especially useful when observing activities about which the researcher knew very little, compared with other methods that need greater preparation and prior knowledge before observing.

Details that should be recorded in the field notes include basic information such as where the observation took place, who was present, what the physical setting was like, what social interaction occurred, and what activities took place (Patton, 2002). Such

descriptive information, Patton said, helps the observer later recall an observation during analysis. Furthermore, field notes should also contain direct quotations or a summary of what was said during observed activities. Quotations provide the insider perspective. Third, field notes also contain the observer's own experiences, which are part of the data. Finally, field notes should include any insight that occurs to the observer while in the field, as this will help shape analysis.

My field notes contain descriptions of what was being experienced and observed, quotations from the people observed, my feelings and reactions to what was observed, and field-generated insights and interpretations. A sample from May 6, 2014 and May 19, 2014 observations is presented as Appendix E.

3.5.3 Document analysis and collateral description

In addition to data collected from human sources through interviewing and participant observation, this study also used data from documents and media produced by Centre 12 in responding to the mass violence situation. Documents and other written materials were collected from the Centre's official website, four annual reports, and five training manuals. Those documents were used for answering RQ 1. The documents also allowed for cross-checking with the interview data to further explain mental health communication programmes launched in the 10 years of the on-going crisis. Five booklets using religious principles in mental health healing and rehabilitation were chosen for analysis as they were recommended by most of the Centre's staff as outstanding media. The analysis of these booklets was then used to answer RQ 2 and RQ 3, which cover the planning and implementation of mental health communication programmes.

Yin (2009) emphasised four strengths of using document analysis as part of a case study: stability; unobtrusiveness; providing the exact name, reference, and detail of an event; and broad coverage. Documents are most important in case study research as they support or analyse the evidence from other sources. Consequently, I used documents from Centre 12's website and annual reports to verify the correct spelling, title or names of any organisation recorded in the interviews, and read annual reports before interviews and observations. This was useful to see whether the evidence from the variety of sources was consistent or contradictory and allowed me to ask additional questions or observe more specific practice points.

Documents are “constructed in particular contexts, by particular people, with particular purposes, and with consequences—intended and unintended” (Mason, 2002, p. 110). I was guided by Mason in the analysis of the five booklets, exploring why and how these documents “were prepared, made, or displayed, by whom, for whom, under what conditions, according to what rules and conventions, and what they have been used for, whether they have been kept and so on” (Mason, 2002, p. 110).

The five booklets are religious-based media supporting the mental health communication programme, *Healing according to Buddhist and Muslim Principles*. Among these five booklets, two were produced for Muslims (*How to respond when we are tested* and *Mental rehabilitation by Du-a [praying]*) and three were produced for Buddhists: *Self-awareness and mental treatment*, *Rehabilitating ourselves*, and *Rehabilitating other people*. Further details and pictures of these five booklets are presented in Appendix F.

There are, however, limitations in undertaking document analysis. According to Mason (2002), “documents may be more or less detailed and comprehensive, they may or may not be authentic and genuine (what they purport to be), reliable, accurate, and so on. They may or may not be readily identifiable and available” (p. 110). I was concerned about this limitation and was also apprehensive about over-relying on documents, most of which were official materials and annual reports. The documents were useful to confirm and provide more information in support of the interviews, and were carefully compared with interviews to help investigate how closely official reporting matched the views of those undertaking the activities

3.6 Document analysis and collateral description

Review of the draft report by those who have participated in the study is an essential way to improve the quality of case studies and to ensure their validity: “From a methodology standpoint, the corrections made through this process will enhance the accuracy of the case study, hence increasing the *construct validity* of the study” (Yin, 2009, p.183). This process can be used to confirm important facts, identify any disagreements, and as an opportunity to search for further evidence. Furthermore, the review could also provide more information that the participants might not have recalled during the initial data collection period.

In this study, participants reviewed the draft findings when I returned to Thailand. On April 27, 2016, I went to Songkhla Rajanagarindra Psychiatric Hospital where Centre 12 conducted its monthly meeting. (See Appendix L for the summary sheet I provided for the attendees). The Director and eight of the original participants, along with ten other people, mainly public health officers, and administrative and financial staff of the Centre, attended my briefing. The session lasted from 9 am to 10 am.

The Director talked briefly about my study and her interest in the evaluation of the Centre's manuals and books. I then introduced myself and explained how the study's focus had changed from the original focus on media to the Centre's overall practices and identified this study as a case study. I summarised the total number of participants and data collection methods, emphasising that this review meeting was important to enhance the accuracy of the findings. I talked through the findings slowly and the attendees gave feedback as I went along. There were two sections of my presentation: contextual findings and the Centre's practices in mental health communication programmes. For the first section, I used a timeline of mental health service delivery between 2004 and 2014, which I had mapped out. After looking at the timeline, the Director said there was an error about the years in which the Centre worked on behalf of the Rehabilitation Sub-Committee. Furthermore, the Director and staff also said that in the last phase of the Centre's practice, they were not only working with the four groups aligned to the developmental stages of life, but also worked specifically with complicated cases, such as people who were suspected to be the terrorists and those with disabilities.

In the second section about the Centre's practices and mental health communication programmes, I presented the participants' perceptions of their work and the mental health communication programme cycle (planning, implementation, and evaluation). The Director and staff discussed the radio programming they had commissioned and confirmed they did not participate in selecting actual content of the programme. The participants also agreed with my findings that the communication programme evaluation process was challenging for them and they wanted to know more about my recommendation for programme evaluation methods. The meeting ended with discussion of effective practices as perceived by the participants. The participants agreed with the findings in this section, especially about the role of the Director as one of the success factors. At the end of the meeting, the Director said this case study was

different from the other studies that had mostly focused on communication in the post-conflict stage.

3.7 Conclusion

This study uses the qualitative case study approach, which provides a wealth of detailed material so as to encourage understanding of human experience and social context. This chapter covers planning and research in practice. Ethical considerations applied during fieldwork were unpacked. During 2 months of data collection, 12 participants from the 12th Mental Health Centre and five partner group representatives were involved in three methods of data collection. Interview and observation data collected from these participants and from documents provided by Centre 12 form the basis of my analysis of the mental health communication programmes. The following chapter presents the findings on the 12th Mental Health Centre's practices of mental health service delivery and mental health communication programmes in response to the mass violence crisis in southern Thailand from 2004 to 2014.

CHAPTER FOUR: POLICY IMPACT ON MENTAL HEALTH COMMUNICATION PROGRAMMES

4.1 Introduction

This chapter aims to answer the first research question (RQ 1): “In what way did Thai government policies impact on the establishment, funding, and delivery of mental health communication programmes during the mass violence situation in southern Thailand?” The chapter initially provides a framework of mental health service delivery in two circumstances: the normal Thai situation, and the mass violence situation. The chapter describes the changing structures and functions of government agencies set up in response to mental health issues. The focus then turns to identify the 12th Mental Health Centre’s (the site of this study) development and roles as the centre of the mental health communication programme delivery. The section concludes with a summative timeline of mental health delivery across the 10 years studied.

The chapter presents material from interviews with the Director of the 12th Mental Health Centre, 11 of the Centre’s staff who participated in mental health communication programmes between 2004 and 2014. Additional data come from Centre 12’s 2012 annual report, along with documentation from websites of the 12th Mental Health Centre, National Statistical Office of Thailand, Pattani Provincial Health Office, Songkhlarajanagarindra Psychiatric Hospital, Southern Border Provinces Administration Centre, and Suansaranrom Psychiatric Hospital. Further confirmatory material was obtained from a journal article by the Centre 12’s Director on mental health therapy for people affected by the unrest in the study area (Tohmeena, 2013).

The key informants in this study were 12 Mental Health Centre staff members, including the Director. As explained in 3.5.1.1, although all staff members gave permission for their names to appear in the report, this study omits individual names, except for the Centre 12’s Director and an academic partner representative. Participants are referred to by numbers which reflect the interview order.

The demographics and work experiences of the informants are summarised in Table 4.1. This information is important because participants’ understanding of the area’s cultural and religious context will influence their perceptions of working in the area and how

they communicate about mental health issues. Where appropriate, the participants' demographics and work experiences are also provided to contextualise interview comments.

Table 4.1 The Centre 12 Director and staff members' demographics and work experiences

Staff No	Educational background			Home town		Religious		Work experience			Notes
	Psychology	Public Health and nurse	Social work	In	Out	Islam	Buddhist	1-3 years	4-10 years	More than 10 years	
1	✓			✓			✓			✓	Worked since 1987 at Songkhla province where the Centre 12 was originally located and still works there until now.
2			✓		✓		✓	✓			Said this work is similar to her previous work especially focus on people who are affected by the crisis.
3			✓		✓	✓			✓		Hometown is out of the mass violence area but lived here since 13 years old.
4	✓			✓		✓		✓			Has worked at the provincial hospital since 2007.
5		✓			✓	✓		2 months			Passed the exam and this area is near her hometown.
6		✓		✓		✓		✓			Has experience working in the other Mental Health Centres.
7	✓				✓	✓			✓		Has worked since the Centre was set up.
8	✓			✓		✓			✓		Has worked in the hospital and moved to Centre 12 in 2007.
9		✓			✓		✓			✓	Has more than ten years of work experience including the other Mental Health Centres outside the crisis area.
10	✓				✓		✓	✓			Previously worked in another Mental Health Centre (outside the crisis area). Passed the exam and has only studied in this province.
11	✓			✓		✓		✓			Worked in the hospital before working in the Centre 12.
The Director		✓		✓		✓				✓	Graduated in Bachelor of Science, Doctor of Medicine, and Community Mental Health. Was only one Director of the 15 th Mental Health Centre, (then renamed as the Centre 12 in 2013), for 10 years.
Total	6	4	2	6	6	8	4	6	3	3	

Half of the staff members are trained psychologists – four are counselling psychologists and two clinical psychologists. Four other staff members, including the Director, graduated in public health and nursing, or policy and social planning. The last two staff members graduated in social work. The Centre staff's hometowns are evenly spread: six were born in the three southern border provinces and the other six came from outside the area; however, in the southern provinces all except one staff member came from the eastern province of Thailand. Five staff members whose hometowns are out of the violence area have chosen to work at Centre 12 because it was near their hometowns and two of them have only ever lived or studied in this area. Eight of the participants, including the Director, are Muslims and four are Buddhists.

There is a range of experience present in the staff members. At the time of the study, six have worked with Centre 12 for between 1 and 3 years (during the new system following the restructuring of the Department of Mental Health in 2011); the Director and three staff for 8–9 years, and two staff have worked more than 10 years. These different levels of work experience are likely to influence informants' reflections about the Centre's practices, and their perceptions of designing and delivering mental health communication programmes.

4.2 Policies underpinning the mental health communication programmes

After the mass violence began in 2004, the Thai government set up many organisations focused on solving the southern problem. This study focuses only on organisations relevant to mental health delivery in response to the crisis situation. This section briefly provides the background and context of mental health service delivery in Thailand and presents the changing structure of mental health service delivery in response to the mass violence situation. It then examines more specifically responses at the government policy level and the practitioner level.

4.2.1 Thailand's mental health services' responses to the mass violence

Public health services in Thailand come under the jurisdiction of the Ministry of Public Health (MOPH), which generally sets the policy for delivery of the budgets and services to 11 agencies, one of which is the Department of Mental Health. Mental health service delivery in Thailand initially developed in 1889 as the Hospital for Psychiatric Patients

in Bangkok. Thirty years later, the other four regional psychiatric hospitals were established. These hospitals also expanded their functions gradually from mental health treatment to mental health promotion, mental health prevention, and community medicine (Department of Mental Health, 2015). In the southern region, the Suan Saranrom Psychiatric Hospital, constructed in 1936, was responsible for psychiatric patients in 14 provinces in the south (Suansaranrom Psychiatric Hospital, 2014).

In 1956, the second Psychiatric Hospital, Songkhlara Nagarindra, was established in the south. Its objectives were not only to provide mental health treatment, prevent mental health issues, and promote mental health, but also to educate and disseminate mental health knowledge to the public health practitioners. This is borne out in the vision statement laid out on the hospital's official website:

To expand medical services and Neurological disorder diagnosis for people in the southern region. Moreover, the hospital was established to provide training and seminars to physicians, nurses, and related personnel so that they can use this beneficial knowledge to treat and prevent people from having chronic diseases, or becoming disabled. (Songkhlara Nagarindra Psychiatric Hospital, 2014)

Songkhlara Nagarindra Psychiatric Hospital's additional role in responding to the mass violence crisis will be described later in 4.2.3.

In 1993 the Department of Mental Health further decentralised its responsibilities through 15 geographic zones termed "Mental Health Centres". In the southern zone, there are two Centres: the 11th Mental Health Centre, serving seven provinces in the upper south, and the 12th Mental Health Centre, the subject of this study, serving seven provinces in the lower south including the three southern border provinces – Pattani, Yala, and Narathiwat – where mass violence occurs. Centre 12's history and functions are described in 4.3.

The eruption of violence in 2004 led to the direct involvement of the Prime Minister in policy making and the subsequent development of the Policymaking Committee on Rehabilitation for People Affected by a Series of Southern Violence (from 2005 to 2010), which reported directly to the Prime Minister. Additionally, as will be seen later,

the Department of Mental Health (through the person of the Director General) also helped shape the delivery of mental health programmes responding to the crisis.

Figure 1 shows the structure of the mental health healing and rehabilitation system set up to support delivery process during 2004–2014. It identifies two levels – the government policy level and the practitioner level. While the policy level mainly focuses on strategic planning and budgets, those involved at the practitioner level are directly working with people in the area who are affected by mass violence.

4.2.2 Responses at the government policy level

Figure 1 shows two main reporting lines at the government policy level: organisations reporting directly to the Prime Minister and organisations based under the Ministry of Public Health.

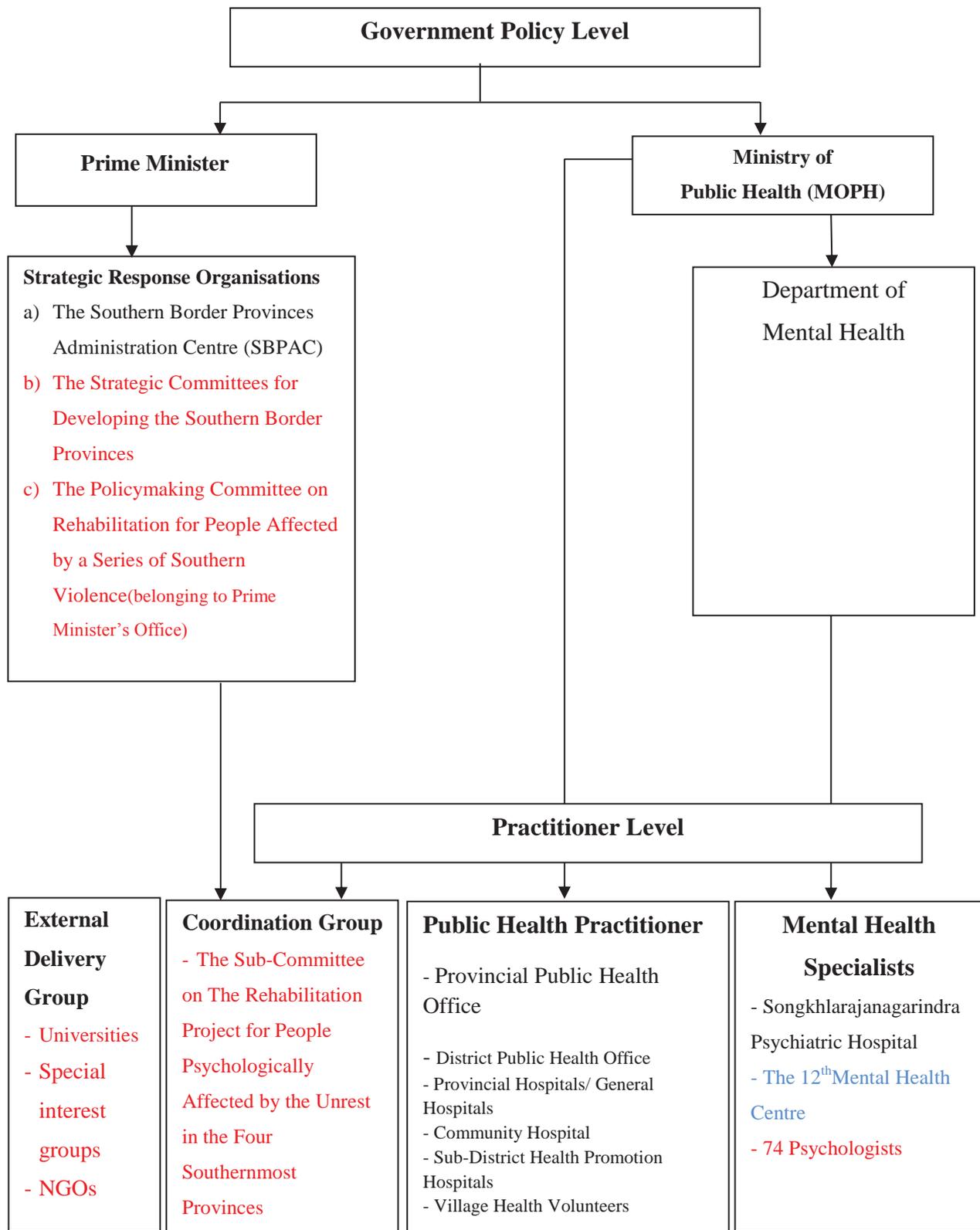


Figure 3.1 Mental health service delivery responding to mass violence crisis in southern Thailand³

³ Black refers to the earlier structures, red refers to the new structures that were set up in response to the mass violence situation, and blue refers to the site of this study

Three strategic response organisations work under the Prime Minister. First, the Southern Border Provinces Administration Centre (SBPAC), established in 1981, was responsible for economic and social development in the southern border provinces. As these provinces are located far from the capital, Bangkok, and local people have a different religion, language, and culture from the rest of Thailand, the Thai government set up SBPAC as a special development organisation.

SBPAC was abolished in 2002 due to a change of national policy but was re-established in 2006 after 2 years of mass violence. The major role of SBPAC from 2006 was to integrate working plans and projects, and provide budgets for all developmental organisations in the southern border provinces. The Administration Centre's strategic development focuses on understanding the way of life and cultures, and in particular building peace in the area (SBPAC, 2014).

The second policy level organisation, The Strategic Committee for Developing the Southern Border Provinces, was appointed in 2010. The Committee has 36 members, including the Prime Minister as chairperson: 30 members from the government sector; and five members from the civic sector. The committee's role is to consider and approve working plans, projects, and budgets to support the development of the three southern border provinces. Additionally, these committees also approve the strategic plans presented by the Administration Centre and identify the most effective development practices (SBPAC, 2014).

The Policymaking Committee on Rehabilitation for People Affected by a Series of Southern Violence, the third organisation, was appointed in 2006 specifically to deal with people affected by the mass violence. The committee enacts its policies through a series of sub-committees (Prime Minister's Office, 2008). This thesis is concerned with the sub-committee working on mental health issues, that is, the Sub-Committee on The Rehabilitation Project for People Psychologically Affected by the Unrest in the Three Southernmost Provinces. For brevity this will be termed the Rehabilitation Sub-Committee.

A second line of reporting at the policy level is under the control of the Ministry of Public Health (MOPH), which is the core of the Thai public health system (see Figure 1). MOPH plays the major role in managing Thai health care and formulating national health policies (MOPH, 2002). In particular, the Department of Mental Health (DMH)

(one of seven departments under the monitoring of the Ministry of Public Health) takes direct responsibility for mental health promotion and prevention, therapy and rehabilitation of mental health problems responding to the mass violence crisis.

4.2.3 Responses at the practitioner level

As shown in Figure 1, there are four groups of mental health deliverers at the practitioner level: the External Delivery group, the Coordination group (working together on crisis mental health response), Public Health Practitioners, and Mental Health Specialists. Table 4.2 briefly identifies the main role of each group.

Table 4.2 *Four Groups of Mental Health Deliverers*

Mental health deliverers at the practitioner level	Group's characteristics and main role
External Delivery	<ul style="list-style-type: none"> - various organisations outside the public health service (such as universities, special interest groups, and NGOs) - variety of funding source - main role is supporting information and knowledge for public health practitioners (see also 5.3)
Coordination group	<p>The Rehabilitation Sub-Committee (see details in 4.3.1)</p> <ul style="list-style-type: none"> - members from government and civic sectors - report to the Policymaking Committee
Public Health Practitioners	<ul style="list-style-type: none"> - operate under the Ministry of Public Health - core of local healthcare system and deal with both physical and psychological patients - work directly with community hospitals and provincial hospitals - take responsibility for the Village Health Volunteers
Mental Health Specialists	<ul style="list-style-type: none"> - work under the jurisdiction of the Department of Mental Health - includes Songkharajanagarindra Psychiatric Hospital and the 12th Mental Health Centre - produce and provide mental health media and collateral - disseminate mental health knowledge and interventions - advise on severe cases

4.3 Background of mental health centre 12: History and development

The 12th Mental Health Centre was specifically set up to support mental health healing and rehabilitation during the crisis. It is part of the Department of Mental Health within the Ministry of Public Health. In 1993, there were four centres covering all of Thailand but their responsibilities were too widespread to function efficiently (Mental Health Centre 2, 2015). As a result, the Department of Mental Health set up nine more centres in 1999 and then in 2004 added Centre 15 in response to the crisis. This study focuses on the 15th Mental Health Centre (in 2013 renamed the 12th Mental Health Centre, which is how it is referred to throughout this thesis). The 15th Mental Health Centre was officially established in December 27, 2004. Its area of responsibility covered four provinces: Pattani, Yala, Narathiwat, Satun, and four districts in Songkha province: Chana, Thepha, Sabayoi, and Nathawi (Mental Health Centre 12, n.d.).

The Director General of the Department of Mental Health, Somchai Chakrabhand, M.L.,⁴ was a key mover in setting up Centre 15. Within 10 months of the outbreak of mass violence, he proposed the idea of a mental health centre specifically to help people affected by the violence. He then appointed Pechdau Tohmeena, M.D. as the Director in December 2004. Additionally, M.L. Somchai also proposed hiring 74 full time psychologists to work in every hospital in the three southern provinces of Thailand. According to the Centre's Director, this policy allowed rapid progress in mental health action in responding to the mass violence crisis:

Since we started to work in this area, M.L. Somchai has supported our progress. He has suggested the Pyramid Model...people who are directly affected by the violence are in the top part, at-risk groups such as the families of affected people, government officers such as teachers, police, and soldiers are in the middle part, general people are on the bottom of the pyramid. Our work focused on the specific targets at the top part... now our mental health treatment is systematic because every hospital in the three southern border provinces had a psychologist. (Pechdau Tohmeena, Interview, June 4, 2014)

⁴M.L.: Mom-Luang in Thai (<http://www.royin.go.th/th/knowledge/detail.php?ID=996>), which means great-great-grandchild of a king. Thai tradition normally places such acknowledgement in front of the name: M.L. Somchai Chakrabhand

A staff member who has worked in the Centre since it was established explained the benefit of having psychologists on the ground:

When the violence incidents occur, we do not go to the community immediately. The 74 psychologists who have been hired in each hospital will go to the cases. These psychologists are ready to help people in their area. The Centre's staff will go to help only the severe cases or when the psychologists cannot work due to safety reason. (Staff no. 7, Interview, May 26, 2014)

The Centre's role is therefore largely as a background support for practitioners (both within and outside the public health service). This is borne out in the vision statement of the Mental Health Centre as laid out in the annual report of 2012:

The 15th Mental Health Centre is an academic center of the General Region 8 for promoting, protecting, and developing community mental health for enhancing the mental health of people. (Mental Health Centre 15, 2012)

To achieve this vision, three missions were identified:

- 1) Develop the potential of networks both inside and outside the public health system in community mental health services
- 2) Develop knowledge about community mental health promotion and the prevention of mental illness
- 3) Provide knowledge about mental health promotion and the prevention of mental illness in the community (Ibid, p. 2)

The three missions show Centre 12's focus on promoting mental health and training the people who deliver mental health services. Interviews indicated the Centre's staff understood knowledge provision as their major role. Five staff out of eleven mentioned that as the Centre is an academic support organisation, their responsibility is to develop and disseminate mental health knowledge. Four staff considered they worked in mental health promotion and prevention, while the other two staff members explained their responsibility was to oversee mental health projects and activities. The Centre's overall responsibility was neatly summarised by a senior staff member:

...we are an academic supporter which has two major roles: 1) developing mental health knowledge and disseminating the necessary interventions such as new technologies and 2) supervising, following, and evaluating mental health operation of the hospitals in the south. (Staff no. 1, Interview, May19, 2014)

Even though the official vision and missions do not specifically mention the Centre's role in responding to the mass violence, all the staff at the Centre agreed with the statement by a long-serving staff member (Staff no.7) that:

Launching mental health programmes for people in the three southern border provinces is important part of our work since the centre started to operate. (Interview, May 26, 2014)

Centre 12's relocation in late 2007 is further evidence that the Thai government has prioritised the mass violence situation:

In 2004 the Department of Mental Health discussed setting up an office for taking care of mental health of people in the three southern border provinces. Then, they appointed me to be the director. I started working in early 2005...Our office was initially located at Songkhla province for two years but I thought Songkhla was too far away. We needed to move to somewhere from which it was easy to access the crisis area. So, we moved to stay here in Pattani province for seven years now. (Pechdau Tohmeena, pers. comm., June 4, 2014).

However, significant change for the Centre occurred in 2013 when the Department of Mental Health responded to the restructuring of the Ministry of Public Health. At this stage, the 15th Mental Health Centre was disestablished and merged with the 12th Mental Health Centre. Moreover, the new Centre expanded its area of work from four to seven provinces (covering Trang, Pattalung, Satun, Songkhla, Pattani, Yala, and Narathiwat) under the same director (Mental Health Centre 12, n.d.)

Dr Tohmeena, the Director, summarised the central mission of the new Centre:

Our Centre's working processes are the same as all the other Centres which focus on mental health promotion and prevention; however, in the three southern provinces we have an additional focus on mental health healing and rehabilitation for people affected by the mass violence.

4.3.1 Coordination with the Rehabilitation Sub-Committee from 2005 to 2010

After the outbreak of violence, the Thai government acted swiftly to appoint the Policymaking Committee on Rehabilitation on May 3, 2005. The Rehabilitation Sub-Committee was appointed on July 20, 2005 as the practitioner level response in the crisis area (Tohmeena, 2013).

To ensure greater representation, the Sub-Committee appointees came from various parts of society such as health professionals, religious representatives, academics, and non-government organisations; however, the Sub-Committee works under the supervision of the Prime Minister's Office. The Director of Mental Health Centre 12 was appointed as both a committee member and secretary. She said this close relationship was seen as an advantage in the delivery process from the outset because the Sub-Committee was both flexible and fast working:

We received funding and all supporting systems such as human resources thus our work went fast in the first few years. It was a new issue while the main authorities in the country became involved and gave advice, we could see our work more clearly. (Pechdau Tohmeena, Interview, June 4, 2014)

Additionally, the Director also noted that the Sub-Committee has worked for the three broad target groups in the initial stage of mental rehabilitation and healing: 1) people directly affected by violence; 2), groups of people at risk, such as families of people who are affected by the crisis, e.g. teachers, government officers, policemen, and soldiers; and 3) people in general.

After gaining more experience in mental health rehabilitation in response to the crisis, the Sub-Committee narrowed their targets to seven specific groups: women affected by the violence, especially widows; children; those with disabilities; channels of public communication; severe and complicated cases; opponents of the Thai government; and

people acting as liaison between the government sector and NGOs. Each group set up their own committees and wrote their action plans and budget proposals. They met regularly to report on outcomes of their activities and to share their experiences from the field with the whole group.

A member of the Rehabilitation Sub-Committee representing the civic sector, who works with several target group committees, explained:

Previously, mental health programmes originated from the Sub-Committee on Rehabilitation which received its budgets directly from the Prime Minister's Office. Members of the Sub-Committee also included people in the civic sector. At the beginning, we were a big group and our work covered all issues. However, after we worked for a while we divided our targets into the seven groups. (Partner group, No. 2, Interview, 3 June 2014)

Most interview participants described their satisfaction with the seven working groups, especially in the successful outcomes. For instance, Centre 12's Director mentioned the large number of NGOs who worked on mental health issues:

The working group of people who liaised between the government sector and the NGOs brought together about 100 NGOs who have worked on mental health in our area. Some people represented groups outside our province, some are insiders, some people come from the capital [Bangkok], and some come from abroad. In the beginning, many people got together to help in healing those in the crisis situation. (Interview, June 4, 2014)

In another example, a long-term staff member described the working processes of the women's group:

Previously, from 2005 to 2012, we had many groups working together both government and private sectors in the Sub-Committee on Rehabilitation. Our director was the principal of the women's group. We identified the number of women affected by mass violence, how they were affected, and their occupations. We invited staff from 33 hospitals and asked them about the situation of women and especially how they wanted to be supported. (Staff no. 7, pers. comm., May 26, 2014)

The overall operation report of the Sub-Committee on Rehabilitation between 2005 and 2006 (Mental Health Centre 15, 2006) summarised six programmes achieved in the first 2 years of the violence: producing mental health media; developing staff potential; providing mental support and healing services; developing and supporting networks; treating children and widows affected by the unrest; and supporting mental health treatment practice (such as psychological first aid).

4.3.2 Changes after 2010

The seven working groups operated until the end of 2010. Following the election of Prime Minister Yingluck Shinawatra in August 2011, the Ministry of Public Health was reformed. This restructuring affected the Department of Mental Health in terms of budget and work procedures. Originally, the budget for developing the three southern border provinces went from the Policymaking Committee to the Southern Border Provinces Administrative Center (SBPAC) (see Figure 1). After 2010, SBPAC became the main organisation to deal with the crisis and provide budgets for rehabilitation and treatment in southern Thailand. The Rehabilitation Sub-Committee was disestablished and the budget for mental health programmes was reduced. A long-term staff member said:

The Sub-Committee later had a problem due to changing the Prime Minister and the changing policy. However, despite the reduced budget, the Centre has continued to develop new programmes because we wanted to develop the rehabilitation system. (Staff No. 3, pers. comm., May 20, 2014)

Since 2010, the mental health policy of the Department of Mental Health has changed to focus on four groups aligned to the developmental stages of life: children, teenagers, adults, and elderly people, instead of the former seven target groups. However, the six staff working with the Centre for more than 2 years agreed that the seven target groups approach was actually more effective in the crisis context because it involved stronger relationships with support groups. As one explained:

Previously our activities were vigorous in the seven work groups. Each group had the leader and they will come to meet and report about their work progress every month. It was an effective process because we were concerned about context area. However, now our work mostly followed the policy, which did not focus on considering the particular context of this area. (Staff no. 7, pers. comm., May 26, 2014)

The impacts of these changes on the communication programme delivery are explained in section 4.5.3. Figure 4.2 summarises the development of mental health service delivery responses from 2004 to 2014. The upper part of the timeline shows the government policy on mental health issues and the lower part of the timeline focuses on the 12th Mental Health Centre's development and events relevant to the Centre's operation.

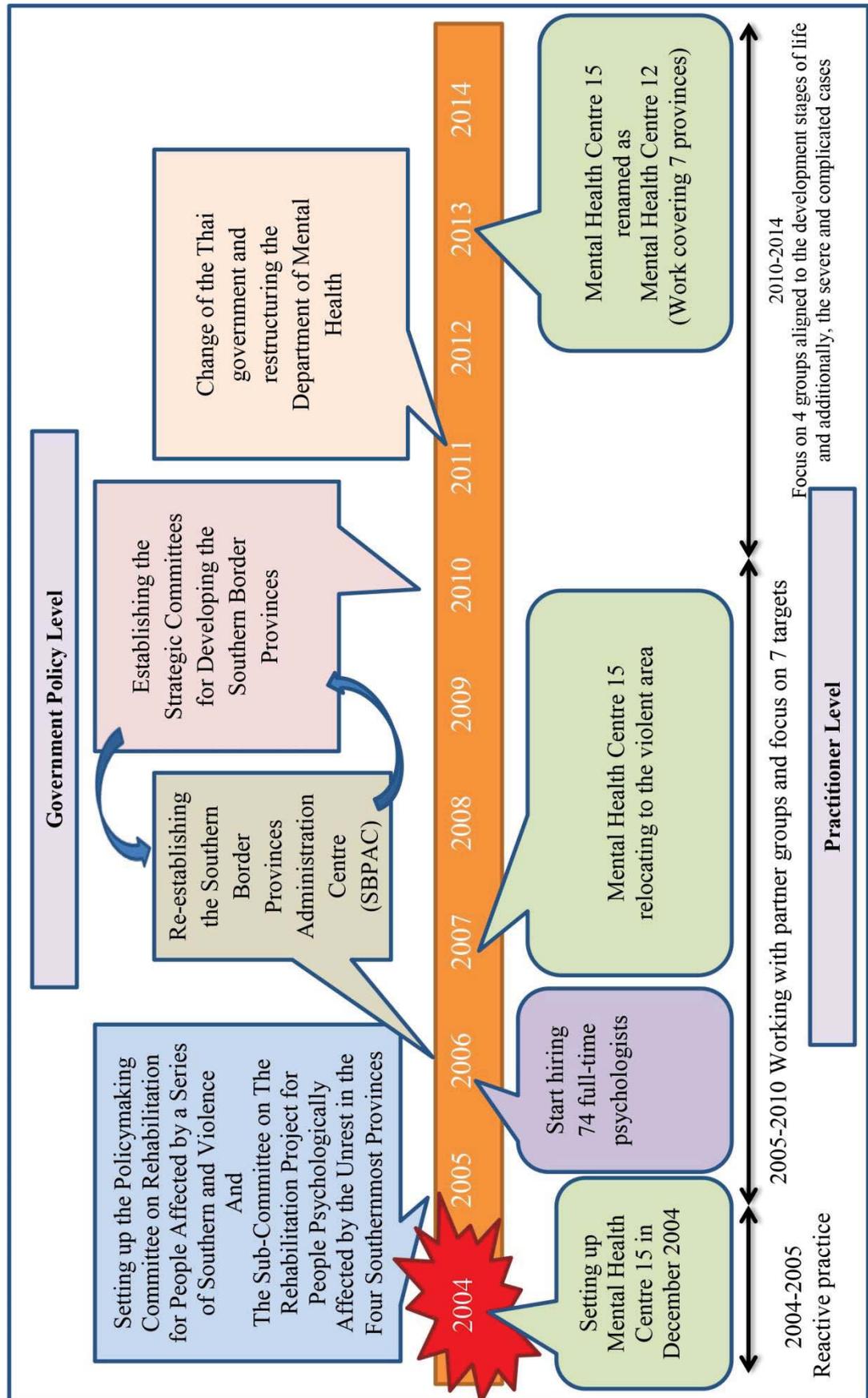


Figure 4.2 The Development of Mental Health Service Delivery Responses from 2004 to 2014.

4.4 Centre staff perceptions of the impact of the violence on their work

As shown in Table 4.1, although the eleven Centre staff have varying lengths of work experience, most have worked only at Centre 12, with just three working in other mental health centres. However, participants said they often met with staff from other centres at Department of Mental Health meetings and workshops. Interviews aimed to explore the participants' perceptions of how the context of mass violence affects their work. Most of the participants explained that while working at Centre 12 has some similarities with other mental health centres in Thailand, as all centres have to meet mental health policy goals, they have an additional focus responding to the mass violence. This difference is particularly related to the number of programmes:

In general, our programmes were based on the Department of Mental Health's policy... Specifically, our centre launched more activities than the other centres because we are in the special area so we have to work on mental rehabilitation. Apart from the routine jobs, we have to add programmes responding to the crisis situation. (Staff no. 5)

The growing number of programmes placed pressure on staff:

We have quite a lot of staff, but looking at our work load, when we added healing programmes, sometimes this was not enough. While launching this programme, another programme or activity has to operate at the same time. It was hard to share responsibility. (Staff no. 6)

However, the participant quickly added, “*However, it did not happen every time, sometimes we could share the staff and it was enough, it just depended on the period of time*”. It is worth noting that as interviews were conducted in the work place, the participants may be cautious of criticising the organisation. This limitation was discussed earlier in Chapter 3 (3.5.1.4) and is also in conclusions.

Differences between Centre 12 and other centres also included programme content, with Centre 12 emphasising healing aspects. One of three staff members experienced in working both inside and outside the crisis area said:

Compared to another Centre such as ...XXX... province [name is withheld for ethical reasons] outside the mass violence area, there are a lot of differences. The other Centres will not work on mental health healing. They have launched campaigns for educating about mental health for people in general and organisations which focused on mental health in daily life. For instance, the relationship between parents and their children, the staff will educate about the difference of ages and how to adjust for living. Here, because of the mass violence crisis we will focus on mental health healing, mental rehabilitation and resilience. (Staff no. 10)

Half the participants gave examples of programmes and activities in which they have participated at Centre 12. Some talked about general communication programmes they have rolled out following Mental Health Department policy, such as programmes for understanding and preventing mental health problems like stress, anxiety, depression, and post-traumatic stress disorder. Others referred to the area-based programmes related to the mass violence, such as rehabilitation programmes where they provided consulting, mental health screening, and assessment specifically for people affected by the mass violence in their communities.

A long-term staff member confirmed community-based services, especially home visiting, were a key part of Centre 12's practice:

The other Centres undertook less home visiting...they would not visit case by case. It was opposite to our Centre, we thought home visiting was our responsibility because we got deeper information especially each particular case's problem as we knew their context. (Staff no. 3)

Staff also said their activities have increased and they perceived their services to be different from other Centres, mostly providing community-based services rather than psychiatric treatment. Furthermore, mental health healing and rehabilitation is the main focus rather than general mental health promotion and prevention:

We mostly work on rehabilitation. Target audiences were widows, orphans, and sometimes government officers affected by the violence. We also visit some cases who have complained to the National Human Rights Commission. If the affected people think the government should have done more to rehabilitate them, they can ask for more support from the Commission. We [the Centre staff] will visit the Commission, ask for information and help to solve their problems. (Staff no. 10)

An experienced staff member clarified how her expectations of roles and staff members' relationships have changed due to the mass violence:

There are a lot differences between working in the mass violence area and the normal area especially the personnel's motivations. The first important thing is 'heart'. Working here you need to adjust your heart, be ready to sacrifice and walk with fear. In the normal area, we followed the Department's policies and plans. There were few barriers, rarely solving unexpected problems. In this area we have to prepare ourselves to be ready in every situation. More importantly, we need to look after our staff in the same organisation. (Staff no. 9)

Similarly, two participants fairly new to the Centre, emphasised “working with heart and high patience” (Staff no 5 and 6) when they discussed their experiences of home visiting. They reported having to go several times until they were trusted by people affected by the violence. However, it is not easy to overcome the feeling of fear. Four participants said they lived and worked with fear. One junior staff member expressed their inner conflict:

One obstacle of working here is safety. When bombings happen, we contact the hospitals to see whether they need help. If they request us to go out at that time, we are scared. We want to help people but we are scared to go by ourselves. If somebody comes and picks us up, we will go. However, if we have to go out by ourselves, we will not dare. I know that working here is working with heart. (Staff no. 8)

In summary, two areas of operation are believed to differentiate Centre 12 from the other centres in Thailand: more healing-based and community-based services, and

a feeling that the mass violence impacts on work circumstances including the expectations of roles and relationships among colleagues. Overcoming fear was shown as an obstacle for at least some of the practitioners who have worked in the crisis area.

