An *Intervention Special Issue*

Integrating mental health care into existing systems of health care: during and after complex humanitarian emergencies

Peter Ventevogel, Pau Pérez-Sales, Alberto Férnandez-Liria & Florence Baingana

Complex humanitarian emergencies, whether arising from armed conflict or natural disaster, challenge the mental health system of a country in many ways. Not least because they increase the risk of mental disorder in the population, and undermine the pre-existing structures of care. They may, however, also bring new opportunities to create change. In this way, new structures and paradigms may emerge from the midst of a crisis. The probabilities for such a change to occur vary from one setting to another. Regardless, it has been seen that interventions in complex humanitarian emergencies should not be limited to the deployment of specialised resources that will disappear once the emergency has lost its urgency, or visibility. Apart from provision of direct services, interventions in these circumstances should also aim to build local capacity and install sustainable systems of mental health care at the time of the intervention. This paper serves as an introduction to this special issue of 'Intervention' and examines the various aspects surrounding integration of mental health care and psychosocial support into overall health systems during, or after, complex humanitarian emergencies.

Keywords: capacity building, complex humanitarian emergencies, documentation, mental health care, sustainability

Complex humanitarian emergencies: context

A disaster is the result of a vast ecological breakdown between a population and the environment, on such a vast scale that the demands exceed available resources (Gunn, 2003). The disaster situation overwhelms the response capacity of the affected community and causes disruption and disintegration of the social fabric by prohibiting the survivors from functioning normally (Pérez-Sales, 2004). Traditionally, disasters are categorised as either natural disasters (such as earthquakes or floods) or man-made disasters (such as technological disasters, environmental disasters, terrorist acts, armed conflicts or refugee crises). However, this historical dichotomy is losing its utility. For example, the impact of *'natural'* disasters is often compounded when occurring in already fragile ecological or political contexts, while armed conflicts and massive displacements are, in turn, fuelled by ecological factors such as population pressure, and struggles for control over scarce natural resources such as fertile land and water. Many disasters do not have a single cause. The 2010 earthquake in Haiti occurred in a context characterised by social inequalities,

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

grossly inefficient public services and ill prepared physical infrastructures. As a result, the earthquake had a much more devastating impact than it would have had in a politically stable, high income country with fully functional public services. For these situations, the term *complex humanitarian emergency* was coined, specifically to describe settings in which multiple, often historically and politically determined, aetiological factors both predispose an area to disaster, and mitigate its outcomes. Complex humanitarian emergencies are often characterised by factors such as: dislocation of populations, destruction of social networks and ecosystems, insecurity affecting civilians and others not engaged in fighting, and abuses of human rights (Leaning, Briggs, & Chen, 1999). In such multidimensional disasters, natural and man-made factors are closely intertwined. High levels of violence and social insecurity, in particular, threaten the capacity of the population to sustain livelihood and life (Zwi & Ugalde, 1991).

Complex humanitarian emergencies: three phases of assistance

The conventional classification for the sequence of humanitarian assistance uses three phases: relief, rehabilitation and development. Activities included in the *relief phase* aim to provide essential services to those whose survival is threatened. This phase is followed by *rehabilitation,* in which basic services such as schools, health care, and water supply are restored, and damaged infrastructure is rebuilt. Finally, the assistance can focus on broader goals, such as economic growth, improving living standards and creation of wealth and social capital (Ryscavage, 2003). While this relief–rehabilitation–development continuum is meant to organise the post disaster response in a logical way, there are fundamental flaws with it in complex humanitarian emergencies. For example, this continuum tends to obscure the social, macro-economic and environmental factors contributing to the disaster in these settings, and it may serve to legitimate restoration of a socially and morally unjust, fragile status quo.

Documents that provide consensus frameworks to guide humanitarian responses after disasters, emphasise community based approaches and the need to reinforce the responses of the local population (IASC, 2007; The Sphere Project, 2011). Typically, these frameworks limit their scope to the responses occurring *in the midst of an emergency*, generally the first months after a disaster. Within one to two years after an emergency, many organisations have ended their programmes and moved to new emergency settings. The changing nature of humanitarian emergencies, however, from short term emergencies in confined areas to prolonged emergencies in large geographical areas, need a different approach, with due attention given to capacity building of national staff and public institutions (Salama et al., 2004). In this post disaster phase, the need for new leaders and unconventional approaches may arise. This can call into question the status quo of '*how things were always done*', and may lead to rethinking and redefining public service delivery. The influx of local and foreign qualified professionals, and the provision of aid funds, can provide additional factors to create opportunities for change, if the opportunities are seized at the right moment. This requires the use of long term perspectives that go beyond immediate services delivery, and aim to restore and restructure the systems that provide these services (de Jong, 2002).

