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Announcement

Funding opportunity in global mental health

The goals of the Grand Challenges Canada's (GCC) *Global Mental Health programme* are to improve mental health treatments, expand access to care, and reduce stigma in low resource settings. This is done in order to save and improve the lives of those affected by mental illness. To date, GCC has committed approximately $27 million Canadian dollars to 38 projects in 28 low and middle income countries.

In October 2013, GCC announced the third call for *Proposals*. GCC seeks bold ideas with integrated scientific, business, and technological innovations, which solve mental health challenges. This call specifically targets situations of emergency, humanitarian concern, and protracted conflict. For details on the Global Mental Health portfolio and how to apply, please see: http://www.grandchallenges.ca/grand-challenges/global-mental-health/

From the editors... Introduction to a Special Issue: long term perspectives on mental health and psychosocial programming in (post) conflict settings

Peter Ventevogel, Valerie DeMarinis, Pau Pérez-Sales & Derrick Silove

This special issue of 'Intervention' focuses on programmes for mental health and psychosocial support in three very different war affected contexts: Bosnia-Herzegovina, Sierra Leone and Syria. In this introduction to the issue, the editors present the three case examples and provide reflections on what we can learn from them. They argue that the rather narrow focus of initiatives in global mental health on rapidly scaling up essential psychiatric services needs to be complemented by attention to contextual factors, particularly in relation to (post) conflict settings. They stress the importance of 1) using a thorough contextual analysis that includes a wide range of perspectives of stakeholders at various levels; 2) using a broad public mental health approach that goes beyond treatment of people with mental disorders and focuses on prevention and resilience building; 3) giving attention to meaning making processes and elements, such as justice, reconciliation and reparation; and 4) conceptualising the process of evaluation as an iterative and multidimensional process that is most functional when designed in tandem with programme formation, and which follows and interacts with programme developments.

Keywords: Bosnia Herzegovina, context analysis, evaluation, mental health and psychosocial support programmes, public mental health, Sierra Leone, Syria

Background to this issue

Publications on mental health and psychosocial support (MHPSS) interventions in areas affected by conflict tend to be like snapshots; focusing on particular aspects of a problem, at a particular moment in time. This issue of *Intervention* tries to take a broader view, in an explicit attempt to see mental health and psychosocial support interventions as multifaceted approaches that develop over a longer period of time.

The idea for this special issue was born at a conference, in 2011, in Uppsala, Sweden. The conference theme was '*Coping with humanitarian crisis after war: mitigating consequences of conflicts and strengthening resilience*'. This meeting highlighted and discussed two mental health programmes, one in post war Bosnia Herzegovina, and one around Iraqi refugees in Syria. The experiences derived from both programmes are important to share with a wider audience of practitioners and academics because it is rare that such programmes are documented so thoroughly.

One important challenge in planning mental health and psychosocial services within complex (post) conflict settings is to ensure that the interventions have immediate, measurable benefits and, at the same time,

contribute to sustainable long term development in services that are integrated within the existing systems of health care. This issue has been explored earlier in this journal, for example in a special issue (Ventevogel et al., 2011). That issue of the journal showed that a key component for lasting and sustainable impact is to adopt a long term perspective and to integrate mental health and psychosocial activities into primary health care, or other existing services, from the very onset of the programme (Pérez-Sales et al., 2011).

One problem in this arises when planning services: financial donors often require that short term funding is used solely for the alleviation of immediate needs, arising directly from the emergency situation, and do no allow the setting up of programmes with a longer term perspective. This is unfortunate, because a lot can be achieved if a longer term perspective is adopted from the onset, without forfeiting the focus on immediate needs. A new publication by the World Health Organization showcases remarkable successes in building better mental health systems, with a longer term perspective, after major emergencies – *'against the odds'* (WHO, 2013).

While the special issue of this journal in 2011 showed that a clear consensus has emerged among practitioners about the scope and components of mental health and psychosocial interventions in complex humanitarian emergencies, there is still no generally accepted, overall framework that unifies various approaches. The consensus that has grown among major intergovernmental and nongovernmental organisations over the last decade emphasises combining the empowerment of community based approaches with the integration of MHPSS services into general services for health, education and social services (Allden et al.,

