Int Health 2013; **5**: 9–10
doi:10.1093/inthealth/ihs005 Advance Access publication 20 November 2012

COMMENTARY

Mental health in humanitarian settings: shifting focus to care systems

Mark J.D. Jordans[a,b,*] and Wietse A. Tol[a,c]

[a]*Research and Development Department, HealthNet TPO, Lizzy Ansinghstraat 163, 1072 RG Amsterdam, the Netherlands;* [b]*Global Center for Mental Health, London School of Hygiene and Tropical Medicine, London, UK;* [c]*Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Baltimore, USA*

*Corresponding author: Tel: +0031 206200005; E-mail: mark.jordans@hntpo.org

Received 8 August 2012; revised 20 September 2012; accepted 4 October 2012

Mental health in low- and middle income countries has received increasing attention. This attention has shifted focus, roughly moving from demonstrating the burden of mental health problems, to establishing an evidence base for interventions, to thinking about care delivery frameworks. This paper reviews these trends specifically for humanitarian settings and discusses lessons learned. Notably, that mental health assessments need to go beyond measuring the impact of traumatic events on circumscribed psychiatric disorders; that evidence for effectiveness of interventions is still too weak and its focus too limited; and that development of service delivery in the context of instable community and health systems should be an area of key priority.

Keywords: Humanitarian setting, Emergency, Mental health, Psychosocial

Attention for what has been coined Global Mental Health has increased significantly in recent years, exemplified in series in *The Lancet*, *PLoS Medicine*[1] and evidence-based guidelines for mental, neurological and substance abuse disorders.[2] The overall aim of this movement is to reduce the enormous treatment gap – the percentage of people with mental disorders that do not receive treatment – especially in low- and middle income countries (LMIC). This commentary will look at what that has meant for humanitarian settings.

We use the term humanitarian settings to refer to a broad range of emergency situations, including natural disasters and armed conflicts. As populations affected by such humanitarian crises predominantly reside in LMIC, they deserve distinct attention. Prevalence of mental health and psychosocial problems in these populations is high, due to multiple simultaneously occurring risk factors including violence, poverty, systematic marginalization of specific population groups, and disrupted community and health systems.[3]

We argue that attention for global mental health has historically largely followed different trends that have focused on three core themes: from questions on prevalence and burden of mental health problems (what is the problem?), to questions on effectiveness of interventions (what works?), to questions on care delivery (how can it be implemented?). We will discuss each of these with a focus on humanitarian settings in LMIC.

First, considerable efforts have been undertaken to demonstrate the public health importance of mental health problems in LMIC. Evidence for the large contribution of mental, neurological and substance abuse disorders to the global burden of disease has led to increased attention to mental health on the international health agenda. Similarly, a multitude of epidemiological studies with populations in humanitarian settings has focused on demonstrating the detrimental mental health impact of emergencies.[4] For example a systematic review of the most robust studies in conflict-affected populations showed average prevalence rates of 15.4% for post traumatic stress disorder (PTSD) and 17.3% for depression.[4] Mental health in humanitarian settings has commonly been associated, and at times equated, with PTSD and trauma-focused interventions. While attention for the impact of potentially traumatic events is justified (given its strong and consistent relation with an increase in a variety of mental health problems), current thinking increasingly advocates a more balanced approach that broadens the focus of psychiatric epidemiological research to include common and (pre-existing) severe mental disorders.[3] In addition, other mental health problems, including non-disordered and ongoing daily distress as well as resources for coping, should be taken into account. A recent study among refugees in Jordan and Nepal supports this trend, demonstrating that currently perceived needs were found to mediate the association between past exposure to traumatic events and distress.[5]

Second, after establishing the mental health needs and treatment gap in LMIC, attention in global mental health shifted to obtaining evidence for effective treatments and interventions. This evidence-base is tentatively emerging, with multiple studies demonstrating efficacy of task-shifting models,[6] culminating in evidence based guidelines.[2] Within humanitarian settings, where the treatment gap is possibly even greater due to an extremely weak care infrastructure, evidence for effective interventions is also accruing for both adults and children.[3] This trend is important to demonstrate that effective interventions delivered by non-specialists are attainable, also in emergency settings. At the same time, this evidence-base is

© *Royal Society of Tropical Medicine and Hygiene 2012. All rights reserved. For Permissions, please email: journals.permissions@oup.com*

Downloaded from http://inthealth.oxfordjournals.org/ by guest on February 22, 2016

characterized by a divide between research and practice. Evidence focuses on interventions that are infrequently implemented, whereas the most commonly used interventions have had little rigorous scrutiny.[3] Furthermore, demonstrated efficacy of treatment alone is insufficient to close the treatment gap. There is a dire need to develop service delivery frameworks that are feasible across LMIC, but especially in humanitarian settings.