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

Mental health and psychosocial support in complex humanitarian emergencies

Attention to mental health and psychosocial support (MHPSS) in the aftermath of disasters is relatively new, and has led to fierce and often polarised debates about what kind of mental health care and psychosocial support needs to be organised (Ager, Strang & Wessells, 2006; Galappatti, 2003; van Ommeren, Morris, & Saxena, 2006; Williamson & Robinson, 2006). The widely diverging views among MHPSS practitioners working in complex humanitarian emergencies contributed heavily to poor coordination across approaches, resulting in fragmented services and a lack of comprehensive support. The wide range of opinions about what should be done is partly related to the absence of a solid base of evidence on the results of MHPSS interventions in complex humanitarian emergencies (Wessells & van Ommeren, 2008). The need to create such an evidence base is obvious (Tol et al., 2011), yet too often, intervention strategies are employed where the effectiveness is not at all clear. It is also, as yet, unclear how emergency MHPSS may contribute to lasting mental health reforms in the post disaster/post conflict phases, and whether the efforts during emergencies actually do lead to an improved mental health care delivery for the population (Allden et al., 2009). MHPSS service providers in complex humanitarian emergencies can learn from experiences elsewhere in the developing world, and, in turn, may provide data that are useful for the emerging global mental health movement.

Mental health, an emerging global priority

Mental health is becoming a global health priority because of the relative high prevalence of mental disorders and the associated disability (Prince et al., 2007). Among the most prevalent mental disorders are: depression, schizophrenia and alcohol or drug abuse disorders (World Health Organization, 2005). While non-communicable diseases, including mental disorders, already pose a substantial global economic burden, this burden is expected to rise more than double in the next two decades. Within this group of noncommunicable disorders, the most important contributors to the global economic burden are mental health conditions and cardiovascular disease (Bloom et al., 2011). In low income countries, the resources for mental health care are very limited, typically less than 1% of an already low health care budget (Saxena et al., 2007). Although there has been a lobby to promote mental health care in the development agenda in low income countries, there are also major challenges about *how* to integrate mental health care into health sector reform plans. Some of these challenges include: engaging mental health professionals in general health sector reforms; strengthening the links between mental health and social development; and intensifying resource mobilisation (Jenkins et al., 2010). One key to improving mental health in communities is to look beyond narrowly defined health care systems. Treatment of mental disorders requires more than just individual therapies for the sufferers. They should also foster the inclusion of mental health interventions into general health systems, thereby strengthening policies (Jenkins et al., 2011), as well as foster integration of mental health aspects in general social policies to improve the wellbeing of the population (Friedli, 2009). A recent consensus seeking exercise among hundreds of researchers, advocates and clinicians, identified the most urgent research priorities

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

for improving the lives of people with mental illness around the world. The five most important areas to be researched are related to: 1) strengthening the mental health component in the training of all health care personnel, 2) integrating screening and core packages of services into routine primary health care, 3) reducing the cost and improving the supply of effective medications, 4) providing effective and affordable community based care and rehabilitation, and 5) improving children's access to evidence based care by trained health providers in low and middle income countries (Collins et al., 2011).

One of the main strategies to improve access of the population to mental health services is to integrate such services within the general health care system, and to avoid stand-alone systems based on specialised psychiatric hospitals. Integrating mental health services into primary health care (PHC) is often considered the most viable way of ensuring that people get the mental health care they need (World Health Organization & Wonca, 2008). Primary health care is defined as the first level of health system contact with the population. It includes various aspects, such as: health promotion, prevention, care for common illnesses, and management of on-going chronic health problems. Primary health services act as the principal point of consultation for patients within a health care system, and depending on the conditions of the system in the area, and the type of structure, it can be carried out by a doctor, nurse, midwife, community health worker, traditional healer, or members of the group or the community. There is no single best practice model for the integration of mental health care into PHC that fits all contexts. In documenting 11 examples of successful integration of mental health care into primary care, only one country, Uganda, was a post conflict or post emergency setting (World Health Organization & Wonca, 2008). Among the basic requirements to make the integration a success are elements such as adapting mental health policies, ensuring that primary care workers are adequately trained, organising appropriate supervision, ensuring that primary care workers are not burdened with unrealistic amounts of tasks, and making specialist mental health care professionals and facilities available to support primary care. One important practical lesson was the need to collaborate with other government non health sectors, nongovernmental organisations (NGOs) and community networks.

