Scaling up mental health interventions in conflict zones

More than 170 million people worldwide are currently affected by armed conflict, with the vast majority in low-income and middle-income countries (LMICs). These include more than 70 million people who have been forcibly displaced within their own countries as internally displaced people or into other countries as refugees. Exposure to armed conflict, forced displacement, and associated adversities such as poverty, unemployment, and social isolation substantially increase vulnerability to psychosocial distress, and the prevalence of mental disorders (including depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia) among conflict-affected populations is higher than 20%.[1]

In addition to addressing the underlying causes of the burden and psychosocial distress of such mental disorders, there is a need to treat these disorders among conflict-affected populations. There is growing, but still limited, evidence from intervention studies on the effectiveness of community-based mental health interventions among conflict-affected populations in LMICs, with few high-quality studies published.[2] However, there are concerns about the feasibility of the delivery of these interventions and their sustained effectiveness, thus impeding the ability to deliver mental health services to a scale that will meet the needs of this population. Indeed, the treatment gap for mental health services among conflict-affected people is very high, with studies showing more than 80% of those who report symptoms of mental disorders do not receive mental health care.[3] A key challenge is therefore to scale up effective community-based mental health interventions to benefit more people and reduce the treatment gap. This involves both horizontal scaling up to expand effective interventions to more people and vertical scaling up to ensure the intervention is institutionalised through policy, political, legal, budgetary, and other health systems changes.[4]

To help to scale up mental health interventions for conflict-affected populations, we highlight four types of necessary evidence. The first is evidence on the effectiveness of the intervention. This should be data from randomised controlled trials, which should also include qualitative data on the observed benefits and sociocultural relevance for affected populations.

The second type is evidence on the costs and cost-effectiveness of the intervention,[5] ideally modelling the costs of its planned scale up,[6] to ensure that financial investments maximise mental health benefits. The third type is evidence on the process of implementing the intervention to understand discrepancies between observed and expected outcomes (ie, failure of concept vs failure of implementation), which can provide unique data to support its application to other conflict-affected contexts. Process information should go beyond what is being delivered (eg, fidelity, dose, and adaptation) and include data on mechanisms of impact (eg, participant responses and unexpected consequences) and local contextual factors affecting the intervention and its delivery.[7] Fourth, evidence is required on the broader health system and policy context in which the intervention is to be scaled up. This includes research on the required health system inputs (so-called building blocks) and potential constraints (eg, financial, health workforce, policy, legislative, and governance barriers) and strategies to overcome these constraints.[8,9]

Our own research shows that randomised controlled trials evaluating mental health interventions among conflict-affected populations rarely include economic data or in-depth process evaluations, nor investigate how the social, organisational, and political context influences outcomes. It is possible that more comprehensive process data have been collected but have not been reported, but withholding such data impedes future adaptation, application, and dissemination at a wider scale. There also seems to be a lack of health systems and policy research for scaling up, including on how effective mental health interventions can be nested within other humanitarian activities such as programmes for gender-based violence. This information is urgently needed to understand which platforms of care are most suitable for the delivery of mental health interventions for conflict-affected populations at a greater scale.

Mental health professionals and researchers developing and evaluating mental health interventions with conflict-affected populations in LMICs need to be more cognisant of scaling up and adopt longer-term public health approaches. This means addressing not only epidemiological effectiveness but better utilising health economics and other social sciences such as

sociology and anthropology to more rigorously support sustainable implementation strategies.

Recent innovations in the development of deliberately scalable transdiagnostic psychological therapies include Problem Management Plus and the Common Elements Treatment Approach.[10] These have shown effectiveness and might also be socioculturally relevant and feasible because they are delivered in the community by lay health workers (including by conflict-affected people). The task now is to build on these therapies and collect the necessary evidence to have an impact at scale and to reduce the mental health treatment gap among conflict-affected populations.

*Bayard Roberts, Daniela C Fuhr

Department of Health Services Research and Policy, London School of Hygiene & Tropical Medicine, London WC1H 9SH, UK
bayard.roberts@lshtm.ac.uk

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