2009; Eisenman et al., 2006; IASC, 2007; The Sphere Project, 2011). Regardless, there remains an unfortunate divide between the discourse of policy makers and nongovernmental organisations on one side, and the dominant academic discourse in psychiatry and psychology (with a focus on psychological trauma), on the other (Cardozo, 2008; Tol et al., 2011a; Tol et al., 2011b; van Ommeren & Wessells, 2008). Furthermore, the issue of psychological trauma and posttraumatic stress disorder continues to be divisive (Miller & Rasmussen, 2010; Neuner, 2010), even though there are initiatives to integrate scientific findings related to traumatic stress disorders into a broader, public mental health framework (De Jong, 2002, 2010; Hobfoll, 2012; Miller & Rasco, 2004). Fortunately, in the few last years we have witnessed attempts to close the divide between *'trauma research'* and *'MHPSS implementation'*. For example, the attention given to the psychological effects of traumatic stress in a new module of the Mental Health Gap Action Programme (mhGAP) *Intervention Guide*, published by the World Health Organization (Tol et al., 2013a). However, despite these encouraging signs of healing the *'trauma divide'*, the search for a comprehensive, overarching framework to guide an integrated approach continues. This special issue contributes to that search.

The search for a conceptual framework for MHPSS in (post)war settings

The issue opens with a paper by *Derrick Silove*, who describes the conceptual framework that he and his colleagues in Australia have developed over the years. The Adaptation and Development after Persecution and Trauma (ADAPT) model provides a comprehensive framework to inform and

guide policies and practices in settings affected by collective violence. It links a continuum of psychological responses to mass conflict, with a spectrum of interventions to support psychological and social recovery. The model identifies five core psychosocial domains (*'pillars'*) that are profoundly affected by mass conflict: (1) safety and security; (2) bonds and networks; (3) justice; (4) roles and identities; and (5) existential meaning. Ideally, psychosocial and mental health interventions should work towards restoring these five pillars. The ADAPT model goes a step further than most other psychosocial models by providing an integrated view that incorporates key aspects not routinely considered elsewhere. The model explicitly includes *'political'* issues such as: truth, justice or reparation, and gives attention to the impact of collective violence on world views and systems of existential meaning. In this regard, the ADAPT offers a broader framework that accommodates the global mental health focus on efficiently *'scaling up'* low cost mental health interventions within health care systems (Eaton et al., 2011; Goldberg, Thornicroft & van Ginneken, 2013; Saxena et al., 2013) while also extending the perspective to considerations of power inequalities and social injustices that are pivotal concerns within each local context (Campbell & Burgess, 2012; Fernando, 2012). The goals of ADAPT are largely aspirational, and have not been fully achieved in real world programmes. However, they have provided a conceptual pubic mental health framework for programming in post war settings, such as East Timor (Silove et al., 2011), and in protracted refugee settings such as Syria, as described elsewhere in this issue.

Three case examples of mental health capacity building programmes in very different settings affected by war: Bosnia-Herzegovina, Sierra Leone, and Syria are presented in this special focus issue. Although these examples encompass differing contexts spanning post war or protracted refugee situations, there are several points in common that are touched on by each of these cases.

Bosnia Herzegovina

The first case example is that of Bosnia Herzegovina. During and after the terrible war following the break up of Yugoslavia there has been an influx of many short term mental health interventions. These have often focused on treatment of psychological trauma and *'therapeutic interventions'* in order to improve psychosocial wellbeing (Pupavac, 2004). These projects concluded after a few years, but some developed into programmes that aimed to incorporate mental health into the basic health care system (Mooren et al., 2003). *Bengt Lagerkvist, Nermana Mehic-Basara, Ismet Ceric & Lars Jacobsson* describe how an intensive and sustained collaboration between mental health professionals from Sweden and colleagues in Bosnia Herzegovina, with the generous support from their respective governments for a period of more than seven years (1997 – 2004), has had a major impact on how mental health care is being been delivered in that setting. The country has made a major shift, from a hospital based model of psychiatry to one centred on community mental health centres. Within these centres, multidisciplinary teams of psychiatrists, nurses, psychologists and social workers treat and support people with disabling mental disorders.

Sierra Leone

Not every post conflict setting is as fortunate. More than a decade after the end of a

protracted war, the West African country of Sierra Leone, remains very much in need of mental health services. In this second case example, *Jane Shackman & Brian Price* discuss a community mental health capacity building project in northern Sierra Leone. Over the course of two years (2010 – 2012), the authors did a comprehensive evaluation that involved an impressive array of stakeholders, including users of mental health services, mental health professionals, policy makers, community members and traditional healers. The authors found that the effect of war on mental health and psychosocial wellbeing did not express itself in direct ways, for example through large numbers of people seeking help for individual, war related trauma (few patients attributed their mental disorder directly to war experiences), but rather in indirect ways, through continued collective suffering as a consequence of the conflict. This was expressed through diminished community cohesion and the breakdown of functional systems of health care and social services. The scorecard at the end of the programme is mixed. The authors revealed huge problems, including the low priority given to mental health by the health authorities and health care staff, problems in management of services, and the challenging issue of how to negotiate a functioning role for traditional healers as a potential mental health resource in collaboration with the formal, mental health services. Despite the huge challenges that the programme faced, it has had a clear impact on the lives of a substantial number of people with mental disorders who otherwise would have been completely deprived of formal mental health care.