The World Health Organization has launched the comprehensive mental health Gap Action Programme (mhGAP) to address this lack of care, especially in low and middle income countries, for people suffering from mental, neurological and substance use disorders. This includes an intervention guide with evidence based mental health interventions for general health workers (World Health Organization, 2010). There is now an urgent need to use these available tools on a larger scale, and to document what we can learn from the process to scale up mental health services in low resource settings (Eaton et al., 2011).

A closer look at mental health interventions in emergencies: what should be done?

There is an important and large gap between the rapidly increasing knowledge base on community mental health care in low and middle income countries, and the mental health and psychosocial work that is actually done in emergencies (Allden et al., 2009). One important challenge in planning

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

mental health services in complex emergencies is how to ensure that the service has immediate, measurable benefits, while at the same time building a model that is-sustainable and ultimately integrated within the broader primary health service (Silove, 2004b). The World Health Organization advocates strengthening pre-existing mental health services. Particularly after the most acute distress has decreased, and the most basic needs have been addressed, efforts should be directed towards establishing a more comprehensive range of community based mental health interventions, ensuring that 1) people with severe mental disorders (e.g. psychosis, severe depression) have access to effective care in the community, 2) mental health care is available within general health settings and 3) links to outside the formal health sector are established and made functional. This last point could include, for example, training and supervising of social workers, teachers, community leaders, and, when feasible, and traditional healers (van Ommeren, Saraceno, & Saxena, 2004).

Many papers published on mental health problems in humanitarian emergencies focus on the prevalence of mental disorders, with a strong emphasis on posttraumatic stress disorder (PTSD) and depression. Reported prevalence figures of depression and PTSD vary widely between surveys of conflict affected populations. While this may be a result of contextual factors, such as the extent of exposure to adversity, they are also strongly affected by methodological differences (Rodin & van Ommeren, 2009). Trauma focused surveys are also often unable to identify the effects of a complex emergency on a population's ability to care for itself (Ager, 2002), or to identify locally used cultural expressions on the lack of wellbeing (Miller, Kulkarni, & Kushner, 2006). Prevalence rates of severe mental disorders, such as psychosis and bipolar disorder, are largely unknown. A rough estimation is that a humanitarian crisis leads to an increase of the prevalence of severe mental disorders from 2–3% to 3–4% in the first 12 months, and for common mental disorders from an estimated 10% at baseline (pre-crisis) to 20% (van Ommeren, Saxena, & Saraceno, 2005). In striking contrast to the impressive amount of scientific papers on prevalence figures in complex emergencies, is the dearth of papers describing the outcome of actual interventions to tackle such problems. The published literature is skewed towards psychological interventions for PTSD. This emphasis on trauma related mental problems is not consistent with the kind of programmes that are usually implemented, and for which there is an urgent need to assess the effectiveness. MHPSS interventions initiated by external actors, such as international NGOs, frequently are not well connected to existing systems of care. A recent survey of 160 reports of actual interventions found that the vast majority of them took place and were funded outside existing systems of care, such as national mental health care systems (Tol et al., 2011). A World Bank report in 2005 identified this lack of systematic documentation of mental health and psychosocial interventions in post emergency and post conflict settings as the major obstacle to more effective and better targeted interventions (Baingana, Bannon, & Thomas, 2005). Others have called for a public discussion on the results of assessments and evaluations of mental health activities in complex humanitarian emergencies, so that lessons can be learnt for future interventions (Mollica et al., 2004).