4.5 Participants' perception of policy content and its implications for how they work

All Centre staff were asked to recall mental health communication programmes they had launched in response to the violence. The participants' responses to this question provide an initial view of Centre 12's programmes over 10 years of on-going crisis. This information provides background for understanding the programme delivery processes before exploring deeply the effective practices and challenges of delivering mental health communication programmes in section 5.4 and 5.5.

As mentioned earlier, there were similar proportions of Centre staff who worked for 2 or 2 years and more than 3 years. Unsurprisingly, the five staff members working with the Centre more than 3 years provided greater details on their experiences launching mental health communication programmes.

Interview material pointed to four overlapping phases of programme development, influenced by policy shifts over the period 2004–2014: reactive (2004–2005), policy of targeted groups (2005–2010), policy of general age-group targets (2011–2014), and emerging phase of complicated cases (2014). There is some overlap between these four phases. Their relationship to policy changes is summarised in Table 4.3 and discussed in the following sub-sections.

Table 4.3 *The timeline of the four phases of mental health communication programme delivery between 2004 and 2014*

Phase	Programmes' characteristic	Programmes' aims	Programmes' activities
1 2004–2005	Reactive programme	Response to the urgent violence situation	Children's camp workshop
2 2005–2010	Policy of targeted groups	Set the structure of mental health delivery system and merge into the public health service system	<ul style="list-style-type: none"> - working on behalf of the Rehabilitation Sub-Committee which focuses on the seven target groups - training mental health deliverers; the new psychologists, public health officers, mass media, and religious leaders - launching programmes for people directly affected by the mass violence and people in general and at-risk groups
3 2011–2014	Policy of general age-group targets	Maintain mental health delivery system and work following the Department of Mental Health's policy	- Launching programmes that focus on four age groups child, teenager, adult, and elderly
4 2014 on	Emerging phase of severe and complicated cases	The addition of practices aimed at very specific target groups	- launching programmes specifically for the severe and complicated cases

4.5.1 Phase 1: Reactive programme (2004–2005)

In phase 1, the Centre's practices were explained by the Director as "trial and error because we did not have the prototype". This evidence was supported by the staff no.3's interview. She was the only staff member who talked about the Centre's first programme, a children's camp workshop, launched in 2005 (after Centre 12 had moved to Pattani province early in 2005):

We took children both Buddhist and Muslim affected by the violence to Khao-Yai national park out of the crisis area for two weeks. We had ice-breaking activities and provided mental health knowledge through the Department's staff and a religious foundation. (Staff no. 3)

Before a clear vision for a mental health delivery system was defined, Centre 12 ran a reactive programme with tasks responding to the real-time situation. This approach is discussed in the Director's chapter in *Healing under fire: The case of southern Thailand* (2014), where she writes that "In 2004 when the brutal violence erupted, the mental health practitioners based in the South were in no way trained to cope with trauma associated with violent conflict" (p. 62). As the interview above shows, staff began with a children's programme responding to the first violence incident, when 18 schools were burned down in one of the southern border provinces. The Centre identified the people directly affected by the crisis as their first priority; an idea confirmed by all the Centre's staff members when they were asked about the main target group of their early mental health communication programmes.

4.5.2 Phase 2: Policy of targeted groups (2005–2010)

Centre 12's work and communication practices were more structured in the second phase. Two key policy influences in this phase were the Rehabilitation Sub-Committee and the Psychologists Hiring initiative (see Section 4.3). Long-term staff members specifically related their work experiences from 2005 to 2010 to the Rehabilitation Sub-Committee and the seven work groups set up to help the seven target groups: women affected by the violence, especially widows; children; those with disabilities; channels of public communication; severe and complicated cases; opponents of the Thai government; and people acting as liaison between the government sector and NGOs. One participant outlined the targeted process:

we divided into seven sub-groups for helping the seven target audiences. Every group set up their own team and appointed their own principal and members. (Staff no. 7)

This participant explained that initially the work groups focused on “collecting the numbers and information about people affected by the violence and asking about their needs for support”. All the Centre staff who had worked with the Sub-Committee thought this system was effective because it combined a variety of people inside and outside the health sector, and gave Centre staff autonomy to design community-based programmes especially for people directly affected by the violence such as the women’s group:

Our director was the principal. We supported them to set up a women’s club in their villages. For the children’s group, a child psychiatrist was the principal and he focused on mental health healing and building EQ. For the disabilities and channels of public communication groups, Miss..X.. [one of the Centre 12’s partner groups who represented a spiritual development group, name is withheld for ethical reasons] was appointed as a principal. Through those seven work groups, we got deep, insightful information from each group as they and their teams went out home visiting and came back sharing information about the cases they met so we could plan to help. (Staff no. 3)

Although Centre 12 has supported all seven groups, the staff were also assigned as members of the women and children groups. Therefore, their examples referred more to programmes for children and women than other target groups. The Centre’s Director, selected as the principal of the women’s group, explained their working process:

We used a lesson-learned technique. The women would list their problems and the ways they used to solve the problems. When we met them, we asked them to share with the whole group. So, they could learn from their friends’ experiences. Most of the women’s problems were about their sons who might become aggressive after losing their fathers. We would analyze their situation and provide mental health healing knowledge. (The Director)

Staff no7 was a member of the children’s group. She described her first experience of launching a children’s programme in the 2nd phase, which was more strategically

planned. She noted children's programmes were a good start because children's connections could reach parents and even the whole community:

I had a good experience of launching children's summer camp programme during school semester break for 5–6 days. This programme was instituted in 2006. We chose a model community having high level of community participation. In that programme, mothers and many organisations in the community joined us, such as local government officers, religious leaders, schools and child development centres of local administrative organizations. People there told us the programme was good because children could learn more about ethics from teachers in the religious schools and from religious leaders. (Staff no. 7)

This participant was seen by the other staff as the leader when launching community-based programmes. She strongly emphasised community participation as an important factor in sustainable programmes:

The children's camp was mainly organized by the community. There were 120 children combined, those affected and not affected by the violence. Children were taught about morality by the religious leaders and joined mental healing activities. The Centre 12 had a budget of only about \$1000 for 5 days' camp. It was totally not enough. So, the community had to plan and run the programme by themselves. This programme was mainly led by the mothers of children affected by the violence. These women planned to provide food for 5 days. They brought and shared something they had in their families such as coconuts and rice. Further, they rotated to cook for three meals every day. In my opinion, if we let them manage, it will be their own programme and more sustainable than programmes which we set up. We did not live in the community so if we set up a programme for them, it will be instituted only once, not continued. Our Centre will observe and support when requested. For example, people told us that they want to know more about mental screening. So, we have trained the Village Health Volunteers and parents about how to use the mental screening test. (Staff no. 7)

A senior staff member who has worked in an administrative position also agreed the Sub-Committee model was an effective "bottom-up approach" because they had some

autonomy to design community-based programmes that could access people who really needed help, segmenting them into sub-groups such as widows or children in the secondary schools:

We could access the risk groups, people directly affected by the violence and their families. We provided programmes to empower their mental health and using the principle of resilience for helping them to stand again. (Staff no. 9)

The interviews confirm that in the early stage of setting up the rehabilitation system, Centre 12 worked on behalf of the Rehabilitation Sub-Committee. This practice was judged effective because it used the power of networks in collecting data about people affected by the violence. The community-based approach, especially through home visiting, was seen as a way to get more detailed information about the cases. Programmes at this stage were mostly aimed at mental health healing and rehabilitating through interpersonal and face-to-face communication, and the specific target groups identified by the Sub-Committee.

The second way in which policy impacted on Centre 12's programme development in 2005–2010 was finding and training mental health deliverers. As mentioned above (in section 4.3) full-time psychologists were hired to work in every district hospital. Although Centre 12 did not directly pay their salaries (these were paid by the Mental Health Department), these 74 psychologists were perceived as an important tool for Centre 12 in dealing with mental health problems in the mass violence area. The Centre's main responsibility was providing training workshops for the psychologists, as staffer no. 3 explained:

Firstly, this position opened for people in the area who had graduated as clinical psychologists. However, we got only two to three applicants with that qualification. Later, we opened for people who had also graduated as counselling psychologists. They did not have mental health healing knowledge so we had to train them. We provided a lot of workshops for many years. These psychologists worked in the District Rehabilitation Centre which our Director had set up in every district hospital.

Many participants, such as the Centre's Director, proudly talked about training these full-time psychologists. Not only did the training cover all districts, they were also the

largest number of trained psychologists in the country. However, the changing health policy undermined this achievement:

Those 74 psychologists worked under the Department of Mental Health for 5 years. Then, based on the Cabinet resolution, they had to work in the hospitals which belonged to the Ministry of Public Health.... When they worked in these hospitals, their job depended on the assignment of the hospitals' directors and nurses. Mental health rehabilitation was no longer their main job anymore.
(The Director)

Mental health training programmes were also provided by Centre 12 for public health officers, mass media, and religious leaders as these groups were perceived as helpers in delivering mental health messages (or in public relations terms, as intervening publics):

Our training programmes mostly focused on helper groups. It meant we empowered helpers and gave them knowledge, technologies, and tools for using in their areas....We had many programmes. If they were action programmes, we went to the schools and communities. If they were promotion programmes, we focused on how to access mental health consultation channels. We have had a radio programme too. We even launched a workshop for radio deejays educating them about mental health...because people here mostly access radio channels. (Staff no. 9)

We also launched a workshop for religious leaders on mental health treatment. We hoped the religious leaders could use the knowledge for helping people in their area. People here believe in the religious leaders. They expect religious leaders will be experts in mental healing. (Staff no. 3)

However, after 6 years of working on behalf of the Rehabilitation Sub-Committee, Centre 12's practices significantly altered following the election of a new Thai government in 2011. At this stage the target groups were changed from the seven groups to four age groups aligned to the development stages of life: children, teenagers, adults, and elderly. However, it is noted, and will be reported later, that some groups were able to continue when they obtained further support from their communities or other sectors. The next section describes this change in policy and its impact on communication programmes.

4.5.3 Phase 3: Policy of general age-group targets (2011–2014)

Interview material about phase 1 and phase 2 came from the Centre's Director and four staff members who had worked there since the Centre was set up. In the 3rd phase, information largely came from the other six staff members who had worked with the Centre less than 3 years and discussed communication programmes in relation to the Department of Mental Health's policy.

A relatively new staff member explained the Centre's mental health promotion and education programmes this way:

We have launched many programmes. Based on the Department of Mental Health's policy, we distinguished the targets through age groups: children, teenagers, adults, elders. Last year, we launched programmes to promote mental health for students in schools, the elderly, and people in general. We chose different media for different audiences. (Staff no. 2)

Another also thought of promotion and prevention programmes when she was asked to explain her work experience:

For example, on a school open day, we will have a section for teaching students about mental health, providing activities and disseminating our print media. (Staff no. 5)

A further participant also described providing mental health screening, quizzes, and disseminating media at open days.

Besides promoting mental health at school, policy-based programmes for the wider public were mentioned by a staff member who took responsibility for this. She also noted the difficulties of mental health promotion for the general public:

We launched a campaign in Mental Health Week in 1–7 November 2013 at Big C supermarket. Mental health is difficult to explain because it is subjective. So, the activities in that day were providing our print media for education about mental health and staff there to answer questions. (Staff no. 2)

Similarly, a senior professional staff member mentioned problems with the 2013 Mental Health Week campaign, especially with the theme, set at the upper policy level, and the

appropriateness of communication channels, although she clearly enjoyed the campaign activity:

Last year campaign's theme was Happiness Hormone aimed to promote happiness to people at every age. This theme was set by the Department of Mental Health. This innovation might be useful or useless depending on the context of each area. However, it was a short-term campaign. We thought about making radio spot in Yawi language [the spoken language widely used in the three southern provinces of Thailand] but we did not produce this. We just promoted mental health at Big C for the general people. It was fun.
(Staff no. 1)

The interviews show a difference between the longer-term and newer staff. It was apparent that in the early stage of Centre 12's work, mental health rehabilitation programmes were provided specifically for people directly affected by the mass violence. Mental health training programmes for deliverers also developed at the same time. Later, when the rehabilitation system was merged into the public health system, the Centre focused on mental health education and promotion programmes for general targets, becoming more of a delivery service than an initiator of programmes.

However, in a 2016 meeting to verify the initial findings of this study, Centre 12's Director argued that the Centre's works are on-going from phase 2. Although the budgets were decreased, some groups, such as widows and disabilities, were able to continue their activities. More importantly, she emphasised that mental rehabilitation has been integrated into the public health service system allowing local hospitals to take charge. As a result, alongside the general targets in phase 3, the Centre's practice was now focusing more on what she referred to as "the complicated cases".

4.5.4 Phase 4: Emerging phase of severe and complicated cases (2014 on)

Centre 12's Director explained that in the last phase the Centre's programmes have become very focused on "the complicated cases", for instance, specific groups such as orphans and prisoners who have undergone torture. Interview material from two senior staff members also clarified the target audiences:

The complicated cases such as former inmates held on security charges, they were arrested and then released. It was not our duty to judge them, our duty

was to rehabilitate them, their families, and including their communities to build acceptance of them. (Staff no. 9)

The cases which were difficult to manage and care for such as post-traumatic stress disorder occurring with people who live in area of a high rate of violent incidents. (Staff no. 1)

Most of the participants did not specifically talk about this sensitive emerging phase. As a result, interview material was limited. However, further evidence comes from the 2015 annual report, which emphasised that Centre 12's practices are different from the other mental health centres because the Centre rehabilitates people affected by the mass violence including a broad, generally affected group; at risk groups; mentally ill people; and severe and complicated cases. Furthermore, the report also identifies a specific programme – “Programme for Strengthening Mental Health of the Severe and Complicated Cases Affected by the Mass Violence Situation in Southern Thailand”. There are three activities in this programme: two training workshops for developing capacity of public health officers (focused on cognitive behavioural therapy, PTSD, and anger stress), and one workshop about case analysis and family-based treatment.

4.5.5 Concerns and summary of policy implications

Only one participant directly linked changing policy to a downgrading of the Centre's mental health communication programmes. This highly experienced staff member preferred the second targeted group phase because “work focused on community”. In the third phase, these focussed mental health communication programmes were discontinued and new general ones were hard to evaluate:

I thought it [the general programme] was useless. This year we worked on this issue and then next year the policy was changed to the new issue, unless the local community thought it was useful and they have continued by themselves. For us as the staff, we had to work following the policy because we needed to report the output to the Department of Mental Health. (Staff no. 7)

She also insisted phase 2 for the Rehabilitation Sub-Committee was successful because it was on-going and she could see positive changes over this time:

We worked on children's programmes for 5 to 6 years. We could see the changes from those children who have always cried or women who did not talk to became helpers and set up their self-help club. Those widows who had only ever stayed home and did nothing because their husbands looked after them could turn out to be the family leaders. (Staff no. 7)

Another participant did not criticise the policy but tried to explain why Centre 12 changed its focus:

Later, many organisations went in for home visiting, such as the Provincial Public Health Office, the Social Development and Human Security, NGOs. People became tired of answering the same questions so many times. So, the Department of Mental Health said we did not have to go anymore. (Staff no. 3)

4.6 Conclusion

The 12th Mental Health Centre was set up specifically as an academic support organisation. The Centre's major role is using communication strategies and techniques to promote mental health and provide mental health knowledge through home visiting, group meetings, training the deliverers, and producing and disseminating mental health media and collateral. This case study of Centre 12's mental health communication programmes in response to a decade of the mass violence situation in southern Thailand reveals government policy is a key factor in influencing practice. Interviews, participant observation, and document analysis illustrated four interrelated phases of programme development, reflecting policy shifts. They are a reactive programme (2004–2005); policy of targeted groups (2005–2010); policy of general age-group targets (2011–2014); and the emerging phase of “severe and complicated cases” (2014 on).

In the first phase, one year after the violence broke out, the programme mainly responded to the urgent violence situation because the rehabilitation system was just being set up. In the second phase, during 6 years of on-going crisis, the Centre's practices were judged by participants as effective in terms of setting up the delivery system by hiring and training 73 psychologists and merging them into the public health service system. Those psychologists had been sent to work in every hospital in the three southern border provinces. Furthermore, in this second phase, Centre 12 worked on

behalf of the government-appointed Rehabilitation Sub-Committee, which focused on seven target groups. Mental health communication programmes were perceived as effective for several reasons. For instance, working with networks both inside and outside public health sectors, delivering programmes to people who were directly affected by the violence, focusing on mental health healing and rehabilitation rather than psychiatric treatment, a community-based focus (and bottom-up approach), and training mental health deliverers or intervening publics (psychologists, public health practitioners, mass media, teachers, religious leaders, and opinion leaders) to deliver mental health messages.

In the third phase, Centre 12's practice was affected by the new Thai government's policy, especially by the dissolution of the Rehabilitation Sub-Committee. The Centre's communication programmes in general changed to focus on the four age groups (children, teenagers, adult, and the elderly) whom Centre 12 provided with mental health promotion and mental health education. Last, in the fourth phase, Centre 12's activities, while continuing the four age group programmes, were supplemented by a specific focus on 'severe and complicated cases', which were explained as traumatised people in the dangerous area or people who were suspected of being terrorists.

The mass violence context impacted on Centre 12's staff members' work in various ways such as an increasing numbers of mental health communication programmes and workloads, programme contents that emphasised healing aspects and resilience (new knowledge in which they needed to be trained), and the expectations of roles and staff members' courage. Additionally, while the staff mentioned mutual caring and support, it is worth noting here that there was no evidence in the interviews about systematic support for staff and mental health practitioners working in the crisis area who may themselves suffer secondary traumatic stress.

CHAPTER FIVE: MENTAL HEALTH COMMUNICATION PROGRAMME DELIVERY, AND THE SUCCESSES AND CHALLENGES OF CENTRE 12'S PROGRAMME DELIVERY

5.1 Introduction

Chapter Four identified the impact of policies on the establishment, funding, and delivery of Centre 12's mental health communication programme, and reported in detail on the four overlapping phases of programme delivery across the decade. This chapter is related with programme delivery, answering research questions two to five that is, how Centre 12's mental health communication programmes were planned, implemented, evaluated, and relating successes and challenges of Centre 12's programme delivery in the mass violence area.

This chapter draws on interviews with the Director of the 12th Mental Health Centre, eleven of the Centre's staff, and five participant representatives of partner groups. Additional material comes from field notes made by the researcher during participant observation in 2014, seven annual reports from the Mental Health Centre (2005–2006, 2008, 2009, 2012, 2013, 2014, and 2015), and a journal article by Centre 12's Director on mental health therapy for people affected by the unrest in the study area (Tohmeena, 2013).

The chapter begins by identifying the participants' perceptions of the overall communication programme framework, then provides details about programme planning, media/message development, implementation, and evaluation. Next, the major roles and relationships of partner groups involved in communication programme delivery are identified. Last, the chapter illustrates the perceptions of successes and challenges of staff members and the Director in delivering mental health communication programmes, particularly in a context of mass violence.

5.2 Key informants' perceptions of communication programming framework

When interviewed about programme strategies, the Director and staff were asked specifically about the design process, sources, messages, and channels, and whether and how any evaluation was used. They indicated they saw the communication delivery framework as involving four stages: programme planning, media/message design and testing, programme implementation, and programme evaluation. Participants' perceptions of these key stages varied depending on their experiences in various mental health communication programmes.

This subsection draws on case study evidence from a range of sources. As noted in the introduction, a 2005 survey explored the mental health situation of people living in the area of mass violence (Thongphecsri et al., 2005). Although this survey was not mentioned in the interviews, this evidence emerged when searching empirical studies about the impacts on mental health from the mass violence in southern Thailand. The Centre's survey found nearly 90% of the participants said the unrest, along with feeling insecure about their life and property, was a major cause of their stress. Further, the Centre employed a focus group to identify the needs of people affected by the violence, and findings showed that people wanted information workshops or seminars on mental health promotion and mental health treatment, and especially on self-management for dealing with stress. Additionally, it is worth noting that several programmes and much media and collateral were produced in response to this information. The other three sources of information on which Centre 12 has relied are: the Violence-Related Mental Health Surveillance (VMS), the Deep South Coordination Centre (DSCC), and the Deep South Watch. While the VMS database was initially developed by the Rehabilitation Sub-Committee, local hospitals later took responsibility for inputting patient information. However, problems developed because of the hospital staff's limited capacity in using computers and databases (Mental Health Centre 15, 2008). The other two organisations, DSCC and Deep South Watch, collect data about violent incidents and provide situation analysis. Evidence showing Centre 12 used information from the DSCC was found in Centre 12's 2008 annual report, while Centre 12's 2012 annual report contained information from the Deep South Watch's database. Field notes

from participant observation record that the Director mentioned DSCC's database (see Appendix E).

5.2.1 Programme planning priorities

Participants identified three priorities when planning mental health communication programmes, with differences reflecting roles and work experiences: seven participants, including the Director, prioritised the target audience and audience analysis; two participants thought budgets were an operational point of first concern; and another participant identified the programme's purpose and communication strategies to reach programme's goals.

Overall, understanding the audience was a major planning priority for Centre 12. Participants discussed three methods of audience analysis: one informal method (observing people's way of life, religious dress and lifestyles); and two more formal techniques (using information from a summative survey and meeting with opinion leaders in the communities). Centre 12 also conducted a formal survey to understand the needs of the affected people, although this was not mentioned in the interviews.

The Director argued that a target-based approach is the most important concern for programme planners: "it has to come from what the targets want, not what we think they should do or should know" and "audience segmentation was also important because different audiences need different content". She also referred to informal observation and general knowledge:

we need to notice people's way of life, religions, lifestyles. For instance, most of the people here like watching television than reading, men like talking at tea houses, women like to meet and talk at the religious ceremony or marriage ceremony.

A participant who took responsibility for collecting and analysing programme outcomes said their first priority was using information from the previous summative survey to design the new programmes:

When we ran any workshops, at the end we surveyed their needs for further activities. Then, we identified the most important topic they requested and set up new programmes based on their desires. (Staff no. 6)

Two staff members with experience in launching community-based programmes said they organise meetings in communities and make a plan together with opinion leaders. One of them, who had launched programmes for women and children, said they started by identifying community opinion leaders and seeking their views:

I took responsibility for the programme supporting children affected by the crisis which was funded by UNICEF. Before we presented our project to UNICEF, we identified the area's needs by organising meetings with community representatives and asked them how they wanted to be supported. Then, we summarized all of their desires and planned programmes.... This is the main factor of our success. (Staff no. 10)

Programme planning with community leaders was confirmed as an effective strategy by another staff member who also worked on community-based programmes. She said it could build up a sense of ownership:

Before we started every programme, we invited the community leaders, parents, religious leaders, community health staff and other relevant sectors to attend the meeting and told them what we were going to do. Then we asked for their suggestions about how the programme suited the area. They would make some suggestions. For instance, on timing, in Ramadan month people feel unhappy joining the activities because they have to cook in the afternoon and pray in the day time. (Staff no. 7)

A different priority for programme planning came from two social worker staff members who said the source of budgets was their first planning concern because the Centre received budgets from several sources and each provided for a specific purpose:

Firstly, we will separate programmes through sources of budget. Our main source comes from the Department of Mental Health which aims to run the same activities as the other centres such as the four development age groups programme. The second source also come from the Department of Mental Health but it is specific for the southern border provinces which focuses only on the rehabilitation programmes for the three southern border provinces and four districts in Songkhla province. The last budget comes from outside organizations. If using the budget from the Department of Mental Health, in

the end of August or September we will plan the programmes broadly and design the activities in each programme. For instance, the Department provided budget on the four age groups programme but what activities we did depending on us, such as the activities for children in school or for adults to educate about mental health or potential supporting activities. Activities will vary depending on problems in the area at that time. (Staff no. 3)

This participant confirms the earlier discussion (see section 4.5.3) about the impact of policy and the resultant government budgeting structures on Centre 12's activities. However, the Centre had some flexibility because of access to funding from UNICEF, the National Health Security Office of Thailand, and the Southern Border Provinces Administration Centre (Staff No. 2).

Budgeting was also noted as a priority by one of the longest serving staff members, who focused on cost-effectiveness:

Media production for instance, we need to think that people will use our media in practice. So we have to ask users whether our programmes suit their needs. It was about the desired outcome we received from the amount of money we paid. (Staff no. 1)

This participant, whose responsibility was researching and exploring new knowledge about mental health, said he thought of a programme's overall direction first when planning. For instance, with programmes aiming to disseminate new interventions, he first set up models that guided the participants to see the overall picture of interventions and then presented them to the target audiences for feedback:

As programmes' facilitators, sometimes we created models which we wanted to disseminate in the [geographic] area which was mostly high risk or had some severe cases. At first those models might not meet with people's needs. Then, we organised workshops for criticising the models by people and organisations which were relevant to the models' applications. We told them to add or edit those models as much as they wanted. It was an area-based consideration. We gave people freedom to share ideas. (Staff no. 1)

Participants' reflections in this section show priorities included audience analysis and audience segmentation; source of budgets; and programme objectives and

communication strategies to reach the goals. Audience analysis was provided by informal observation, summative surveys, and community meetings with opinion leaders. Additionally, there is other evidence of survey and audience analysis research conducted by Centre 12 and its use of information from other organisations. Interestingly, most (seven) of the participants said they put the target audiences as the first priority, which ideally should bring about programme success and sustainability. However, as a government agency, Centre 12 had to overcome limitations such as budgets and changing government policy.

5.2.2 Programme deliverers' planning concerns

To get deeper insight on programme planning during the mass violence, interviews explored the participants' concerns for programme planners working in this area. Four concerns were raised from the programme deliverers' perspective: language was perceived as the most concerning challenge by half the staff; choosing trustworthy senders; reducing suspicion; and safety were also perceived as important concerns for programme planners in the violence area.

Six staff members said language is the most important challenge, and identified several language problems. Interestingly, all problems referred to language for communicating with Muslim receivers, not Buddhists. This might be because Muslims are the majority of people in the area (85.16%; Thailand National Statistical Office, 2010), so are the main programme focuses. Buddhist staff members gave many examples of language problems, while Muslim members were familiar with Arabic language. A senior Buddhist staff member noted the variety of languages used in this area:

People cannot read and write in the Arabic language but they can speak Arabic. However, they also speak Melayu, both Malay Dialect and Bahasa Malay. They also write in Jawi alphabets. These became problems when we wanted to design programmes or media for them. (Staff no. 9)

Another Buddhist staff member reflected on the difficulty of translating specialist content without distorting the meaning:

... when we communicated about mental health, some contents could be translated, such as emotional issues. However, if contents were specialist, such as in the mental health screening form, it was difficult to translate and make it

easy to understand. The receivers might not get the intended meaning or sometimes the meaning was distorted. (Staff no. 2)

Spoken language, especially pronunciation, was also a potential concern for those staff who came from other provinces or who could not speak the local language. A Buddhist staff member from outside the area spoke about the challenges:

I went to a community for a children's IQ test. My friend taught me some words for admiring those children but my accent was wrong and it became another word, another meaning. So, we needed to be very careful. If we were not sure, we needed to speak with people who were more expert at communicating. (Staff no. 10)

For a senior Muslim staff member, the language problem was important in the religious context: it is important to be careful with manuals or books that use religious words because if some symbols are put in the wrong place, it changes the meaning (Staff no. 11). Three Muslim staff members also confirmed that in sensitive contexts, the Centre staff who can speak the local language were chosen to work with people in the community (or otherwise lead them) because they were perceived as “the same” and will find it “easy to access people in the area” (Staff no. 5).

A related concern was choosing trustworthy sources. A social worker participant referred to the Director in this context:

The Director has explored who is trusted by people in this area. She found that firstly people here trusted in the religious leaders followed by public health officers while policemen and soldiers were mentioned in the last order. A trustworthy sender is very important because if people do not open their hearts to listen or accept us, we cannot help. (Staff no. 2)

A related communication concern is to reduce suspicion, as illustrated by an experienced staff member:

If focusing on government sector, a public health officer is the most reliable in people's view. Previously, we often went to the danger area for home visiting. Our Director went everywhere, even the dangerous or prohibited areas. There was one place where the villagers closed the door, did not accept outsiders.

They asked whether she came with the soldiers. She said no, we are public health officers. So, they talked to us; however, just a short talk. After that she went to visit them regularly, talking to them until they began to trust, until they believed that we are not on the opposite side or someone they feel insecure with. (Staff no. 3)

According to participants, using the same language as the villagers and visiting people in the community regularly is the key to reducing suspicion. However, gaining trust is not easy and takes time: “It needs heart. Some cases we had to visit several times until they accepted us. We needed to show our sincerity” (Staff no. 5). Also, given the crisis context, it is not surprising that safety was identified as a major concern when planning programmes. This comment was from an experienced staff member:

First, we have to think of our safety. Second, we have to think about the area’s needs, are they ready to meet with us. We have to think about timing. When the crisis happens, we have to contact our network such as community hospitals. If they need help, we will go and support. (Staff no. 8)

Putting her own safety first, followed by others’ needs, was an interesting point congruent with section 4.4, where staff reflected on the impact of the violence on their work.

In summary, most of the participants indicated that language is the first factor of concern for programme design and planning in an area with a number of home languages. Social context and audience characteristics also need to be identified before planning programmes. Choosing trustworthy senders, reducing suspicion, and personal safety were also mentioned. However, systematic planning for programme evaluation did not appear in interviewees’ discussion of the programme planning stage. The following section provides the participants’ reflections on the second stage in their mental health communication programme cycle – collateral design and testing.

5.2.3 Media and message development

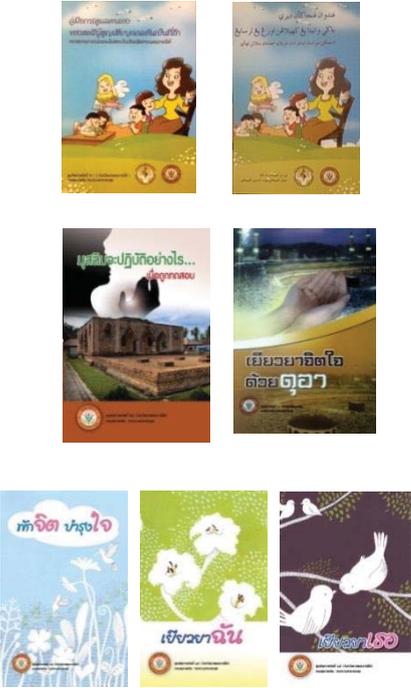
As collateral or media was identified by interviewees as an important tool in their mental health communication programmes, this section focuses on developing, pre-testing, and using collateral. Nine staff members, including the Director, talked about print media, such as brochures, leaflets, and the newsletter they have disseminated when

implementing mental health programmes. The Director said Centre 12 produced media for three intended target audiences:

1) people in the health sector – mostly manuals, 2) people in general; the contents have to be easy to understand, such as how to cope with stress, how to massage for relieving stress; and 3) specific target groups such as women or children.

This section first covers (in Table 5.1) the main supporting media especially in phases 2 and 3 (between 2006 and 2012). Then, the five notable booklets produced by the Centre, covering healing according to religious principles, are discussed in greater detail. While pamphlets, newsletters, and other collateral were produced throughout the study period, there was no evidence of major media (see Appendix I).

Table 5.1 Examples of the major media in phases 2 and 3

Phase	Collateral descriptions	Collateral illustrations
<p>Phase 2: Policy of targeted groups (2005–2010)</p>	<ol style="list-style-type: none"> 1) Self- help manual for the general public (2006, reprinted in 2007) 2) Training manual (home visiting) for public health officials / deliverers group (2007) 3) Training manual for village Health Volunteers and Community leaders (2007) 4) Three cartoon books for children (2009, reprinted in 2013) 	
<p>Phase 3: Policy of general age-group targets (2011–2014)</p>	<ol style="list-style-type: none"> 1) Self-help manual for widows from the violence (in Thai and Melayu) (2011) 2) Two books about healing according to Muslim principles (2011) 3) Three booklets about healing according to Buddhist principles (2012) 	

As Table 5.1 shows, the first manual produced in 2006 (with a second edition in 2007) was a general self-help manual. The manual covers how-to techniques, such as relaxing from stress, exercising, practising positive thinking, talking with friends and families, and practising religious observances. Between 2006 and 2007, manuals were more focused on the deliverer groups such as public health practitioners, village health volunteers, and community leaders. From 2009 to 2012, print media were produced for specific target audiences, especially children and widows. Religious-based booklets were produced in 2011 and 2012. Additional examples of media production to support programmes are provided in Appendix I. Staff manuals, leaflets, brochures, and Centre 12's newsletter were also mentioned by participants as useful resources, even though they were more general and did not specifically respond to the crisis situation.

In addition, the role of mass media was also identified by the Centre's Director and a senior staff member. Radio was used to promote Centre 12 in the initial stages when it moved to Pattani province. While the Director thought radio was an effective channel to reach people in the area, giving an example of a well-known talk programme, Centre 12 did not fully utilise it. One reason is the limited budget, according to a senior staff member: "radio programmes helped to promote our Centre and how people could access our service in the beginning stage. Then, it was cancelled because we did not have budget for that part" (Staff no. 9).

5.2.3.1 Media development

The Director initially discussed the audience influences on media development:

Mostly people will tell us what they want. They want something easy, they say do not use English language, do not use high level language and produce in two languages [Thai and Malayu] if possible. However, it depends on the area. Some areas are not interested in two languages but it is necessary in others.

Another staff member explained broadly the variety of media produced:

In the beginning, we produced training manuals for health staff and self-help manuals for people in general. Then, we produced many manuals. Later, we produced media based on case problems we met, such as books for disabilities, widows, and children affected by mass violence. (Staff no. 3)

Staff member no.7 explained further:

We produced media in two versions – Thai and Malayu languages. We produced media with the psychological hospital such as psychological manuals for health practitioners. Another type of media is self-help manuals for people in general. The media production process began with inviting media design experts. Sometimes people in the area told us that they want media to help protect their mental health from the crisis. For example, when bombing occurs, it would be good if they have a small book in their pockets which they can read immediately. From this request, we invited professionals from a number of universities, and religious leaders to design the contents of the book.

Interestingly, all the staff members referred to three booklets in *Healing according to Buddhist Principles* and two booklets in *Healing according to Muslim Principles* as the media they remembered and perceived as noteworthy. These five religious-based booklets are now analysed in depth. Two staff members took the roles of main coordinator and producer of religious-based booklets. Participant No. 8, a long-term Muslim staff member, was the main coordinator of *Healing according to Muslim Principles* production. Staff No. 9, a Buddhist senior staff member, was the main driver of *Healing according to Buddhist Principles* production. Additional information came from interviews with staff who helped in the production. Document analysis undertaken by the researcher is also included here.

These books resulted from area-based research conducted by the Director that asked who provided support for people facing a crisis in life:

The results showed religious leaders were the first people and religious principles were an important coping tool... This was the background reason why we produced Healing according to Muslim Principles books. (Staff no. 3)

Buddhist booklets were produced the following year:

The idea of producing Healing according to Buddhist Principles books began when we went into a community for home visiting. We provided mental health screening and asked the villagers about their needs for support. They did not tell us directly that they used religious principles to cope with problems. It was indirect information from our staff's notes. They recorded that people prayed, went to the temples to receive merit when they felt suffering. They felt better and could accept when bad situations happened in their lives. This information was a part of the media production idea. (Staff no. 9)

The interviewee went on to provide details of the media production process, which mainly occurred outside the mass violence area because the specialist who was invited to advise about the books' content was a well-known Buddhist monk, PhraPaisal Visalo:

In the beginning, we invited PhraPaisal Visalo to give us some suggestions about contents. Firstly, we went to his temple in Chaiyaphum province [located in the north-eastern, Thailand]. Then we met him again in Bangkok with our Buddhist team including Buddhist people in the area. We discussed content and wrote the first draft including Buddhist principles from the monk and applied principles from people. We shared experiences and recorded.

Therefore, the three Buddhist books were produced as “how to” books for everyday living rather than in-depth doctrine.

A participant who started work in 2012, when these media were still being developed, said those five booklets were used to support religious-based healing programmes:

This was our stand-out programme because it was specific to the three southern border provinces. We were living in a multi-cultural society with different religions. So, we thought it would be good if we use religious discipline in rehabilitation. Actually, everybody has religion; however, when facing the crisis, they forget the principles. (Staff no. 5)

In explaining why these five booklets were perceived as noteworthy, five staff members said that developing the books was an inclusive process:

In media production, we invited many experts to be on the producer team. For example, for the Healing according to Muslim Principles book, we invited religious leaders and Islamic lecturers. For the Healing according to Buddhist Principles book, we invited Buddhist monks and Buddhist people in the area to provide ideas in the workshops. We asked them about content they wanted in the book. (Staff no. 2)

The main producer of the Muslim booklets said:

At first, we realised that most of people in the three southern border provinces are Muslim. For Muslim people, religion is life, the way of daily life but we did not have any religious collateral which could be used when facing the crisis situation. That was the first idea of producing books related to religion.

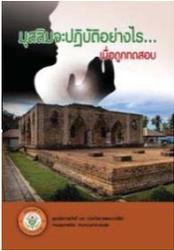
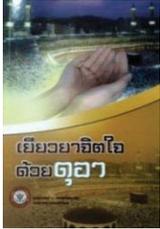
She emphasised the number of religious leaders and academics who participated in designing and content selection and the “many” meetings this took, along with input from community leaders and people affected by the crisis. Only then, when every detail had been summarised, were writers and editors chosen.

Another participant spoke about the content of *Healing according to Muslim Principles*:

In the book, we had many examples of people who were tested. Some people had lost someone they loved. Everything came from God, including suffering. They were the tests. When people read and they think ‘everything comes from God’, they will accept and forgive. (Staff no. 7)

Tables 5.2 and 5.3 provide the overall document analysis of the religious-healing books, concentrating on the cover design, language, and overall content.