Syria

The third case example comprises six articles on MHPSS in Syria. After the fall of Saddam Hussein in 2003, and the civil war that followed, hundreds of thousands of Iraqi refugees found a safe haven in neighbouring Syria. However, over the last two years, Syria has radically changed from being the third largest host country for refugees in the world, to being the largest producer of refugees in the world. These six papers look at the complexity of this unusual crisis, from a variety of perspectives.

The section opens with a paper by *Constanze Quosh, Liyam Eloul & Rawan Ajlani* with a systematic literature review of the MHPSS context, as well as the mental health profile of both refugees and civilians in Syria. Their review covers two periods: the complex emergency around Iraqi refugees that began in 2006, and the current acute complex emergency, beginning in 2011, that led to many casualties and mass displacement of millions of Syrians. In a second article, *Constanze Quosh*, who worked for the UNHCR in Syria, describes a programme for MHPSS that was initiated after the massive influx of Iraqi refugees into Syria in 2006. The aim of this article is to provide an overall description and initial outcome data relating to the MHPSS programme for refugees implemented in Damascus. The programme was informed by the ADAPT model, and implemented three interrelated approaches: 1) mental and psychosocial case management; 2) community outreach and a psychosocial centre that serves as a safe space; and 3) capacity building of the local mental health system and displaced community. These components were gradually transferred to national organisations in Syria. This process was severely affected by the recent crisis and civil war in Syria. In a lively and moving field report, *Zahra Mirghani*, who has also worked with UNHCR in Syria, writes in greater detail about the outreach initiative

with Iraqi refugee women in Syria that is one component of the integrated programme described by Quosh. The goal of this outreach programme was to identify and support the most vulnerable refugees. Activities grew dramatically, with volunteers assisting more than 6000 refugees each month, with remarkable outcomes for the community, the overall aid operation, and the sense of wellbeing of workers. This last point, the psychosocial wellbeing of volunteers, deserves more attention in future issues of *Intervention*. In many settings, agencies are concerned that it is '*not fair*' to base an intervention on unpaid volunteers, asserting also that it is too taxing physically and mentally. It is, however, important to note that within the Syrian project the volunteer group had the highest rate of improved wellbeing and resilience of all the sub-groups included. This raises the question: did conditions for volunteers, with better access to resources, close supervision, and a daily life function contribute to a new identity within a protracted refugee setting? *Maha Ismael*, an Iraqi psychologist who fled to Syria, describes her own experiences as a psychosocial refugee outreach volunteer in Syria. She volunteered to help other refugees and her work includes the facilitation of peer support groups, including groups where participants learn practical skills. In another personal reflection *Maysaa Hassan*, a Syrian psychologist who worked as a programme supervisor for UNHCR, touches on the importance of psychosocial community outreach and the outreach-counselling centre. She reflects on her background, motivation and challenges, as well as the impact of the current situation.

The special focus on Syria ends with an article by *Liyam Eloul, Constanze Quosh, Rawan Ajlani, Naira Avetisyan, Mouta Barakat, Lidia Barakat, Mohammad Waleed Ikram, Louay*

Shammas & Victoria Diekkamp, who work with various organisations in Syria. Their paper focuses on the consequences of the civil war in Syria, and provides an analysis of the shifting resources and infrastructure available to the affected populations in that country. They describe how previous efforts to evaluate and improve the mental health and psychosocial support for Iraqi refugees who came to Syria can now be used as a foundation to address the current crisis affecting the Syrian population. The authors of the two field reports, Maha Ismael and Maysaa Hassan, were also co-authors in a field report that was published in the July issue in *Intervention* and that describes how the work for and with Iraqi refugees provided a base for working with Syrians themselves (Harrison et al., 2013).