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

How trying to help can make things worse: the example of Sri Lanka

In the aftermath of some humanitarian emergencies, the influx of organisations and groups providing all kinds of assistance can be quite overwhelming. More to the point, they may also inadvertently undermine existing assistance structures, and discredit local ways of coping with adversity. This has been poignantly described in post tsunami Sri Lanka, where delivering of mental health care and psychosocial support in affected areas was compromised by the massive destruction of infrastructure, and difficulties coordinating responses between many organisations were involved (Ashraf, 2005). A Sri Lankan psychiatrist, Ganesan (2006), saw dozens of experts in mental health and psychosocial support being *'parachuted'* in to the east coast of Sri Lanka to start a multitude of trauma- focussed activities, while there was far less attention given to much more urgent social work projects and programmes to care for those with severe mental disorders such as psychosis. In his chapter *'The wave that brought PTSD to Sri Lanka'*, Watters (2010) provides disconcerting examples of the rather toxic combination of cultural naiveté and the therapeutic arrogance of many of these experts. Humanitarian interventions, such as mental health training of local staff, may amount to the imposition of western concepts of distress and disorder, to populations with different ways of understanding human suffering (Abramowitz, 2010). Moreover, the efforts of outsiders to provide mental health assistance tends to obscure the efforts by local stakeholders (Fernando, Pedersen, & Weerackody, 2010). There is also a risk that NGO programmes take away mental health professionals from the public system. As Ganesan (2011) mentions in this issue, he was the only psychiatrist in the heaviest affected area of Sri Lanka post tsunami, and felt pressured by external agencies and the media to decrease the time he spent treating people with severe mental disorders, and to favour trauma focused interventions of the newly started programmes instead.

How something good may come out of a disaster: the example of Sri Lanka

Fortunately, there are also good examples where mental health interventions in the setting of complex humanitarian emergencies have had long lasting, positive effects on mental health service delivery. Again, Sri Lanka may serve as an example. The financial aid generated as a response to the tsunami boosted the development of community centred, and therefore decentralised, mental health care in Sri Lanka. For example, in the northern town of Jaffna, local organisations and authorities formed a joint Mental Health Task Force in the first months after the disaster, in order to coordinate their activities (van der Veen & Somasundaram, 2006). The ad hoc task force was later transformed into a formal intrasectoral, coordinating body for local governmental and NGOs involved in mental health and psychosocial work, and continued to be a driving force for improving MHPSS services in the area (Krishnakumar, Sivayokan, & Somasundaram, 2008).
Prior to the tsunami, in the north-eastern areas of Sri Lanka, there was a long history of protracted armed conflict. There, local mental health workers had already started innovative mental health services within secondary and primary care. The World Health Organization advised using this model for other districts in Sri Lanka (Saraceno & van Ommeren, 2003). Unfortunately,

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

donors were initially uninterested, that is until the 2004 Asian tsunami. The sudden availability of funds for mental health care prompted the development of a national mental health policy that encouraged decentralisation of service, and that was *de facto* based on the innovative work developed in the conflict affected areas in the north east (Saraceno, 2005). The increased awareness of the importance of mental health care after the tsunami, prompted the establishment of decentralised mental health services integrated into general health care, and led to training of general health workers to provide treatment for people with mental health problems in the tsunami affected areas (Mahoney et al., 2006). Several years after the tsunami, there are still mental health services in seven tsunami affected districts of Sri Lanka, run by the Ministry of Health (WHO, 2008). A map of the diversity and spread of mental health services shows the improvements quite dramatically (*Figure 1*).

The importance of documenting experiences

The brief examples of Sri Lanka above may serve to highlight the importance of describing the process of how interventions in these settings, often starting with a relief perspective, can lead to more fundamental changes in mental health service delivery. Perhaps there are many experiences of mental health care being integrated into existing systems of care during humanitarian emergencies, but to our knowledge, they are rarely documented. Edited volumes on mental health in post war and post conflict settings pay limited attention to aspects related to the integration of mental health care into existing systems, and focus instead on the development of NGO based services. Or they describe the immediate mental health response without taking a longer term perspective, while in turn, books on mental health care development in resource poor settings often do not address the specific context of humanitarian emergencies.

