Afghan civilian casualties: a grim reality

S Sabawoon/epa/Corbis

Civilian casualties in conflict, whether the result of intentional targeting or collateral damage, are always unacceptable. With 1319 deaths and 2533 injuries, the number of Afghan civilians killed or injured in the first 6 months of 2013 rose by 23% compared with the same period last year, according to the UN Assistance Mission in Afghanistan (UNAMA) mid-year report released on July 31. Improvised explosive devices (eg, roadside bombs), suicide bombings, and complex attacks accounted for 52% of all civilian casualties. Combat between Afghan forces and antigovernment insurgents accounted for 25% of all civilian casualties. Unexploded and abandoned explosives pose increasing risks to the safety of civilians. Of the 145 casualties from such explosives documented, 79% of the victims were children. The UNAMA mid-year report—with all the limitations linked to recording and verifying casualties—provides valuable data to promote changes in policy and practices, and to remind all parties of their obligations to protect civilians, during and after combat operations.

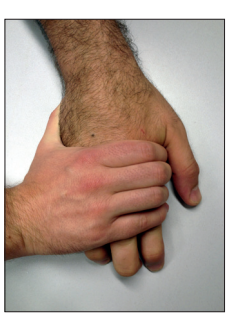
The report also highlights the disproportionate price paid by women and children: deaths and injuries increased by 38% compared with the same period last year. In a country where children are already facing high malnutrition and mortality rates, and where women and girls' rights are severely repressed, this trend is particularly concerning.

Civilians are affected by the conflict directly—as victims of violence, but also indirectly—because they face difficulties accessing health care. Although progress has been made with the implementation of the Basic Package of Health Services, access to health services is challenging: insecurity and violence, combined with the paucity of infrastructures and health-care workers, especially women, threaten access and delivery of health care. The fragile nature of Afghanistan's nascent health-care system coupled with continuing civilian casualties demands urgent and concerted action.

Protecting civilians and providing access to a sustainable health system must be key strategic priority for national and international leaders even after 2014. ■ *The Lancet*

For the **UNAMA mid-year report** see http://unama.unmissions.org/LinkClick.aspx?fileticket=EZoxNuqDtps%3d&tabid=12254&language=en-US

Facing up to restraint in mental health units



The Lancet

Physical restraint of patients in mental health units, in order to prevent harm to themselves or others, has been a controversial and emotive topic for well over a century. In Victorian Britain, the non-restraint movement advocated for the removal of the straitjacket and other forms of mechanical restraints. Ultimately, it was successful, and mechanical restraints are not employed in inpatient units in the UK today. In other countries, however, such devices continue to be used. This is an area of medicine in which best practice cannot be determined by quantitative evidence alone: the solutions will require medical, legal, cultural, historical, and humanitarian arguments in equal measure.

The need for any form of restraint—whether mechanical, physical, or chemical—should be questioned, and the contribution of poorly resourced services to its use must be addressed. Psychiatrists, allied professionals, and patients need to send a clear message to governments and the public that the purpose of inpatient care is to help distressed individuals, not to confine them: mental health services need the funds, the staff, and the physical space with which to do this. Within health systems, staff who use restraint to abuse patients should face the full weight of professional censure and legal prosecution.

Most importantly, patients must be listened to. What forms of (or alternatives to) restraint would be possible and acceptable? And what is the effect of restraint on the way a patient thinks and feels? Restraint might re-traumatise patients who have already experienced physical and sexual abuse, and it can shatter the therapeutic alliance. Restraining a patient might leave staff with feelings of shock and guilt: it is natural to want to forget about such experiences, and to brush them aside. But to do so serves neither patients, nor the development of mental health care into a modern and humane branch of medicine. If any aspect of the mental health system causes harm—even if, as might be argued, this harm is regrettable yet unavoidable—the system has a duty to understand the damage done, and to help patients to heal. ■ *The Lancet*

For **Mind's campaign for national standards on the use of restraint in England and Wales** see http://www.mind.org.uk/campaigns_and_issues/current_campaigns/care_in_crisis