What can we learn from the three case examples?
The mental health capacity building programmes in Bosnia Herzegovina, Sierra Leone, and Syria represent three very different contexts, but all took place in settings in which war and destruction has had profound effects at multiple levels, on the individual wellbeing of affected people and the mental health care system itself. There are several common points, outlined below, that are touched upon in each of these cases that may provide a meta-perspective lens for approaching the case studies and learning from them.

The paramount importance of context analysis
Each of the case studies points to the importance of political analysis related to the governance structures within the context in which mental health programmes are to be delivered. This level of analysis for mental health programme design, development and evaluation is important in all contexts, but even more so within post

conflict and other complex humanitarian contexts in which it may not be obvious who the decision makers are and what they want (De Vries & Klazinga, 2006; Sharma & Piachaud, 2011). A context analysis should include an assessment of the political underpinnings of the mental health systems itself, both those within the existing context or the remnants of remaining systems, as well as those of the outside agencies and their agendas. This level of analysis provides important knowledge for understanding and addressing areas of exclusion and stigma regarding mental health, building or revitalizing existing structures, or working towards the transformation of services.

Using a public mental health approach

In different ways, the three case examples used a public mental health orientation that recognises the importance of familial and community resources, and of formal and informal networking structures (Fairbank et al., 2003; Kalra et al., 2012). A public mental health approach also emphasises health promotion, ensuring that resources are directed towards facilitating recovery and promoting resilience, the overall aim being to bolster mental health and psychosocial wellbeing in the majority of the population (Panter-Brick & Eggerman, 2012; Tol et al., 2013b; Wessells & van Ommeren, 2008). Importantly however, it does not imply a neglect of the needs of those with severe or complex mental problems (IASC, 2007; Jones et al., 2009; Silove et al., 2000).

Paying attention to meaning making processes and existential meaning

Although only the Syrian case study draws explicitly on the ADAPT model described above, issues relating to meaning making processes, one of the pillars in the model, are evident in each of the case studies.

Several challenges are noted: ethnic differences related to religious affiliations, conflicts between traditional healers and mental health workers, a political context that prohibits open discussion of existential and or religious information, and a restricted, biomedical approach to mental health care that ignores the role of existential meaning. The recognition of these challenges, in each of the case studies, adds to the growing discussion related to the inclusion of this complex area of analysis into mental health programming in complex humanitarian settings (Schafer, 2010). Exploring issues around existential meaning may provide important information on protective and risk factors in public mental health programmes (DeMarinis, 2008).

Multi-dimensional evaluation

The three case studies each highlight the importance of evaluating programmes. The nature, timing and function of the evaluation process have implications for the capacity of programme managers to best use the information. The papers in this issue make it clear how important it is to use multiple methods for data gathering, involving all stakeholder groups, in order to include various perspectives (see also Mikus Kos, 2008). These papers also make it clear how challenging programme evaluation can be, especially in terms of assessing the actual impact of the programme on mental health and psychosocial wellbeing within a rapidly changing context. Nowhere is this more clearly illustrated than in the case of Syria, where an impact assessment of the programme on the wellbeing of Iraqi refugees in Syria is heavily confounded by the occurrence of mass violence in the host country. In any case, the studies show that a proper and consistent documentation of basic data, and the monitoring of variables

related to security, staffing, and professional competencies are of critical importance (Ajdukovic, 2008; WHO & UNHCR, 2012).

Conclusions

As editors of this issue we hope that this collection of papers will provide encouragement and inspiration to others, to honestly document and openly evaluate their experiences of setting up programmes for MHPSS in protracted humanitarian emergencies and post conflict settings. The papers in this issue show that, however difficult the objective may be, it is a realistic and important goal to aim for change and development in services that incorporate a longer term view, and adopt a broad public mental health framework that includes attention to wellbeing and resilience.

Conflicts of interest

All papers were reviewed by the editorial team for this special issue, this team consisted of two regular members of the editorial board (PV and PP), and two guest editors (VDM and DS). In addition, each article in this issue has also been reviewed by three to four external peer reviewers, according to the standard double blind peer review process of the journal. PV has done work for UNHCR as a consultant, not related to the programmes described in this issue. From October 1st he will start working with UNHCR. VDM has been an external evaluator of the UNHCR programme in Syria that is described in this issue. DS authored a paper for this issue, and has not been involved in the editorial process around this article.

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Announcement

This *Intervention Special Focus Issue* has been made possible through the financial contribution of the United Nations High Commissioner for Refugees (UNHCR) in Geneva. UNHCR strives to provide integrated mental health and psychosocial support services to refugees, asylum seekers, stateless and internally displaced peoples. The UNHCR staff was not involved in the editorial processes of this issue.