There are many reports of successful mental health training of general health workers in humanitarian settings (Budosan, 2011; Budosan et al., 2007; Henderson et al., 2006; Mohit et al., 1999; Sadik et al., 2011; Ventevogel & Kortmann, 2004). These articles usually describe how it was feasible to install basic mental health care skills in general health workers. However, we are left with the question of what happened after? Some articles describe how attempts to start primary mental health services within primary care proved feasible within the project period, showing clear increases of numbers of patients receiving treatment (Budosan & Jones, 2009; Jones et al., 2007a; Jones et al., 2009; Somasundaram et al., 1999; Souza, Yasuda, & Cristofani, 2009). Yet, most of these publications focus on direct output (building mental health skills in staff, increasing the number of patients in treatment) with less attention to a systematic description of *how* these interventions could contribute to long lasting changes in public mental health services delivery. It is rare to find published documentation on how mental health projects, that started in the aftermath of a humanitarian emergency, moved from a project with an initial focus on relieving immediate suffering to long term programmes to strengthen mental health care services. There are exceptions. In the 1980s in Guinea-Bissau, then recovering from an 18 year long war of independence, a community mental health programme was set

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

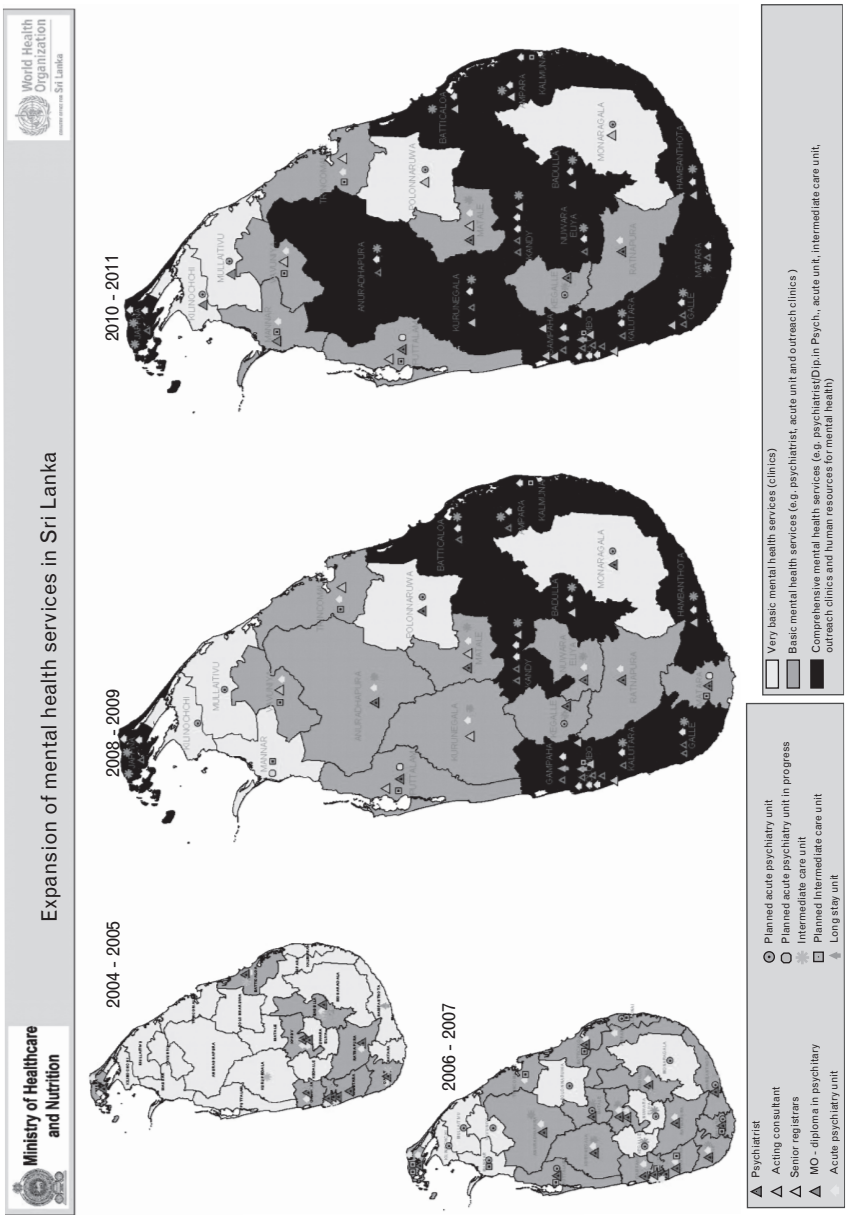

Figure 1: Map of Sri Lanka showing the development of mental health services, 2004– 2011. (Source: Ministry of Health & Nutrition andWorld Health Organization Sri Lanka.)