Table 5.2 *The analysis of two books on Healing according to Muslim Principles*

Characteristics of books	How to respond when we are tested	Mental rehabilitation by Du-a [praying]
Book's cover		
Picture and meaning in the book's cover	<p>Muslim man praying above Krue Se Mosque, which was the historical sign of Islam religion in southern border provinces of Thailand.</p>	<p>Hand sign which means the blessing from Allah (God) and background picture of Mecca, in western Saudi Arabia. It is Islam's holiest city as it's the birthplace of the Prophet Muhammad. Every Muslim hopes to go there at least once in their life.</p>
Book's size	<p>A 130-page book. Handy size; approximately A5.</p>	<p>A handy size approximately A5 size with 64 pages.</p>
Language	<p>The book was printed in Thai; however, it uses Arabic when quoting religious principles in Al-Quran.</p>	<p>Largely in Arabic, and in Thai when explaining the meaning of doctrines.</p>
Content	<p>Four chapters, including</p> <ol style="list-style-type: none"> 1) The truth in which Muslims have to believe, such as everybody is tested by Allah, everybody has to die 2) How to react when tested, such as thankfulness, tolerance, acceptance, and forgiveness 3) Examples of people who have passed the test 4) Du-a support for mental strength. 	<p>Its content focuses on selecting Du-a⁵ from Al-Quran which could enhance will power, such as Du-a when feeling hopeless in life, facing unwanted situations, when other people do something good for us, and overcoming danger.</p>

⁵ Du-a is an Islamic terminology that means the act of supplication. It is calling out to God or a conversation with God

Table 5.3 *The analysis of three books on Healing according to Buddhist Principles*

Characteristics of books	Self-Consciousness and Mental Treatment	Rehabilitating ourselves	Rehabilitating other people
Book's cover			
Picture and meaning in the book's cover	<p>These three books use drawings of birds, trees, and flowers. Similar to the other meditation books, the design reflects relaxation rather than the religious text book. Also, they have used drawings instead of real images and inside, the books include cartoon pictures matching with content they presented.</p>		
Book's size	Handy size, approximately A5, 72 pages	Pocket-book size, 54 pages	Pocket-book size, 54 pages
Language	Thai		
Content	<p>Focuses on being conscious in everyday activities such as breathing, walking, travelling, working, and using technology, etc., [mindfulness].</p>	<p>Presents guidelines for self-care when facing crises in life, such as accepting the fact, self-awareness and accepting the feeling of pain, adjusting to change, building optimism and will-power.</p>	<p>Stories of people who suffer because of the mass violence situations; understanding the nature of pain; mental rehabilitation and adjustment; things to do and not do when helping people affected by the violence; and the benefit of joining self-help groups.</p>

5.2.3.2 Media and content pre-testing

Interview material shows Centre 12's media were checked, verified, and trialled, with several participants saying the content, especially of the religious-based media, was strengthened by verification from experts. According to Staff no. 11, "most of the media were checked many times by inviting experts from outside organisations especially religious specialists to verify their contents".

An emphasis on the pre-testing process was most noteworthy with the *Healing according to Muslim Principles* booklets. Interviews show that after the booklets were complete, they were sent for verification by professionals again and then tried out by a focus group before publishing. Three staff members who participated in this process agreed that media trial was an effective way to gain feedback from the target audiences:

After a draft of the books were published, we chose ..XXX.. [name is withheld for ethical reasons]. Health Promotion Hospital to test the books because one of the hospital staff was a team producer of the books. Then, we organised a meeting and invited people there to reflect on outcomes after reading the books. (Staff no. 6)

Similarly, a combined workshop was instituted to test the booklets' content. The excerpt below shows workshop process and some comments from the target audiences, mainly about the books' format and design rather than content:

We launched a workshop where the participants included people affected by the violence, public health officers, and village health volunteers. We tried out the books. At that time, we produced parallel Buddhist and Muslim books. In workshop, we invited representatives from both religions and discussed the similar and different principles. Before inviting people, we gave them our books. So, in that workshop, we asked about their opinions, such as about the book's application, contents, and improvements. People gave some feedback, such as it should be in bigger fonts, use easy language, and to produce small-size books which are easy to carry. Some comments said they wanted a CD for people who did not like reading, the uneducated, and elders.

Media and message pre-testing led to three design changes: making a bigger font, making a smaller pocket book, and adding additional collateral. As explained by

staff no. 9, “Finally we put the books and chanting CD together in one set and improved packaging”. The following picture shows this:



A set of booklets and collaterals in Healing according to Buddhist Principles

5.2.3.3 Distribution of Centre 12’s media

Two staff members described how media and collateral such as pamphlets, brochures and newsletters were disseminated during programme implementation:

We mostly disseminated our material when we went into the community. Sometimes, we gave them to people or any organizations that came to contact us at the centre. Some people had seen our media and emailed us. Mostly, we provided our media as much as we could because we realized that they were useful. Additionally, we disseminated them in seminars or school’s open day.
(Staff no. 7)

As for the five religious-based booklets, two thousand copies of each book were published. The main producer of the *Healing according to Muslim Principles* books was happy with the outcome because people liked them. However, she said she could only disseminate them in workshops and seminars (mainly to community leaders and health practitioners) because of the limited number of the booklets.

Another media output is Centre 12’s newsletter, which is published every 3 months. It is sent to the other Mental Health Centres, Provincial Public Health Offices, and hospitals in southern Thailand. The staff also disseminated newsletters and pamphlets (e.g. reducing stress by using visualization, experiences from losing loved ones, and

overcoming crisis by the power of mental health) when they ran mental health communication programmes.

5.2.4 Programme implementation

Staff members were asked about mental health communication programme roll out: most of them agreed that workshops were the main method of implementing their various programmes in 2004–2014. Therefore, this section concentrates on implementing workshops for deliverers and then target audiences. Given that partnerships were deemed a key part of the Centre's communication programmes, there is an additional section on partnership and delivery, later in this chapter.

5.2.4.1 Workshops for the deliverers group

More than half the Centre staff members said they had run workshops mainly for the deliverers of mental health communication rather than directly to people affected by the mass violence. The value of workshops for the deliverers group was well illustrated by the following excerpt:

I took responsibility for children affected by the crisis programme. Step one, we did not provide intervention to children but we gave it to people who are relevant to [reaching] children, such as teachers, local government officers, community leaders, and public health officers. We ran workshops to provide mental health knowledge to the leader groups in communities. Then those leaders would disseminate the knowledge to children in their communities.
(Staff no. 10)

One of these workshops targeting children but disseminating mental health knowledge through the deliverers group was observed by the researcher. The varied processes in the workshop combined one-way and two-way communication as evidenced in the following field note:

This workshop is focused on educating. In the morning session, a doctor from SongkhlaRajanagarindra Psychiatric Hospital provided credible knowledge about IQ and EQ of children by using PowerPoint on the stage. The participants sit below and listen without giving any feedback. It is one-way communication like teaching in the classroom. However, in the afternoon

session, it was more fun and relaxed. The key speaker is a person from Rajanukul Institute, Bangkok. She has more than 20 years' experience working in mental health. Her communication strategy is mainly using music and pictures such as a relaxing song for meditation with a picture about love and relationship between mother and child. She moved off the stage to speak near the audience and always asked some interesting questions. It was two-way communication, which persuaded the audience to participate in her talk. (Participant observation 6/05/2014)

Interview material that also captured the range of communication activities in the workshop supported these field notes. As one staff member said:

We analysed the objectives of each programme and invited experts in that topic to educate or share their experiences. Most of the activities in workshops were lecturing, talking, discussion, group activity, brain storming. The audiences were not affected by mass violence but they are the deliverer groups who have to work with the people affected by the violence. (Staff no. 6)

The following field note comes from a workshop for disseminating new interventions for the deliverer groups:

The title of this workshop is “Developing a clinical prototype for treating mental health of people affected by the crisis”. During these 2 days of observation, I noticed that this workshop was very well planned. Everything was set as a model from the 12th Mental Health Centre, such as the geographic area setting, role and function of the clinical prototype. Three areas were chosen from three provinces. Likewise, the earlier observation on May 6, the participants were puzzled about why their areas were chosen for developing the clinical prototype. To help answer this question, I personally asked a staff member and she explained that these three areas have been chosen because of the very high level of violent incidents. Later, the staff member answered this question for the whole workshop. (Observation, May 19, 2014)

Many workshops also used partners to deliver. This is explored in section 5.3.

5.2.4.2 Workshops for people directly affected by the mass violence

Most of the Centre staff saw their responsibility as support rather than direct contact with people affected by the mass violence. However, a highly experienced staff member remembered the children's camp workshop in 2005 and reflected on that programme's implementation process:

The first programme we launched was a workshop for children at Kao Yai [the national park located in the central region of Thailand]. We took the children affected by the mass violence crisis to stay there for 2 weeks. The programme aimed to provide knowledge about mental health in general and how to develop good mental health even in a difficult situation. We provided activities which focused on living together between Buddhists and Muslims. Religious-based NGOs and our professional academic staff members were the keynote speakers. (Staff no. 3)

Another reflected specifically on the way they have designed messages in workshops for those directly affected:

We organised workshops with contents related to the target audiences. People affected by the violence mostly want to know about their rights. In case of losing property, we will advise where to ask for their rights. If they have lost people they loved, they will need mental support so we will provide contents about how to cope with the situation, [develop] resilience and the ways to come back to normal as fast as they can. (Staff no. 5)

Further, a senior staff member explained how activities were also included in community workshops:

Mental health promotions can be added in every activity such as when we launched activities in community to show respect for elders, we can add some recreation activities such as talking about their dreams or a laughing competition in there. (Staff no. 1)

All interviews explained well-planned programmes mostly launched through workshops and prepared activities. However, one participant illustrated a quick-response programme rolled out suddenly when an incident of mass violence occurred:

Yesterday after the violence occurred, firstly we contacted the hospital in the area. They said they could manage the patients who were admitted to the hospital. For patients who were affected by the violence but could go home, they will provide home visiting within a week. For our Centre, we went to provide mental health screening in the community. The hospitals' staff could not [deliver this] service like us, because they had to take care of patients in the hospitals. We had to help people who live in the violence area but were not injured or affected by bombing. Our process was setting up a tent for screening mental health and diagnosis by psychiatric doctors. Some cases were considered as patients who needed further treatment, such as those with a high level of insomnia. (Staff no. 8)

However, more often there are delivery processes able to be adapted during programme rollout if safety issues arise, as the Centre 12's Director said:

One day before went out to provide mental health screening in a community, there were rumors about three areas being particularly dangerous. Somebody told us that we should cancel our screening programme. We said if we cancel who will go and help the villagers? So, we changed our plan by sending a small team and walking in to each house.

The interview reveals that working in the crisis area requires developing alternative plans. Mental health practitioners often have information from networks in the area. If there are risks, they can be flexible and adapt the delivery plan.

5.2.5 Programme evaluation

Staff were asked about the evaluation process. Interviews revealed both the extent and limitations of the Centre's evaluative methods for communication programmes and of the media used to support the various programmes. They also showed a substantial proportion of participants were aware of, and in some cases frustrated by, the inability to fully measure effectiveness.

The Centre's Director identified problems with evaluating media use:

I accept that media evaluation is our weakness. We have evaluated only what we saw, such as when we disseminated our books in the library, we saw children borrowed them for their younger brother or sister at home. However, it was not an academic evaluation. We need research which shows the popular or good media which we should re-produce. (The Director)

The Centre did attempt focus group-style feedback one year after the Muslim and Buddhist healing books had been disseminated, organising another workshop with those originally selected as the leaders to promote the books in their communities. Unfortunately, the participants' feedback on *Healing according to Buddhist Principles* was less favorable than expected:

They reported that people mostly did not read them. People in the community mostly thought of earning a living rather than mental healing. (Staff no. 9)

Similarly, another staff member who participated in the workshop said:

The target group reflected that nowadays a lot of Buddhist principle books were produced and when the crisis happened, people mainly thought of their living more than mental healing. Buddhist books were rarely read compared to the Muslim books. (Staff no. 5)

Another reflection about the books' evaluation reveals a focus on the number of media disseminated rather than content utilisation:

Our media did not provide for every family, only the leader groups got them. We produced 2,000 copies mostly disseminated in our workshops, just few copies left to provide in the community. We also disseminate to other organizations and some organizations requested them for using in their workshops... We did not know how individuals, used [our media] because we did not evaluate, we just got feedback about the beautiful package and attractive books. Public health officers reported that they gave the books to their patients or used them in the beginning part of workshops to practice meditation or gave them to some severe cases because they had contents about praying. (Staff no. 9)

The Director also pointed out that the radio programme commissioned to promote Centre 12 and mental health issues lacked systematic evaluation. She believed radio

was an effective channel, but said she really wanted to know “the number of people who have accessed us through the radio programme.”

In terms of communication programmes, staff said there was evaluation but generally only in terms of audience satisfaction with the workshops. These concerns are discussed further in this section. Three participants discussed two evaluation methods they have used: feedback meetings and sending evaluation forms to workshop participants:

We have organised case meetings to discuss the severe cases and asking [community health practitioners] about the knowledge they will be using for solving case problems. (Staff no. 8)

A few months after the workshops, we sent evaluation forms to the participants again. We wanted to know whether they have applied the knowledge in their community or workplace. (Staff no. 3)

However, according to this member of staff, the response rates did not meet their expectations. She gave an example of the developing IQ and EQ programme where they had hoped teachers would send them the follow-up evaluation, but mostly they did not do so.

Another staff member explained the Centre’s method for feedback evaluation by the programme designers:

Sometimes, we had a team discussion after we finished programmes. We found some problems such as the participants came late, the number of participants did not meet with our expectations, the documents provided were not enough for all participants, some technical problems such as power point presentations were out of order or key speakers we chose were not appropriate for the topic. (Staff no. 8)

The sample questionnaire in Appendix J is a standard official form Centre 12 used to get attendees’ feedback from meetings, seminars, and workshops. The participants did not provide information about results from these questionnaires; however, two participants recommended the researcher check the Centre’s annual reports and books. One participant said:

Our staff, we have to discuss activities and programmes which have been done and summarise them in an annual report. We considered the answers from questionnaires of the previous activities which include a section about evaluation and suggestions for programme improvement. (Staff no. 11)

All government departments report their outcomes. However, when examining the annual reports, evaluations were only output-based. For instance, the 2008 Annual Report shows outputs from the children's and women's rehabilitation programmes include running children's activities for 154 students in 5 schools, producing 2 manuals about standards for taking care of children, producing 2 brochures (6,000 copies), and producing 2 posters (6,000 copies).

The concentration on recording workshop attendees' satisfaction was of limited value in terms of evaluation, and a highly experienced staff member saw it as a major problem:

We just evaluated the participants' satisfaction, which I thought it was useless. We asked about food, venue, and the ability of the facilitator. Actually, we should evaluate the utilisation of the programme; how they used knowledge they learned from us. (Staff no. 7)

Another three participants also pointed out they evaluated only programme attendees' satisfaction. Although, as noted earlier (in 4.8.1.1), the summative evaluations are also designed to see if any improvements should be made in programme delivery, this was recognised as insufficient:

We were normally launching training programmes, so we just evaluated their satisfaction. The problem was knowledge application. We launched a lot of workshops but we did not know whether they were used. (Staff no. 8)

The excerpt above reveals that at least some participants realised that the evaluation method they had used for a long time was of limited value, but it was used officially (and they are familiar with using it). Ideally, outcomes from programme evaluation are used as evidence when planning new programmes. With little robust evaluation, participants said they had insufficient evidence to make an argument for continuing the programmes. A highly experienced staff member complained about lack of programme continuity:

No programme has continued every year. Although we have the age group programme which continued for 2–3 years, it was not continued. The children's group for instance, this year we worked on their IQ and EQ then next year we will change. (Staff no. 7)

Another participant emphasised her desire to improve the evaluation process:

We need post-programme evaluation. After we disseminate innovations, we should follow how the attendees use the innovation in their community. (Staff no. 11)

Finally, it was suggested by a participant that the researcher read a book in which the Director has summarised the overall practices of Centre 12 between 2004 and 2012 (in press). This published self-assessment by directors and authorities is not unusual in Thailand and is also seen in articles published by the authorities in responses to the Tsunami disaster (Chakrabhand, Panyayong, & Sirivech, 2006; Visanuyothin et al., 2006).

5.2.4.1 Summary of communication programme framework

This section has provided insider views about the mental health communication programme delivery processes in Centre 12 during 2004–2014. Participant comments cover four stages of programme delivery: programme planning, collateral design and testing, programme implementation, and programme evaluation. Figure 4.2 summarises this programme cycle within the context of the mass violence and multi-cultural society, based on the participants' reflections throughout this section.

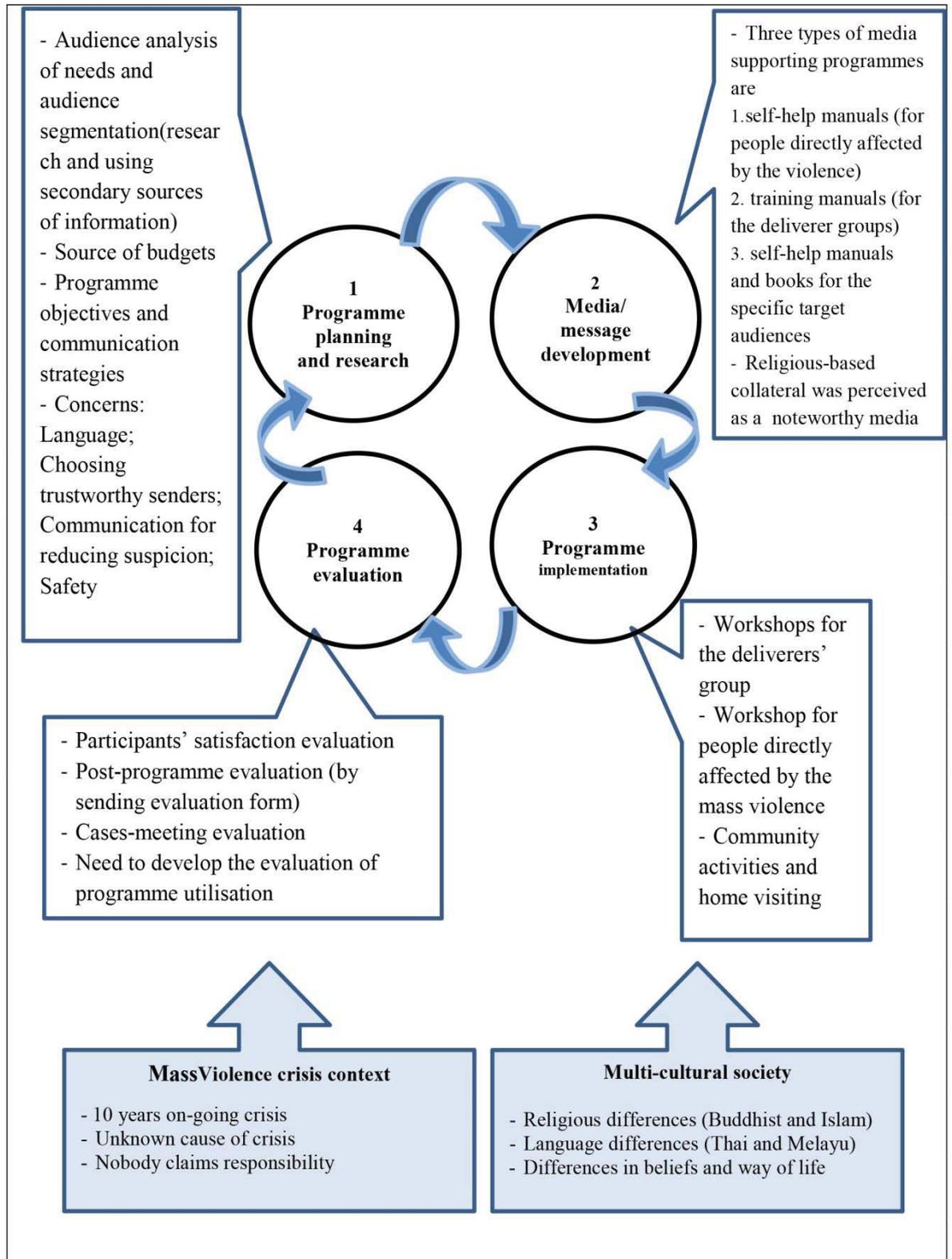


Figure 5.1 Four stages of mental health communication programme cycle within the context of the mass violence and multi-cultural society.

5.3 Partnership in mental health communication programme delivery

As noted earlier in this chapter, the Centre works with others in delivering programmes. Several participants talked about partnerships with key people and organisations. It is pertinent to note that the concept of partnership varied. Perceptions of which people or groups were partners, as opposed to deliverers, of Centre 12's services varied according to participants. Further, many interviewees used the word "network" interchangeably with "partner" and the words "working with" to convey their interpretations of "partners".

Partners, identified by the Director and staff, were interviewed exploring their roles in the crisis situation and their relationship with Centre 12. These five participants came from the academic sector, a special interest group (Brahma Kumaris Foundation), the National Radio network, and the public health sector.

This section explores RQ 3: How were the mental health communication programmes implemented? It first draws on interviews with Centre 12's Director and staff about partner groups, then covers the five representatives' perceptions about the partnership with Centre 12, along with key case story examples.

5.3.1 Who is involved in Centre 12's programme delivery process?

Centre 12's Director and staff were asked to identify their community-based partners. More than half the participants saw public health practitioners as their main partner, and this included community hospitals, sub-district health promotion hospitals and psychologists. This reflection is congruent with Centre 12's mission, which focuses on "developing the potential of networks both inside and outside the public health system in community mental health services" (Mental Health Centre 15, 2012, p. 2). The Centre provided many training workshops and met with public health practitioners regularly for 6 years during 2005–2011. Academics, special interest groups, NGOs, local government, and community partners were also identified as partners by about half the Centre staff. However, these relationships were different from that of the training relationship with public health practitioners because the other groups mainly share information and resources with the Centre. Finally, media networks were also mentioned by the Director and a senior staff member as partners in promoting Centre 12 and mental health issues with the public.

5.3.1.1 Public health practitioners

Seven staff members said without hesitation that public health practitioners were their main partner. Centre 12's role as a knowledge provider for public health practitioners was summarised by a clinical psychologist who had worked at the community hospital for several years as: "Their duty is treatment; our duty is providing them knowledge" (Staff no. 11).

Interviews also show that the Centre staff perceived themselves as trainers, and the public health practitioners were trained by them. The categories of health practitioners include community hospitals, sub-district health promotion hospitals and psychologists. Those three health sectors are under the jurisdiction of the Provincial Public Health Offices. As a result, two staff who have worked as public health technical officers saw the Provincial Public Health Office as one of Centre 12's partner groups because the office has facilitated coordination with public health practitioners.

This quotation shows the nature of the perceived partnership:

In general, we did not contact the Provincial Public Health Office except when we had the relevant situations or cases. Sometimes we have asked for their help such as when we organized training workshops for health staff. However, if we have some interesting projects such as a scholarship for staff in the area or some project which will benefit both of us, we will tell them. Besides, when we have produced some useful media, we will give it to them and if they want any support, they will just coordinate with the Centre. (Staff no. 5)

5.3.1.2 Academics, special interest groups and NGOs

Academics, special interest groups and NGOs were mentioned as partner groups by the Director and three other participants who worked with the Centre since it was set up. Interviewees also identified specific people in this group and their important role as information sources, such as "We work with The Deep South Coordination Centre, Miss X, Y, and Z [name are withheld for ethical reasons], they worked on database and women issue" (Staff no. 9). The Director also said "Miss Y and Z [names are withheld for ethical reasons] are NGOs who help us especially on training programmes for the 74 psychologists".

The staff's reflections on partner groups appeared related to their work experiences. Staff who had worked with the Centre for more than 3 years thought of people and groups outside the health sector while staff who worked for less than 3 years mostly talked about public health staff. This might be because the more experienced staff had participated with the Rehabilitation Sub-Committee which combined the various groups who have worked with Centre 12.

5.3.1.3 Community partners

One new staff member with several years of experience working in the community hospital thought of community leaders and religious leaders as partner groups. Her view of partnership as networks was based on her previous experience working closely with the communities:

Community leaders and religious leaders are the important networks, especially when we want to go to the area. We will tell them before going and sometimes we went together for home visiting. (Staff no. 4)

It is interesting to note that in section 4.8.3.1 community leaders and religious leaders were described by several other staff as mental health deliverers (helper groups) rather than partners. They were also perceived as people who could help to reduce suspicion when the Centre staff undertook home visiting, as is indicated in the excerpt above.

5.3.1.4 Media networks

A different perspective on partnership was provided by Centre 12's Director and a senior staff member who, when asked about partners, spoke about working with radio.

We are strong in collaborating with media networks. We could see the overall picture of mental health work which was not restricted to only public health officers or hospital staff. We found that mental health messages could be disseminated by many groups especially radio producers... When the Centre was set up we had budgets for mental health promotion and we funded a radio station to promote our Centre. It was effective because people here could remember us and knew about our functions. (The Director)

Based on Centre 12 interviews, five people representing four partner groups were selected for interviews. The rest of this section reports on these interviews and provides

an insight into how the partner groups see their role and includes two case stories, one on the power of community partnership, the other on the power of community participation.

Table 5.4 describes the background and work experience of the five participants.

Table 5.4 *The five partner group representatives' background and work experience*

Participant No.	Representative of	Work experience
1	Academic research sector: The Director of the Deep South Coordination Centre (DSCC)	Director, Assist Prof Dr Metta Kuning, has a solid background in statistics. Currently a lecturer in the Department of Mathematics and Computer Science, Faculty of Science and Technology, Prince of Songkla University in Pattani province. DSCC's main role is database management. Also works on home visiting and empowering people affected by the violence, especially widows.
2 and 3	Special interest group: Two volunteers of Brahma Kumaris Foundation	Works on inner spiritual development Working in the Deep South Coordination Centre (DSCC) which focuses on building community strength and disseminating their knowledge about spiritual development, thinking positively, and living together with respect, to public health practitioners through training courses and workshops.
4	The public health practitioner: A staff member of the Provincial Public Health Office	Major role is supporting physical and psychological health systems Provides budgets, materials, and knowledge for all public health practitioners in the province.
5	Media network: A radio deejay of the National Radio Thailand in the Three Southern Border Provinces	Radio producer and performer with 8 years' experience in the National Broadcasting Services of Thailand, based in the southern border provinces. Major role is a programme director who controls chart shows, broadcast schedules and coordinates with all radio deejays.

5.3.2 Partner group perception of the partnership role

5.3.2.1 The Director of the Deep South Coordination Centre (DSCC)

The DSCC's Director, Dr Metta Kuning, described DSCC as a research project that focuses on database management in responding to the crisis situation. The project started in 2006 (one year after Centre 12 was established) when the number of people affected by the mass violence was continually increasing but there was a lack of systematic data collection:

At first, we collected the information about people affected by the crisis and types of crisis incidents they faced. To check the case information, we choose random cases and our staff went home visiting. Therefore, our work has two responsibilities: database management and checking cases and helping to improve their quality of life.

Dr Kuning described her data collection and management and utilisation of the database:

My routine work begins when I wake up: I get the information from police or army officers about the unrest situation. Then I sort the information [from their reports]; name and surname of wounded people and dead people; and the types of incident violence. Mostly, the new reports come in A4 format. After I sort the new information, it will be sent to psychologists at Mental Health Centre 12, Southern Border Provinces Administration Centre, Provincial Health Office, and other organisations in my list. I have staff helping me in summarising information from the news I receive.

The interview reveals the DSCC functions as an information source for many sectors not only the 12th Mental Health Centre. This role in collecting the number of people affected by the violence was very similar to the Centre 12 work on behalf of the Rehabilitation Sub-Committee. However, the DSCC's Director did not identify any link to the Sub-Committee, but perceived Centre 12 as her information user. In addition to collecting statistics, the DSCC also works on building community resilience, the same focus as Centre 12.

One of the successful programmes the DSCC's Director was proud to present was the group of "Volunteer Minded Women". She explained the overall concept behind this group and argued it was an excellent model of mental health delivery from which other government agencies and Centre 12 should learn:

We have provided workshops for them [widows] to meet and listened to them. They told us what they want to learn. Then, we provided them courses they needed and talked about what [trials] they have encountered and the methods they used to work through their hard time. Miss X [the second partner representative in the Brahma Kumaris Foundation, name is withheld for ethical reasons] also worked with DSCC. She taught about positive thinking, which is needed by the widows.

After participating in mental health healing and training courses from the DSCC, the widows were empowered and strengthened. They then wanted to help other people, shifting from those needing help to helper:

We asked the widows about their intentions, what they wanted to do. It is based on their needs. The first issue they have discussed is about visiting their neighbours. They thought home visiting should do by the insiders rather than outsiders.

The Volunteer Minded Women model was claimed as an outstanding community-based intervention because participants became community leaders and was accepted by the government sector. "After volunteer minded women were trained, they could coordinate with the government sector and many organizations. Some were hired by government officers as they have coordination skills. Most became leaders of their villages".

Furthermore, they had developed their communication skills and become community reporters:

When they have information, or encounter a situation where help is needed, they will report to DSCC. We also trained them about taking photos and sending SMS. We have even trained them using weblog; however, this was ineffective as they could not access the internet when they went back to their communities. We have no money to spend in this facility so we mainly used SMS. After we got SMS, our staff go to the area, summarise the situation and write a brief text with photo attached to send to our centre.

The DSCC's Director emphasised again later that Centre 12 was the main information user when she talked about the outcome of her work with the Volunteer Minded Women:

The first group who benefit from my work is the psychologists. My work focuses on physical and mental health healing so the main network is the 12th Mental Health Centre...After I read a text from the Volunteer Minded Women about cases which need help, I will forward it to people or organizations who can help each case such as the director of the Institute of Research and Development for Health of Southern Thailand, the Southern Border Provinces Administration Centre and the 12th Mental Health Centre...My purpose is people who work in the area must have information so we know who needs help. Even though they can receive the information by themselves, they still have to read and analyse. So here we categorise the information; they can copy and check, and not waste their time. (The DSCC Director)

However, Centre 12 also benefits DSCC, not only in terms of case support (as above), but also in media provision:

At first, I wanted to produce some media, but finally I did not because the Mental Health Centre has produced a lot of media. I am a user, no need to produce. About the media of Mental Health Centre, there were a lot of media patterns, produced every year, and provided in many languages. No need to produce, [it is] better use what they did. (The DSCC Director)

The interview with the DSCC's Director shows Centre 12 was not involved in DSCC's work although their roles in data collection and building community resilience were similar. These two organisations were set up at the same time but each developed their

own systems and practices. These differences meant it took time for a real partnership to develop. As the DSCC's Director said "Previously, we were suspicious of other but now we trust each other because we have worked together for many years". Interviews show partnership between Centre 12 and the DSCC involved using their strengths to support each other, especially sharing information and media sources.

Interestingly, there was one case story which the DSCC's Director and the Centre 12's Director both referred to when they talked about the power of partnership:

Case story 1: The power of partnership

This is the story of Mr M [name is withheld for ethical reasons]. He was shot in 2007 and cannot walk. Previously he was a family leader. He planted and sold chilli but after he was disabled he was stressed because his role had changed. He just helped his wife do small tasks such as watering the plants. Their main income still came from selling chilli. However, a further problem arose when his son began stealing. Mr M lost his will-power and did not want to live. After this he became severely ill, his wound was infected and he developed damaging pressure sores. At first, he was admitted to the community hospital and he seemed likely to die. Then he was referred to the provincial hospital. Our Volunteer Minded Woman went to visit him and saw that he needed blood. So, she coordinated with the Internal Security Operations Command which sent their staff to donate blood. She informed me and I contacted my University and asked for blood donations. Finally, he recovered and could go back home. He still slept in the same way so the same problem of pressure sores occurred again. I liaised with Dr Pechdao [Centre 12's Director] and a month later, she went to his house and gave him an air mattress. Then Dr Pechdao noticed his wheelchair was broken, so she liaised with her friend who could provide a new wheelchair. After that Centre 12's Director knew that he was worried about his son's education so she helped by enrolling his son into the government school. (The DSCC Director)

The story above shows the power of a personal relationship with Centre 12's Director helping the patient. Personal relationships to achieve good outcomes may be very useful when the problems are urgent and needing immediate solutions. However, this also is a risk when the problems are multiplied and those people who have used personal

relationships to help are no longer there. Solutions need to become part of a systematic structure; this will be discussed further in Chapter 6.

5.3.2.2 Two volunteers of Brahma Kumaris Foundation: Inner spiritual development

Two participants representing a special interest group are volunteers of Brahma Kumaris Foundation. They were an important part of Centre 12's programmes at the beginning because they were members of the Rehabilitation Sub-Committee and trained some Centre staff in the "*Bright life, strong mind*" programme in 2004. Later, they were invited by the Department of Mental Health to facilitate Centre 12's training workshops for psychologists and public health practitioners. One of them explained their approach:

In Brahma Kumaris we have learnt about disciplining and directing our thinking. We believe everybody can improve and change no matter what race, religion or language. So, if we meet people who are suffering, we share our techniques or lessons we have learned to help them.

Their role as a partner was clear: it was a formal rather than informal partnership under the Rehabilitation Sub-Committee. Their relationship with Centre 12 lessened after the Centre's work practice changed following the new Department of Mental Health policy and dismantling of the Rehabilitation Sub-Committee in 2011.

Additionally, these two participants also provided training workshops for the Volunteer Minded Women group described above. Some members in the Volunteer Minded Women group also joined in the widows group of Centre 12. Although this workshop was run specifically for the Volunteer Minded Women group, two Centre 12 staff members who took responsibility for programme planning were invited to participate in this workshop, showing the partnership is continuous. It is revived whenever programmes of mutual interest are run.

The following story as told by one of representatives from the Brahma Kumaris Foundation shows the cooperation between these two participants and Centre 12 when they worked together on behalf of the Rehabilitation Sub-Committee.

Case story 2: The power of community participation

When I was a leader of the Disabilities' Working Group, I worked on community rehabilitation. Disabilities are chronic so I thought it was hard if communities did not play a key role in looking after them. We went to XXX community [name is withheld for ethical reasons] in which most of the people are Buddhist. There were mostly elders and widows living there. Most of the men had died. If not dead, they were injured by the mass violence crisis. What I did was to ask them about what they wanted to do. This community was strong and every part wanted to participate in their community development from government officers, schools, religious leaders, community leaders, through to hospitals. We found a man who was shot and had become disabled. We asked him what he did previously. He said he was a puppeteer. So, we suggested that he use puppets in mental health rehabilitation. Then, Centre 12's Director bought many puppet characters for him. Luckily, there was another group of people in the community who could perform folk-dancing [Manora, the traditional folk dance in southern Thailand]. In the evening, they both taught children. Now, this group [of puppeteer and folk dancers] is supported by the community and has developed further and became a community strength and received a trophy from the government. Although we [the NGOs] are no longer part of the programme, this group is still active.

This Disabilities Group is also identified (in section 5.4) as a programme showing concrete outcomes. As with the earlier case story, it also shows Centre 12's Director using her personal power to help an individual case.

5.3.2.3 Staff of the Provincial Public Health Office

The next participant was a public health practitioner partner. She is a Public Health Technical Officer, Professional Level, in the Pattani Provincial Public Office. The participant explained the role of the Provincial Public Health Office in responding to mental health issues:

The Provincial Health Office is a supporting unit which provides budgets and equipment. The main community-based workers under our supervision are the Village Health Volunteers (VHV) we have provided workshops to help them look after people in the village. However, to communicate about mental health issues, our direct communication is through psychologists' home visiting and indirectly we have used radio broadcasting.

One of Centre 12's staff described the Provincial Public Health Office as a core organisation that "functioned for driving *overall operational* efficiency of the hospitals". If Centre 12 wants to provide a programme for public health practitioners, they contact the Provincial Public Health Office before approaching local healthcare staff (the office acts as a gate keeper). However, the partner participant perceived herself as Centre 12's media user:

In mental health issues, we coordinate with the Mental Health Centre. We use media which the centre has produced. If there are not enough media resources, our office will reprint them for disseminating to twelve districts. The media we use, such as pamphlets, we disseminate to the mass media, such as national radio and local broadcasting in the villages.

The relationship between the Provincial Public Health Office and the 12th Mental Health Centre is formal. Both government agencies work at the local policy level. Their responsibilities focus on supporting the mental health delivery system and mental health deliverers rather than working directly with people affected by the mass violence.

5.3.2.4 Media network: National Radio Thailand in the three southern border provinces

The last identified partner group was National Radio in the Three Southern Border Provinces of Thailand. This station received a budget from Centre 12 to produce a radio programme "*Good mental health, happy life*" for promoting people's mental health. The participant representing this group is a station staff member who took responsibility for designing and presenting this programme. She explained the importance of communicating about mental health through radio:

Most people do not understand about mental health and refuse to mix with psychiatric patients. The knowledge and understanding about looking after the mental health of ourselves, family members, and how to be happy in daily life has to be promoted. So, providing knowledge and education about mental health through radio broadcasting can be the best way to reach people because it helps to build awareness about mental health problems, helping each other in the society, building good mental health in individuals, family, and society.

Centre 12's Director confirmed that the Centre did not provide content, instead the radio producer searched for the information from the Department of Mental Health's media and official website.

National radio in Pattani province conducted a survey evaluating the programme's exposure across five stations. They found that the programme was popular but could be improved by talking with more ordinary people and providing a small reward for these participants.

This evaluation was followed up by Centre 12 as it needed to use those outcomes in the annual report. However, the Centre did not apply the recommendations because of the limited budget. The partnership was therefore limited because it mainly depended on the budget. However, Centre 12's Director believed that the radio programme was an effective channel in promoting mental health and she saw media networks as a "partner".

In summary, this section provides different examples of partners and partnerships. Centre 12's staff members perceived public health practitioners as their main partner, and the relationship as a formal one. Academics and the special interest groups were also identified as partner groups who provided new knowledge and shared information and resources. Interviews show the combination of formal and informal patterns of relationship depending on the purpose of their interaction. Centre 12 and partners mostly work on their own tasks but are ready to join each other's activities and help each other when needed.

Interviews with partner group representatives unsurprisingly show a different perspective of partnership than Centre 12 staff. They focus on their own activities, although they see the relationship with Centre 12 as helping meet mutual goals.

This chapter now turns to RQ 5, exploring the major factors of success and the challenges in mental health communication in the mass violence area.

5.4 Participants' perception of major factors of success in mental health communication in the mass violence area

The key informants from Centre 12 were asked to judge the success of their practices and analyse the major factors of that success. All staff members agreed that their practice between 2004 and 2014 was successful. The Centre's Director and several staff members identified working with networks as their major factor of success. Second, several staff members cited the unique nature of programme delivery as a success. Third, the mass violence crisis itself was seen as an opportunity to develop their potential and service systems. A fourth success factor has been identified by the researcher and backed up by extracts from various interviews – the role of Director.

First, though, it is useful to explore how participants defined and understood “success”. An important characteristic of success reflected by most of the participants was “programme sustainability”. Interestingly, all the staff members and the Director first thought of programmes in which they had participated on behalf of the Rehabilitation Sub-Committee (or the seven working groups). The widows, children, and disabilities groups were each described as building sustainable outcomes.

The Director and two staff members saw the widows' group as the most sustainable programme because it later became a self-help group that continued without Centre 12's budget support:

We firstly urged 37 hospitals in the area to be the main hosts working on this issue [widows' support]. Each district identified the widows both from the violence and other causes to join the activities. In the beginning, they came and divided into 33 clubs belonging to their areas. After they joined, they rehabilitated each other and other people. Widows in area ..XXX.. [name is withheld for ethical reasons] for instance, began at the local hospital. After they became strong, they went on to rent their own office and launched activities. Now we do not have a budget for supporting them but they are still active. (The Director)

The Director's example was echoed by Staff No. 9, who said once the widows' group raised their own funds, they were self-sustaining.

Another two participants pointed to the disabilities group. One said:

The leader of this group, Mr S [name is withheld for ethical reasons] who is an able puppeteer and he trains the children and people in his community. Now this community has become the learning centre for developing puppet show for rehabilitation. (Staff no. 8)

As with the widows' group, the disabilities' group was perceived as successful and sustainable because they could continue without Centre 12's budget. However, the sustainability of this group was also a result of community participation: "Their activities are still ongoing because they were supported by the Sub-District Administrative Organisation and the community hospitals" (Staff no. 2).

Several interviews reveal the concept of "concrete outcomes" was understood by the participants as showing "programme sustainability". Another participant saw long-term programmes as the sign of sustainability. She gave an example of the children's programme, which, she said: "was run continually for 4–5 years" (Staff no. 7).