This has led to the third trend, which is characterized by the question of how care can best be organized. Integration of mental health into primary health care is now commonly advocated. For example WHO's Mental Health Gap Action Programme (mhGAP) aims to scale up services for mental disorders through primary health care providers, especially in LMIC.[7] However, it is unclear how to do that in settings with limited health infrastructure or instability that accompanies humanitarian settings. Where and how to deliver cost-effective interventions in a low-resource setting are among the most commonly prioritized questions for global mental health research.[8] This important focus of research was also strongly represented in a recent research priority setting study for mental health and psychosocial support in humanitarian settings, wherein question around methods of assessing, monitoring and delivery of interventions are among the most highly prioritized.[9] Rather than narrow stand-alone interventions (currently more often than not targeting PTSD through generic counseling approaches), there is a need for a more community and health systems-based approach that caters for multiple needs in a stepped-care approach, while taking into account existing community and health resources.[10] Such a multi-tiered approach is advocated by international consensus based guidelines for mental health and psychosocial support in emergency settings.[11] In doing so, especially in humanitarian settings, a balance needs to be found between integration of mental health within health care systems and working with existing community-level psychosocial support mechanisms. How this can best be done and subsequently brought to scale is something that is being investigated at present by the Program for the Improvement of Mental Health Care (PRIME www.prime.uct.ac.za). In a fragile setting such as post-conflict Nepal, PRIME is focusing on the development of a mental health care package that is feasible and effective even in the face of unstable government systems and volatile community settings.

Attention for mental health in humanitarian settings can be said to have focused broadly on the same issues as the field of global mental health. However, certain lessons learned are specific to the context of emergencies. These include: that mental health assessments in humanitarian settings need to go beyond measuring the impact of traumatic events on circumscribed psychiatric disorders; that evidence for effectiveness is still scarce and characterized by a large divide between what we know works and what is practiced; and that development of service delivery is faced with the challenge of operating in unstable health and community systems. Fortunately, mental health and psychosocial interventions are increasingly integrated within overall humanitarian assistance programs,[3] albeit too often consisting of narrowly conceptualized and stand-alone interventions that do not take existing health and community systems into account. In practice, there is a need for the development and evaluation of multi-tiered public health-inspired care packages implemented across existing health, community development, education, social welfare and other sectors.

Authors' contributions: MJ and WT conceived, drafted, revised, finalized and approved the manuscript. MJ and WT are guarantors of the paper.

Funding: None.

Competing interests: None declared.

Ethical approval: Not required.

References

1 Patel V, Jenkins R, Lund C, the Plos Medicine Editors. Putting evidence into practice: the PLoS Medicine Series on Global Mental Health Practice. PLoS Med. 2012;9:e1001226.

2 Dua T, Barbui C, Clark N et al. Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: summary of WHO recommendations. PLoS Med 2011; 8:1–11.

3 Tol WA, Barbui C, Galappattti A et al. Mental health and psychosocial support in humanitarian settings: linking practice and research. Lancet. 2011;378:1–11.

4 Steel Z, Chey T, Silovve D et al. Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement. JAMA. 2009;302:537–47.

5 Role of current perceived needs in explaining the association between past trauma exposure and distress in humanitarian settings in Jordan and Nepal. Br J Psychiatry. 2012;201:276–81.

6 Patel V, Weiss HA, Chowdhary N et al. Effectiveness of an intervention led by lay heath counsellors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomized controlled trial. Lancet. 2010;376:2086–95.

7 WHO. Mental Health Gap Action Programme (mhGAP): Scaling Up Care for Mental, Neurological and Substance Abuse Disorders. Geneva: World Health Organization; 2008.

8 Tomlinson M, Rudan I, Saxena S et al. Setting priorities for global mental health research. Bull World Health Organ 2009;87:438–46.

9 Tol WA, Patel V, Tomlinson M et al. Research priorities for mental health and psychosocial support in humanitarian settings. PLoS Med 2011;8:1–6.

10 Jordans MJD, Komproe IH, Tol WA et al. Practice-driven evaluation of a multi-layered psychosocial care package for children in areas of armed conflict. Community Ment Health J 2011;47:267–77.

11 IASC. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva, Switzerland: Inter-Agency Standing Committee; 2007.

Downloaded from http://inthealth.oxfordjournals.org/ by guest on February 22, 2016