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

up to train primary health care workers in mental health, and the evolution of this programme was described for a period covering more than a decade (de Jong, 1996). In Timor Leste, overwhelmed by the effects of mass violence, displacement and destruction of infrastructure after its violent cessation from Indonesia in 1999, a mental health care programme with a strong community oriented outlook was described for a period covering more than a decade (Silove et al., 2011). In Afghanistan, after the fall of the Taliban in 2001, NGO led mental health projects started with the aim of integrating mental health into existing governmental health care services. Several NGOs and the WHO contributed to curriculum development and advocacy for the inclusion of mental health into the Basic Package of Health Services (Ventevogel, Faiz & van Mierlo, 2011).

There are however many more complex humanitarian emergencies in which governments, local organisations and international NGO design and implement mental health programmes. Unfortunately, little is known about these experiences. For example, in Aceh, the emergency programme by an international NGO after the 2004 tsunami (Jones et al., 2007) was later taken over by another international NGO with a strong focus on development. The health authorities made annual budgetary allocation to continue the primary health centre based community mental health services, but this experience has not yet been documented (A. Mohanraj, personal communication). Much of the experience of organisations that actually make the transition from emergency relief to the adoption and promotion of structural changes in service delivery for people with mental disorders, remain undocumented to this day.

Emergencies: risks and opportunities for strengthening existing mental health care systems

Complex humanitarian emergencies create both enormous challenges and opportunities for structural improvement of mental health services. A discursive reading of the published literature led us to identify the following opportunities and challenges for the development of sustainable mental health services, during and after complex humanitarian emergencies:

Risks

1. *Creating parallel systems*
   The breakdown of often already weak and inefficient public services often prompts aid organisations to start services by themselves. While there may not always be an alternative, the risk is that unsustainable programmes are created, with the result that instead of supporting the public system, it may undermine it. Interventions may focus on one particular type of '*mental disorder*', while ignoring that the spectrum of mental health problems in complex emergencies is much broader (Summerfield, 1999). If separate services are started, it is often challenging NGOs to make the transition towards integrated, horizontal programming (de Jong, 2007).
2. *Interventions by outsiders may ignore what people do themselves*
   Humanitarian interventions may silence, or marginalise, local perspectives and local views (Abramowitz & Kleinman, 2008). The acceptable, or dominant form of healing communities after mass upheaval, is expected to come from humanitarian aid and this tends to obscure the *healing the social wounds of war.*

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

In other words, how communities themselves mobilise their own social, and other resources, in order to recover in their own time and in their own way (Last, 2000).

3. *Medicalising non pathological distress and social problems*
   The World Health Organization warns of the risk of misapplication of the medical model by general health workers with basic training in mental health care (van Ommeren et al., 2004). This has been documented as a real problem in complex humanitarian emergencies, such as Afghanistan (Ventevogel, Faiz, & van Mierlo, 2011).
4. *Overburdening general health workers with skills and knowledge they cannot use*
   General health workers in overloaded health care facilities have limited time for each encounter, and often do not have the time to go deeper into the presented complaints and therefore miss mental health disorders that present as physical problems (Afana et al., 2002).
5. *Providing insufficient supervision and follow up training*
   Systematic supervision and training, preferably attached to existing institutions, is an essential ingredient of capacity building, but may also be given limited attention in practice (Silove, 2004a).

Many of these risks are not specific to the situation of complex humanitarian emergencies, but may become more pronounced and urgent in such emergencies. Similarly, the unusual context of complex humanitarian emergencies can also provide opportunities that, again, may not be specific for these contexts, but may be more pronounced.

Opportunities

1. *Increased funding opportunities*
   Some complex humanitarian emergencies, particularly those involving acute natural disasters such as earthquakes or tsunamis, may generate many millions of dollars in emergency relief. This is usually distributed by multilateral agencies and foreign governments, and translated into short term projects by international NGOs. The unprecedented amount of funding, in an otherwise disadvantaged or marginalised region, can provide opportunities to start new initiatives that boost mental health care.
2. *Possibilities to involve different categories of health workers in mental health activities*
   The massive needs arising in emergencies may lead health authorities to accept piloting new initiatives for mental health care provision, including the training of general health workers, the use of paramedical staff and working closely with communities. Mental health care should be linked with other sectors, outside the health care system in order to become effective on a community level (World Health Organization, 2003). Perhaps the most powerful interventions to improve the mental health status of people in impoverished circumstances are outside the formal health sector. Interventions dealing with mental health can play an important role in effective post conflict reconciliation and reconstruction (Baingana, Bannon, & Thomas, 2005). The influx of organisations with community focused orientations may make help to improve such inter-sectoral links.
3. *Including mental health care in health sector reforms*
   Mental health care should not be isolated from other parts of health care.