5.4.1 Working with networks

A senior staff member who took responsibility for conducting research and disseminating mental health interventions emphasised "networking is Centre 12's strength" and identified broad networks that contributed to their outcomes:

We have many networks, such as public health officers, local government, schools and teachers, NGOs, in academic issues; we are supported by the universities around this area. (Staff no. 1)

A less experienced staff member also said public health practitioners were the main network. In her view, this compatibility was a key strength:

We were in the same system so we knew how to work with them and we also worked together on every issue either mental health promotion or mental health prevention. (Staff no. 5)

Another interview with a public health technical officer also identified the public health sector and local government as the Centre's network. However, his reflection highlighted local government as a network in developing and implementing the mental health programme called "DSS or District Self System" (Staff no. 6). This programme aimed to improve mental health in selected pilot communities.

Another senior staff member spoke about the benefit of working with networks. However, she focused on networks outside the health sector:

We had networks outside the health sector such as community leaders, village health volunteers, religious leaders, and NGOs. They help us in many ways. They can access more people. We also provided some interventions to them such as psychological first aid. (Staff no. 9)

These excerpts show the Centre staff's perceptions of supportive networks. While organisations inside the health sector were perceived as networks because they worked for the same goal, organisations outside the health sector were networks because of mutual help and sharing of benefits.

The Centre's Director also thought working with networks was the major success factor. Interestingly, she perceived herself as a network coordinator who plays a key role in strengthening networks:

I did not work only at the 12th Mental Health Centre, but I have been appointed to committees in many groups which were useful for coordination in networks. Our strength is about this coordination which allows us to see the overall picture, which is mental health which is not just narrowly focused on public

health practitioners. We have been able to build up networks with many groups. (The Director)

The role of the Director in the Centre's success was mentioned indirectly in six interviews and is discussed further in 5.4.4.

5.4.2 Unique nature of programme delivery

The unique characteristic is the term used by two staff members to identify the effective ways they have used in delivery mental health communication programmes. One of them talked broadly about the main role of the Centre 12 in responding to the mass violence, especially in implementing training workshops for public health practitioners:

I saw this Centre's role as the mental health support for the hospitals. We organised workshops for disseminating mental health knowledge for hospital staff especially about mental treatment and rehabilitation for people affected by the violence. (Staff no. 4)

Another staff member pointed out that the community-based service Centre 12 coordinated with local public health practitioners was a unique and effective service:

One success in the past was providing mobile hospitals. Following home visiting we have mobile hospitals. If we went to a community, we invited the doctors from the local community hospital to go with us. Sometimes we invited nurses, staff from sub-district health promotion hospitals and community leaders who joined in the visiting team. After checking blood pressure, we provided a mental health screening and consultation service. (Staff no. 3)

The community-based service above was perceived as a good practice and proudly presented by the staff. However, this participant added later that "Now this service has been cancelled because of the policy under which the authorities decided we were not the appropriate organization for treatment". This was one of several examples provided by staff that demonstrated the negative impact of policy changes on programme delivery.

Another staff member with the Centre since it was set up said an additional factor contributing to the Centre's success was that health is an area which affects everyone:

It was a health issue which is useful for every people everywhere. We went to the communities with doctors and nurses and gave them knowledge about physical and psychological health. We educated and consulted both individual and groups. People accepted us as they could see the benefit for their health. (Staff no. 7)

5.4.3 Turning crisis into the opportunity for development

Interestingly, three staff members talked about the mass violence crisis as the factor supporting their work. Two of them illustrated the benefits they have received from the mass violence incidents: developing staff's potential and setting up the rehabilitation system through community participation:

I thought we were successful. It might be because of the crisis. Even though it was a serious crisis, but we have changed this to the opportunities for our work. The government gave priority to mental health so we had chance to develop our potential much more than the other areas. (Staff no. 8)

I think we are successful because we built up the rehabilitation system. We empowered people, especially the leader groups in communities. Now, when a crisis occurs, the local government, community leaders and people in the area help each other. It is a self-sustaining system now. (Staff no. 2)

Another staff member, experienced in working outside the crisis area, noted Centre staff have to employ especial concern for the target audiences' needs when implementing mental health communication programmes in the crisis-affected community:

As we faced the violence, before doing anything in the community we had to ask people's needs. It was important to know what people think compared to the other areas and I thought this was the main factor of our success. (Staff no. 10)

The staff specifically summarised three factors of success, including working with networks; the unique nature of programme delivery; and the mass violence crisis itself producing opportunities for action. However, another factor of success that arose indirectly from the interview material, is the role of Centre 12's Director. The following section provides evidence from staff interviews that referred to the Director's role in

supporting Centre 12's success in communication programme planning and implementation.

5.4.4 Role of Centre 12's Director

Although the 11 staff members were not specifically asked to comment on the Director's role, interview evidence from six staff members showed the role was seen as essential to success in a variety of circumstances. As a result, the Director's role was identified by the researcher and discussed here as one factor of success. Based on staff reflections, the impact of Director's role is divided into five areas: coordinator, budget and instrument provider, programme theme setter, researcher, and inspirational community-based worker.

Earlier (in 5.4.1) the Director said that she perceived herself as network coordinator. Similarly, staff no.8 when talking about safety concerns said: "We are very lucky, our director has a lot of networks. When we want to go into the dangerous areas, they will assess the risk and confirm whether we can go to the area".

Another two interviews showed it was the Director who tried to find additional budget to support Centre 12's work. A social worker staff member said as a result they were able to work beyond the parameters set by the government policy:

For example, programmes which the Director has asked for support from the outside organisations, such as UNICEF, the National Health Security Office, and the Southern Border Administrative Centre. (Staff no. 2)

Similarly, a counselling psychologist participant said: "The director tried to find budget from other sources and provided to a variety of groups in the communities. She said that earlier we mainly supported health practitioners, now we should focus on teachers and communities" (Staff no. 10).

Participants also identified that the Director used her personal power to provide equipment helping people affected by the violence crisis as shown earlier in Case story 1 and Case story 2 (see section 5.3.2).

The Director's third role as programme planning theme setter was illustrated by an experienced staff member:

The Director will give us the big theme. Such as with the budget we got from UNICEF, the Director said she wanted to use this for developing children affected the violence, wanted to see community participation in the programme, and supporting the community to look after their own children when facing the crisis. Based on this theme, we have to design the programme. (Staff no. 3)

A staff member who took responsibility for disseminating mental health interventions said the Director was the source of the original idea for the programme for the complicated cases:

Actually, the Director was the first person who thought of this programme. She set the theme in setting pilot areas and trying to implement it, but it was not structured. We got the idea and developed the model which was able to be easily applied to additional areas. (Staff no. 1)

The role of the Director as researcher was pointed out several times both by the staff and by the Director herself. Reflecting on her local knowledge, the Director suggested the importance of observing people's cultures and ways of life before designing programmes targeting the specific audiences. Further, findings from the Director's research were also applied in programme implementation (for instance, the area-based research she conducted about trustworthy people and coping strategies). She found religious leaders were recognised as trustworthy and religious principles were an important coping tool. As a participant stressed, "This [research finding] was the background reason we produced *Healing according to Muslim Principles* books".

The last role of the director as a community worker was referred to several times, and was perceived as an inspiration by several staff members:

Earlier, when we worked on behalf of the Rehabilitation Sub-Committee we went home visiting regularly, the Director went with us everywhere. Some areas were prohibited because they were dangerous, but the Director still went to visit. (Staff no. 7)

The Director did everything by herself even measuring people [to assess their physical health]. The villagers really liked her. (Staff no. 3)

The excerpts above support the idea that Centre 12's Director is one of the major factors of success. Five roles are identified by the researcher based on material that emerged from interviews with the Centre staff. The Director was also acknowledged as the only leader of this organisation for 10 years. The analysis of her role in this section will be discussed further in the following chapter to generate insight and understanding of the role of the organisational leader in times of crisis. The next section explores the second half of RQ 5, the participants' perception of the barriers to success in communication programmes in the mass violence area.

5.5 Participants' perception of the factors they perceived as barriers

As mental health practitioners in the mass violence crisis situation and a multi-cultural society, the Centre 12's Director and staff reported many barriers impacting on their work. Barriers or challenges identified from interviews fall into two categories: what is outside Centre's control and what is more able to be managed.

5.5.1 Barriers outside the Centre's control

Seven staff members thought working in the mass violence area was the main external barrier for them, while a highly experienced staff member pointed to change in government policy as her main difficulty.

While the crisis situation was perceived by two staff members as a supporting factor of success, seven staff members said feeling insecure due to the violence was their biggest difficulty:

It is about the crisis situation. Some places or some periods of time are dangerous, not suitable for working. (Staff no. 5)

I think about safety. Sometimes when violence has occurred, we wanted to help people but we were afraid of the dangers. When we go to the area, we have to coordinate with the community leaders, NGOs or local hospitals. (Staff no. 8)

The excerpts above reveal that the Centre 12's delivery process is more complicated due to the mass violence situation because staff members need to ensure their safety before going to the community.

The changeability of the government's policy was also identified as a difficulty by a staff member with the Centre since it was set up:

Then, there were no programmes or activities which were organized annually. Now, programmes and activities have to change in according with the Department's policy every year. We have to follow that policy because our outcomes will be evaluated. (Staff no. 7)

5.5.2 Manageable barriers

Two staff members saw lack of networks from the local government as their main barrier. A staff member who takes responsibility for programme planning said getting the audience they want could present difficulties when implementing mental health programmes. Third, the Centre's Director thought an ineffective communication channel used to promote their work was a difficulty. The section below provides interview and observation material.

Earlier, working with networks was identified as a major success factor but lack of them turned out to be a barrier identified by two staff members. However, they focused on the local government network particularly the Sub District Administrative Organisation in communities being "the important key to connect us with the community" (Staff no. 2). Furthermore, Staff no. 10 commented that this group lacks sufficient mental health knowledge. Centre 12 staff hoped that the Sub-District Administrative Organisations would participate in their programmes because they help access people in communities and organisation officers can be trained to be mental health deliverers. However, a highly experienced staff member identified the reason for this group's lack of participation: "the Sub-District Administrative Organisation did not join our programmes because their work was mostly focused on the infrastructure" [such as road, water, electricity supply] (Staff no. 9).

One staff member, a programme planner, said their work could meet with difficulties when they were unable to reach the community participants they need because of insufficient community liaison ahead of the events:

Sometimes in the meeting, participants did not come from the group which we have targeted and the numbers of participants did not meet with the amount we expected. (Staff no. 3)

Identifying and communicating clearly with programme's target audience was also observed to be a difficulty of programme design. The following excerpt describes a participant observation in one programme the 12th Mental Health Centre launched based on the Department of Mental Health's policy for educating about children's intelligence quotient (IQ) and emotional quotient (EQ):

I went to attend a programme which the Centre 12 launched on 6–8 May 2014. On the first day, I noticed that the target groups (which include teachers, parents, and staff of Sub-District Health Promoting Hospital in Pattani province) were puzzled about why their schools were chosen to attend this workshop. They were worried whether their children have mental health problems. Then, the staff explain that they were randomly selected. Their children have no problems currently but they were chosen as a pilot group to make people aware when problems arise in their family, school, and community. I noticed that the explanation should be done before the meeting. (Observation, 6/05/2014)

Another barrier observed from the same workshop was academic or specialist content that was too advanced or time consuming for the audience, as evidenced in the following field notes:

The communication strategy was learning by doing. Firstly, the key speaker opened with an emotive video of a boy who was intellectually disabled and how his parents took care of him. Then, the participants were taught about how to measure general intelligence by using the IQ test. There are 60 questions which the participants need to read and evaluate the behaviour of children. Some examples are accepting others' ideas, trying to do difficult things by themselves, accept when they do something wrong etc. There are four levels of evaluation: never, sometimes, often, and regularly. I noticed that this activity took a long time as some participants had limited reading skills and they found it was difficult to calculate the overall score. (Observation, 6/05/2014)

Centre 12's Director reflected that some of mental health communication channels they have used were also a problem:

At the beginning of setting up this centre, we hired a radio station to promote our centre. An outcome was people knew and remembered our centre. However, we did not evaluate people's exposure [to the messages]. We also had a hotline to the Department of Mental Health, 1667. This radio programme was broadcast by the Psychiatric Hospitals which used two languages for listeners in the southern area. However, most phone-ins were consulting about love, not about the violence crisis. It might be because the listeners were mostly teenagers who can access social media. So, this channel might not be effective for accessing lay people in the south.

It is worth noting that this is the second comment by the Director about the lack of media evaluation planning (see her comment in section 5.2.5).

5.6 Conclusion

This case study of Centre 12's mental health communication programmes in response to a decade of the mass violence situation in southern Thailand (between 2004 and 2014) captures the communication programme cycle. Centre 12's staff members commented on four stages of mental health communication programming: programme planning; collateral design and testing; programme implementation; and programme evaluation. In programme planning, audience analysis and audience segmentation were highlighted as a planning priority. Three methods of audience analysis were pointed out: one informal method (observing people's way of life, religious dress and lifestyles), and two more formal techniques (using information from a summative survey and meeting with opinion leaders in the communities). Additional evidence shows Centre 12 conducted formal audience research when the Centre was in its early stages. Staff also use data and information from secondary sources about disaster impacts to design mental health communication programmes. Other programme planning priorities mentioned were budget considerations (in terms of flexibility and cost-effectiveness), and programme goals and communication strategies to reach these goals.

In discussing factors of concern for programme planning and design, language was highlighted as the major concern in an area with several home languages. Staff said the social context of a multi-cultural society that combines Buddhists and Muslims, in addition to the tensions caused by the violence, also needed to be explored and taken

into account before planning programmes. Furthermore, choosing trustworthy senders, reducing suspicion, and personal safety were also mentioned as concerns for programme planners. However, systematic planning for programme evaluation was necessary in the planning stage.

The second programming stage was identified as media/message development, print media were mainly used to support programmes in phase 2 and 3. Additionally, the development, content pre-testing and distribution of five key religious-based booklets, two books on healing according to Muslim principles and three books on healing according to Buddhist principles, were identified in greater depth. Key informants explained that Centre 12 invited experts such as academics, religious leaders (both inside and outside the area), and opinion leaders to design and verify the contents of the books. Media were tested several times in selected communities, especially by the deliverers who participated in mental health media production team. Last, media and collateral were disseminated through workshops, seminars, and at local hospitals.

The third stage, programme implementation, shows Centre 12's programmes were implemented largely through workshops for the deliverers group and for people directly affected by the violence. The deliverers group (or 'intervening publics') included public health officers, teachers, local government officers, and community leaders. They were upskilled in learning of mental health knowledge in the hope they would influence those directly affected by the violence. Participants mentioned children several times as an at-risk group (reached through workshops and school activities). For instance, the children's camp programme instituted in response to school bombings are run with support of the community leaders, and the psycho-education programme for teachers and parents to learn about children's IQ and EQ. Findings also showed that in addition to the well-planned and systematically delivered communication activities, the staff also operated quick response programmes, by responding to emergency situations which require alternative plans.

In exploring the last stage, programme evaluation, findings show the limitations of Centre 12's evaluative methods. Generally, communication programmes relied on after-workshop questionnaires (which used a standard official form and emphasised audience satisfaction). Apart from a few focus groups there was little effective evaluation of

media produced. The Director and some staff wanted to measure programme and media effectiveness and utilization more fully.

Interviews with five partner group representatives show different perceptions surrounding partners and partnerships. Public health practitioners were perceived as Centre 12's main partner. This, however, was a formal relationship because they both are government agencies working in the health sector. Academics and the special interest group in the study were identified as partner groups who provided new knowledge and shared information and resources. Media (radio) was limited partner as the relationship depended on budget. Centre 12 was perceived as a source of mental health media resources for partner groups. While each partner group focused on their own activities, they saw the relationship with Centre 12 as helping meet mutual goals.

The key informants also discussed programme success, defined as the sustainability of programmes. Programmes identified were those with women's and disability groups, a number of which have proved to be self-sustaining, and the children's programme, which was run over a number of years. Success factors discussed by the participants were: working with networks, the unique nature of programme delivery, and the mass violence crisis itself (an opportunity to develop the participants' potential and service systems). Additionally, the role of the Centre's Director emerged indirectly from interview material as another success factor.

Last, findings reveal two types of challenges for Centre 12's communication programmes: barriers outside their control (working in the mass violence area and the changeability of policy) and manageable barriers (lack of networks with local government, inability to access the intended community participants, and sometimes inappropriate communication channels for the intended audience).

In the next chapter, these development, delivery, and evaluation of mental health communication programmes at Centre 12 will be discussed in relation to the relevant literature on public communication and public relations, health communication, and development communication. In this way, this study contributes to the understanding of a functional or normative framework of public communication, specifically in the context of mass violence.

CHAPTER SIX: DISCUSSION

6.1 Introduction

This case study focuses on the establishment, funding, and delivery of Centre 12's mental health communication programmes in response to the mass violence situation in southern Thailand. Two particular conditions which impact on the Centre's practice and programme delivery are a context of on-going (over 10 years) violence, and a multicultural society which combines Buddhist and Muslim populations. An in-depth exploration of mental health communication programmes from the deliverers' perspective looks to enhance our practical understanding of public health communication practically and expands knowledge about campaign/programme planning frameworks in a particular context of mass violence.

This chapter discusses key findings seen in Chapter 4 and 5 in relation to the three theoretical frameworks that underpin this study: public relations, health communication, and development communication. The chapter begins by discussing the value of taking a multi-disciplinary approach to the study; then each research question will be discussed.

6.2 A multidisciplinary approach to the study

This study uses the strength of the three approaches and their interrelationships in order to discuss Centre 12's mental health communication programmes. The study is designed so as to respond to several requests from health communication studies, such as lessons learned from integrating multi-disciplinary approaches (Schiavo, 2007), evidence-based research of the successes of outreach strategies (Naturale, 2006), and experience from health practitioners for developing theories, models, and guide health communication campaign planners (Noar, 2006; Schiavo, 2007).

From the public relations approach, management of communication and building long-term relationships (Grunig & Hunt, 1984; Houston et al., 2015; Public Relations Society of America, 2017) is applied to analyse Centre 12's programme planning and delivery and its relationships with its partners. In the health communication approach, health promotion perspective (Kreps, 2014; Kreps et al., 1998) and the operational approach

(Ratzan et al., 1996) provide an initial understanding of applying communication strategies to promote health and prevent health risks. From the development communication approach, the participative model (Hoffmann, 2014; Rogers, 1976) adds to our understanding of Centre 12's participatory communication with their partners, community-based interventions, and sustainability development, which are major components of community resilience (Norris et al., 2008). The combination of the three approaches, especially in a campaign planning framework, and the ideal of two-way participatory communication are applicable in discussing Centre 12's programme planning, implementation, and evaluation (see section 2.5). The value of integrating development communication with public relations and health communication is a key contribution of this research and is also presented in the following chapter.

6.3 Mental health policies and practices in response to the mass violence situation

The study findings clearly show the Thai government took the mass violence situation in southern Thailand seriously. As Centre 12's Director said, the wide impact of violent incidents meant the Thai government prioritised this crisis and promptly responded by setting up the mental health rehabilitation system at both policy and practitioner level (Interview, June 4, 2014). This high-level response is crucial as when dealing with social problems – who defines the problems is key (Salmon, 1989). Those who have political power and resources are advantaged. Findings capture how the government's immediate strategic policy response flowed through to the practitioner level, which focused on the on-going response. These two levels are discussed below in answering RQ 1: In what way did Thai government policies impact on the establishment, funding, and delivery of mental health communication programmes in the mass violence situation in southern Thailand?

6.3.1 Government strategic policy response

The response of the Thai government in recent crises, both natural and manmade disasters, confirms that governments have prime responsibility in response and recovery. Birkmann et al. (2010), in discussing the roles of government in responding to mega-disasters (the 2004 tsunami in Indonesia and Sri Lanka) said the disasters provided “windows of opportunity” (p. 639) for governments to develop new structures,

including establishing regulations, developing early warning systems, and setting up a disaster management centre. In Thailand's mass violence, the government-driven response began with an immediate high-level focus on setting strategy. At this stage, the government provided policy support by establishing the rehabilitation system, including setting up strategic response organisations that reported directly to the Prime Minister's Office and the powerful rehabilitation committee and sub-committee (see section 4.2.2). The government also provided budgets, and resources (especially setting up the 12th Mental Health Centre as a knowledge provider and mental health service coordinator, and hiring 74 full time psychologists; see section 4.2.3 and 4.3).

Interviews and document analysis show that the idea for the Centre and psychologists came from the Director General of the Department of Mental Health, M.L. Somchai Chakrabhand, who repeated strategies used in response to Thailand's 2004 tsunami disaster. As Visanuyothin et al. (2006) said, the Department of Mental Health produced a prompt mental health response to the tsunami disaster by establishing a Mental Health Centre as a central operations centre (similar to Centre 12's responsibilities) and mobile mental health teams as the frontline operations centre (similar to those psychologists' responsibilities).

However, the changeability of government policy and the difficulty of mental health communication programme evaluation were important challenges for Centre 12 in dealing with the mass violence. This is partly reflecting of the long timeframe, given the mass violence spanned at least the 10 years of this study. Similarly, Birkmann et al. (2010) identified the uncertainty of regulations and the difficulty of evaluating the effectiveness of new disaster response organisations as problems facing those delivering government programmes in Sri Lanka. They also mentioned the inequity of treatment and the short-term mind-set of the political leaders. Centre 12's participants did not directly refer to these two difficulties, but the findings show the change of government and the increasing national political conflicts between 2010 and 2014 impacted on policy responses to the mass violence. The social power and resources of the government began to focus on the national conflict (Dalpino, 2011). The impact of policy changes will be discussed further in the practitioner level in the following section.

6.3.2 Government response at the practitioner level

The practitioner level focuses on the ongoing response, especially types and tactics of the delivery of the mental health communication programme. Centre 12's programmes from 2004 to 2014 can be viewed as health information or public communication campaigns about mental health. In this sense, they fit with Salmon's (1989) description of classic public communication campaigns as an early attempt by the government to deal with an emerging problem. They also reflect Salmon's critique that it is easier to change individual behaviour rather than to change the system. However, the attention paid to individual self-management in the Thai response to the violence is understandable, given the perpetrators of the violence have remained unknown. Further, Weiss and Tschirhart (1994) argue that information campaigns have the capacity to provide a positive relationship between citizens and government. In this study, interviews show that among government agencies, public health officers were seen as highly trustworthy.

This study's findings highlighted four interrelated phases of programme development by practitioners reflecting government policy shifts: the reactive programme (2004–2005); the policy of targeted groups (2005–2010); the policy of general age-group targets (2011–2014); and the emerging phase of severe and complicated cases (2014 onwards). These phases are broadly related to the stages of the mass violence itself, or to stages of crises as described by Cutlip et al. (2006).

In the first phase, a year after the mass violence exploded, the Director described Centre 12's practice as "trial and error" (Interview 4 June 2014). A children's camp programme was immediately instituted as a reactive response to the burning of 18 schools in January 2004. Cutlip et al. (2006) identified that when an unexpected situation suddenly occurs, communication practitioners react with a general plan to avoid confusion, conflict, and delay. This phase was a response to an immediate crisis. Furthermore, Centre 12's limited response at this stage is typical. Reviews of mental health interventions by Watson, Brymer, and Bonanno (2011) and behavioural interventions by Gray and Litz (2005) also show a very limited response in the early stages of disaster. Watson et al. said mainly psychological interventions, such as psychological debriefing and psychological first aid, were commonly used in this first

response. This is the nature of Centre 12's children's camp response, which provided mental support from peers, religious foundations, and mental health practitioners.

Western governments tend to rely on mass media in the early stages of a crisis (Njenga, Nyamai, & Kigamwa, 2003; Perez-Lugo, 2004). However, as findings here show, the government's response programmes instituted by Centre 12 made relatively little use of mass media. This is in contrast with the U.S. response to the World Trade Centre attacks where a large media campaign was central (Felton, 2004; Frank et al., 2006; Rudenstine et al., 2003). There was some limited use of radio for promoting Centre 12 when it was initially set up, but the main communication strategy was interpersonal communication through community activities, and group communication through meetings and workshops. This is also in contrast to New York in 2011, where Felton (2004) said media campaigns were effective in encouraging local people to seek help. However, government responses to crisis and disaster, especially in developing countries, use similar strategies as Centre 12 (Birkmann et al., 2010; Griffith et al., 2005; Houston et al., 2016; Williams, Carr, & Blampied, 2007) with less reliance on mass media. This reflects the influence that budgeting and resourcing have on the disaster response, which is discussed later in this chapter.

In contrast to 9/11, the Thai situation is a long-term disaster (Watson et al., 2011) or a sustained crisis (Cutlip et al., 2006) and involves chronic threats (Norris, 2006, p. 5) so requires long-term solutions. In the second phase (2005–2010) of Centre 12's programme development, government policy meant that Centre 12 practitioners and the newly recruited psychologists became part of the public health system. At this stage, the mental health rehabilitation system was more fully developed and organised. Several studies about long-term conflict situations (for instance, Ghosh, Mohit, & Murthy, 2004a; Griffith et al., 2005; Stratta et al., 2015) stressed the importance of community-based approaches. Stratta et al. (2015) argued, "mental health interventions after disasters should mobilize the internal resources of the people, i.e. improve personal and community resilience, strengthening the capacity for self-control and self-efficacy, improving community resources, and destigmatize services coming out of the traditional clinical settings" (p. 507).

In this second phase, Centre 12 focused largely on community activities and community-based programmes with specific targets such as widows, children, and those with disabilities. Several interviews captured Centre 12's effort in analysing the needs of target audiences and enhancing two-way communication between Centre 12 and affected communities. For instance, a community-based worker said, "We invited the community leaders, parents, religious leaders, community health staff and other relevant sectors to attend the meeting and told them what we were going to do. Then we asked for their suggestions about how the programme suited the area" (Interview 26 May 2014). Rice and Paisley (1981) and Weiss and Tschirhart (1994) said assessment of the target audiences' needs and goals is an initial key principle of effective public relations campaigns. Similarly, in relation to the development communication approach, Servaes and Malikhao (2008) said dialogue is a catalyst for individual and community empowerment. This phase clearly shows Centre 12's effort to empower local people by giving them the authority and opportunity to design programmes suitable for their religions, cultures, and ways of life.

While the most successful community programmes for people directly affected by the mass violence, introduced in the second phase, were continuing, Centre 12's delivery changed direction following the change of government in 2011. Mental health communication programmes in the third phase (2011–2013) targeted the four age groups: children, teenagers, adults, and elderly. This phase clearly reflects how government policy impacts on Centre 12's programme delivery. This sort of change is found in other studies, such as Larrat, Marcoux, and Vogenberg's (2012) discussion of healthcare reform after the U.S. government had altered regulations and decreased budgets. Some participants in this study expressed concern about the shifting treatment focus from the seven target groups, specifically connected to the mass violence context, to a more broadly applicable focus on the four age groups reflecting life development stages. It follows that the nature and changes in programme delivery of Centre 12 reflect social power (Salmon, 1989) in terms of how decision makers define the problem posed by the violence. Further details about the impact of those changes on Centre 12's mental health communication programme implementation are discussed later in section 6.7.

This changing of mental health policy continued to impact on the Centre and underpins its 4th phase. After 2011, psychologists' salaries were no longer paid through Department of Mental Health and Centre 12 but were transferred to the Ministry of Public Health and local hospitals. This in turn meant that the local hospitals were given charge of mental health rehabilitation. Within limited budgets and more restricted resources, the Centre used its skills and strengths to focus on the severe and complicated cases (Mental Health Centre 12, 2015), which the Director identified as cases rarely reached by other organisations, such as people who lived in the dangerous area or those who were suspected as terrorists.

Although government policy guided Centre 12's practices throughout the four phases, study findings also reveal that combinations of one-way or top-down communication with two-way dialogic or participatory communication (especially building relationships with community through interpersonal communication in home visiting, group communication with community leaders in programme design, and training programmes for the deliverers) were used in the different phases of Centre 12's programme development. This finding is congruent with empirical findings from public relations, health communication, and development communication. However, in terms of public relations, Centre 12's communication activities do not fully reflect contemporary normative ideals of public relations as their practices continue to involve press agency and publicity (through radio promotion and collateral dissemination). In health communication, the participative model was preferable but there are questions about its use and impact in reality (Smith, 1989; see also Dutta & Rebecca, 2008). In development communication, 44 health campaigns conducted in developing countries used semi-participatory communication, a mix between diffusion and participation approaches (Morris, 2003).

To sum up, in the light of the severe mental health impact on victims of disaster and violence (DiMaggio & Galea, 2006; Murthy & Lakshminarayana, 2006; Thongphecsri et al., 2005; Udomratn, 2008), the Thai government initially responded to the onset of violence in 2004 by setting the high level of strategic policy. The Thai government also followed the precedence of the 2004 tsunami in setting up Centre 12. The Centre's overall development and practices, as categorised in the four phases of programme delivery, reflect the impacts of changing government policy and the Centre's leadership and active response to the changing situations. Centre 12's responses (including a

community oriented-approach and the mix of one-way and two-way communication) mirror those in similar studies. These include religious-based programmes in Kenya (Thielman, 2004), the family-based programmes in Thailand and Kosova (Griffith et al., 2005; Tuicomepee & Romano, 2008), and a community reflection group in Guatemala (Berliner et al., 2006). The details of the programmes are discussed later in answering research questions 2 to 5, beginning with consideration of the programme framework.

6.4 Centre 12's programme planning framework

This section discusses the typical framework of communication programming used by Centre 12 and identified through the interview questions and participant observation. This framework is useful in extending our understanding of the communication programme process to answer research questions two to four in the following sections. This study focuses on the holistic view of mental health communication programmes over the 10 years from 2004 to 2014. While this longitudinal perspective means that fewer data were gathered on each specific activity, and the emphasis is on four overall phases of the Centre 12's response to the crisis, the study covers a variety of different programmes.

As indicated in Chapter 2, a common programme framework has been developed and used broadly in different communication disciplines, including public relations, health communication, and development communication. In public relations, several four and five step frameworks have been generated and adaptations have continued since (see Crifasi, 2000; Hendrix, 1998; Kendall, 1996; Marston, 1979). These Western frameworks have also been adopted in Thailand's public relations and communication practices (Ekachai & Komolsevin, 1996; Sriramesh, 2004; Srisai, 2011). Furthermore, the four stages in health communication (see Arkin & National Cancer Inst, 1989; O'Sullivan et al., 2003), and also the four stages in development communication (UNICEF - Programme Division, 2014) reflect a similar planning and delivery approach.

All the frameworks above include aspects of research, strategy-development and programme planning, implementing, and evaluation. In this study, the participants spoke about programme planning, implementation, and evaluation; however, findings showed most of the staff members talked about media and message development as

steps falling between programme planning and implementation. Media and message development are important in Thai PR activities, but whereas the U.S. model separates the technical role such as media-relations and design from public relations management (Broom & Dozier, 1986), Thai PR managers also frequently undertake media-relations and graphic technician roles and act as “editor” (Ekachai & Komolsevin, 1996, p. 166). Therefore, in the results the mental health communication programme process was presented in four stages: programme planning and research, media/message development, programme implementation, and programme evaluation. This process is congruent with several frameworks as shown above. However, it is most closely related to Arkin and National Cancer Institute’s (1989) four stages of health communication.

The next four sections discuss the specifics of each stage of the planning framework with reference to public relations, health communication, and development communication literatures, in order to answer RQ 2 (programme planning), RQ 3 (programme implementation), and RQ 4 (programme evaluation).

6.5 Centre 12’s programme planning and formative research

As Chapter 4 shows, most of the Centre staff emphasised that understanding target audiences was their planning priority and this was also reflected in the Director’s interviews, “it [the programme] has to come from what the targets want, not what we think they should do or should know” (Interview, June 4, 2014). Centre 12 used several methods for exploring audiences’ needs, including formal research such as surveys and focus groups, and informal research such as observing and finding information from news reports and using data collected by other organisations. Conducting this formative research is regarded as one of the key elements influencing the success of programme implementation (Bowen, 2003; Harrison, 2011; Kirby, 2009; Syed et al., 2008; Walker, 1994) and campaign effectiveness (Coffman, 2002; Paisley, 2001; Rice & Paisley, 1981; Rogers & Storey, 1987). Formative research helps practitioners to identify target audiences’ characteristics and tailor suitable communication strategies to reach the specific audience (Bowen et al., 2010; McGuire, 1981; Stacks, 2002). However, it is well established that while both formative research and evaluation are acknowledged by practitioners as highly important, in practice much literature acknowledges formative research is limited (Atkin & Freimuth, 2013; Grunig & Hickson, 1976; Harrison, 2011; Macnamara, 2008; Walker, 1994), and this includes government programmes (Hiebert

& Devine, 1985; Yun, 2006). It is not surprising, therefore, that several senior staff members identified similar barriers to their practice when they discussed the difficulty of conducting the level of research, and particularly the evaluation that they would have liked.

In chapter 4, the Director and two senior staff members talked specifically about research they had undertaken and the importance of using research findings for designing Centre 12's communication programmes. As Judd (1990) said, practitioners who reported research as important were more likely to practice it. This agrees with Dozier's (1990) review, which found practitioners in a managerial role are more likely to do research and utilise it than those who are in a technical role, because managers have to use information for making decisions and setting directions. In the Thai context, Ekachai and Komolsevin (1996, 2004) claimed that public relations practice relied largely on press agency and public information models. However, there were also signs of a shift from the one-way asymmetrical model to the two-way symmetrical model, as seen in increasing use of strategic management and research. Centre 12's Director prioritised research, which was shown several times in her interviews, her article (Tohmeena, 2013), and comments in interviews with the Centre staff. For instance, a highly-experienced staff member confirmed that the Director's area-based research about trustworthy people and coping strategies informed the production of the *Healing according to Muslim Principles* books.

During the study period, Centre 12 undertook audience analysis, environmental scanning/situational analysis, and summative surveys of the earlier programmes. Staff's research methods are discussed in more detail below in relation to each phase of the Centre's programme development. A major finding across the years studied is the importance of secondary research used both to locate target audiences for the programmes and to understand their main needs. In the first phase, information from secondary research led Centre 12 to set up a children camp's programme in response to the burning of 18 schools. Later in Phase 2, 3, and 4, secondary information was essential for developing and delivering mental health communication programmes for the specific target audiences.

From the outset, the Centre used secondary research, defined by DiStaso and Stacks (2010) as "searching existing resources for information or data related to a particular

need, strategy, or goal” (p. 329). Initially, secondary research was mainly aimed at finding out “what is going on out there” (Dozier, 1990, p. 5). Stewart (1984) said secondary research has the significant advantage of saving time and cost and this method was the most used by public relations professionals in the previous decade (DiStaso & Stacks, 2010). In 2004, the Centre followed local and national daily news reporting about the violent incidents that occurred. Subsequently, the 2005 annual report shows the Centre used information collected by the Deep South Watch (an organisation based on Prince of Songkla University) to locate target audiences and find out their problems. Secondary research continued to be used in Phase 2, 3, and 4. As the Director said, in Phase 2 the Centre also used information from the Deep South Coordination Centre (DSCC), a research project also based on Prince of Songkla University (one of the partner group representatives discussed in section 5.3.2). DSCC’s information was also used later in Phase 4 when Centre 12 wanted to locate and support severe and complicated cases. Additionally, in Phase 2, the staff members said they also used databases from local hospitals (Violence-Related Mental Health Surveillance or VMS) in order to reach victims admitted to the hospitals and assessed by psychologists. Later, evidence from Tohmeena (2013), writing from her position as the Director, revealed that in the second phase the trainee staff read international journals to find research about mental health recovery in mass violence situations and applied the knowledge locally. However, my participants did not refer to this in their interviews.

Centre 12 instituted formal primary research toward the end of 2004 (one year after the violence broke out), undertaking a major survey and a high-level focus group. A survey was conducted to explore mental health impacts of those exposed to the violence (Thongphec Sri et al., 2005). As reported in many disaster studies (such as DiMaggio & Galea, 2006; García-Vera et al., 2016; Murthy & Lakshminarayana, 2006; Thielman, 2004; Thienkrua et al., 2006; Tuicomepee & Romano, 2008; Udomratn, 2008), surveys were conducted to measure mental health consequences and to explore coping strategies. Centre 12’s survey found nearly 90% of participants were fearful and stressed. A focus group then showed that people wanted information workshops or seminars on mental health promotion and mental health treatment, and especially self-management with stress. Focus groups are a particularly useful tool for identifying in-depth information of problems and opportunities (Dozier & Repper, 1992). Focus groups are also cheap, quick, and easily replicated for data confirmation, with a

structure that encourages open-ended discussion and interaction between participants (DiStaso & Stacks, 2010; Dozier & Repper, 1992; Harrison, 2011).

Between 2005 and 2010, Centre 12's situational analysis was less formal and aimed at specific target audiences. As Chapter 4 showed, the Rehabilitation Sub-Committee used earlier knowledge to segment seven target groups (see section 4.3.1). The Sub-Committee set up seven working groups to collect numbers of victims and key information about them. When discussing the main type of data gathering, the community-based workers said they used informal conversational interviews (Patton, 1990 cited by DiStaso & Stacks, 2010) during home visits and meetings with local people in communities.

Another type of research undertaken by Centre 12, initially at the end of 2010 and increasingly in 2011–2014, was summative survey research. Results show participants used information from Centre 12's summative surveys of previous programmes in order to design new programmes to train the deliverers, promote positive mental health, and prevent mental health disorders within the four target age groups. This type of research using information from former campaigns is economical and efficient (Walker, 1994).

In 2014, Centre 12 focused on the severe and complicated cases. NATO (2008, p. 54) terms those highly impacted by crisis situations as “dysfunctional people” (p. 53) who need the highest level of expertise to treat. Staff no.2 said Centre 12 gained information about these cases from NGO networks and lawyers. During this last phase, Centre staff were pulling together secondary information and their own knowledge to identify the cases and provide help. As the Director confirmed, these groups were very hard to access, except through the Centre's networks, and they needed specialised knowledge provided by the Centre for their mental health rehabilitation.

In summary, participants saw understanding target audiences as their main planning priority. However, secondary research was the main method used by Centre 12 and only two senior staff members actually discussed their research practice in detail. This agrees with Walker's (1994) discussion of two research problems for public relations practitioners: they used informal methods rather than scientific methods and they did not recognise their informal practice as research. Most Centre 12 staff customarily undertook easily accessible research on previous campaigns, “almost a gut feeling” (Walker, 1994, p. 153). There is evidence to indicate that while communication

practitioners understand they undertake insufficient research, they continue to rely on secondary and informal methods because they are cheap and quick (see for instance, Harrison, 2011; Walker, 1994). Ekachai and Komolsevin (2004) suggested that PR professionals should help government agencies in setting up strategic public relations and tactics to develop more efficient and cost-effective campaigns. The collaboration of PR professionals and government sectors is one of the recommendations of this study, and is discussed further in Chapter 5.

6.6 An emphasis on media/message development, testing, and refinement

This section also helps answering RQ 2 about programme planning. The participants identified media and message development as the second stage of programme framework (see section 5.2.3). Media and collateral produced by Centre 12 were mainly print material, such as manuals, pamphlets, booklets, and newsletters. This is consistent with Ekachai and Komolsevin's (2004) findings that print media and newsletters were the main channels used by the Thai government to disseminate development information and national policy.