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

It needs to be linked with other, more general approaches to strengthen the health care sector, including aspects such as general health sector reform and results based financing. Emergencies often lead to health sector reforms, and in several post conflict settings, such as Afghanistan, Somalia and Liberia, this has led to the incorporation of mental health into minimum packages of care (Ventevogel et al., 2002). Health policy makers are also more likely to accept and implement mental health care reforms (Munir et al., 2004; Pandu Setiawan & Viora, 2006)

This *Special Issue* of *Intervention* documents a variety of examples from mental health programmes in the aftermath of natural disasters and armed conflict. Some of the main lessons learned are described in the closing article of this issue (Pérez-Sales et al., 2011). We hope it will contribute to building an evidence base for integrating mental health care into existing systems of health care, in complex humanitarian emergencies.

Acknowledgements

The authors would like to thank Julian Eaton, Ananda Galappatti, Andrew Mohanraj and Mark van Ommeren for their comments on earlier versions of this paper.

References

Abramowitz, S. & Kleinman, A. (2008). Humanitarian intervention and cultural translation: a review of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. *Intervention, 6*(3/4), 219-227.

Abramowitz, S. A. (2010). Trauma and humanitarian translation in Liberia: the tale of open mole. *Culture, Medicine & Psychiatry, 34*, 353-379.

Afana, AH., Dalgard, OS., Bjertness, E. & Grunfeld, B. (2002). The ability of general practitioners to detect mental disorders among primary care patients in a stressful environment: Gaza Strip. *Journal of Public Health Medicine, 24*(4), 326-331.

Ager, A. (2002). Psychosocial needs in complex emergencies. *Lancet, 360*(Suppl), s43-s44.

Ager, A., Strang, A. & Wessells, M. (2006). Integrating psychosocial issues in humanitarian and development assistance: A response to Williamson and Robinson. *Intervention, 4*, 29-31.

Allden, K., Jones, L., Weissbecker, I., Wessells, M., Bolton, P., Betancourt, TS. & Sumathipala, A. (2009). Mental health and psychosocial support in crisis and conflict: report of the mental health working group. *Prehospital & Disaster Medicine, 24*(Suppl 2), s217-s227.

Ashraf, H. (2005). Tsunami wreaks mental health havoc. *Bulletin World Health Organization, 83*(6), 405-406.

Baingana, F., Bannon, I. & Thomas, R. (2005). *Mental health and conflicts. Conceptual Framework and Approaches.* Washington, DC: World Bank.

Bloom, DE., Cafiero, ET., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, LR., Fathima, S. & Weinstein, C. (2011). *The Global Economic Burden of Non-communicable Diseases.* Geneva: World Economic Forum.

Budosan, B. (2011). Mental health training of primary health care workers: case reports from Sri Lanka, Pakistan and Jordan. *Intervention, 9*(2), 125-136.

Budosan, B., & Jones, L. (2009). Evaluation of effectiveness of mental health training

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

program for primary health care staff in Hambantota District, Sri Lanka post-tsunami. *Journal of Humanitarian Assistance* (May 2009). Retrieved from http://sites.tufts.edu/jha/archives/509

Budosan, B., Jones, L., Wickramasinghe, W. A. L., Farook, A. L., Edirisooriya, V., Abeywardena, G., & Nowfel, M. J. (2007). *After the Wave: A Pilot Project to Develop Mental Health Services in Ampara District, Sri Lanka Post-Tsunami.* (September 2007). Retrieved from http://sites.tufts.edu/jha/archives/53

Collins, P. Y., Patel, V., Joestl, S. S., March, D., Insel, T. R. & Daar, A. S. (2011). Grand challenges in global mental health. *Nature, 475*, 27-30.

de Jong, J. (2007). Nongovernmental organizations and the role of the mental health professional. In R. J. Ursano, C. S. Fullerton, L. Weisaeth & B. Raphael (Eds.), *Textbook of Disaster Psychiatry* (pp. 206–224). Cambridge: Cambridge University Press.

de Jong, J. (Ed.). (2002). *Trauma, war, and violence: Public mental health in socio-cultural context.* New York, NY: Kluwer Academic /Plenum.

de Jong, JT (1996). A comprehensive public mental health programme in Guinea-Bissau: a useful model for African, Asian and Latin-American countries. *Psychological Medicine, 26*(1), 97-108.