Aronoff and Baskin (1983) identified print material, especially pamphlets and booklets, as advantageous in providing detailed messages and supplementing personal communication. Similarly, Hoffmann and Worrall (2004) described the advantages of using written materials supporting health education. In this study, print materials especially the 'manuals', were used as guidelines supporting the deliverers, such as the home-visiting manual for public health practitioners and psychologists, and the mental health rehabilitation manual for Village Health Volunteers and community leaders. Written materials that provide 'how to' information rather than facts and statistics are recommended for adults because people mainly want information that helps them solve their problems (Hoffmann & Worrall, 2004). As well as these training manuals, self-help manuals for people affected by the mass violence were also produced for the general public in the area, with more specialised materials for widows and children. These manuals were produced in two languages, Thai and Melayu. Communicating in the home language is important for mental health practitioners working in disaster contexts (Butler et al., 2003; Hall et al., 2014; Heath, Nickerson, Annandale, Kemple, & Dean, 2009). For instance, in Israel, provision of psycho-educational material in

different languages was important to supplement Israel mental health providers' explanations, and victims were provided with print material written in their own languages (Hebrew, English, Russian, Arabic, and Amharic) about ways of coping and reaching mental health assistance (Ben-Gershon et al., 2005).

When asked about good examples, the key informants of Centre 12 all talked about five religious-based booklets (*Healing according to Muslim Principles* and *Healing according to Buddhist Principles*) produced by Centre 12. The participants said the strength of the production lay in the verification of its contents by a number of experts and its pre-testing by the target audiences. In this example of programme refinement research (Stacks, 2002), booklets were first pre-tested in a Health Promotion Hospital and then in a workshop with people affected by the violence, public health officers, and village health volunteers. While this process is recommended (Arkin & National Cancer Inst, 1989; Atkin & Freimuth, 2013; The Centres for Diseases Control and Prevention (CDC), 2001), it is often omitted. Although print materials are widely used in health communication, there is little evidence of research about the costs and processes involved in developing the material (Hoffmann & Worrall, 2004; Paul et al., 1998). For instance, Paul et al. (1998) found that while nearly twenty per cent of 183 health education pamphlets were pretested, only ten per cent of pamphlets were developed by using focus groups, nearly five per cent were pre-tested by using questionnaires, and only one per cent used interviews.

In addition to print media, radio was also mentioned several times by Centre 12's Director as an effective channel to reach people in the area. The role of radio during disasters has been illustrated in many studies (such as Birowo, 2010; Curtis, 2000; Moody, 2009; Romo-Murphy et al., 2011; Shaw et al., 2012). Radio continues to be at the forefront of the media used in emergencies because of its portability and prompt reporting (Moody, 2009). Ewart and Dekker (2013) argued talkback radio was effective in re-establishing communities, supporting active networks, and building community resilience after natural disasters in Australia (see also Curtis, 2000). Talkback programming was also mentioned as an effective channel by Centre 12's Director; however, for a different reason. She emphasised the anonymity of talkback as important in the context of violence, with people afraid to trust one another: "[those] who did not dare to express their opinion face to face, but through radio they can talk about what they want without telling who they are and where they live" (Interview, June 4, 2014).

Perez-Lugo (2004) argued that radio not only disseminated information during disasters, but also provided emotional support and companionship, which could reduce negative effects. He suggested radio DJs should be involved in disaster communication because, “they inspire friendship, commitment, and respect” (p. 223). In this study, radio DJs were in one of the partner groups trained by Centre 12. However, although radio is likely to be interactive and lively, it is difficult to control the discussion. The Director said that often the audiences called in and talked about love rather than the mass violence problems or stress. While radio is relatively cheap, compared with television (Aronoff & Baskin, 1983), Centre 12’s limited budget meant it could not use radio to the extent the Director would have liked. It is also worth noting that Centre 12’s Director was the only one who recognised the importance of radio, possibly because her management role focuses on setting strategy, while most of the staff focus on the technical roles of disseminating information and implementing mental health communication programmes (Ekachai & Komolsevin, 1996)

In summary, two strengths of Centre 12’s media/message development can be seen in this study. The first is well-crafted print materials and their verification and pre-testing. The second is the use of radio (to promote the Centre and pre-test people’s media exposure and media uses) and training radio DJs as mental health deliverers, in particular, talkback radio programme that allow anonymity are particularly useful in the context of a violent crisis. Finally, while staff talked about several types of media used in programmes, Centre 12’s mental health delivery is largely interpersonal, although it is supported by mass and print media, as discussed below.

6.7 Interpersonal communication: A key channel of Centre 12’s programme implementation

This section aims to answer RQ 3 about programme implementation. As mentioned in 5.2.4, Centre 12’s mental health communication programmes, like others in similar contexts, were mainly implemented through interpersonal communication such as workshops, home visiting, and community activities rather than mass communication (Houston & Franken, 2015). This agrees with Houston, First, Spialek, Sorenson, and Koch’s (2016) review of empirical studies about public disaster communication, where “campaigns may include more interpersonal components than in some other domains of health communication” (p. 3). Wells et al. (2004) argued that in mental health

promotion programmes, mass media can encourage people to access services or change attitudes, but “individual behaviour change requires local face-to-face intervention” (p. 957).

Centre 12’s staff members said workshops were the main method used in programme implementation, particularly in the second and third phase of programme development. When resources are limited, group meetings and workshops are the most common types of interventions used to cope with mental health problems (Abeldaño & Fernández, 2016). Centre 12 workshops focused more on developing the potential of the deliverers than on workshops for healing and rehabilitating people directly affected by the mass violence. The deliverers group in this study included public health practitioners, community leaders, religious leaders, local government officers, and teachers (when programmes targeted students). The Centre’s delivery technique is typical of practice in this area, and made use of “intervening publics or influentials”, defined by Bowen et al. (2010) as those who pass information on to the key publics and act as opinion leaders. Influentials can influence the knowledge, attitudes, and behaviours of other people (Bowen et al.). So, identifying those who are perceived as the influentials by target audiences is essential to the success of programme implementation (Broom & Sha, 2013; Weimann, 1991). In health communication, opinion leaders who are trained as mental health educators are described as “gate keepers” (Dumesnil & Verger, 2009, p. 1205). Similarly, in development communication, Weiss and Tschirhart (1994, p. 90) identified “social support groups for behavioural change”, such as family, friends, neighbours, or co-workers. In the Thai situation, Tuicomepee and Romano (2008) found workshops for training parents in ways to prevent or reduce youth behaviour problems were key to rehabilitating young people suffering from the tsunami’s impacts. They also suggested other social supports in the Thai context, such as religious leaders, indigenous healers, and health professionals can be trained to educate about youth behavioural problems. These groups are largely the same social support groups used by Centre 12.

In the second phase of programme development, Centre 12’s staff members emphasised community participation in programme implementation as the main factor of sustainable programmes (as shown in section 4.5.5). In disaster situations, people do not seek help for a variety of reasons, for example, thinking mental disorders related to the disasters are “understandable” and “common” consequences (Stratta et al., 2015, p. 506). Community-based programmes are seen as a solution to this problem. Ghosh et al.

(2004), Houston (2012), and Watson et al. (2011) argued mental health interventions, particularly in the recovery phase, should focus on a community-oriented approach rather than on individuals, should combine local stakeholders, and should be culturally appropriate. Griffith et al. (2005) and Stratta et al. (2015) also claimed community-based intervention is appropriate, especially where resources for coping with mental health problems are limited. Many studies also confirmed the effectiveness of community-based interventions and programmes encompassing cultural concerns (Ben-Gershon et al., 2005; Berliner et al., 2006; Griffith et al., 2005; Hall et al., 2014; Honwana, 1997). Programmes such as this are also reflected in Centre 12 activities, such as the children's summer camp programme, programmes empowering widows and those with disabilities, and the practice of applying religious principles to programme implementation, which participants identified as successful community-based activities. As Srivastava (2010) reiterates, in the South East Asian region, understanding social context and culture is a key factor influencing the deliverers' success in mental health recovery. Despite widespread case-based endorsement of community-based programmes, a recent review by Henderson et al. (2016) found mental health intervention studies focus largely on professionals. They suggested more studies measuring the efficacy of community-based programmes, which this study also addresses, were needed.

The concerns of Centre 12's staff about the limitations of effective programme evaluation are now discussed in the section which follows.

6.8 Centre 12's programme evaluation

Programme evaluation emerged as the last step in the programme framework of this research. While evaluation is important to demonstrate the effectiveness of programmes (Bowen et al., 2010; Gregory, 2006; Stacks, 2002), lack of thorough evaluation was "the great tragedy as clients and practitioners don't get the impact of their own work" (Walker, 1994, p. 151). All the Centre 12's staff members and the Director were aware of the importance of evaluation; however, interviews show they were not satisfied with evaluation they have undertaken, especially the inability to measure effectiveness fully.

As identified in Chapter 5, Centre 12 undertook formative evaluation when producing the five religious-based booklets by using focus groups and launching workshops to test the books' contents and designs (section 5.2.3.2). The subsequent changes reflected the advice given by Hoffmann and Worrall (2004) about using simple language, highlighting important points, using simple line drawings rather than abstract graphics, and designing attractive covers. Furthermore, Centre 12 staff engaged in informal conversations with opinion leaders when designing community-based programmes (section 5.2.1). In response to this target audience feedback, Centre 12 changed the time and venue of community workshops. Results from formative evaluation "often generate user recommendations for refining program features that can be implemented to improve intervention programs" (Kreps, 2014, p. 1452). This evidence reveals formative evaluation was conducted and results were used, but the participants did not claim this practice as evaluation. As found by Walker (1994) (see section 5.2.1), public relations practitioners do not recognise their practice as research because they perceive research as using scientific and formal methods.

In relation to media evaluation, most participants said they struggled with evaluating media use, and results show they relied on what has been identified as output measurement (Broom & Sha, 2013; Coffman, 2002). As the Director stated, media evaluation was one of Centre 12's weaknesses because they simply observed people's reaction when material was handed out or noticed the high number of requests for the cartoon booklets. Dozier (1990) called this common informal type of information-gathering "seats-of-pants evaluation", noting it is used because it is simple and familiar to practitioners. Similarly, a lack of health media evaluation was also identified by Paul et al. (1998), and in disaster contexts, Houston et al. (2016) found numerous psycho-education materials had been produced, but not tested. The difficulty of measuring media impacts is shown by the fact that Centre 12 reported only the number of booklets and pamphlets produced (Mental Health Centre 15, 2008). Yet as Hoffmann and Worrall (2004) said, though measuring media impact is difficult, more research on the effects of health materials on patients' outcomes is needed.

Overall, programme evaluation faced the same problem. Interviews show experienced staff found it difficult to measure programme effectiveness. Most of the participants recognised that Centre 12 focused on outputs rather than outcomes or impacts evaluation. This is similar to Broom and Sha's (2013) comment, "the most common

error in programme evaluation is substituting measures from one phase for those at another level such as practitioners evaluating the number of messages disseminated and placement in the implementation stage in order to report programme's impact and outcomes" (p. 320). This evaluation, as the case study participants recognised, could not actually measure the changes in audiences' knowledge, opinion, and behaviour.

Further, a number of staff identified a problem with the official post-workshop evaluation form. Although the staff wanted to know how attendees applied the knowledge they gained, their summative survey concentrated on "participants' satisfaction about food, venue, and the ability of the facilitator" (Staff no. 7). One of the problems in evaluating health communication programmes is using existing research tools and standardized scales, even though they may not measure the important variables of effectiveness (Kreps, 2014).

It is perhaps no surprise that although Centre staff are aware of the importance of evaluation, it is challenging for them. This problem is also found in many studies both of public relations and health communication. In public relations in Thailand, practitioners working in the government sector rarely evaluated their programmes because of the lack of funds and personnel (Ekachai & Komolsevin, 1996). Without evaluation, government practitioners largely paid attention to "have to do activity" (p. 160) to meet policy requirement. Other barriers include lack of time, lack of understanding of research (Ekachai & Komolsevin, 1996; Hiebert & Devine, 1985; Watson & Simmons, 2004), and insufficient measurement of programme impacts (Kabucua et al., 2016 see also Sixsmith, Fox, Doyle, & Barry, 2014; U.S. Department of Health and Human Services Centers for Disease Control and Prevention, Office of the Director, & Office of Strategy and Innovation, 2011; Weiss & Tschirhart, 1994; Kreps, 2014). Lack of systematic evaluation of the effectiveness of mental health interventions is also found in disaster contexts (Ben-Gershon et al., 2005; Felton, 2004). Baingana et al. (2005) argued limited funding and resources were the main problem in conducting evaluation research in conflict and post-conflict settings. The difficulty of evaluating the success of government-sponsored initiatives was also experienced by Centre 12 (see section 5.2.5).

6.9 The challenges of mental health communication programme delivery in mass violence

This section discusses RQ 5, Centre 12's challenges and successes of mental health communication programme delivery. Eight challenges to the mental health communication programme delivery were highlighted by participants: safety; changeability of policy; language; choosing trustworthy senders and communicating to reduce suspicion; inability to access the intended community participants; lack of local government networking; programme evaluation; and budget. The first two challenges are identified as factors outside Centre12's control but that directly impacted on their practice; the other six are manageable and interrelated challenges.

It is not surprising that safety was the first challenge for programme deliverers working in the mass violence context. As Silove (2013) highlighted, safety and security is the first concern in post conflict settings, "because of its fundamental importance to recovery" (p. 238). Several staff members said feeling insecure was their initial working difficulty, where "we wanted to help people, but we were afraid of the dangers". Cohen (2002) identified mental health practitioners (such as rescue and recovery personnel, medical, nursing, mental health, and emergency staff) as third-level survivors, saying their jobs can expose them to the most painful experiences. NATO's (2008) guidelines stated that the needs of staff working in crisis areas must be considered, for instance by providing positive support from team members, colleagues, and managers to continue working effectively. In this study, the participants said their collegial relationships were strong as they had to look after each other. Further, to ensure their safety before going to the community, they said they needed well-developed plans. As suggested, "if staff are well-informed, consulted and involved, their confidence in the plans and their equipment is enhanced, their uncertainties are reduced and their psychological resilience is augmented" (NATO, 2008, p. 112). Safety, then, while a factor outside the control of the Centre 12, was to some extent managed by clearly explaining the whole plan to staff members, identifying each staff's anticipated role to enhance their confidence when working, and providing mental support from peers in order to reduce psychological consequences.

A second factor outside Centre 12's control was the changeability of national policy. Findings showed significant shifts in the Centre's practice after the change of Thai

government in 2011, particularly through reduction of budget and alteration of the rehabilitation structure. According to McFarlane and Williams's (2012) review, when additional funds for disaster responses are withdrawn, "this presents challenges because the people who have long-term mental health needs may still require active interventions" (p. 11). McFarlane and Williams therefore suggested integrating disaster responses services into mainstream delivery structures. Similarly, Centre 12's Director and staff members said some effective practices in phase two were discontinued after the Centre's budget was reduced. However, a mainstream delivery response was one of the successes mentioned by the Director. This was the setting up of Mental Health Rehabilitation Units in each of the 37 district hospitals across the unrest areas in 2008 (Tohmeena, 2013).

In terms of challenges within the control of the Centre, most participants identified language as the top communication challenge. Language problems included the inability of staff members to speak the languages of target audiences, the difficulty of translating technical terms so they are understandable for local people, and using the same language as the target audiences. To solve these problems, Centre 12 emphasised leading with staff who could speak local languages to increase access to people and build acceptance and reduce suspicion. This is consistent with successful mental health interventions in Uganda where local staff could speak the local language and use proverbs to explain psychological terms (Hall et al., 2014). Also, the importance of employing rescuers who were familiar with the disaster area, and understood local language, culture and customs of that area was also noted in an Iranian study (Ali et al., 2014).

Another related communication challenge for programme deliverers was choosing trustworthy senders and communicating to reduce suspicion. This was recognised by Centre 12 as an important factor especially in the mass violence area where people had become highly suspicious of each other. As a participant said, "a trustworthy sender is very important because if people do not open their hearts to listen or accept us, we cannot help". As mentioned above (section 5.2.4.1), Centre 12 selected and trained religious leaders and public health practitioners as "influencers" (Bowen et al., 2010) because they were trusted by people in the area. Expert and trustworthy sources, such as local leaders and mental health practitioners (Hall et al., 2014), traditional healers (Honwana,

1997), and teachers (Ibrahim & Hameed, 2006) are more persuasive (Kreuter & McClure, 2004).

However, deliverers need not to be recognised as leaders. The best “Emotional First Aid” (Abeldaño & Fernández, 2016, p. 437) could be delivered by those belonging to the community who could immediately contact the victims, be sensitive to the emotional needs of the victims, were prepared to listen and interact with others, and who created an atmosphere of safety and hope (Abeldaño & Fernández, 2016). This role is very similar to the role of the Volunteer Minded Women’s group who were claimed by an academic partner as an excellent model of mental health delivery (see details in section 5.3.2).

Another two challenges are related to programme planning. Two staff members identified insufficient community liaison before the Centre activities, resulting in the inability to access the intended audience. This difficulty reflects the problem of coordination between Centre 12 and networks (who help access communities), and the lack of Centre 12’s follow-up activities to ensure the right target audiences. Similarly, the International Federation of Red Cross and Red Crescent Societies’ (2000) guidelines identified barriers to coordination in disasters. Among these barriers, coordination was viewed as low priority by some organisations, as was the lack of coordination skills, knowledge, and experience among response staff. The guidelines also recommended the importance of following-up coordination decisions. Findings show Centre 12, when wishing to set up new activities, first had to contact the Provincial Public Health Office and wait for the office to coordinate with local hospitals. Participants indicate that following up with the Provincial Public Health Office was often neglected and the Centre staff were unable to reach the target audiences they need.

The second challenge to programme planning was the Centre’s limited collaboration with the Sub-District Administrative Organisation (SAO) to support programme implementation. Local government is an essential factor in disaster management (Col, 2007). However, few studies have analysed collaborative activities with local governments in disaster management (Lee & Fleming, 2015). In this study, some long-term successful local government partnerships with Centre 12 were noted. However, most of the local government in the area did not participate in the Centre’s activities because they had different priorities. While Centre 12 hoped the SAO could help them

access people in the communities and deliver mental health messages, the SAO thought its main work was providing infrastructure and enhancing communities' living conditions. In conclusion, following the suggestion by Dowling et al. (2004), it is also important for Centre 12 (and government organisations generally) to carefully build up new partnerships, clearly identifying the mutual goals, responsibilities, and benefits from collaboration. Moreover, it is also essential to maintain partnerships and established long-term relationships through regular communication (Nelson et al., 2000).

The seventh challenge recognised by participants was effective programme evaluation. This problem has been discussed earlier in sections 5.2.5. Finally, the last challenge reported by the participants was finance. As mentioned earlier, inadequate budgets impacted on Centre 12's promotion planning (especially through radio) and programme implementation (as they could not fully support programmes for the specific target groups such as widows and those with disabilities). However, the limitation of budget also provides opportunities for designing programmes which mainly rely on the community. As Griffith et al. (2005) and Stratta et al. (2015) said, community-based intervention is appropriate where resources for coping with mental health problems are limited. It is also recognised as an effective intervention (Chakrabhand et al., 2006; Ghosh et al., 2004; Henderson et al., 2016; Tuicomepee & Romano, 2008). For earlier discussions of communication-based programmes, see section 5.2 and in more detail section 5.4. Most of the participants said the community-based widows and disabilities groups were a success because they showed concrete outcomes and programme sustainability without Centre 12's funding, raising their own funds, developing self-help groups, and continuing community-participation programmes.

This section has discussed the eight challenges identified by Centre 12's staff members and how the Centre has responded to them. Some challenges can be identified as communication and management problems, such as programme evaluation, budgets, and coordinating with local government. Two major challenges are directly relevant to the long-term disaster context and political approach: safety and changeability of policy. Further challenges are particularly related to the sociocultural dimension are language and choosing trustworthy senders for reducing suspicion. The following section discusses more fully the factors of success.

6.10 The success factors of mental health communication programme delivery for Centre 12

In this study, participants identified three major factors of success in mental health communication in the mass violence area: working with networks, the unique nature of programme delivery, and the mass violence crisis itself resulting in opportunities to develop the potential of the staff and service systems. Additionally, the role of leadership emerged as another success factor, identified by the researcher on the basis of interview material. This section begins with opportunities presented by the crisis itself, and closely linked with this, the unique nature of Centre 12's programmes. The section then discusses networks and partnership, followed by discussion of the role of Centre 12's leadership.

Although disasters cause massive losses, such crises may also provide opportunities, especially setting new policies and services (Birkmann et al., 2010; McFarlane & Williams, 2012; Samira Sadat, Ali, & Mohammad Hossien, 2015; World Health Organization, 2013a). This is borne out with three staff members saying the mass violence situation provided an opportunity to develop staff potential in dealing with crisis and develop and integrate mental health rehabilitation into the public health system. "Crises generate a window of opportunity in which a leader has the chance to reform institutional structures and long-standing policies" (Demiroz & Kapucu, 2016, p. 92). For instance, long-term plans for mental health recovery and psychosocial interventions of disaster preparedness have been developed in response to the tsunami in the Maldives (Ibrahim & Hameed, 2006). Such evidences from Western and developing countries shows that disasters provide opportunities to change the recovery policy and healthcare system in any circumstance and apply in both acute-onset (Norris, 2006) or on-going and long-term disasters.

During interviews, two staff members referred to the unique nature of Centre 12's programmes as a success factor. This uniqueness, which refers to the strength of community-based programmes, has been described in Chapter 4 and discussed previously in section 6.7. In this study, an understanding of multi-cultural context and sensitivity to different religion was an essential consideration when planning and delivering Centre 12's mental health communication programmes. Religious disciplines, both Buddhist and Islam, were generally integrated into mental health

recovery workshops and print media contents. Religious leaders were also trained to be mental health deliverers. Using religion discipline as a coping tool is applicable both in short-term and long-term disaster impact situations; however, it is mostly found in the contest of developing countries (e.g. Muhwezi et al., 2014; Thielman, 2004; Udomratn, 2008). Mental health rehabilitation by integrating religious faiths was an effective strategy because “people who were prayerful were more hopeful and resilient” and “religious coping affects well-being by providing a feeling of comfort, sense of control, and connectedness to self and others...religious coping is linked to lower levels of depression” (Muhwezi et al., 2014, p. 6).

Most of the participants, including the Director, identified working with networks as the most important factor of success. Centre 12 described psychologists and public health practitioners as their main networks followed by those outside the health sector, including local government officers, teachers, NGOs, academics, media networks, community leaders, and religious leaders. These networks were frequently termed partners and partnership. There have been a number of articles and reviews on the nature and role of partnership in health communication and crisis and disaster recovery (Chavis, 1995; Hatton & Schroeder, 2007; Weiss, Anderson, & Lasker, 2002). Nelson et al. (2000) said two main partner groups should be involved in programme delivery: “those traditionally regarded as “experts” sent to “fix” the focal problem and those most vulnerable to the problem itself” (p. 126). However, in practice, the vulnerable population is rarely involved. Similarly, in this study the experts, e.g. mental health practitioners, psychologists, NGOs, and community leaders, were called “helper groups” by participants. They were involved early on because Centre 12 trained and planned mental health communication programmes with this group from the beginning of the crisis, the community partners (e.g. widows, parents and teachers of affected children), however, generally became involved only when programmes were implemented.

A number of partnerships identified by the participants fit Dowling, Powell, and Glendinning’s (2004) definition based on the Audit Commission (1998), “a joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint programme, as well as sharing relevant information, risks and rewards” (Dowling et al., 2004, p. 310). Most studies evaluated

the success of partnership through process (such as partnership activities and the relationship between partnerships) rather than outcome (benefits from partnership). This study aimed to examine both the relationship between Centre 12 and partner groups and the participants' view of benefits of working with partners. Findings reveal two different perspectives of partnerships. First, the relationships between Centre 12 and partners in health sector were formal in structure (according to a "command structure"; see Bharosa, Lee, & Janssen, 2010, p.55) and focused on goal achievement (training the deliverers). Second, the relationships between the Centre and the other three partner group representatives of academics and special interest groups were informal and focused on sharing information and resources within multi-level information flow (N Bharosa et al., 2010). The overall pattern of partnership in this latter group showed that each partner focused on their own activities, although partnering helped them to meet mutual goals. This finding indicates that Centre 12's partnership differs from Dowling et al.'s (2004) requirements of successful partnership. An informal and flexible style of partnership might, however, be appropriate in the volatile context of frequent and on-going violent incidents, rather than slowly developing formal partnership with a high level of engagement, commitment, and agreement about purpose of and need for the partnership (Dowling et al., 2004).

The study findings reveal Centre 12's effort in enhancing two-way communication and participation with community partners. As a community-based worker said, they provided meetings and discussions with community leaders when planning community programmes because it is very important for building the feeling of programmes' ownership and sustainability. This shows Centre 12 recognised the importance of two-way and dialogic communication in practice. Grunig and Grunig (2008) identified the excellent model of public relations that "it is designed to build relationship with stakeholders, rather than a set of messaging activities designed to buffer the organization from them" (p. 331). Although the excellence model is recognised as an ideal (Grunig, Grunig, & Dozier, 2002; Leichty & Springston, 1993; Leitch & Neilson, 2001) – particularly the two-way symmetric model (first described in Grunig and Hunt, 1984) – this study argues that it could be initially applied in programme planning even in the conflict situations.

Additionally, when we move from discussion of partnership in public relations to the disaster recovery delivery, a broader range of 'partnering' is recognised. Martin et al.

(2016), who explored partnerships in disasters, identified the Four Cs: communication, cooperation, coordination, and collaboration. Partnering activities could range from informal and low-risk partnering (communication) to formal and high-risk partnering (collaboration). In this study, three of Martin et al.'s Four Cs are evident. The partnership process involves collecting and sharing information of disaster impacts and disaster consequences through face to face and database *communication*. Partners in this study also *cooperated* in short-term activities when they were requested, such as training programmes to accomplish common missions and avoid programme duplication. Further, findings also show evidence of partnership *coordination* with partner groups sharing their own resources and using their strengths in helping severe cases. Martin et al.'s coordination function was also identified by Centre 12's Director as she perceived herself as network coordinator of many groups (see details in section 4.10.1). However, the relationship between Centre 12 and partner group representatives did not fully reach the collaboration level. Martin et al. (2016) said, "Collaboration was seen as the most embedded, riskiest and costly activity of the partnering continuum, signalling a deep relationship that required change and strategic action within both partner organisations" (p. 626). Partnership collaboration at Centre 12 is likely to be difficult because it has insufficient resources to invest in the development of a long-term collaborative partnership. Further, in disaster situations, coordination between relief agencies is difficult because of "a variety of elements, systems, processes, and actors, and it is hard to get a clear picture of the entire situation within the timeframe of the crisis" (Bharosa et al., 2010, p. 50). Finally, the mass violence situation in southern Thailand has caused suspicion between groups and individuals, meaning that relationships developed by the Centre are likely to experience tension.

Despite these points, partnering remains a crucial component in the success of Centre 12's programme delivery and leadership is crucial to the effectiveness of partnership (Berliner et al., 2006). Centre 12's Director plays a key role in coordinating with partner groups and setting the directions of the organisation, by "influencing the activities of others in effective efforts toward achievement of specified goals" (Cuny, 2000, p. 70). Interviews captured how the Director's leading roles notably influenced Centre 12's success (see section 5.4.4). In this study, five roles of the Director emerged, those of coordinator, budget and instrument provider, programme theme setter, researcher, and inspirational community-based worker. Providing knowledge and eliciting admiration

are among the ways leaders can gain influence in non-command situations (Cuny, 2000). For instance, interviews show the Director used her local knowledge and area-based research to plan and deliver mental health communication programmes. Further, she was admired by the staff members as a role model of a community-based worker: as one of the staff said, “She went with us everywhere, some areas were prohibited because of the danger but she still went to visit”. Additionally, “supportive leadership style” (Cuny, 2000, p. 72) is a highly important for leaders working in stressful and frustrating jobs. Centre 12’s Director supportive style was mentioned by several staff members.

Centre 12’s Director was also recognised by a partner group representative as being flexible when she used her personal relationships and networks to provide equipment for people affected by the violence (see section 5.3.2, which includes an example of help given in a disability case). Demiroz and Kapucu’s (2012) review of the roles of leadership in disaster management noted that being flexible in decision making and operations was one of four important leadership traits. They also mentioned “surprise management” or doing something “out of the box” of bureaucracies (pp. 95–96) as useful in crises and emergency-driven events. In the Thai context, giving help and resources to individual stakeholders (as the Director did) is normal for leaders. As Srisai (2011) stated, public relations practices in Thailand are significantly influenced by the Thai culture: “Thai people prefer ‘giving’ by heart than doing by ‘responsibility’ ... Thai generally do not care much about rules or regulations as their behaviour within social networks tends to be quite particularistic” (p. 264). Srisai also concluded that although the Thai PR practitioners adopted Western concepts, they adapted and blended these with the Thai culture. Sthapitanonda and Gumpai (2013) identified key factors for successful health campaigns implementation in Thailand. They found building and managing a positive relationship is crucial for PR practice. Unsurprisingly, using personal relationships (as Centre 12’s Director did) can achieve good outcomes in the Thai context. However, it is also risk if the people who have personal relationships are no longer there. Systematic problem solving needs to be structured. This is considered further in Chapter 7.

6.11 Summary and Conclusion

This chapter discussed case study findings in relation to three theoretical approaches that underpin this study (public relations and public communication campaigns, health communication, and development communication) along with relevant empirical studies. The overall discussion expands our understanding of government responses to long-term crises, and communication campaigns in the particular context of mass violence, including the successes and challenges of delivering mental health communication programmes in affected areas.

Numerous studies claim that national governments have a prime responsibility to provide support and resources in crisis and disaster situations and the Thai government response follows this pattern. The discussion considering RQ 1 (the government policies' impact on the establishment, funding, and delivery of mental health communication programmes in the mass violence situation in southern Thailand) showed two levels of responses: an immediate high level of strategic policies (focusing on developing policies and regulations, setting up committees and organisations), and the practitioner level (focusing on developing the rehabilitation systems and integrating them into the mainstream public health system). In particular, the Thai government appears to have applied lessons from the 2004 tsunami in structuring the whole response delivery system. Centre 12's programme framework as most closely related to Arkin and National Cancer Institute's (1989) health communication framework of planning and strategy development; developing and pretesting concepts, messages, and materials; implementing the programme; and assessing effectiveness and making refinements. However, it also showed a new order for media/message development that appears to reflect the cultural location of Thailand.

Writers agree that conducting formative research is the key to effective programme planning and programme implementation. The discussion of RQ 2 (programme planning), secondary research, and informal research methods, such as observations and informal conversations, were the main methods used by Centre 12 for situational analysis and audience analysis and have been identified as prevalent in communication practice. Several reviews of public relations practice, for instance, have found secondary research is favoured by practitioners because it is cheap and quick. Centre 12 also relied on summative survey research, although it is criticised as a limited method.

Related to RQ 2, the chapter commented that, in common with reports of public relations in Thailand and health communication in the U.S. (Arkin & National Cancer Inst, 1989), media and message development was an important stage of programme framework. Centre 12's comparative strength in the media development process lies in its content verification from experts and media produced with cultural sensitivity. Centre 12 also conducted focus groups for testing media and then undertook media refinement based on participants' recommendations.

In considering RQ 3 (programme implementation), Centre 12 mainly used interpersonal communication, rather than mass communication which is an important channel in short-term, large-scale disasters. This agrees with empirical studies in developing countries that show interpersonal communication is the core channel used in long-term crises where a budget for mental health communication is limited. The chapter discussed Centre 12's interpersonal communication through group meetings, workshops, and home visiting. Centre 12 also trained helper groups, termed 'intervening publics or influentials' in public relations, and 'gate keepers' in health communication, or 'social support groups' in disaster scholarship. Having these social support groups and understanding social contexts and cultures were discussed as the key element of programme implementation in mass violence situations.

Public relations, health communication, and development communication literatures all emphasise the important of knowing the audience as an initial factor of successful campaigns. The chapter examined the extent to which Centre 12 has been able to do this. In Phase 2 of programme delivery, the Centre attempted to use two-way communication and dialogue with local stakeholders to design community-based programmes based on the needs of the target audiences. The community-based approach is described as an effective practice in many disaster studies, especially the emphasis on psychosocial interventions and social support systems that are appropriate in disaster situations where budget and resources are limited. This was linked to study findings that identified social support groups or helper groups, including those inside and outside the health sector, such as public health practitioners, psychologists, community leaders, religious leaders, teachers, parents, and radio DJs.

In relation to RQ 4 (programme evaluation), the discussion adds to existing evidence that practitioners in public relations, health communication and development

communication find programme evaluation challenging. In common with other communication practitioners, Centre 12 staff realised they were unable to easily measure media impacts and programme outcomes. Part of this shortcoming arose from the insufficiency of the Centre's research tools, which could not measure the variables of programme effectiveness. The literature on communication programmes provides many instances of limited evaluation that, as in the case of Centre 12, result from lack of time, budget, and research training.

Last, the chapter discussed RQ 5. A number of success factors and barriers to mental health communication programme delivery from the deliverers' perspective were covered, reflecting the range of challenges faced by health communication and mental health communication programmes documented in other crisis and disaster contexts. Like other studies of delivery in mass violence settings, safety was identified as the first barrier for workers. However, Centre 12 partly managed this barrier by clearly communicating the full plan among staff members. As recommended in published disaster response guidelines, uncertainty is decreased when workers know their place in the whole process.

As in other disaster reviews, language was highlighted as a major barrier for health practitioners. The ability to speak local languages and the provision of appropriate written materials are paramount. This was particularly the case in southern Thailand, where using the same language was important to reduce suspicion among individuals and groups.

Unlike the ideal of partnership described in many disaster communication studies, Centre 12's relationship with partners was limited due to focus on their main responsibilities, and the limited time and resources. The discussion revealed Centre 12's relationship with partners relied on communication, cooperation, and coordination, rather than reaching the full collaboration level identified by Martin et al. (2016). Although working effectively with partners was one of the challenges identified by the Centre's staff, some sustainable programmes derived from partnership were judged successful. The difficulty facing partnering and realising the benefits of full symmetrical communication is a problem recognised in the literature on effective partnership and dialogic communication.

Finally, leadership is an important success factor in disaster management. The five roles of Centre 12's Director were discussed. The chapter concluded by arguing that Thai public relations practices, although adopting Western concepts, remain strongly influenced by Thai culture.

The next and final chapter begins by identifying the study limitations, then summarises the study key contributions. It will also address the implications of the study and recommendations for future research.

CHAPTER SEVEN: CONCLUSIONS

7.1 Introduction

The focus of this research has been Centre 12's mental health communication programmes in response to the mass violence situation in southern Thailand between 2004 and 2014. As outlined in Chapter One, during that time, 14,128 violent incidents occurred, with about 6,097 deaths (Jitpiromsri, 2014). In response to this long-term and ongoing violent conflict and the associated chronic threats, the Thai government set up a rehabilitation system at both policy and practitioner level. The 12th Mental Health Centre, the key site of this study, was specifically set up in 2004 for mental health healing and rehabilitation, and, along with its partners, delivered a number of mental health communication programmes. Using a case study approach, this thesis has examined these programmes within the government policy context in which they were designed and executed.

The seventeen key informants of this study were the Director of the 12th Mental Health Centre, eleven Centre staff members, and five partner group representatives, and the study particularly focused on exploring their experiences in, and perspectives of, delivering mental health programmes in the context of the mass violence. This addressed Naturale's (2006) observation that most disaster research focuses on the mental health consequences of disasters but few studies explore "the mode of service delivery" (p. 366). Naturale argued that "evidence-based and evidence-informed research is necessary to further support the current understanding of best practices in both the clinical outcomes and **the success of outreach strategies in this area**" (Naturale, 2006, p. 366, my emphasis).

As outlined in Chapter One, the aim of the study was to explore how mental health communication programmes in the mass violence area have been designed and delivered. The five research questions were:

1. In what way did Thai government policies impact on the establishment, funding and delivery of mental health communication programmes in the mass violence situation in southern Thailand?
2. How were the mental health communication programmes responding to mass violence in southern Thailand planned?
3. How were the mental health communication programmes responding to mass violence in southern Thailand implemented?
4. How were the mental health communication programmes responding to mass violence in southern Thailand evaluated?
5. What are the effective practices and challenges of these mental health communication programmes, from the deliverers' perspective?

The theoretical framework of this case study of Centre 12 draws is built on public relations, health communication, and development communication. Together, these three approaches were used to clarify mental health communication programme planning and delivery.

7.2 Summary of key findings

The findings presented in Chapter Four, which answer RQ 1, came from semi-structured in-depth interviews, supported by document analysis. Centre 12's documents and reports, comprising media and collateral, annual reports, journal articles, and organisational websites, were used to confirm and extend interview data. Using multiple sources of data gathering allowed for triangulation and cross-data validity checks (Carter et al., 2014; Patton, 1999). Multiple sources of evidence are also particularly important for creating a case study and linking the chain of evidence (Yin, 2009). Furthermore, the official materials helped contextualise Centre 12 within the Thai policy/government setting. Organisational websites and documents of the Ministry of Public Health and the Department of Mental Health were studied to explore the background of the mental health system in Thailand. The government's notifications on appointments to the Rehabilitation Committee and the Sub-Committee and Centre 12's website have been used to identify the structure of the rehabilitation system and the development of Centre 12.

Findings also showed two levels of Thai government response to the mass violence situation: an immediate high level of strategic policies, and the resulting professional practice. While the immediate high level response focused on setting up the rehabilitation structures (such as the Rehabilitation Committee, Sub-Committee, and the 12th Mental Health Centre), the practitioner level mainly focused on Centre 12's practice and mental health communication programme delivery. Government response to mental health problems was very similar to the strategies used in Thailand's 2004 tsunami, for example, setting up a Mental Health Centre, training mental health teams, and providing community services. Policies impacted on the four phases identified in Centre 12's programme development (including the reactive programme, the policy of targeted groups, the policy of general age-group targets, and the emerging phase of severe and complicated cases).

Findings presented in Chapter Five, which answer RQ 2, 3, 4, and 5, came from semi-structured in-depth interviews, supported by participant observations of meetings and workshops. Four stages of programme delivery, including programme planning and research, media/message development, programme implementation, and programme evaluation, were described. Chapter Five identified successes and difficulties in delivering mental health communication programmes in the mass violence area. Safety and the changeability of government policies proved early difficulties for practitioners. Although these barriers were mostly outside their control, Centre 12 tried to manage them. The other challenges covered the ability of staff to use local languages; choice of trustworthy senders and communication to reduce suspicion; programme evaluation; budgets; and inter-agency coordination. Success factors involved working with networks; the unique nature of the programme delivery; the mass violence crisis itself, which resulted in opportunities to develop the potential of the staff and service systems; and Centre 12's leadership.

Chapter Six discussed the key findings above in relation to three communication frameworks (public communication and public relations, health communication, and development communication), and various empirical studies about the mental health consequences of disasters and crises, coping strategies, and mental health communication programmes and interventions. While this study is clearly situated within a particular geographical setting (southern Thailand) and has for various reasons (explained in Chapters Two and Five) defined itself as a mass violence context, there

are important learnings from this illustrative case for the literature on crisis and terrorism, and for our understanding of cultural dimensions in public relations practice, including international crisis communication.

The significance of this thesis's findings and their implications for government policy response and mental health communication programme delivery in a broader context of global instability are discussed in section 7.4. The next section first considers the study's overall limitations.

7.3 Limitations

Two significant research limitations need to be acknowledged – the site of study and the impact of safety considerations on data gathering.

This study is limited by its exclusive focus on Centre 12's Director and staff members, their work and experiences. The deliverers' own perspectives are shaped by their organisational setting and they are likely to exhibit at least some positive bias when answering questions about their own work and organisation. As part of arranging access to the Centre, the researcher informed all participants that this research would take the form of a single case study focused on understanding Centre 12's activities in a particular context, not evaluating their actions. In this way, the methodology permitted depth of insight but was structurally limited in its scope. However, it should be noted that interviews also occurred with partner groups, who were able to express an outsider perspective on the Centre and its activities. These interviews allowed a broader picture to emerge, for instance, when the Director of the Deep South Coordination Centre (DSCC) said Centre 12 could learn from her excellent model of setting up the "Volunteer Minded Women" group, see details in Chapter 5 at 5.3.2), and at least partially offset this limitation.

A second limitation of this study relates to the context of violence and the ways in which regard for researcher safety necessarily impact on research design. Unfortunately, two bombings, on May 24 and May 28, 2014, occurred during data collection in the field (see Chapter Three at 3.5.1.1, and Appendix H). These situations impacted on interview appointments, which had to be postponed, and the researcher needed to be flexible with scheduling interviews. Given the need to complete interviews in a certain timeframe because of travel arrangements, each participant was interviewed only once,

possibly affecting the reliability of interview data as the participants did not have the chance to add or change information after interviewing. The researcher took steps to mitigate this limitation by returning to the research setting in April 2016, with a summary of initial findings, and presenting them for participants' feedback (see Chapter 3 at 3.6). Some follow up questions were also asked via email. These two steps help ensure interview the data's validity (Yin, 2009) and minimise the limitation of shortened fieldwork.

A further limitation related to safety reasons when choosing interview venues. Most of the participants chose to be interviewed in a private meeting room at their Centre 12 office rather than a neutral (but potentially more dangerous) external setting. The researcher acknowledges that interviewing at the work place might impact on interview responses, with participants possibly feeling less able to speak openly. However, interview questions focused on experiences rather than opinion, and the participants were professionals and familiar with the research process, meaning the impact of the setting on data gathering is likely to be slight.

7.4 Contributions to the field

This analysis of the establishment, funding, and delivery of mental health communication programmes in Thailand's mass violence situation draws on public relations, health communication, and the of development communication frameworks, and contributes to knowledge on communication campaigns in response to disasters and crisis. This section identifies five key research contributions, followed by a separate section explaining the research's implications for practice.

7.4.1 Capturing a long-term government response

The design of this case study captures the changes in government policies over a period of ten years, and how these impacted upon Centre 12's programme planning. This longer-term focus enables a realistic insight into the nature of policy development and change over time, which extends our understanding beyond limited snapshots of the policy environment.

Although victims who experience manmade disasters are more psychologically affected in the long term than those experiencing natural disasters (Norris et al., 2002; Stratta et

al., 2015), empirical studies have been more likely to focus on disaster response and psychological consequences of natural disasters. This might be because of the nature of natural disasters, which are generally short-term events with large-scale impacts, meaning the overall pattern of events and stages of recovery are more explicit. In manmade disasters, victims may cope better if the violent conflict seems reasonable and justified (McDonald, 2007). Both of these points are in contrast to the southern Thailand case, where the causes of violent actions and the perpetrators are highly complex. This condition is challenging for the government. Findings show two levels of the Thai government response: the high-level policy response, which includes setting up the rehabilitation committee and the sub-committee and the 12th Mental Health Centre, and the practitioner-level response, which included developing and implementing a number of mental health communication programmes.

Further, the existing literature generally categorise disasters into three stages: before, during, and after disasters, and provide associated interventions used in each stage (e.g. Ghosh et al., 2004; Houston, 2012; Stratta et al., 2015). However, the nature of southern Thailand's violence does not fit neatly with these categories because it is long-term, ongoing, and day-to-day violence. This research therefore provides insight into how the change of government policy over time impacts on the planning, implementation, and evaluation of government-sponsored programmes. For implementers of similar sorts of campaigns, Centre 12 models an adaptive understanding of the policy environment, showing how an awareness of policy change helps practitioners to predict trends and adjust campaigns to be most beneficial for target audiences. Furthermore, it addresses the need for future research into the success of the outreach strategies used in the disaster context, which are seen as limited in recent literature (Naturale, 2006).

7.4.2 New emphasis on media/message development in programme planning

The main focus of this study is mental health communication programme delivery in the context of mass violence. Interviews show how Centre 12 staff drive their work through launching a number of mental health communication programmes. Their programme delivery combines the elements of research, media/message development, programme implementation, and programme evaluation. These stages are very similar to the normative patterns of the programme-planning framework provided in public relations, health communication, and development communication approaches (see details in

Chapter Two at 2.5), and thus confirms that typical programme frameworks from Western countries are able to be used in the Thai context. This finding is somewhat congruent with other studies (such as Ekachai & Komolsevin, 2004; Sriramesh, 2004) that conclude that public relations practices of Asian countries (including Thailand) are influenced by Western theories, especially those from the U.S. These similarities also extend to the tensions between normative ideals and actual practice, especially conducting properly formative research and effective evaluation (Broom & Sha, 2013; Kabucua et al., 2016; Kreps, 2014; Walker, 1994; Watson & Simmons, 2004). Furthermore, based on this study, these normative programme planning frameworks are not only applicable in Thailand, but also in unusual situations such as a mass violence context and a multi-cultural society where programme planning needs to recognise the value of cultural differences.

However, while this thesis found broad similarities in the ways noted above, there are also interesting areas of divergence that add to our knowledge about communication programme delivery in different contexts. While the typical programme planning frameworks mostly refer to the three broad stages of planning, implementation, and evaluation. The emphasis in Centre 12's programme delivery is different. It is more focused on the second stage: media/message development. This partly reflects the nature of the workforce in Thai public relations, which strongly relies on the technical role that focuses on message production and distribution (Ekachai & Komolsevin, 1996). Interviews showed most of Centre 12's staff members emphasised media production processes and how print media were particularly strengthened through verifying content via experts, media try-outs, and media refinements after feedback. This finding reinforces Ekachai and Komolsevin's (1996) study of public relations models in Thailand and the roles of PR practitioners. They state "Thai public relations practitioners in both the public and private sectors appear to be governed by the press-agentry and public-information models...In government organizations, practitioners devoted most of their time to technical chores of disseminating information to target audiences" (p. 159). More than twenty years later, this study reveals practitioners have continued to rely on the same public relations models and the same role.

In this case study, part of the reason that Centre 12 focused on media/message development was because those media (such as *Healing according to Muslim Principles* and *Healing according to Buddhist Principles* booklets) reflected their respect of both

religions and multicultural understanding. This emphasis is likely to be even greater during a crisis, where promoting understanding and harmony will be at the forefront of practitioners' planning around collateral. However, this focus is also likely to have fed Centre 12's tendency to largely evaluate programme outputs (such as the number of media produced and placement) rather than programme outcomes (media utilisation).

This thesis therefore reinforces that in many respects Thai practitioners continue to follow Western models, even many years later (25 years since Ekachai and Komolseven's study) and during an ongoing violent conflict. However, it also indicates an emphasis on written materials where their production processes were influenced by three conditions: the Thai's typical workforce; the cultural context of multi-cultural society; and the situation where high levels of tension between the different religions are evident. Centre 12's practices therefore also strongly reflect their cultural context. This is an interesting addition to our understanding of Thai PR programme delivery, and also a useful insight into different cultural practices. Further studies about public communication programmes in other violent situations around the globe would extend our knowledge of such cultural practices.

7.4.3 Identifying qualities for planning sustainable responses to disasters

One of the difficulties found in several empirical studies is how to enhance sustainable responses in disaster situations (for instance, Rabiei et al., 2014; Hall et al., 2014; Stratta et al., 2015). Participants in this study, however, saw 'programme sustainability' as an important measure of the success of Centre 12's programme delivery. In Chapter Five, participants identified their perceptions of major factors of success (see details in 5.4). Based on those success factors, this section identifies two key contributions to our understanding of sustainable responses during a crisis: the importance of empowered individual and community potential, and the value of maintaining informal partnerships.

7.4.3.1 Empowered individual and community potential

As indicated in Chapter Four, Centre 12's Director and staff members initially talked about hiring and training 74 full-time psychologists and integrating them into the local public health system, as effective strategies leading to the sustainable response. This confirms McFarlane and Williams' (2012) point that disaster and mental health response services have to integrate into mainstream delivery structures because the

services have to be continued even after government funds are withdrawn. Further, Centre 12 also focused on empowering the potential of other deliverers, including public health staff, community leaders, religious leaders, parents, teachers, and radio DJs by providing a number of training programmes, educating them about mental health recovery from disasters, and promoting positive mental health. As this study focused on a long period of time, it enabled the researcher to capture more insight into those programmes and activities that were truly sustainable. As mentioned, the government invested in hiring 74 full-time psychologists in 2006 and Centre 12 staff were engaged in efforts to empower and train them. However, 5 years later, when the national health policy changed, these trained psychologists' roles also changed and are unlikely to be sustained. As Centre 12's Director pointed out, "they [psychologists] had to work in the hospitals which belonged to the Ministry of Public Health....When they worked in these hospitals, their job depended on the assignment of the hospitals' directors and nurses. Mental health rehabilitation was no longer to be their main job anymore" (The Director, Interview, June 4, 2014). This contrasts with the empowering of the widows and disabilities groups, evaluated by the participants as sustainable programmes because of community involvement in continuing activities over 10 years even without government sponsorship. Long-term case studies such as this research are thus able to capture the ebbs and flows in sustainable outcomes.

7.4.3.2 Partnership

Centre 12's Director and several staff members identified working with networks as a major factor of their success. However, results from this study reveal the nature of partnerships between Centre 12 and partners outside the health sector relied on informal and flexible relationships. This is different from the ideal of successful partnership provided in existing literature where there is a tendency to focus on the formal (such as Nitesh Bharosa, JinKyu, & Janssen, 2010; Dowling et al., 2004). Centre 12's informal and flexible style of partnership meant each partner focused mainly on their own activities, but was willing to help another partner by sharing information and resources when requested, realising that partnering helped them to meet mutual goals. With these kinds of partnerships, organisations can be flexible in practice and make quick decisions to respond to the onset of problems. This is likely to be suitable in the context of on-going and day-to-day violent incidents where a task-based approach is prioritised over developing a formal and high level of engagement to establish partnerships. This

informal style of partnerships during disasters is similar to the concept of ‘agility’, a new trend in public relations planning theory where organisations need to reduce complexity, create more flexibility, and respond quickly to the new opportunities for maintaining an organisation’s competitive advantage (Ruler, 2015). While ‘agility’ has been mostly used in the context of business public relations, this study suggests this concept is also helpful in analysing campaign partnerships during crisis/disasters.

7.4.4 Identifying the impact of Thai culture on public relations practice

The results of this study capture ways in which culture impacted on Centre 12’s planning and practice, both direct/observable and indirect/subtle. In an observable way, cultural considerations clearly showed in collateral production where messages were carefully designed using local languages and respecting the differences of Buddhism and Islam. More indirect and subtle is Centre 12’s leadership. Results highlighted the role of Centre 12’s Director as a factor of success. Her pragmatic leadership style is consistent with what is culturally valued in terms of leadership in Thailand (Peltz et al., 2006; Selvarajah et al., 2013). As several interviews with the Centre’s staff members and partner group representatives showed, the Director used her interpersonal relationships in order to resolve urgent problems (such as finding a wheelchair for a victim who was shot in 2007; see section 5.3.2). This study reinforces Srisai’s (2011) finding that although Thai PR practitioners adopted Western concepts, *Wattana-dharm Thai* [Thai culture] has a strong influence on Thai PR practice especially the ‘relationship orientation’:

For the Thais, personal relationship and social relationships are usually uninhibited in every single area of Thai society. Thai society is “relational”. The Thais are very much aware that the right relationship, the right connection, or being in the right place at the right time, could be the means of advancing oneself (Srisai, 2011, p. 148).

Based on this understanding of Thai culture, it is not surprising that practitioners tend to use their personal relationship to help them achieve their goals without too much concern for the rules and regulations (Srisai, 2011). This case study therefore confirms culture as a significant factor that impacts on practice, and extends this understanding to leadership within public communication campaign delivery. However, relationship-based leadership can be risky if the leaders who have personal relationships leave the

organisation, without any sort of systematic succession planning. Further studies could explore the impact of relationship-based approach to leadership and leadership styles in mass violence situations.

7.4.5 Approaching development communication in supplementing public relations and health communication approaches

The interdisciplinary approach of this study, drawing on theories from public relations, health communication, and development communication, allows a depth and breadth of understanding of the framework of health communication programming in mass violence. As explained in Chapter Two, the public relations approach provides the framework of campaign planning and delivery, and the development of long-term relationships. The health communication approach identifies communication strategies and techniques for enhancing the effectiveness of health service delivery and health promotion. The development communication approach suggests ways to develop effective community-based programmes by considering social and cultural contexts. All three approaches shared two commonalities: the typical programme planning framework and the shifting flow of communication from one-way to two-way communication, which values the ideal of participatory and dialogic communication.

Public relations and health communication approaches are often applied in campaign studies. This thesis has further integrated development communication in analysing the case of Centre 12's communication programme planning and delivery. The study therefore provides a different perspective to campaign studies. While the public relations approach relies mainly on the Western contexts especially those of the U.S., the development communication framework focuses on exploring communication activities in the developing countries, which fits with the context of this thesis and helps extend existing scholarship. The development communication approach has been used in other studies of conflict situations (Curtis, 2000; Hoffmann, 2014; Lynch, 2008), as its focuses on community-based philosophy, cultural sensitivity and sustainable development, which are key goals in disaster response (Moemeka, 1999). However, while previous studies have used development communication frameworks in analysing mass communication activities such as local radio in Rwanda and Bosnia (Curtis, 2000), this research expands the literature by applying development communication to

interpersonal communication activities between Centre 12's staff members and community leaders in programme planning.

In a related point, this research was conducted by a researcher who lived in the area for 8 years. Being a local of the area and having a deep understanding of the context is particularly important for exploring communication practices and programme delivery during a time of crisis. The design of the thesis and its inclusion of a development communication framework help offset the tendency for research to be conducted in western countries while the subjects of research are located in developing countries and to limit the involvement of local researchers (Gumucio-Dagron, 2008).

Based on this study's results, discussions, and conclusions, the following section considers implications for governments, authorities, and health communicators facing similar challenges of mass violence, as well as for campaign planners in general.

7.5 Implications for practice

This study is particularly applicable in contexts with a shared commonality of disaster-impacted areas, government response and community-based programmes. In this section, research implications are divided into two levels: the operational level and the delivery level. The operational level identifies implications for those having responsibility at the policy level, including for rehabilitation systems. The delivery level presents implications for those communication practitioners in public relations, as well as for health and mental health practitioners, and community workers.

7.5.1 The operational level

The first implication for practice relates to the importance of organisational structure. For governments or authorities who take responsibility for mental health recovery from disasters, this research provides an insight into the development and functions of the 12th Mental Health Centre, an organisation set up specifically to respond to community issues of mental health healing and rehabilitation. Centre 12's major role was as a support centre overseeing mental health training, a media and collateral producer and disseminator, a mental health coordinator, and a mental health knowledge provider. This supportive role is very helpful in dealing with crisis. Unifying its oversight of various tasks is applicable for other countries structuring and planning mental health

responses. Also, while literature largely highlights the importance of psychosocial interventions in disasters, few of them explain clearly how such effective interventions are to be implemented and maintained. This study suggests a structure and setting like Centre 12 to support mental health services and expand mental health communication programme delivery into the communities in collaboration with various partners.

7.5.2 The delivery framework

For practitioners who have to communicate about mental health issues and deliver mental health communication programmes, this study reinforces the value of the four stages of the programme planning framework, which includes planning and research, media and message development, programme implementation, and programme evaluation. During these four stages, media/message development can be strengthened through content verification by experts and media pre-tests. This practice is particularly useful for programme deliverers who work in multicultural societies where media must be designed appropriately for targeted publics in different religions, cultures, language, and ways of life. In this way, the Centre 12 case study reinforces culturally sensitive media as a practice worth widespread adoption, especially given the increasingly diverse nature of many countries around the world, including those accommodating refugees, new migrants, and indigenous populations.

The results also show areas where practitioners could learn from weaknesses identified at Centre 12. Like many other organisations studied in the literature (see DiStaso & Stacks, 2010; Harrison, 2011; Walker, 1994; Watson & Simmons, 2004), Centre 12 undertook inadequate formative and evaluative research of its programmes, linked to a lack of funds and personnel. Public relations professionals and government organisations are advised to collaborate to provide training in research process and techniques. For campaign planners in general, campaign goals need to be set clearly and include the design of tools to measure campaign effectiveness to achieve those goals. Additionally, one of Centre 12's difficulties in programme evaluation was using the official post-workshop evaluation form (about participants' satisfaction about food, venue, and the ability of the facilitator, see Appendix J), which could not actually measure programme outcomes/impacts. As a result, this thesis provides an example of questions used to measure programme outcomes (see Appendix K) that focuses more on

evaluating programme effectiveness. This confirms the value of academic collaboration with practitioners for driving good practice.

Although community-based approaches, interagency coordination, and partnerships are important success factors of mental health delivery, they also have human resource implications. In disaster and crisis contexts, public health officers are likely to be easily burnt out from their work in difficult situations. This case study recommends systematic support for staff and mental health practitioners working in the crisis area, and is a reminder of the need to plan for responding to staff's personal needs.

Leadership is also crucial to the success of disaster response. This research showed a leader using her personal relationships to achieve her organisational goals. However, it is problematic to rely on this approach, given leadership can change. As a result, organisations should have a sustainable succession plan or process to help support recovery, rather than relying too much on an individual leader.

Last, this case study extends the literature about disaster response and programme planning frameworks, which are mostly developed by Western theories. In the particular context of southern Thailand, campaigns are highly influenced by culture, as seen in Centre 12's religious-based media, relationship-based leadership, and interpersonal communication. As a result, cultural understanding is crucial for programme planners working in disaster contexts.

7.6 Conclusion

Both natural and manmade disasters occur around the world. Between 2003 and 2012, more than 100,000 people were killed and over 200 million were affected by natural disasters. A U.S. report in 2004 found nearly 10,000 terrorist attacks worldwide, resulting in more than 17,000 deaths and over 30,000 injuries (Schwarz et al., 2016). Consequently, this is a particularly important time for all nations to be prepared for disaster and crisis responses.

This case study of Centre 12's communication programme delivery in Thailand's challenging environment reveals some lessons for other initiatives. This case study design, which covers a period of over 10 years of violence, permits understanding of government policy changes and its impact on Centre 12's mental health communication

programme delivery. This long-term observation helps practitioners analyse and determine truly sustainable programmes and effective styles of partnership while coordinating in an uncertain environment. The value of combining multidisciplinary approaches expands our knowledge on programme planning frameworks and effective community-based programmes, particularly in the disaster context. It highlights how the nature of the workforce and cultural aspects significantly influence communication practice. This case study therefore makes a valuable contribution to our understanding of mental health communication programme delivery in Thailand and other mass violence situations around the developing world.

REFERENCES

- Abeldaño, R. A., & Fernández, R. (2016). Community mental health in disaster situations. A review of community-based models of approach. *Revista Ciência & Saúde Coletiva*, 21(2), 431–442.
- Abuza, Z. (2011). *The ongoing insurgency in southern Thailand: Trends in violence, counterinsurgency operations, and the impact of national politics*. Washington, DC: National Defense University Press.
- Adler, P. A., & Adler, P. (1994). Observation techniques. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 377–392). Thousand Oaks, CA: Sage.
- Amornpipata, I., & Sorodb, B.-O. (2017). Development of Thai authentic leadership measure: An application in a military context. *Journal of Community Development Research (Humanities and Social Sciences)*, 10(2), 11–24.
- Arkin, E. B., & National Cancer Inst, B. M. D. (1989). *Making health communication programs work: A planner's guide*. Bethesda, MD: Department of Health and Human Services.
- Aronoff, C. E., & Baskin, O. W. (1983). *Public relations: The profession and the practice*. San Francisco, CA: West Publishing Company.
- Askew, M. (2010). Fighting with ghosts: Querying Thailand's "Southern Fire". *Contemporary Southeast Asia: A Journal of International & Strategic Affairs*, 32(2), 117–155.
- Atkin, C. K., & Freimuth, V. (2013). Guidelines for formative evaluation research in campaign design. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns* (pp. 53–68). Thousand Oaks, CA: Sage.
- Atkin, C. K., & Rice, R. E. (2013). Theory and principles of public communication campaigns. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns* (4th ed., pp. 3–20). Thousand Oaks, CA: Sage.
- Austin, E. W., & Pinkleton, B. E. (2015). *Strategic public relations management: Planning and managing effective communication programs* (3rd ed.). New York: Routledge, Taylor & Francis Group.
- Babrow, A. S., & Mattson, M. (2003). Theorizing about health communication. In T. L. Thompson (Ed.), *Handbook of health communication* (pp. 35–62). Mahwah, NJ; London: Lawrence Erlbaum.
- Baingana, F., Bannon, I., & Thomas, R. (2005). *Mental health and conflicts: Conceptual framework and approaches*. Washington, DC: The International Bank for Reconstruction and Development.
- Barter, S. J. (2011). Strong state, smothered society: Explaining terrorist violence in Thailand's deep south. *Terrorism & Political Violence*, 23(2), 213–232. doi:10.1080/09546553.2010.526869

- Beaudoin, C. E. (2008). Assessment of a media campaign and related crisis help line following Hurricane Katrina. *Public Health Reports*, 123(5), 646–651.
- Beaudoin, C. E. (2009). Evaluating a media campaign that targeted PTSD after Hurricane Katrina. *Health Communication*, 24(6), 515–523.
doi:10.1080/10410230903104905
- Beck, S., & Knecht, M. (2016). “Crisis” in social anthropology: rethinking a missing concept. In A. Schwarz, M. W. Seeger, & C. Auer (Eds.), *The handbook of international crisis communication research* (pp. 56–65). Chichester, UK; Malden, MA: Wiley Blackwell.
- Beech, H. (2009). Despite outreach: Violence is up in southern Thailand. *Time*. Retrieved from <http://content.time.com/time/world/article/0,8599,1919977,00.html#ixzz1CPvW52FM%20Updated>
- Ben-Gershon, B., Grinshpoon, A., & Ponizovsky, A. M. (2005). Mental health services preparing for the psychological consequences of terrorism. *Journal of Aggression, Maltreatment & Trauma*, 10(3–4), 743–753.
doi:10.1300/J146v10n03_08
- Berg, B. L. (2009). *Qualitative research methods for the social sciences*. Boston, MA: Allyn & Bacon.
- Berkowitz, S., Bryant, R., Brymer, M., Hamblen, J., Jacobs, A., Layne, C., . . . Watson, P. (2010). Skills for psychological recovery (SPR). Retrieved from <http://www.nctsn.org/content/skills-psychological-recovery-spr>
- Berliner, P., Dominguez, M., Kjaerulf, F., & Mikkelsen, E. N. (2006). What can be learned from ‘crazy’ psychologists? A community approach to psychosocial support in post-conflict Guatemala. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict*, 4(1), 67–73.
- Berlo, D. K. (1960). *The process of communication: An introduction to theory and practice*. New York, NY: Holt, Rinehart and Winston.
- Bernard, H. R. (1994). *Research methods in anthropology : qualitative and quantitative approaches*: Thousand Oaks, CA: Sage.
- Bernhardt, J. M. (2004). Communication at the core of effective public health. *American Journal of Public Health*, 94(12), 2051–2053.
- Bharosa, N., Lee, J., & Janssen, M. (2010). Challenges and obstacles in sharing and coordinating information during multi-agency disaster response: Propositions from field exercises. *Information Systems Frontiers*, 12(1), 49–65.
doi:10.1007/s1079-009-9174z
- Birkmann, J., Buckle, P., Jaeger, J., Pelling, M., Setiadi, N., Garschagen, M., . . . Kropp, J. (2010). Extreme events and disasters: a window of opportunity for change? Analysis of organizational, institutional and political changes, formal and informal responses after mega-disasters. *Natural Hazards*(3), 637.

- Birowo, M. A. (2010). The use of community radio in managing natural disaster in Indonesia. *Bulletin of the American Society for Information Science & Technology*, 36(5), 18–21.
- Bonanno, G. A., Brewin, C. R., Kaniasty, K., & La Greca, A. M. (2010). Weighing the costs of disaster: Consequences, risks, and resilience in individuals, families, and communities, *Psychological Science in the Public Interest*, 11(1) 1–49.
- Bowen, S. A. (2003). 'I thought it would be more glamorous': Preconceptions and misconceptions of public relations among students in the principles course. *Public Relations Review*, 29, 199–214.
- Bowen, S. A., Rawlins, B., & Martin, T. (2010). *An overview of the public relations function* (1st ed). New York : Business Expert Press.
- Bradley, D. T., McFarland, M., & Clarke, M. (2014). The effectiveness of disaster risk communication: A systematic review of intervention studies. *Plos Currents*, 6. doi:10.1371/currents.dis.349062e0db1048bb9fc3a3fa67d8a4f8
- Broom, G. M., & Dozier, D. M. (1986). Advancement for public relations role models. *Public Relations Review*, 12(1), 37–56.
- Broom, G. M., & Sha, B. L. (2013). *Cutlip and Center's effective public relations* (11th ed.). Boston, MA: Pearson.
- Bryman, A., & Bell, E. (2007). *Business research methods* (2nd ed.). New York, NY: Oxford University Press.
- Bryman, A., & Bell, E. (2011). *Business research methods* (3rd ed.). New York, NY: Oxford University Press.
- Burke, A., Tweedie, P., & Poocharoen, O.-o. (2013). *The contested corners of Asia: Subnational conflict and international development assistance, the case of southern Thailand*. San Francisco, CA: The Asia Foundation.
- Butler, A. S., Panzer, A. M., & Goldfrank, L. R. (2003). *Preparing for the psychological consequences of terrorism: A public health strategy*. Washington, DC: National Academies Press.
- Cappella, J. N. (2006). Integrating message effects and behavior change theories: Organizing comments and unanswered questions. *Journal of Communication*, 56 (Suppl 1), S265–S279. doi:10.1111/j.1460-2466.2006.00293.x
- Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum*, 41(5), 545–547. doi:10.1188/14.ONF.545-547
- Cassata, D. M. (1980). Health communication theory and research: A definition overview. In Nimmo, D (Ed.), *Communication Yearbook 4* (pp. 583–589). Thousand Oaks, CA: Sage.
- Center, A. H., Jackson, P., Smith, S., & Stansberry, F. R. (2014). *Public relations practices : managerial case studies and problems* (8th ed.). Boston, MA: Pearson.

- Chakrabhand, S., Panyayong, B., & Sirivech, P. (2006). Mental health and psychosocial support after the tsunami in Thailand. *International Review of Psychiatry*, 18(6), 599–605. doi:10.1080/09540260601038274
- Chalk, P., & United, S. (2008). *The Malay-Muslim insurgency in Southern Thailand : Understanding the conflict's evolving dynamic*. Santa Monica, CA: Rand Corporation.
- Chavis, D. M. (1995). Building community capacity to prevent violence through coalitions and partnerships. *Journal of Health Care for the Poor and Underserved*, 6(2), 234–245.
- Coffman, J. (2002). *Public communication campaign evaluation: An environmental scan of challenges, criticisms, practice, and opportunities*. Retrieved from <http://www.hfrp.org/evaluation/publications-resources/public-communication-campaign-evaluation-an-environmental-scan-of-challenges-criticisms-practice-and-opportunities>
- Cohen, R. E. (2002). Mental health services for victims of disasters. *World Psychiatry*, 1(3), 149–152.
- Col, J. M. (2007). Managing disasters: The role of local government[Special issue]. *Public Administration Review*, 114–124.
- Collins, S. (2007). *Patient participation in health care consultations: Qualitative perspectives*. Maidenhead, Berkshire, England: Open University Press.
- Connors, M. (2006). War on error and the Southern fire: How terrorism analysts get it wrong. *Critical Asian Studies*, 38(1), 151–175. doi:10.1080/14672710600556528
- Conrad, C. (1985). *Strategic organizational communication: Cultures, situations, and adaptation*. New York, NY: Holt, Rinehart & Winston.
- Craig, R. T. (1989). Communication as a practical discipline. In B. Dervin (Ed.), *Rethinking communication* (pp. 97–122). Newbury Park, CA: Sage.
- Crifasi, S. C. (2000). Everything's coming up ROSIE. *Public Relations Tactics*, 7(9), 22.
- Croissant, A. (2005). Unrest in south Thailand: Contours, causes, and consequences since 2001. *Contemporary Southeast Asia: A Journal of International and Strategic Affairs*(1), 21–43.
- Croissant, A. (2007). Muslim insurgency, political violence, and democracy in Thailand. *Terrorism & Political Violence*, 19(1), 1–18. doi:10.1080/09546550601054485
- Cuny, F. C. (2000). Principles of disaster management lesson 7: Management leadership styles and methods. *Prehospital & Disaster Medicine*, 15(1), 70–78.
- Curtis, D. E. A. (2000). Broadcasting peace: An analysis of local media post-conflict peacebuilding projects in Rwanda and Bosnia. *Canadian Journal of*

Development Studies / Revue canadienne d'études du développement, 21(1), 141–166. doi:10.1080/02255189.2000.9669886

- Cutlip, S. M., Center, A. H., & Broom, G. M. (2006). *Effective public relations*. Upper Saddle River, NJ: Pearson Prentice Hall.
- Dalpino, C. (2011). Thailand in 2010: Rupture and attempts at reconciliation. *Asian Survey*, 51(1), 155–162.
- DeMarrais, K. B., & Lapan, S. D. (Eds.) (2004). *Foundations for research: methods of inquiry in education and the social sciences*. Mahwah, NJ: L. Erlbaum Associates.
- Demiroz, F., & Kapucu, N. (2016). The role of leadership in managing emergencies and disasters. *European Journal of Economic and Political Studies*, 5(1), 91–101.
- Denzin, N. K. (1989). *The research act: A theoretical introduction to sociological methods* (3rd). Englewood Cliffs, NJ: Prentice Hall.
- Denzin, N. K., & Lincoln, Y. S. (1994). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.
- Department of Mental Health. (2015). History of the Department of Mental Health. Retrieved from <http://www.dmh.go.th/intranet/about.asp>.
- DiMaggio, C., & Galea, S. (2006). The behavioral consequences of terrorism: A meta-analysis. *Academic Emergency Medicine*, 13(5), 559–566.
- DiStaso, M. W., & Stacks, D. W. (2010). The use of research in public relations. In R. L. Heath (Ed.), *The SAGE Handbook of Public Relations*. Los Angeles, CA: Sage.
- Dorfman, L., Ervice, J., & Woodruff, K. (2002). *Voices for change: A taxonomy of public communications campaigns and their evaluation challenges*. Berkeley, CA: Berkeley Media Studies Group.
- Dowling, B., Powell, M., & Glendinning, C. (2004). Conceptualising successful partnerships. *Health & Social Care in the Community*, 12(4), 309–317. doi:10.1111/j.1365-2524.2004.00500.x
- Dozier, D. M. (1990). The innovation of research in public relations practice: Review of a program of studies. *Public Relations Research Annual*, 2, 3–28.
- Dozier, D. M., & Repper, F. C. (1992). Research firms and public relations practices In J. E. Grunig (Ed.), *Excellence in public relations and communication management* (pp. 185–215). Hillsdale, NJ: L. Erlbaum Associates.
- Duffy, M., & Gillespie, K. (2009). Trauma-focused cognitive therapy in the context of ongoing civil conflict and terrorist violence In N. Grey (Ed.), *A casebook of cognitive therapy for traumatic stress reactions* (pp. 213–246). London; New York, NY: Routledge.

- Dumesnil, H., & Verger, P. (2009). Public awareness campaigns about depression and suicide: A review. *Psychiatric Services, 60*(9), 1203–1213. doi:10.1176/appi.ps.60.9.1203
- Dutta, M. J., & de Souza, R. (2008). The past, present, and future of health development campaigns: reflexivity and the critical-cultural approach. *Health Communication, 23*(4), 326–339.
- Dziokonski, W. S. J. (1977). Repression-sensitization, perceived vulnerability, and the fear appeal communication. *Journal of Social Psychology, 102*(1), 105.
- Ekachai, D., & Komolsevin, R. (1996). Public relations in Thailand: Its functions and practitioners roles. In H. M. Culbertson & N. Ch'en (Eds.), *International public relations: A comparative analysis* (pp. 155–170). Mahwah, NJ: Erlbaum.
- Ekachai, D., & Komolsevin, R. (2004). From propaganda to strategic communication: The continuing evolution of the public relations profession in Thailand. In K. Sriramesh (Ed.), *Public relations in Asia : an anthology* (pp. 283–320): Singapore: Thomson.
- Ewart, J., & Dekker, S. (2013). Radio, someone still loves you! Talkback radio and community emergence during disasters. *Continuum, 27*(3), 365–381. doi:10.1080/10304312.2013.772106
- Felton, C. J. (2004). Lessons learned since September 11th 2001 concerning the mental health impact of terrorism: Appropriate response strategies and future preparedness. *Psychiatry: Interpersonal & Biological Processes, 67*(2), 147–152.
- Finnegan, J. R., & Viswanath, K. (1989). Health and communication: Medical and public health influences on the research agenda. In E. Berlin-Ray & L. Donohew (Eds.), *Communication and Health: System and Applications* (pp. 9–24). New York, NY: Erlbaum.
- Fontana, A., & Frey, J. H. (1994). Interviewing: The art of science. In N. Denison & Y. Lincoln (Eds.), *The handbook of qualitative research* (pp. 361–376). Thousand Oaks, CA: Sage.
- Forbes, D., Fletcher, S., Wolfgang, B., Varker, T., Creamer, M., Brymer, M. J., . . . Bryant, R. A. (2010). Practitioner perceptions of skills for psychological recovery: A training programme for health practitioners in the aftermath of the Victorian bushfires. *Australian & New Zealand Journal of Psychiatry, 44*(12), 1105–1111. doi:10.3109/00048674.2010.513674
- Francis, C., Perkis, J., Dunt, D., & Blood, R. W., Davis, C. (2002). *Improving mental health literacy: A review of the literature*. University of Melbourne, Melbourne, Vic, Australia: Center for Health Program Evaluation.
- Frank, R. G., Pindyck, T., Donahue, S. A., Pease, E. A., Foster, M. J., Felton, C. J., & Essock, S. M. (2006). Impact of a media campaign for disaster mental health counseling in post-September 11 New York. *Psychiatric Services, 57*(9), 1304–1308.

- Fraser, C., & Villet, J. (1994). *Communication: A key to human development*. Rome: FAO.
- Freimuth, V. S., Massett, H. A., & Meltzer, W. (2006). A descriptive analysis of 10 years of research published in the *Journal of Health Communication* *Journal of Health Communication: International Perspectives*, *11*(1), 11–20.
- Frey, L. R., Botan, C. H., & Kreps, G. L. (2000). *Investigating communication: An introduction to research methods* (2nd ed.). Boston, MA: Allyn & Bacon.
- Galappatti, A. (2003). What is a psychosocial intervention? Mapping the field in Sri Lanka. *Intervention: International Journal of Mental Health, Psychosocial Work & Counselling in Areas of Armed Conflict*, *1*(2), 3–17.
- García-Vera, M. P., Sanz, J., & Gutiérrez, S. (2016). A systematic review of the literature on posttraumatic stress disorder in victims of terrorist attacks. *Psychological Reports*, *119*(1), 328–359. doi:10.1177/0033294116658243
- Ghosh, Mohit, & Murthy. (2004). Mental health promotion in post-conflict countries. *Journal of the Royal Society for the Promotion of Health*, *124*(6), 268–270.
- Glesne, C. (2005). *Becoming qualitative researchers: An introduction*. Boston, MA: Allyn & Bacon.
- Gold, R. L. (1958). Roles in sociological field observations. *Social Forces*, *36*(3), 217–223. doi:10.2307/2573808
- Gray, M. J., & Litz, B. T. (2005). Behavioral interventions for recent trauma: Empirically informed practice guidelines. *Behavior Modification*, *29*(1), 189–215.
- Greenfield, S., Kaplan, S., & Ware, J. E. (1985). Expanding patient involvement in care. *Annals of Internal Medicine*, *102*(4), 520–528.
- Gregory, A. (2006). Public relations as planned communication. In R. Tench & L. Yeomans (Eds.), *Exploring public relations* (pp. 182–206). Harlow, Essex: Pearson Education.
- Griffith, J. L., Agani, F., Weine, S., Ukshini, S., Pulleyblank-Coffey, E., Ulaj, J., . . . Kallaba, M. (2005). A family-based mental health program of recovery from state terror in Kosova. *Behavioral Sciences & the Law*, *23*(4), 547–558.
- Grunig, J. E. & Hunt, T. (1984). *Managing public relations*. New York, NY: Holt, Rinehart and Winston.
- Grunig, J. E. (2006). Furnishing the edifice: Ongoing research on public relations as a strategic management function. *Journal of Public Relations Research*, *18*(2), 151–176. doi:10.1207/s1532754xjpr1802_5
- Grunig, J. E., & Grunig, L. A. (2008). Excellence theory in public relations: Past, present, and future. In A. Zerfass, B. v. Ruler, & K. Sriramesh (Eds.), *Public relations research: European and international perspectives and innovations* (pp. 327–347). Wiesbaden: GWV Fachverlage.

- Grunig, J. E., & Hickson, R. H. (1976). An evaluation of academic Research in Public Relations. *Public Relations Review*, 2(1), 31–43. doi:10.1016/S0363-8111(76)80013-6
- Grunig, J. E., & Repper, F. C. (1992). Strategic management, publics, and issues. In J. E. Grunig (Ed.), *Excellence in public relations and communication management* (pp. 117–157). Hillsdale, NJ: L. Erlbaum Associates.
- Grunig, J. E., Grunig L. A., & Dozier. (2002). *Excellent public relations and effective organizations: A study of communication management in three countries*. Mahwah, NJ : Lawrence Erlbaum.
- Grunig, J. E., Grunig, L. A., Sriramesh, K., Yi-Hui, H., & Lyra, A. (1995). Models of public relations in an international setting. *Journal of Public Relations Research*, 7(3), 163–186.
- Guba, E. G., & Lincoln, Y. S. (1981). *Effective evaluation*. San Francisco, CA: Jossey-Bass.
- Guest, G., Namey, E. E., & Mitchell, M. L. (2013). *Collecting qualitative data: A field manual for applied research*. Thousand Oaks, CA: Sage.
- Gumucio-Dagron, A. (2008). Vertical minds versus horizontal cultures: An overview of participatory process and experiences. In J. Servaes (Ed.), *Communication for Development and Social Change*. New Delhi, India: Sage Publications India Pvt Ltd; UNESCO.
- Gunaratna, R., Acharya, A., & Chua, S. (2005). *Conflict and terrorism in southern Thailand*. Singapore: Marshall Cavendish International.
- Gurwitch, R. H., Sitterle, K. A., Young, B. H., & Pfefferbaum, B. (2002). The aftermath of terrorism. In A. M. La Greca, W. K. Silverman, E. M. Vernberg, M. C. Roberts, A. M. La Greca, W. K. Silverman, E. M. Vernberg, & M. C. Roberts (Eds.), *Helping children cope with disasters and terrorism* (pp. 327–357). Washington, DC: American Psychological Association.
- Guth, D., & Marsh, C. (2006). *Public relations: a values-driven approach* (3rd ed.). Boston, MA: Pearson/Allyn and Bacon.
- Hall, J., d'Ardenne, P., Nsereko, J., Kasujja, R., Baillie, D., Mpango, R., . . . Hunter, E. (2014). Mental health practitioners' reflections on psychological work in Uganda: Exploring perspectives from different professions. *British Journal of Guidance & Counselling*, 42(4), 423–435.
- Hallahan, K. (2001). The dynamics of issues activation and response: An issues processes model. *Journal of Public Relations Research*, 13(1), 27–59.
- Harlow, R. F. (1977). Public relations definitions through the years. *Public Relations Review*, 3(1), 49-63. doi:https://doi.org/10.1016/S0363-8111(77)80018-0
- Harrison, K. (2011). *Strategic public relations: A practical guide to success*. South Yarra, Vic., Australia : Palgrave Macmillan.

- Hatton, M. J., & Schroeder, K. (2007). Partnership theory and practice: Time for a new paradigm. *Canadian Journal of Development Studies*, 28(1), 157–162.
- Heath, M. A., Nickerson, A. B., Annandale, N., Kemple, A., & Dean, B. (2009). Strengthening cultural sensitivity in children's disaster mental health services. *School Psychology International*, 30(4), 347–373.
- Heath, R. L. (2001). *Handbook of public relations*. Los Angeles, CA: Sage.
- Henderson, S., Berliner, P., & Elsass, P. (2016). Disaster mental health: Research and implications for intervention. In R. Dahlberg, O. Rubin, & M. T. Vendelø (Eds.), *Disaster research: Multidisciplinary and international perspectives*. London: Routledge, Taylor & Francis.
- Hendrix, J. A. (1998). *Public relations cases*. Belmont, CA: Wadsworth.
- Hiebert, R. E., & Devine, C. M. (1985). Government's research and evaluation gap. *Public Relations Review*, 11(3), 47–56.
- Hobfoll, S. E., Watson, P., Bell, C. C., Bryant, R. A., Brymer, M. J., Friedman, M. J., . . . Ursano, R. J. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry: Interpersonal & Biological Processes*, 70(4), 283–315.
- Hoffmann, J. (2014). Conceptualising 'communication for peace'. *Peacebuilding*, 2(1), 100–117. doi:10.1080/21647259.2013.866461
- Hoffmann, T. & Worrall, L. (2004). Designing effective written health education materials: Considerations for health professionals. *Disability and Rehabilitation*, 26 (19), 1166–1173.
- Honwana, A. M. (1997). Healing for peace: Traditional healers and post-war reconstruction in Southern Mozambique. *Peace and Conflict: Journal of Peace Psychology*, 3(3), 293–305. doi:10.1207/s15327949pac0303_6
- Houston, J. B. (2012). Public disaster mental/behavioral health communication: Intervention across disaster phases. *Journal of Emergency Management*, 10(4), 283–292. doi:10.5055/jem.2012.0106
- Houston, J. B., & Franken, N. J. (2015). Disaster interpersonal communication and posttraumatic stress following the 2011 Joplin, Missouri, tornado. *Journal of Loss & Trauma*, 20(3), 195–206. doi:10.1080/15325024.2013.848614
- Houston, J. B., First, J., Spialek, M. L., Sorenson, M. E., & Koch, M. (2016). Public disaster communication and child and family disaster mental health: A review of theoretical frameworks and empirical evidence. *Current Psychiatry Reports*, 18(6), 1–9. doi:10.1007/s11920-016-0690-5
- Houston, J. B., Spialek, M. L., Cox, J., Greenwood, M. M., & First, J. (2015). The centrality of communication and media in fostering community resilience: A framework for assessment and intervention. *American Behavioral Scientist*, 59(2), 270–283. doi:10.1177/0002764214548563

- Hutton, J. G. (1999). The definition, dimensions, and domain of public relations. *Public Relations Review*, 25(2), 199-214.
- Hyman, H. H., & Sheatsley, P. B. (1947). Some reasons why information campaigns fail. *The Public Opinion Quarterly*(3), 412-423. doi:10.2307/2745237
- Ibrahim, A., & Hameed, A. (2006). Mental health and psychosocial response after the worst natural disaster in the history of the Maldives. *International Review of Psychiatry*, 18(6), 567-572. doi:10.1080/09540260601038431
- International Federation of Red Cross and Red Crescent Societies. (2000). Improving coordination. Retrieved from <http://www.ifrc.org/Global/Impcoor.pdf>
- Jensen, K. B. (2002). *A handbook of media and communications research: Qualitative and quantitative methodologies / edited by Klaus Bruhn Jensen*: London: Routledge.
- Jitpiromsri, S. (2014). An inconvenient truth about the deep south violent conflict: A decade of chaotic, constrained realities and uncertain resolution. Retrieved from <http://www.deepsouthwatch.org/node/5904>
- Jitpiromsri, S., & McCargo, D. (2010). The southern Thai conflict six years on: Insurgency, not just crime. *Contemporary Southeast Asia*, 32(2), 156-183. doi: 10.1355/cs32-2b
- Jitpiromsri, S., & Sobhonvasu, P. (2006). Unpacking Thailand's southern conflict: The poverty of structural explanations. *Critical Asian Studies*, 38(1), 95-117. doi:10.1080/14672710600556478
- Judd, L. R. (1990). Importance and use of formal research and evaluation. *Public Relations Review*, XVI(4), 17-28.
- Kabucua, J. M., Oriaso, S. O., & Kiambati, K. K. (2016). Linking evaluation of public relations programmes to efficiency of measurement approaches applied. *International Journal of Innovation Research & Development*, 5(7), 246-249.
- Kelly, K. M., Sturm, A. C., Kemp, K., Holland, J., & Ferketich, A. K. (2009). How can we reach them? Information seeking and preferences for a cancer family history campaign in underserved communities. *Journal of Health Communication*, 14(6), 573-589. doi:10.1080/10810730903089580
- Kendall, R. (1996). *Public relations campaign strategies: Planning for implementation* (2nd ed.). New York, NY: HarperColins College Publishers.
- Kirby, B. (2009). Overview of contemporary public relations theory. In M. Sheehan & R. Xavier (Eds.), *Public relations campaigns*. South Melbourne, Victoria, Australia: Oxford University Press Australia & New Zealand.
- Kreps, G. L. (2014). Evaluating health communication programs to enhance health care and health promotion. *Journal of Health Communication*, 19(12), 1449-1459.
- Kreps, G. L., & Bonaguro, E. W. (2009). Health communication as applied communication inquiry. In L. R. Frey & K. N. Cissna (Eds.), *Routledge*

Handbook of Applied Communication Research (pp. 380–404). New York, NY: Taylor & Francis.

- Kreps, G. L., Bonaguro, E. W., & Query, J. L. (1998). The history and development of the field of health communication. In L. D. Jackson & B. K. Duffy (Eds.), *Health Communication Research: Guild to Developments and Directions* (pp. 1–15). Westport, CT: Greenwood Press.
- Kreuter, M. W., & McClure, S. M. (2004). The role of culture in health communication. *Annual Review of Public Health, 25*, 439–455.
- Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing*. Los Angeles, CA: Sage.
- Larrat, E. P., Marcoux, R. M., & Vogenberg, F. R. (2012). Impact of federal and state legal trends on health care services. *Pand T, 37*(4), 218–226.
- Laskin, A. V. (2009). The evolution of models of public relations: An outsider's perspective. *Journal of Communication Management, 13*(1), 37–54. doi:10.1108/13632540910931382
- Lasswell, H. D. (1948). *The structure and function of communication in society*. New York, NY: Harper & Bros.
- Lau, D. H. (2002). Patient empowerment – A patient-centred approach to improve care. *Hong Kong medical journal = Xianggang yi xue za zhi / Hong Kong Academy of Medicine, 8*(5), 372–374.
- Lee, S., & Fleming, R. T. (2015). Collaborative disaster management in local governments: Perception, performance, and challenges. *International Journal of Emergency Management, 11*(4), 343–355. doi:10.1504/IJEM.2015.074048
- Leichty, G., & Springston, J. (1993). Reconsidering public relations models. *Public Relations Review, 19*(4), 327–339.
- Leitch, S., & Neilson, D. (2001). Bringing public into public relations: New theoretical frameworks for practice. In R. L. Heath (Ed.), *Handbook of public relations* (pp. 127–138). London: Sage.
- Lennart, R., Luca, P., Gabriele, P., Yoshiharu, K., Dean, G. K., Grete, D., . . . Meaghan, O. D. (2013). Lessons learned about psychosocial responses to disaster and mass trauma: An international perspective. *European Journal of Psychotraumatology, 4*(0), 1–9. doi:10.3402/ejpt.v4i0.22897
- Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverly Hills, CA: Sage.
- Lipinski, K., Liu, L. L., & Wong, P. W. C. (2016). The effectiveness of psychosocial interventions implemented after the Indian Ocean tsunami: A systematic review. *International Journal of Social Psychiatry, 62*(3), 271–280. doi:10.1177/0020764015623807
- Logan, R. A. (2008). Health campaign research. In M. Bucchi & B. Trench (Eds.), *Handbook of public communication of science and technology* (pp. 77–92). London; New York: Routledge.

- Macnamara, J. (2008). Research in public relations: A review of the use of evaluation and formative research. *Asia-Pacific Public Relations Journal*, Winter, 1–20.
- Maibach, E. W. (2002). Communication for health. Retrieved from <http://www.encyclopedia.com/doc/1G2-3404000202.html>
- Marshall, C., & Rossman, G. B. (2016). *Designing qualitative research* (6th ed.). Thousand Oaks, CA: Sage.
- Marston, J. E. (1979). *Modern public relations*. New York, NY: McGraw-Hill.
- Martin, R. A. (2003). Potential program evaluation questions. Retrieved from <http://www.extension.iastate.edu/ag/staff/info/evalquestions.html>
- Martin, E., Nolte, I., & Vitolo, E. (2016). The Four Cs of disaster partnering: Communication, cooperation, coordination and collaboration. *Disasters*, 40(4), 621–643. doi:10.1111/disa.12173
- Mason, J. (2002). *Qualitative researching*. London: Sage.
- Mattson, M., & Basu, A. (2010). The message development tool: A case for effective operationalization of messaging in social marketing practice. *Health Marketing Quarterly*, 27(3), 275–290. doi:10.1080/07359683.2010.495305
- McCargo, D. (2006). Introduction: Rethinking Thailand's southern violence. *Critical Asian Studies*, 38(1), 3–10. doi:10.1080/14672710600556395
- McCargo, D. (2009). Thai buddhism, Thai buddhists and the southern conflict. *Journal of Southeast Asian Studies*, 40(1), 1–10.
- McCargo, D. (2012). *Mapping national anxieties: Thailand's southern conflict*. Copenhagen: Nordic Institute of Asian Studies Press.
- McDonald, G. (2007). Mental health consequences of long term conflict. *BMJ (Clinical Research Ed.)*, 334(7604), 1121–1122.
- McFarlane, A. C., & Williams, R. (2012). Mental Health Services Required after Disasters: Learning from the Lasting Effects of Disasters. *Depression Research & Treatment*, 1–13. doi:10.1155/2012/970194
- McGuire, W. J. (1981). Theoretical foundations of campaigns. In R. E. Rice & W. J. Paisley (Eds.), *Public communication campaigns* (pp. 41–70). Beverly Hills, CA: Sage.
- Medford-Davis, L. N., & Kapur, G. B. (2014). Preparing for effective communications during disasters: lessons from a World Health Organization quality improvement project. *International Journal of Emergency Medicine*, 7, 15. doi:10.1186/1865-1380-7-15
- Melvin, N. J. (2007). *Conflict in southern Thailand islamism: Violence and the state in the Patani insurgency*. Sweden: Stockholm International Peace Research Institute.
- Men, L. R., & Stacks, D. (2014). The effects of authentic leadership on strategic internal communication and employee-organization relationships. *Journal of*

Public Relations Research, 26(4), 301–324.
doi:10.1080/1062726X.2014.908720

- Mendelsohn, H. (1973). Some reasons why information campaigns can succeed. *Public Opinion Quarterly*, 37(1), 50–61.
- Mental Health Centre 12. (2012). History of Mental Health Centre 12. Retrieved from <http://www.mhc12.go.th/index.php/th/12>
- Mental Health Centre 12. (2015). *Annual report 2015*. Pattani, Thailand: Mental Health Centre 12.
- Mental Health Centre 15. (2006). *Summarizing the overall operation of the Rehabilitation Project for People Psychologically Affected by the Unrest in the Four Southernmost Provinces between 2005 and 2006*. Pattani, Thailand: Mental Health Centre 15.
- Mental Health Centre 15. (2008). *Annual report 2008*. Pattani, Thailand: Mental Health Centre 15.
- Mental Health Centre 15. (2012). *Annual report 2012*. Pattani, Thailand: Mental Health Centre 15.
- Mental Health Centre 2. (2015). History of Mental Health Centre 2. Retrieved from <http://www.mhc2.go.th/2014/index.php?pg=profile>
- Ministry of Public Health. (2002). *Thailand Health Profile 1999-2000*. Bangkok, Thailand: Ministry of Public Health.
- Moemeka, A. A. (1999). *Development communication in action : building understanding and creating participation*: Lanham, MD: University Press of America.
- Moody, R. F. (2009). Radio's role during hurricane Katrina: A case study of WWL radio and the united radio broadcasters of New Orleans. *Journal of Radio & Audio Media*, 16(2), 160–180.
- Morris, N. (2003). A comparative analysis of the diffusion and participatory models in development communication. *Communication Theory*(2), 225–248.
- Morrison, P. (2012). Crisis and loss. In R. Elder, K. Evans, & D. Nizette (Eds.), *Psychiatric and mental health nursing* (Vol. 3, pp. 161–181). Chatswood, NSW, Australia: Mosby; Oxford: Elsevier Science [distributor].
- Muhwezi, W. W., Kinyanda, E., Mungherera, M., Onyango, P., Ngabirano, E., Muron, J., . . . Kajungu, R. (2014). Coping amidst life adversity in post-conflict societies: Qualitative revelations from communities in Eastern Uganda. *Journal of Traumatic Stress Disorders & Treatment*, 3(2), 1–9.
doi:10.4172/2324-8947.100119
- Murphy, P. (1991). The Limits of Symmetry: A game theory approach to symmetric and asymmetric public relations. *Public Relations Research Annual*, 3, 115–131.

- Murthy, R. S. (2007). Mass violence and mental health: Recent epidemiological findings. *International Review of Psychiatry*, 19(3), 183–192. doi:10.1080/09540260701365460
- Murthy, R. S., & Lakshminarayana, R. (2006). Mental health consequences of war: A brief review of research findings. *World Psychiatry*, 5(1), 25–30.
- National Identity Board. (2000). *The land and its people: Thailand into the 2000s*. Bangkok: The Prime Minister's Office, Office of the Permanent Secretary. National Statistical Office of Thailand. (2008). The 2007 survey on health and welfare. Retrieved from http://service.nso.go.th/nso/nsopublish/service/survey/healthyRep_50.pdf
- NATO. (2008). *Psychosocial care for people affected by disasters and major incidents: A model for designing, delivering and managing psychosocial services for people involved in major incidents, conflict, disasters and terrorism*. Brussels: NATO.
- Naturale, A. J. (2006). Outreach strategies: An experiential description of the outreach methodologies used in the September 11, 2001, disaster response in New York. In E. C. Ritchie, P. J. Watson, & M. J. Friedman (Eds.), *Interventions following mass violence and disasters: Strategies for mental health practice* (pp. 365–384). New York, NY: Guilford Press.
- Nelson, G., Amio, J. L., Prilleltensky, I., & Nickels, P. (2000). Partnerships for implementing school and community prevention programs. *Journal of Educational & Psychological Consultation*, 11(1), 121–145. doi:10.1207/S1532768XJEPC1101_7
- Noar, S. M. (2006). A 10-year retrospective of research in health mass media campaigns: Where do we go from here? *Journal of Health Communication*, 11(1), 21–42. doi:10.1080/10810730500461059
- Norris, F. H. (2006). *Methods for disaster mental health research*: New York, NY: Guilford Press.
- Norris, F. H., Friedman, M. J., & Watson, P. J. (2002). 60,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry: Interpersonal and Biological Processes*(3), 240–260.
- Norris, F. H., Stevens, S. P., Pfefferbaum, B., Wyche, K. F., & Pfefferbaum, R. L. (2008). Community resilience as a metaphor, theory, set of capacities, and strategy for disaster readiness. *American Journal of Community Psychology*, 41(1–2), 127–150. doi:10.1007/s10464-007-9156-6
- Njenga, F. G., Nyamai, C., & Kigamwa, P. (2003). Terrorist bombing at the USA Embassy in Nairobi: The media response. *East African Medical Journal*, 80(3), 159–164.
- O'Sullivan, G. A., Yonkler, J. A., Morgan, W., & Merritt, A. P. (2003). *A field guide to designing a health communication strategy*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs.

- Paisley, W. J. (2001). Public communication campaigns: The American experience. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns*. Thousand Oaks, CA: Sage.
- Paisley, W. J., & Atkin, C. K. (2013). Public communication campaigns: The American experience. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns*. Thousand Oaks, CA: Sage.
- Parrott, R. (2004). Emphasizing "Communication" in health communication. *Journal of Communication*, 54(4), 751–787.
- Pattani Provincial Health Office. (2013). District Public Health Office. Retrieved from <http://www.sasukpattani.com/index.php>
- Pattani United Liberation Organisation. (2006). About PULO. Retrieved from <http://puloinfo.net/About.asp?Show=About>
- Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research*, 34(5), 1189–1208.
- Patton, M. Q. (2002). *Qualitative research & Evaluation methods*. Thousand Oaks, CA: Sage.
- Patton, M. Q. (2015). *Qualitative research & evaluation methods: Integrating theory and practice* (4th ed.). Los Angeles, CA: Sage.
- Paul, C. L., Redman, S., & Sanson-Fisher, R. W. (1998). Print material as a public health education tool. *Australian & New Zealand Journal of Public Health*, 22(1), 146–148.
- Paul, C. L., Redman, S., & Sanson-Fisher, R. W. (2003). Print material content and design: is it relevant to effectiveness? *Health Education Research*, 18(2), 181–190.
- Peltz, R., Shushan, O., Nakash, G., Leiba, A., Bar-Dayyan, Y., Ashkenazi, I., . . . Levi, Y. (2006). Disaster healthcare system management and crisis intervention leadership in thailand-lessons learned from the 2004 tsunami disaster. *Prehospital and Disaster Medicine*, 21(5), 299–302.
doi:10.1017/S1049023X00003915
- Perez-Lugo, M. (2004). Media uses in disaster situations: A new focus on the impact phase. *Sociological Inquiry*, 74(2), 210–225.
- Piotrow, P. T., Kincaid, D. L., Hindin, M. J., Lettenmaier, C. L., Kuseka, I., Silberman, T., . . . Kim, Y.-M. (1992). Changing Men's Attitudes and Behavior: The Zimbabwe Male Motivation Project. *Studies in Family Planning*, 23(6), 365–375.
- Pourhosseini, S. S., Ardalan, A., & Mehrolhassani, M. H. (2015). Key aspects of providing healthcare services in disaster response stage. *Iranian Journal of Public Health*, 44(1), 111–118.

- Prime Minister's Office. (2008). *Notification on appointment of The Policy making Committee on Rehabilitation for People Affected by a Series of Southern Violence*. Bangkok: Prime Minister's Office.
- Public Relations Society of America. (2017). About public relations. Retrieved from: <http://apps.prsa.org/AboutPRSA/PublicRelationsDefined>
- Pusu, W. (2011). Pechdau Tohmeena: Investigate the statistic of commit suicide in the southern border of Thailand. *Isranews*. Retrieved from <https://www.isranews.org/south-news/special-talk/53-2009-11-15-11-15-38/4333.html>
- Rabiei, A., Nakhaee, N., & Pourhosseini, S. S. (2014). Shortcomings in dealing with psychological effects of natural disasters in Iran. *Iranian Journal of Public Health*, 43(8), 1132–1138.
- Ratzan, S. C., Payne, J. G., & Bishop, C. (1996). The status and scope of health communication. *Journal of Health Communication*, 1(1), 25–41. doi:10.1080/108107396128211
- Rice, R. E., & Atkin, C. K. (1989). Trends in communication campaign research. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns*. Thousand Oaks, CA: Sage.
- Rice, R. E., & Atkin, C. K. (2009). Public communication campaigns: Theoretical principles and practical applications. In J. Bryant & M. B. Oliver (Eds.), *Media effects: Advances in theory and research* (3rd ed., pp. 436–468). New York, NY: Routledge.
- Rice, R. E., & Paisley, W. L. (1981). *Public communication campaigns*. Beverly Hills, CA: Sage.
- Rogers, E. M. (1976). New perspectives on communication and development overview. *Communication Research*, 3(2), 99–106.
- Rogers, E. M. (1994). *A history of communication study : a biographical approach*: New York, NY: The Free Press, Maxwell Macmillan International; Toronto: Maxwell Macmillan Canada.
- Rogers, E. M. (1996). The field of health communication today: An up-to-date report. *Journal of Health Communication*, 1(1), 15–23. doi:10.1080/108107396128202
- Rogers, E. M., & Hart, W. (2002). The histories of intercultural, international, and development communication. In W. B. Gudykunst & B. Mody (Eds.), *Handbook of international and intercultural communication* (pp. 1–18). Thousand Oaks, CA: Sage.
- Rogers, E. M., & Storey, J. D. (1987). Communication Campaigns. In Charles R. Berger & Steven H. Chaffee (Eds.), *Handbook of communication science* (pp. 817–846). Newbury Park, CA: Sage.

- Rogers, E. M., Vaughan, P. W., Ramadhan, M. A. S., Rao, N., Svenkerud, P., & Sood, S. (1999). Effects of an entertainment-education radio soap opera on family planning behavior in Tanzania. *Studies in Family Planning*, 30(3), 193–211.
- Romo-Murphy, E., James, R., & Adams, M. (2011). Facilitating disaster preparedness through local radio broadcasting. *Disasters*, 35(4), 801–815. doi:10.1111/j.1467-7717.2010.01234.x
- Rowley, J. (2002). Using case studies in research. *Management Research News*, 25(1), 16–27.
- Rudenshtine, S., Galea, S., Ahern, J., Felton, C., & Vlahov, D. (2003). Awareness and perceptions of a communitywide mental health program in New York City after September 11. *Psychiatric Services*, 54(10), 1404–1406. doi:10.1176/appi.ps.54.10.1404
- Salmon, C. T. (1989). *Information campaigns: Balancing social values and social change*. Newbury Park, CA: Sage.
- Salmon, C. T., & Atkin, C. K. (2003). Media campaigns for health promotion. In T. L. Thompson (Ed.), *Handbook of health communication* (pp. 472–494). Mahwah, NJ, London: Lawrence Erlbaum.
- Salmon, C. T., & Murray-Johnson, L. (2013). Communication campaign effectiveness and effects. In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns* (pp. 99–112). Thousand Oaks, CA: Sage.
- Schiavo, R. (2007). *Health communication: From theory to practice*. San Francisco, CA: Jossey-Bass.
- Schlegelmilch, J., Petkova, E., Martinez, S., & Redlener, I. (2017). Acts of terrorism and mass violence targeting schools: Analysis and implications for preparedness in the USA. *Journal of Business Continuity & Emergency Planning*, 10(3), 280–289.
- Schwarz, A., Seeger, M. W., & Auer, C. (2016). Significance and structure of international risk and crisis communication research: Toward an integrative approach. In A. Schwarz, M. W. Seeger, & C. Auer (Eds.), *The handbook of international crisis communication research* (pp. 1–10): Chichester, UK; Malden, MA: Wiley Blackwell.
- Scupin, R. (2013). South Thailand: politics, identity, and culture. *The Journal of Asian Studies*, 72(2), 423–432.
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and the social sciences* (3rd ed.). New York, NY: Teachers College Press.
- Selvarajah, C., Meyer, D., & Donovan, J. (2013). Cultural context and its influence on managerial leadership in Thailand. *Asia Pacific Business Review*, 19(3), 356–380. doi:10.1080/13602381.2012.714630
- Servaes, J. (2008). *Communication for development and social change*. New Delhi, India: Sage.

- Servaes, J., & Malikhao, P. (2008). Development communication approaches in an international perspective. In J. Servaes (Ed.), *Approaches to development communication*. Paris: UNESCO.
- Shannon, C. E., & Weaver, W. (1949). A mathematical theory of communication *The Bell System Technical Journal*, 27, 379–423.
- Shaw, R., Hibino, J., & Matsuura, S. (2012). The role of community radio in disaster. Retrieved from http://www.preventionweb.net/files/29931_29931radioalllowres1.pdf
- Silove, D. (2013). The ADAPT model: A conceptual framework for mental health and psychosocial programming in post conflict settings. *Intervention*, 11(3), 237–248.
- Siriwanarangsarn, P., Liknapichitkul, D., & Khandelwal, S. K. (2004). Thailand mental health country profile. *International Review of Psychiatry*, 16(1–2), 150–158.
- Sixsmith, J., Fox, K.-A., Doyle, P., & Barry, M. M. (2014). *A literature review on health communication campaign evaluation with regard to the prevention and control of communicable diseases in Europe*. Stockholm: European Centre for Disease Prevention and Control (ECDC).
- Smith, D. H. (1989). Studying health communication: An agenda for the future. *Health Communication*, 1(1), 17–27. doi:10.1207/s15327027hc0101_3
- Snyder, L. B. (2001). How effective are medicated health campaigns? In R. E. Rice & C. K. Atkin (Eds.), *Public communication campaigns* (pp. 181–192). Thousand Oaks, CA; London: Sage.
- Snyder, L. B. (2003). Development communication campaigns. In N. G. Calley (Ed.), *International and development communication: A 21st-century perspective* (pp. 167–188). Thousand Oaks, CA; London, Sage.
- Solbjør, M., Rise, M. B., Westerlund, H., & Steinsbekk, A. (2013). Patient participation in mental healthcare: when is it difficult? A qualitative study of users and providers in a mental health hospital in Norway. *The International Journal of Social Psychiatry*, 59(2), 107–113. doi:10.1177/0020764011423464
- Songkharajanagarindra Psychiatric Hospital. (2014). History of Songkharajanagarindra Psychiatric Hospital. Retrieved from <http://www.skph.go.th/newskph/#>.
- Southern Border Provinces Administration Centre. (2014). History of Southern Border Provinces Administration Centre. Retrieved from <http://www.sbpac.go.th/index.php/2014-11-27-03-45-40/2014-11-27-03-47-29>
- Sriramesh, K. (2004). *Public relations in Asia: An anthology*. Singapore: Thomson.
- Srisai, S. (2011). *Saang Kwaampratabjai: The influence of Wattana-dharm Thai on Thai PR practice [Impression building: The influence of Thai culture on Thai PR practice]*. (PhD), University of Stirling, Stirling, Scotland.

- Srivastava, K. (2010). Disaster: Challenges and perspectives. *Industrial Psychiatry Journal*, 19(1), 1–4. doi:10.4103/0972-6748.77623
- Stacks, D. W. (2002). Best practices in public relations research. Retrieved from <http://www.instituteforpr.org/downloads/233>.
- Stake, R. E. (1995). *The art of case study research*: Thousand Oaks, CA: Sage.
- Stappers, J. G. (1983). Mass communication as public communication. *Journal of Communication*, 33(3), 141–145. doi:10.1111/j.1460-2466.1983.tb02415.x
- Stein, B. D., Elliott, M. N., Jaycox, L. H., Collins, R. L., Berry, S. H., Klein, D. J., & Schuster, M. A. (2004). A national longitudinal study of the psychological consequences of the September 11, 2001 terrorist attacks: reactions, impairment, and help-seeking. *Psychiatry: Interpersonal and Biological Processes*(2), 105–117.
- Stewart-Withers, R., Banks, G., McGregor, A., & Meo-Sewabu, L. (2014). Qualitative research. In R. Scheyvens (Ed.), *Development fieldwork: A practical guide* (2 ed.). Los Angeles, CA: Sage.
- Sthapitanonda, P., & Gumpai, K. (2013). Identifying key factors for the successful implementation of health communication campaigns: A study based on in-depth interviews with key campaigners. In S. Angela (Ed.), *Campaigning for health: Case studies in health communication and health promotion* (pp. 210–231). Lengerich, Germany: Pabst.
- Storey, I. (2008). Southern discomfort: Separatist conflict in the kingdom of Thailand. *Asian Affairs: An American Review*, 35(1), 31–52.
- Stratta, P., Cataldo, S., Bonanni, R., & Rossi, A. (2015). Community mental health service utilization after the L'Aquila earthquake. *Community Mental Health Journal*, 51(4), 504–508. doi:10.1007/s10597-014-9822-8
- Suansaranrom Psychiatric Hospital. (2014). History of Suansaranrom psychiatric hospital. Retrieved from <http://223.25.195.228:81/nuke7eng/html/modules.php?name=Content&pa=showpage&pid=2%29>.
- Sugunnasil, W. (2006). Islam, radicalism, and violence in Southern Thailand: Berjihad di Patani and the 28 April 2004 attacks. *Critical Asian Studies*, 38(1), 119–144. doi:10.1080/14672710600556494
- Sultana, F. (2007). Reflexivity, positionality and participatory ethics: Negotiating fieldwork dilemmas in international research. *ACME: An International E-Journal for Critical Geographies*, 6(3), 374–385.
- Syed, U., Khadka, N., Khan, A., & Wall, S. (2008). Care-seeking practices in South Asia: using formative research to design program interventions to save newborn lives. *Journal of Perinatology*, 28, S9–13.
- Telles, S., Naveen, K. V., & Dash, M. (2007). Yoga reduces symptoms of distress in tsunami survivors in the Andaman Islands. *Evidence-based Complementary and Alternative Medicine*, 4(4), 503–509. doi:10.1093/ecam/nem069

- Terrorism Research & Analysis Consortium. (2017). Barisan Revolusi Nasional (BRN). Retrieved from <https://www.trackingterrorism.org/group/barisan-revolusi-nasional-brn>
- Thailand National Statistical Office. (2010). Population and housing census in 2010. Retrieved from <http://popcensus.nso.go.th/file/popcensus-20-12-54.pdf>
- The Centers for Diseases Control and Prevention (CDC). (2001). Building our understanding: Key concepts of evaluation applying theory in the evaluation of communication campaigns. Retrieved from https://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/pdf/apply_theory.pdf
- Thielman, S. B. (2004). Psychiatric consequences of the 1998 US embassy bombing in Nairobi, Kenya. *Psychiatric Annals*, 34(8), 644–650.
- Thienkrua, W., Cardozo, B. L., Chakkraband, M. L. S., Guadamuz, T. E., Pengjuntr, W., Tantipiwatanaskul, P., . . . van Griensven, F. (2006). Symptoms of posttraumatic stress disorder and depression among children in Tsunami-affected areas in Southern Thailand. *JAMA: Journal of the American Medical Association*, 296(5), 549–559.
- Thompson, T. L. Dorsey, A. M., Miller, K. I., Parrott, R. (Eds.). (2003). *Handbook of health communication*. Mahwah, NJ; London: Lawrence Erlbaum.
- Thongphetsri, N., Prabhkri, S., & Chatarat, S. (2005). Stress and the need of mental health promotion of people in the 4 border provinces affected by the unrest situation Retrieved from http://k4ds.psu.ac.th/k4ds_search/pdf/projects/TC0027.pdf
- Tohmeena, P. (2013). Mental remedy for people affected by the unrest in the southernmost provinces of Thailand. *Journal of Mental Health of Thailand*, 21(3), 171–184.
- Tuicomepee, A., & Romano, J. L. (2008). Thai adolescent survivors 1 Year after the 2004 tsunami: A mixed methods study. *Journal of Counseling Psychology*, 55(3), 308–320.
- Turk, J. (1985). Public relations in state government: A typology of management styles. *Journalism & Mass Communication Quarterly*, 62(2), 304–315.
- Turner, S., Yuksel, S., & Silove, D. (2003). Survivors of mass violence and torture. In B. L. Green (Ed.), *Trauma interventions in war and peace: prevention, practice, and policy*: New York, NY: Kluwer Academic/Plenum Publishers.
- U.S. Department of Health and Human Services Centers for Disease Control and Prevention, Office of the Director, & Office of Strategy and Innovation. (2011). *Introduction to program evaluation for public health programs: A self-study guide*. Atlanta, GA: Centers for Disease Control and Prevention.
- U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration Center for Mental Health Services. (2004). *Mental health response to mass violence and terrorism [electronic resource]: a field guide*: Rockville, MD: U.S. Dept. of Health and Human Services, Substance

Abuse and Mental Health Services Administration, Center for Mental Health Services.

- Udomratn, P. (2008). Mental health and the psychosocial consequences of natural disasters in Asia. *International Review of Psychiatry*, 20(5), 441–444. doi:10.1080/09540260802397487
- UNICEF - Programme Division. (2014). *Framework for developing an integrated communication strategy for the introduction of oral cholera vaccine in cholera prevention and control programmes*. New York: UNICEF.
- Unicef Thailand. (2008). Everyday fears: A study of children's perceptions of living in the southern border area of Thailand United Nations Children's Fund (UNICEF). Retrieved from http://www.unicef.org/thailand/Everyday_fears.pdf
- United States Department of Health and Human Services. (2000). Healthy people 2010. Retrieved from <http://www.healthypeople.gov>
- Valente, T. W., Kim, Y. M., Lettenmaier, C., Glass, W., & Dibba, Y. (1994). Radio promotion of family planning in The Gambia. *Family Planning Perspectives* 20(3): 96–100.
- Van Griensven, F., Chakkraband, M. L. S., Thienkrua, W., Pengjuntr, W., Lopes Cardozo, B., Tantipiwatanaskul, P., . . . Tappero, J. W. (2006). Mental health problems among adults in tsunami-affected areas in southern Thailand. *JAMA: The Journal Of The American Medical Association*, 296(5), 537–548.
- Vernberg, E. M. (2002). Intervention approaches following disasters. In A. M. La Greca, W. K. Silverman, E. M. Vernberg, M. C. Roberts, A. M. La Greca, W. K. Silverman, E. M. Vernberg, & M. C. Roberts (Eds.), *Helping children cope with disasters and terrorism*. (pp. 55–72). Washington, DC: American Psychological Association.
- Visanuyothin, T., Chakrabhand, M. L. S., & Bhugra, D. (2006). Tsunami and mental health in Thailand. *International Review of Psychiatry*, 18(3), 271–273. doi:10.1080/09540260600656217
- Wadsworth, S. M. M. (2010). Family risk and resilience in the context of war and terrorism. *Journal of Marriage and Family*, 72(3), 537–556.
- Walker, G. F. (1994). Communicating public relations research. *Journal of Public Relations Research*, 6(3), 141–161.
- Waters, R. D., & Jamal, J. Y. (2011). Short communication: Tweet, tweet, tweet. A content analysis of nonprofit organizations' Twitter updates. *Public Relations Review*, 37, 321–324. doi:10.1016/j.pubrev.2011.03.002
- Watson, P. J., Brymer, M. J., & Bonanno, G. A. (2011). Postdisaster psychological intervention since 9/11. *American Psychologist*, 66(6), 482–494. doi:10.1037/a0024806
- Watson, T., & Simmons, P. (2004). *Public relations evaluation: Survey of Australian practitioners*. Paper presented at the the Australia and New Zealand Communication Association conference, Sydney.

- Weimann, G. (1991). The influentials: Back to the concept of opinion leaders. *The Public Opinion Quarterly*, 55(2), 267–279.
- Weiss, E. S., Anderson, R. M., & Lasker, R. D. (2002). Making the most of collaboration: Exploring the relationship between partnership synergy and partnership functioning. *Health Education & Behavior*, 29(6), 683–698. doi:10.1177/109019802237938
- Weiss, J. A., & Tschirhart, M. (1994). Public information campaigns as policy instruments. *Journal of Policy Analysis and Management*, 13(1), 82–119.
- Wells, K., Miranda, J., Bruce, M. L., Alegria, M., & Wallerstein, N. (2004). Bridging community intervention and mental health services research. *The American Journal Of Psychiatry*, 161(6), 955–963.
- Wessely, S. (2006). What mental health professionals should and should not do. In Yuval Neria, Raz Gross, Randall Marshall, & Ezra Susser (Eds.), *9/11: Mental health in the wake of terrorist attacks* (pp. 543–569). Cambridge: Cambridge University Press.
- Wheeler, M. (2014). Thailand's southern insurgency. *Southeast Asian Affairs*, 319–335.
- Williams. (2007). The psychosocial consequences for children of mass violence, terrorism and disasters. *International Review of Psychiatry*, 19(3), 263–277. doi:10.1080/09540260701349480
- Williams, T., Carr, S. C., & Blampied, N. M. (2007). Psychological intervention in major emergencies: An Asia-Pacific perspective. *New Zealand Journal of Psychology*, 36(3), 126–135.
- Wilson, L. J. (2001). Extending strategic planning to communication tactics. In R. L. Heath (Ed.), *Handbook of public relations* (pp. 215–222). London: Sage.
- World Bank. (2008). *Towards a new policy model for media and communication in post-conflict and fragile states*. Retrieved from <http://documents.worldbank.org/curated/en/556391468313811571/Towards-a-new-policy-model-for-media-and-communication-in-post-conflict-and-fragile-states>
- World Health Organization. (2008). *Integrating mental health into primary health care: A global perspective*. Geneva: WHO.
- World Health Organization. (2011). *Psychological first aid: Guide for field workers*. Geneva: WHO.
- World Health Organization. (2013). *Mental health action plan 2013–2020*. Retrieved from http://www.who.int/mental_health/publications/action_plan/en/
- World Health Organization. (2015). The kingdom of Thailand health system review. Retrieved from <http://www.who.int/iris/handle/10665/208216>
- Worldometers. (2017). Thailand population. Retrieved from <http://www.worldometers.info/world-population/thailand-population/>

- Yin, R. K. (2009). *Case study research: Design and methods*: Los Angeles, CA: Sage.
- Yun, S. H. (2006). Toward public relations theory-based study of public diplomacy: Testing the applicability of the excellence study. *Journal of Public Relations Research*, 18(4), 287–312. doi:10.1207/s1532754xjpr1804_1
- Zorn, M. (2001). Health communication: A review of books since 1990. *Communication Booknotes Quarterly*, 32(3), 149–170.

APPENDICES

Appendix A: Information sheets

The Strategies of Mental Health Campaigns in Pattani Province of Thailand

INFORMATION SHEET FOR DIRECTOR MENTAL HEALTH CENTER

Hello, I would like to introduce myself and invite you to be a part of my project. My name is Aruneewan Buaniaw. I have worked as a lecturer at Faculty of Communication Sciences, Prince of Songkla University, Pattani Campus. I am presently a PhD student of the School of Communication, Journalism, and Marketing at Massey University, New Zealand. For my PhD study, I am interested to learn about communication strategies of mental health campaigns in the mass violence area of southern Thailand from the deliverer's perspective. I am also interested in talking with the significant people who work as partners on mental health issues.

The project will involve collecting data about the underpinning strategy of the major mental health campaigns relating to the mass violence crisis and perspectives from those who design and conduct these campaigns. The methods used are in-depth interviews with key informants, communicators and partners, with participant observation where appropriate. Additionally, materials (such as pamphlets) developed as part of the campaigns will be collected and analysed,

The potential project participants are:

1. Yourself as Director of Mental Health Centre, District 12 who is responsible for policy decisions about mental health issues.
2. Communication staff of the Mental Health Centre, District 12 who take responsibility for mental health campaigns.
3. Professional partners who work on mental health issues in that area.

The anticipated number of the participants in this study will be 25-30 persons (Ten to 12 communication staff including the Director and the number of partner participants) NGO, organisations (are anticipated at ten to 15).

What activities will you participate in if you choose to participate?

With your permission I would like to talk with you and to interview you about your work on mental health communication from 2004 until now. I am especially interested in the mental health communication campaigns used in Pattani province. An interview would take about 45 minutes to one hour of your time and would be conducted in your office or a mutually agreed place where you feel comfortable. With your permission, the interview will be audio-recorded. At any time during your involvement with the project you can ask for the interview to stop and/or you may postpone the interview or withdraw from the project.

All of the information you provide will be analysed by me. I can use a pseudonym rather than your name in reports of the study if you prefer. Please note that as you have a prominent position there is the possibility that your identity will be suspected regardless of pseudonym use (when used). However, all effort will be made to keep your identity confidential if you do not wish for your name to be used in the final reports of this study.

All of your information will be kept in a safe, locked place accessible only to me at Faculty of Communication Sciences, Prince of Songkla University, Pattani Province, Thailand and later in the Communication, Journalism,

and Marketing office at Massey University and disposed of five years after the project is completed. The preliminary aggregate findings will be shared with you via email on request and the final findings will be written into a thesis report, published in articles, shared at conferences and also teaching activities. These research findings will be useful for the development of mental health communication strategies in the mass violence area.

What your rights are if you agree to be a part of this project?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- ask any questions about the study at any time during participation;
- decline to answer any particular question;
- ask for the audio recorder to be turned off at any time during the interview;
- withdraw from the study up until the data collection is completed;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Project Contacts

If you have any questions or concerns about the project please directly contact me or my Thai supervisor listed below.

The researcher: Aruneewan Buaniaw **Email:** buaniaw.aruneewan@gmail.com; **Telephone:** 089-197-3018

Project Supervisors:

<i>In Thailand</i>	<i>In New Zealand</i>	
Prof. DrParichartSthapitanonda Faculty of Communication Arts, Chulalongkorn University	Assoc Prof. Margie Comrie School of Communication, Journalism, and Marketing Massey University, Private Bag 11222, Palmerston North, New Zealand	Dr Niki Murray School of Communication, Journalism, and Marketing Massey University, Private Bag 11222, Palmerston North , New Zealand
Telephone: +66-2-218-2205	Telephone: +64-6-3569099 ext 2368	Telephone: +64-6-3505799ext5941
Facsimile: +66-2-255-9976	Facsimile: +64-6-3505889	Facsimile: +64-6-350 5889
Email: sparicha@yahoo.com	Email: M.A.Comrie@massey.ac.nz	Email: N.S.Murray@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application ___/___ (insert application number). If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

Thank you for the opportunity to inform you about my project and if you are interested to take part in this project please contact me directly. I look forward to hearing from you, regards, Aruneewan.

The Strategies of Mental Health Campaigns in Pattani Province of Thailand

INFORMATION SHEET FOR COMMUNICATION STAFF AND PARTNER GROUPS

Hello, I would like to introduce myself and invite you to be a part of my project. My name is Aruneewan Buaniaw. I have worked as a lecturer at Faculty of Communication Sciences, Prince of Songkla University, Pattani Campus. I am presently a PhD student of the School of Communication, Journalism, and Marketing at Massey University, New Zealand. For my PhD study, I am interested to learn about communication strategies of mental health campaigns in the terrorism crisis area of southern Thailand from the deliverer's perspective. I am also interested in talking with the significant people who work as partners on mental health issues. You have been identified by either the Director of Mental Health Centre, District 15 or one of the District 15 communication staff as a potential participant in this study.

The project will involve collecting data about the underpinning strategy of the major mental health campaigns relating to the mass violence crisis and perspectives from those who design and conduct these campaigns. The methods used are in-depth interviews with key informants, communicators and partners, with participant observation where appropriate. Additionally, materials (such as pamphlets) developed as part of the campaigns will be collected and analysed,

The project participants are:

1. Director of Mental Health Centre, District 15 who is responsible for policy decisions about mental health issues.
2. Communication staff of the Mental Health Centre, District 15 who take responsibility for mental health campaigns.
3. Professional partners who work on mental health issues in that area.

The anticipated number of the participants in this study will be 25-30 persons. (Ten to 12 communication staff including the Director and the number of partner participants)NGO, organizations(is anticipated at ten to 15.)

What activities will you participate in if you choose to participate?

With your permission I would like to talk with you and to interview you about your work on mental health communication from 2004 until now. I am especially interested in the mental health communication campaigns used in Pattani province and your work with NGO and community partners on these mental health campaigns. An interview would take about 45 minutes to one hour of your time and would be conducted in your office or a mutually agreed place where you feel comfortable. With your permission, the interview will be audio-recorded.

I would also like to spend some time with you during your everyday activities for observing and recording my field diary and perhaps some of your explanations about mental health campaigns activities. If you felt comfortable, I would also like to seek your permission for you to share or take some photographs that relate to your work. These activities (observing your work and taking photographs) can be undertaken at appropriate times that suit you during the three month duration of my visit. At any time during your involvement with the project you can ask for interviews or data collection to stop and/or you may postpone the activities or withdraw from the project. Besides, I would be appreciated to engage with some of your organization's task (meeting task, advising task, etc.) if you provide. In this case, my role will be clearly identified before doing tasks.

All of the information you provide will be analysed by me. I can use pseudonyms rather than your name in reports of the study if you prefer. Photos will only be used with permission of the people pictured/owners. Before the report is written, I will seek your consent to use the particular photos. All of your information will be kept in a safe, locked place accessible only to me at Faculty of Communication Sciences, Prince of Songkla University, Pattani Province, Thailand and later in the Communication, Journalism, and Marketing office at Massey University and disposed of five years after the project is completed. The preliminary aggregate findings will be shared with you via email on request and the final findings will be written into a thesis report, published

in articles, shared at conferences and also teaching activities. These research findings will be useful for the development of mental health communication strategies in the mass violence area.

What your rights are if you agree to be a part of this project?

You are under no obligation to accept this invitation. If you decide to participate, you have the right to:

- ask any questions about the study at any time during participation;
- decline to answer any particular question;
- ask for the audio recorder to be turned off at any time during the interview;
- withdraw from the study up until the data collection is completed;
- provide information on the understanding that your name will not be used unless you give permission to the researcher;
- be given access to a summary of the project findings when it is concluded.

Please note that if you have a prominent position there is the possibility that your identity will be suspected regardless of pseudonym use (when used). However, all effort will be made to keep your identity confidential.

Project Contacts

If you have any questions or concerns about the project please directly contact me or my Thai supervisor listed below.

The researcher: Aruneewan Buaniaw **Email:** buaniaw.aruneewan@gmail.com; **Telephone:** 089-197-3018

Project Supervisors:

In Thailand	In New Zealand	
Prof. DrParichartSthapitanonda	Assoc Prof. Margie Comrie	Dr Niki Murray
Faculty of Communication Arts, Chulalongkorn University	School of Communication, Journalism, and Marketing Massey University, Private Bag 11222, Palmerston North, New Zealand	School of Communication, Journalism, and Marketing Massey University, Private Bag 11222, Palmerston North , New Zealand
Telephone: +66-2-218-2205	Telephone: +64-6-3569099 ext 2368	Telephone:+64-6-3505799ext5941
Facsimile: +66-2-255-9976	Facsimile: +64-6-3505889	Facsimile: +64-6-350 5889
Email: sparicha@yahoo.com	Email: M.A.Comrie@massey.ac.nz	Email: N.S.Murray@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application / / (insert application number). If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz

Thank you for the opportunity to inform you about my project and if you are interested to take part in this project please contact me directly. I look forward to hearing from you, regards, Aruneewan

Appendix B: Participant consent forms

The Strategies of Mental Health Campaigns in Pattani Province of Thailand

PARTICIPANT CONSENT FORM: DIRECTOR OF THE MENTAL HEALTH CENTER

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

Please circle the relevant option:

I agree/do not agree to the interview being sound recorded.

I wish/ do not wish to have my recordings returned to me.

I agree/do not agree to my name being used in the reports derived from this research

I agree to participate in this study under the conditions set out in the Information Sheet.

Signature.....Date.....

Full-name printed.....

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application ___/___ (*insert application number*). If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz.

The Strategies of Mental Health Campaigns in Pattani Province of Thailand

PARTICIPANT CONSENT FORM

– INDIVIDUAL INTERVIEWS AND PARTICIPATORY OBSERVATION FOR THE STAFF AND PARTNER GROUPS

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

Please circle the relevant option:

I agree/do not agree to the interview being sound recorded.

I agree/do not agree to allow the researcher to observe my work activities with other people.

I agree/do not agree to photos being taken of my work contingent on my being able to select the ones that can be used in the research.

I wish/ do not wish to have my recordings returned to me.

I agree/do not agree to my name being used in the reports derived from this research.

Partner participants only – please tick:

- I have the permission of my employer to participate in this research project.
- I agree to participate in this study under the conditions set out in the Information Sheet.

Signature.....Date.....

Full-name printed.....

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application ___/___ (*insert application number*). If you have any concerns about the conduct of this research, please contact Dr Brian Finch, Chair, Massey University Human Ethics Committee: Southern A, telephone 06 350 5799 x 84459, email humanethicsoutha@massey.ac.nz

Appendix C: Full interview schedule

Introduction by Interviewer: “I am investigating communication strategies of the delivery of mental health campaigns in the mass violence area. *Include here a quick reminder of the information in the information sheet.* I would like to talk to you today about your work on mental health issues and campaigns in Pattani province. Do you have any questions about anything before we start? Feel free to ask me any questions as we talk if you like”.

The interview will begin with the recording of written consent and demographic data (sex, age, religious, and work length). The consent form is to be read to the participant and any questions answered. The demographic data will be gathered orally and written down by the interviewer.

The semi-structured interview schedules are divided into three groups of participants: the director of Mental Health Centre, District 12, the staff of Mental Health Centre, District 12, and the community partners who work on mental health issues and campaigns in the area. Topics are outlined below by numbers and letters. Key questions will be used in each topic area, followed by more specific questions as required.

The Director of Mental Health Centre, District 12

1. Overall function

a. Responsibilities

Key Question Example: What are the responsibilities of Mental Health Centre, District 15 in general?

b. Roles

c. Purpose

Key Question Example: What is the main purpose of mental health communication in the crisis? Who takes responsibility in communicating with the target audiences?

d. Target Segmentation

Key Question Example: Who are the at-risk groups that you target with mental health campaigns? Do you segment your clients; if so how?

e. Communication Strategies

Key Question Example: What are the communication strategies used in mental health campaigns or information that you use to reach the target audiences?

f. Self-Evaluation

Key Question Example: What are the strengths and challenges in the Centre’s work? Do you evaluate the outcomes of the Centre’s work; if so how?

g. Policy Plan

Key Question Example: What could help to improve the Centre’s work in mental health communication?

The Centre staff

1. Overall function

a. Responsibilities

Key Question Example: Who takes responsibility in communicating with the clients and how are these responsibilities divided?

b. Roles

c. Purpose

Key Question Example: What is the main purpose of mental health communication campaigns in the crisis area?

d. Target Segmentation

Key Question Example: Who are the at-risk groups that you target with mental health campaigns? Do you segment your clients; if so how?

e. Campaign Characteristics

Key Question Examples:

- What are the mental health campaigns which were launched in the crisis situation? Was there a difference between mental health campaigns in general and mental health campaigns in the mass violence area in Pattani province? If so, how and why?

- What are the factors which need to be addressed in designing mental health campaigns in Pattani province?

f. Campaign Strategies

Key Question Examples:

- What is the process undertaken in designing each campaign?

- What kind of sources, messages, and channels do you use to reach your clients?

- Do you evaluate the success of mental health campaigns; if so how?

g. Mental Health Partners

Key Question Examples:

- Who are the community-based partners working on mental health issues in Pattani province?

- How do these partners relate to Mental Health Centre, District 15?

- What are the benefits of working with partners? What are the challenges of working with partners?

- How do you communicate with partners?

- How do you develop a relationship with partners to ensure you are achieving the same goal?

The community-based partners who work on mental health issues/campaigns in the area.

1. Overall function

a. Responsibilities

Key Question Example: What are the responsibilities of your organization? Where does your budget for mental health activities come from?

b. Roles

c. Purpose

Key Question Example: What is the main purpose of your work (in mental health issue)?

d. Work

Key Question Example: What activities have you undertaken since the beginning of the crisis? What are you doing now? What activities are planned for the future?

e. Target Group

Key Question Example: Who are the target groups that you work with? How do you communicate with these groups and individuals?

f. Relationship

Key Question Examples:

- Are you working with Mental Health Centre, District 15 or the other partners; if so, how?
- How do you communicate with other partners?
- How do you develop a relationship with the other partners in order to achieve the same goal?

Thank the participant and remind them that if they have any questions about the study they can contact the people on the Information Sheet.

Appendix D: Participant observation: Description of workshops during field work

1) The first observation

The workshop “Guidelines for helping and supporting IQ and EQ for pre-school children and childhood” workshop, was held on May 6-8, 2014 at Benjamarachutit Pattani School. I went to the workshop at 8.30 am when most participants were registering at the back of a big meeting room. I met Miss Bu-nga Dulayasith at the registration table. She then introduced me to the other staff members as a researcher. After registering, I received the meeting documents, including the schedule, like the other attendees. I then chose to sit at the back of the room, reading the schedule, smiling at the workshop attendees while waiting for the workshop to start. The workshop officially started at 9.00 pm. I used my field notes to record what I have observed. At this stage I observed the overall characteristics of the participants and the key speaker such as age, gender, occupation, and especially the delivery process which was the main focus in this study. I found that the target audiences were teachers, parents, and staff of Sub-district Health Promotion Hospital in Pattani province. The morning session process was mainly a doctor lecturing about children’s IQ and EQ. Then, in the afternoon session, I was invited by an attendee to sit beside her as I had talked with her during the lunch time. In this session, the key speaker was a mental health professional who had more than twenty years’ experience. The overall presentation was about family relationships and how to support children to have good IQ and EQ. At this session, I participated in the recreation activities such as singing and dancing.

On the second day of the workshop, the participants were divided into two groups in the two rooms, a parents group and the teachers and public health staff group. Both were taught about how to evaluate IQ and EQ of children between 6-11 years old. I also participated in the parents’ group for learning and checking the evaluation form. On the last day of the meeting, the participants were asked to write their plan for supporting IQ and EQ of children in their area and what support they wanted from the 12th Mental Health Centre. My first participant observation made me more familiar with the staff. I knew how their workshop was run and the communication strategies used for educating and persuading the target audiences.

2) The second observation

The second observation was on May 19-20, 2014 at the workshop titled “Developing a clinical prototype for treating mental health of people affected by the crisis”. This was held in CS Pattani hotel. As with the first observation, I went to the workshop at the registration time at 8.30 am and sat at the back of the room. I noticed that this workshop was a more formal process as they invited *M. L. Somchai* Chakkraband, Senior Advisor of the Department of Mental Health to make a speech and open the workshop. The attendees were public health officers, local government officers, religious leaders, and community leaders. The process started with the Centre 12’s Director updating attendees about the number of violent incidents and their effects on mental health. Then, a key speaker (a medical doctor), provided the information about the clinical prototype. In the afternoon session, the participants were divided into three groups, based on the area they came from, to discuss the clinical prototype. At that stage, the Centre’s staff members helped in writing ideas from brainstorming of each group. I participated in a group; however, I did not present any ideas because it was about analysing the strength and weakness of their own area and how they might apply the idea of the clinical prototype in practice. The second day was the presentation of results from the brainstorming of each group and the commitment from the participants to apply the idea in each area.

3) The third observation

Third observation happened on May 29, 2014, “The potential development of volunteering women” workshop. The participants at this workshop were widows, whose husbands had died because of the mass violence. This workshop aimed to share the experiences of women who had overcome this crisis in their life. The process aimed to empower the newcomers and discover ways to support each other, especially in legal processes and their rights. I noticed this was a relaxed and informal workshop. It started with participants getting to know each other by asking what they did in their leisure time. The contents included personal empowerment, developing a team spirit, and helping build stronger relationships. I noticed that the strategy used in this workshop was train participants to cope with stress by applying religious principles such as meditation and positive thinking. In this workshop, I was introduced as a researcher and participated in the activities provided by the organizers. I joined in a group and answered the questions about the causes of stress and how to cope with stress, then presented our group’s idea to the whole workshop.

4) The fourth observation

The last observation was on June 3, 2014. In this activity, I went to Khao Tum Sub-District which is located on the border between Pattani and Yala provinces. It was about 64 miles from Pattani city. As this area was subjected to high percentage of the violent incidents, this had prompted a significant number of government officials and citizens to launch a project for mental health rehabilitation, specifically for children. As a result, they invited the two partner group representatives from the spiritual development group to design a programme to support their children. All of the processes at the meeting were mutual sharing of information. For instance, the police talked about the number of violent incidents in the area between 2004 and 2014, the school director talked about the number of students affected by the crisis, and the partner group representatives explained sources that they could provide for this community. In this meeting, I introduced myself as a researcher and a lecturer at Prince of Songkla University. As the purpose of this meeting was to listen to the basic information about the area and to design an area-based children's programme, I also provided information about some activities which the Faculty of Communication Sciences annually instituted which could benefit this area, such as media literacy for teachers and children, and using internet technology for the community's data collection.

Appendix E: Example of participant observation field notes

The table shows a limited example of my field notes. I created the table to describe what happened in the field, my comments from the observation and my notes for the initial interpretations.

Descriptions and quotations	Observer's comments	Interpretations
<p><i>Field notes dates: 6 May 2014 at Benjamarachutit Pattani School.</i></p> <p><i>Time in setting: 7 hours</i></p> <p>The communication strategy was learning by doing. Firstly, the key speaker opened with an emotive video of a boy who was intellectually disabled and how his parents took care of him. Then, the participants were taught about how to measure general intelligence by using the IQ test. There are 60 questions which the participants need to read and evaluate the behaviour of children. Some examples are accepting others' ideas, trying to do difficult things by themselves, accept when they do something wrong etc. There are four levels of evaluation: never, sometimes, often, and regularly.</p>	<p>I noticed that this activity took a long time as some participants had limited reading skills and they found it was difficult to calculate the overall score.</p>	<p>I found the audience analysis was important to effectively inform the programme design and delivery. For instance, most of the audience did not understand about intellectual disabilities and had a negative attitude about this problem as a result. The programme's deliverer used the inspirational movie to educate about the intellectually disabled and to empower the participants as the important key people</p>

Descriptions and quotations	Observer's comments	Interpretations
		<p>in helping children.</p> <p>Problem with audience understanding indicated that innovations such as the IQ test or evaluation form need to be specific for each target audience. One size does not fit all.</p>
<p><i>Field notes dates: May 19, 2014 at CS Pattani Hotel.</i></p> <p><i>Time in setting: 7 hours</i></p> <p>The workshop started with the facilitator providing information about the nature of mass violence and the ways in which this influenced people's mental health. Then, the clinical prototype was presented as an innovation for building community resilience. As the Centre 12's Director said (taken from my recorded material)</p> <p>"Data from the Deep South Watch reported the total number of people affected by the violent incidents was 15,556 in which</p>	<p>I noticed that this workshop was very well planned. Everything was set as a template from the 12th Mental Health Centre, such as the geographic area, role and function of the clinical prototype. Three areas which were chosen from three provinces. Likewise the earlier observation on May 6, the participants were puzzled about why their areas were chosen for developing the clinical</p>	<p>Even though the clinical prototype has been developed as a template -top-down approach, it was flexible. The process in this workshop was brainstorming and criticizing the template to make it more responsive. Then the process allows people who live in each area to adapt it for using in</p>

Descriptions and quotations	Observer's comments	Interpretations
<p>around 5,700 people died and around 4,000 people injured. A lot of people have been directly and indirectly affected by the violence and those incidents also affected the whole society and have caused mental health problems. The 12th Mental Health Centre takes responsibility directly for mental health in this area. Therefore, we think we should have the rehabilitation system for people affected by the violence. As a result, we have developed this programme which we have chosen three prototype areas [from the three southern border provinces]. The participants of this programme include public health practitioners from each provincial public health office, district public health office, staff members from community hospitals, the Rehabilitation Centre, the local government staff, community leaders, religious leaders, village health volunteers, and the Centre 12's staff members and today's keynote speakers. We are 40 in total. The main objective of this</p>	<p>prototype. To help answer this question, I personally asked a staff member and she explained that these three areas have a very high level of violent incidents. Later, that staff member explained the reason why they were chosen to the whole group.</p>	<p>real situations. The deliverers were concerned about the opinion of the people in the area. Top-down mixed with bottom-up approaches may work well in the crisis area.</p> <p>Important information such as background reason about workshop and selecting target audiences should be explained to the attendees.</p>

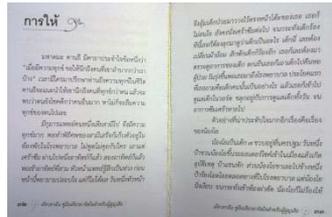
Descriptions and quotations	Observer's comments	Interpretations
<p>programme is to develop the new model of clinical intervention which could apply in these violent areas and could decrease the number of mental disorders”.</p>		

Appendix F: Five books of religious based media

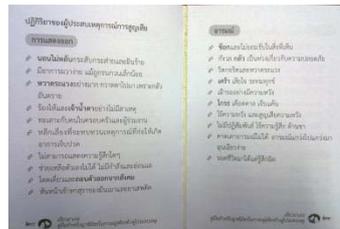
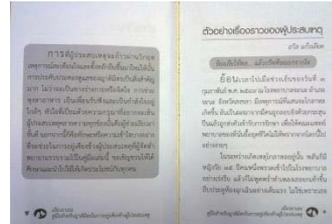
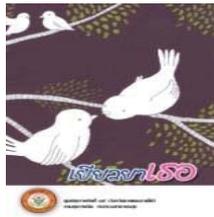
Five booklets in “Healing according to Buddhist Principle” and “Healing according to Muslim Principle” were referred to by all of the participants when they talked about the media they remembered and perceived as noteworthy. The overall description and analysis of the books were presented in the findings. The table below shows more pictures inside the five books.

<p>How to respond when we are tested</p>	
<p>Mental rehabilitation through Du-a [praying]</p>	
<p>Self-awareness and mental treatment</p>	

Rehabilitating ourselves



Rehabilitating other people



Appendix G: Massey University Ethics Application - Responses to seven key questions posed by the Committee. (October 21, 2013)

1. The committee would recommend data collection takes place in a mutually agreed location (out of the participant's offices) and out of work time. Please reconsider and ensure details are clear in the information sheet.

We have carefully considered the request to collect data outside the participants' offices and out of work time. We understand that the committee's desire for the out of office location is connected to participants feeling free to criticise their work practices. However, we believe the option to collect data in office locations it is important for the project for the following reasons.

1) Participant observation of meetings will take place in staff offices as this is the normal location of meetings (As discussed elsewhere in the Ethics Application participant observation (where the researcher takes notes about meetings and gives advice is an important expectation in the Thai culture)). 2) Staff being interviewed about mental health campaigns will want access to collateral, reports, files etc. to aid their memory and discussion – these will be accessible from their offices. 3) In regards to personal safety, offices may be the best meeting places. A public meeting place may in fact be more vulnerable to the random drive by shootings that are an element of the mass violence activity.

However, we also recognise that it is important that participants are given the choice of location. We would therefore like the information sheet to continue to say that interviews “would be conducted in your office or a mutually agreed place where you feel comfortable.”

Prof Parichart of Chulalongkorn University (my overseas adviser and experienced researcher of these sorts of campaigns in Thailand) was consulted. She agreed with the supervisors' conclusions and made the following plea: “Please trust Aruneewan and interviewees. They are local. It is a very sensitive area.” She also mentioned that the interviewees were adults and used to the research process.

However, Prof Parichart was worried about place sensitivity and identifying Pattani Province/city in the published thesis. She recommended a non-identifying descriptor. We will use this and will also not identify Mental Health Centre 15 by its number.

2. Please provide further detail with regard to whether there are any implications to be considered with regard to recruitment from contacts in the area, e.g. will potential participants feel an obligation to participate; will centre staff feel they have a choice if the Director makes

the first approach to them; will the applicant have worked with potential participants – might they feel some pressure to participate? Please provide comment.

With regard to the recruitment, the potential participants will feel free to participate in this study as I will strongly emphasize to the Director of Mental Health Centre, District 15 that the staff do not have to take part in this study. I will ask her to convey this message to the staff. I have written in the information sheet that “You are under no obligation to accept this invitation”. Moreover, I do not think the participants will be pressured to participate by their director because their organizational culture is team based. Their relationship is friendly and benign; it is not based on top-down authority. As a result, I think the staff will feel free to participate in this study. However, they will be assured that although they agree to participate, they can withdraw any time they want as in the information sheet: “At any time during your involvement with the project you can ask for interviews or data collection to stop and/or you may postpone the activities or withdraw from the project”.

3. Please provide further detail of the observation of participants and the participant-observer role, e.g. how will this be undertaken; what expectations surround the observation phase; how will this be managed. Make this clear in the information sheet.

The observation of participants will be used to collect the information about mental health campaign planning such as in the staff’s meeting room and campaign implementation such as in mental health campaigns’ workshops with their targets. In the observations’ process, the researcher will undertake a combined role of participant and observer as appropriate. This position will help the researcher to be able to keep a balance between insider and outsider perspectives. Based on Thai culture, the researcher may be expected to help with some organization’s activities such as note taking, advice, etc. In this case, I have written in the information sheet that “I would appreciate being able to engage with some of your organization’s tasks (meeting tasks, advising tasks, etc.) if you wish. In this case, my participant-observer role will be clearly identified before under taking tasks.” In conducting participant observation in the past, I have found that my Thai participants seem to be comfortable with participant-observer role. During the appropriate time of participant observation, I will also make my field notes for recoding my thoughts and actions in the field.

4. Refer to discussion point 5 above. Please provide further detail regarding the photographs, e.g. what will be photographed, how will they be used (as data or illustrations in the study), how will consent be obtained from those photographed?

Photos will only be used with permission of the people pictured. The permission of the involved persons to use particular photos in reports or presentations will be reaffirmed at the end of the

day meeting and the data collection process before the report is written. No mental health clients will be identifiable in any picture taken. Before the report is written, I will seek the consent to use the particular photos and I have written a choice in the consent form that “I agree/do not agree to photos being taken of my work contingent on my being able to select the ones that can be used in the research”. The photos will be used as evidence in providing for the final context.

5. Will participants be offered the opportunity to review/edit the transcripts? Please comment. Note: It is normal for participants to have such an option and sign a transcript release form; if the researcher does not feel this is appropriate please provide justification.

The project aggregate results will be directly sent to Mental Health Centre, District 15 and partner organizations where key informants work. The individual participants will also be able to access and review their transcripts as either electronic files or hard copies sent from the researcher on request.

6. Might a participant have been personally affected by the violence, e.g. with the loss of a family member or friend. Please reconsider the response to Q36 and outline what strategies might be put in place to manage this possibility. Please provide further detail regarding the reality of the risk of harm to the researcher whilst in the region and provide further detail of the procedures to be used to mitigate risks.

In the unlikely event that a participant does show discomfort related to the loss of a family member or friend, the researcher will immediately stop the interview and ensure the participant can withdraw from the study in any time.

The potential risk to the researcher while in Thailand will be minimized. While this is the area of mass violence, it is not everyday occurrence. For the most part, daily life carries on. This is the researcher’s home and formal work place. I have relatively well place to understand manage the risk. I have discussed this with my supervisors and have accept an assurance that I must withdraw from a participant encounter by cancellation, postponement, or cessation in the situation which I feel at risk in the knowledge that the overall research will still be available.

7. Might participants comment in a negative light in regard to policies, strategies, communication? Might there be some risk to the Centre if this were the case? Please comment.

Participants will be able to criticize policies, strategies, and communication issue as the centre itself welcome such research and critique.

Appendix H: News reporting about two violent incidents which occurred during data collection on May 24, 2014 and May 28, 2014

Three killed and over 50 injured in Pattani's bomb attacks

in [South Watch](#) | May 24, 2014 10:37 pm (1,833 views)

[Like](#) [Share](#) [114](#) [Tweet](#) [43](#) [g+1](#) [2](#)



Three people were killed and over 50 injured in a series of bomb attacks in Pattani province by suspected insurgents Saturday night.

Four petrol stations and five 7-Eleven convenience stores were bombed. Troops guarding an electricity generating plant also engaged in a brief firefight with suspected insurgents.

[NEWS >](#)

Bomb targets Pattani hospital

28 May 2014 at 19:01 [4,492 viewed](#) [2 comments](#)

WRITER: [ONLINE REPORTERS](#)

[18](#) [9](#) [0](#)
[Like](#) [Tweet](#) [g+1](#)

PATTANI - Following a spate of explosions that caused numerous casualties and damage in Pattani on Sunday, another bomb went off at Khok Pho Hospital's motorcycle parking area on Wednesday morning, injuring 10 people, three seriously, and damaging more than 50 vehicles.

A motorcycle bomb exploded at a parking lot of Khok Pho Hospital in Khok Pho district of Pattani on Wednesday. (Photo by Abdulloh Benjakat)

The bomb exploded at about 9.30am, causing a fire that engulfed the area.

Appendix I: Details of media supporting mental health communication programmes

There are a number of media and collateral supporting mental health communication programme implementation. Some examples have been shown in the findings, Chapter 5, The Appendix here provides three more examples of media and collateral supporting mental health communication programme in response to the mass violence situation.

1) Stress resource

This colorful resource made of an A5 heavy paper. It used by staff when launching mental health programmes in the community and also for communicating with children in schools. This resource was also disseminated through the Provincial hospitals, Community hospitals, and District Health Promotion hospitals in the three southern border provinces. It has a series of pullouts, each of which cover an aspect of stress such as the five types of stress and symptoms of stress. The title is “Let’s find out about stress” and two sub-titles are “How do you know that you are stressed?” and “People with stress are not crazy or mentally ill”.



2) Chart the stages of grief.

This 30 cm diameters circular chart which used by public health practitioners and mental health deliverers communicated with those who have lost family members. It explains physical and emotional responses at three stages of grief: at 2 weeks, up to three months, and after three months. Information is presented by a movable panel. The language is formal and could use to read aloud.



3) Newsletter of the 12th Mental Health Centre

The Centre 12's mental health rehabilitation newsletter is used to promote the Centre's activities. It is published in four issues a year (every three months) and it is sent to the other Mental Health Centres and Provincial Public Health Offices and hospitals in southern Thailand. The staff also disseminated it when they launch mental health communication programmes.

Appendix J: Example of Centre 12's programme evaluation form provided to attendees at each workshop

Evaluation issues	Satisfaction Level					
	Most	Very	Average	Few	Least	No comments
1. Knowledge						
1.1 Suitable and up-to-date						
1.2 Understandable						
1.3 Applicable						
1.4 Consistent with programme's aims						
2. Media and collateral supporting knowledge dissemination (ex. books, manuals, brochures, CD, etc.						
2.1 Attractive						
2.2 Easy to use						
2.3 Suitable for the receivers						
2.4 Adequate for the receivers						
3. Pattern of knowledge dissemination (ex. description, practice, group activities, making a study trip, camp, etc.						
3.1 Suitable contents						
3.2 Suitable for the receivers						
3.3 Giving the opportunity for the attendee to participate in the programme						
4. Facilitator						
4.1 Teaching consistent with the contents						
4.2 Understandable						
5. Appropriate time						

Opinions and other advice.....

.....

.....

.....

****Thank you for your cooperation****

Appendix K: Example of questions use to evaluate programme outcomes adapted from Martin (2003)

Potential Program Evaluation Questions

1. What skills did you learn today in this program that you can use?
2. How will you apply the skills you learned in this program?
3. What changes will you make in your operation/situation based on today's program?
4. How do today's program goals meet your needs?
5. In what way was this program useful to you?
6. How will this program help you set production goals?
7. What goals have you set based on today's program?
8. What changes did you make in your operation/situation as a result of programs you attended in the past year?
9. Why did you participate in this program/workshop?
10. What are you doing today in your operation that you did not do prior to this educational program? (Specify the program/context).
11. What result do I expect from using information gained from this workshop/program?
12. What problems will be addressed by you being involved in this program?
13. What practices you currently use will be discontinued as a result of this program?
14. What new practice (s) will you implement as a result of this program?
15. In what way has decision-making been made easier by participation in this program?
16. What is the best thing that can happen if you use the information from this program?
17. What immediate steps/actions will you take as a result of this program?
18. What specific assistance would be helpful to you in implementing the new practices presented in this workshop/program?
19. What will it take for you to implement the new practices/information provided in this program/workshop?
20. What result(s)/impact(s) do you expect from participation in this program?
21. What was the result/impact of your participation?

Appendix L: Summary finding sheets

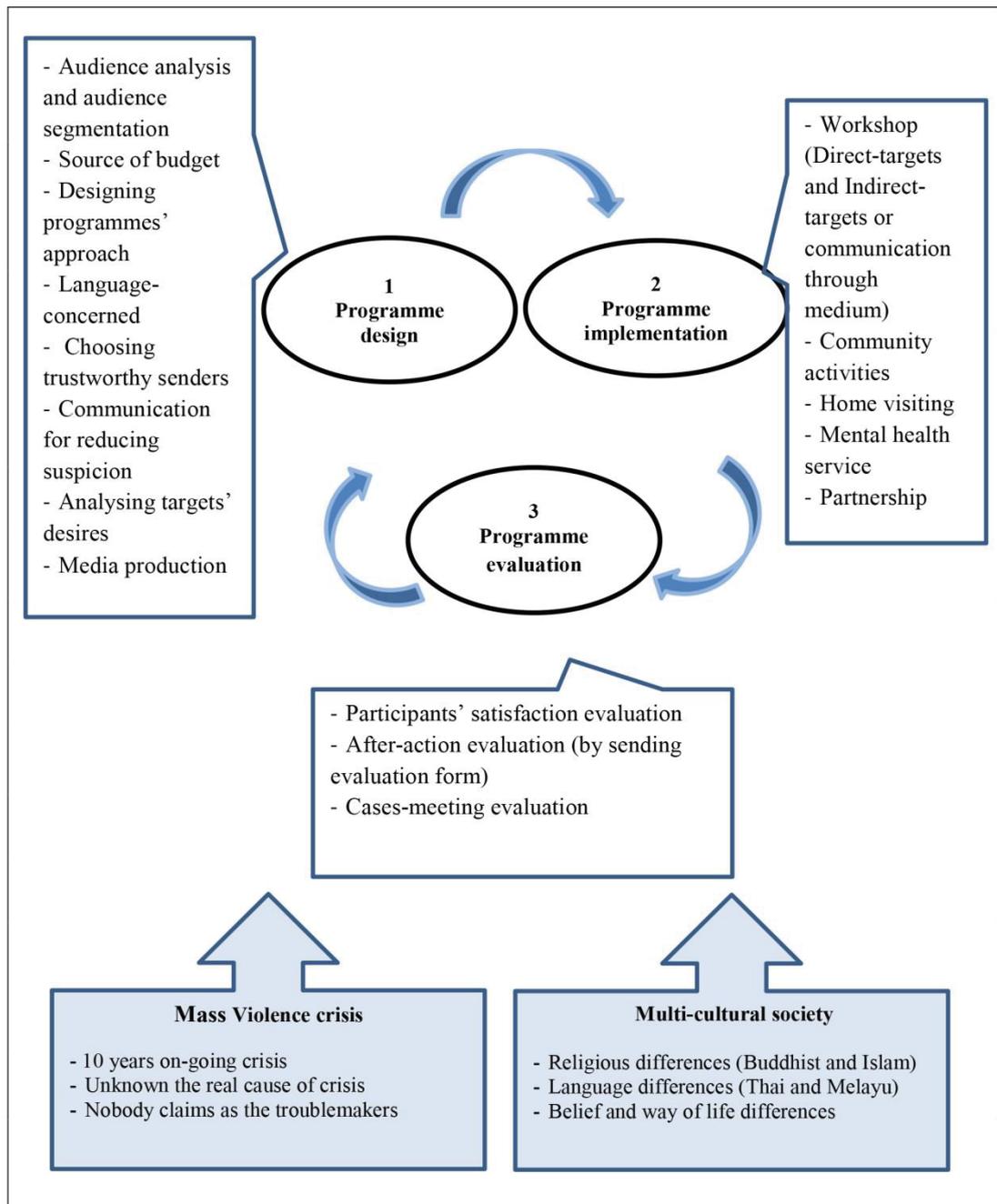
A communication case study of the practices of the 12th Mental Health Centre in response to the mass violence situation in southern Thailand from 2004 to 2014

This study is a qualitative case study research which the 12th Mental Health Centre was selected to be a case. Three data collections methods were semi-structure in-depth interview, participant observation, and document description. Seventeen participants were undertaken in this study. They included the Centre 12's Director and 11 staff members and five participants from partner group representatives.

Preliminary Findings:

Findings were divided into five sections:

1. Context findings about the mass violence situation, mental health problem in the area, and the Centre 12's development (summarised in Timeline below)
2. Centre 12's practices in response to the mass violence situation
 - 2.1 Participants' perception of the differences between mental health communication programmes in general and mass violence area
 - 2.2 Participants' perception of the overall picture of mental health communication programmes in ten years of on-going crisis
3. Mental health communication programmes
 - 3.1 Programme design
 - 3.1.1 Factors which programme's planners need to be concerned when designing mental health communication programmes in the crisis area
 - 3.1.2 Mental health media production and dissemination
 - 3.1.3 Participants' perception of the noteworthy media
 - 3.2 Programme implementation
 - 3.2.1 Implementation process
 - 3.2.2 Partners in programme implementation
 - 3.3 Programme evaluation
4. Participants' perception of the factors they perceived as major factors of success in mental health communication in the mass violence area
5. Participants' perception of the factors they perceived as barriers factors in mental health communication in the mass violence area



The Circle of Mental Health Programmes Delivery Processes Responding to Mass Violence Crisis in Southern Thailand: Based on the 12th Mental Health Centre's Operations

Timeline of Mental Health Service Delivery Responded to Mass Violence Crisis in Southern Thailand