Eaton, J., McCay, L., Semrau, M., Chatterjee, S., Baingana, F., Araya, R. & Saxena, S. (2011). Scale up of services for mental health in low-income and middle-income countries. *Lancet, in press.*

Fernando, S., Pedersen, D., & Weerackody, C. (2010). Mental health in Sri Lanka. *Lancet*, 376 (9735), 89.

Friedli, L. (2009). *Mental health, resilience and inequalities.* Copenhagen: World Health Organization, Regional Office for Europe.

Galappatti, A. (2003). What is a Psychosocial Intervention? Mapping the Field in Sri Lanka. *Intervention, 1* (2), 3-17.

Ganesan, M. (2006). Psychosocial response to disasters–some concerns. *International Review of Psychiatry, 18*(3), 241-247.

Ganesan, M. (2011). Building up mental health services from scratch: experiences from East Sri Lanka. *Intervention, 9*(3), This issue.

Gunn, S. W. A. (2003). The language of disasters: a brief terminology of disaster management and humanitarian action. In K. M. Cahill (Ed.), *Basics of International humanitarian missions* (pp. 35–46). New York: Fordham University Press and Centre for International Health and Cooperation.

Henderson, DC., Mollica, R.F., Tor, S., Lavelle, J., Culhane, MA. & Hayden, D. (2006). Building Primary Care Practitioners' Attitudes and Confidence in Mental Health Skills in a Post-Conflict Society: A Cambodian Example. *Journal of Nervous and Mental Disease, 193*, 551-559.

IASC. (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: Inter-Agency Standing Committee.

Jenkins, R., Baingana, F., Ahmad, R., McDaid, D. & Atun, R. (2011). How can mental health be integrated into health system strengthening? [Editorial]. *Mental Health in Family Medicine, 8*, 115-117.

Jenkins, R., Baingana, F., Belkin, G., Borowitz, M., Daly, A., Francis, P. & Sadiq, S. (2010).

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

Mental health and the development agenda in Sub-Saharan Africa. *Psychiatric Services, 61*(3), 229-234.

Jones, L., Asare, J., Elmasri, M. & Mohanraj, A. (2007a). Mental health in disaster settings. [Editorial]. *BMJ, 335*(7622), 679-680.

Jones, L., Asare, J. B., El Masri, M., Mohanraj, A., Sherief, H. & van Ommeren, M. (2009). Severe mental disorders in complex emergencies. *Lancet, 374*(9690), 654-661.

Jones, L. M., Ghani, H. A., Mohanraj, A., Morrison, S., Smith, P., Stube, D., & Asare, J. (2007). Crisis into opportunity: setting up community mental health services in post-tsunami Aceh. *Asia-Pacific Journal of Public Health, 19 Spec No*, 60-68.

Krishnakumar, G., Sivayokan, S. & Somasundaram, D. (2008). Coordination of psychosocial activities at the Jaffna District level in Sri Lanka. *Intervention, 6*(3–4), 270-274.

Last, M. (2000). Healing the social wounds of war. Medicine. *Conflict & Survival, 16*, 370-382.

Leaning, J., Briggs, S. M., & Chen, L. C. (Eds.). (1999). *Humanitarian Crises: The Medical and Public Health Response*. Boston: Harvard University Press.

Mahoney, J., Chandra, V., Gambheera, H., De Silva, T. & Suveendran, T. (2006). Responding to the mental health and psychosocial needs of the people of Sri Lanka in disasters. *International Review of Psychiatry, 18*, 593-597.

Miller, K.E., Kulkarni, M. & Kushner, H. (2006). Beyond Trauma-Focused Psychiatric Epidemiology: bridging research and practice with war-affected populations. *American Journal of Orthopsychiatry, 76*(4), 409-422.

Mohit, A., Saeed, K., Shahmohammadi, D., Bolhari, J., Bina, M., Gater, R. & Mubbashar, M. (1999). Mental health manpower development in Afghanistan: a report on a training course for primary health care physicians. *Eastern Mediterraen Health Journal, 5*(2), 373-377.

Mollica, R.F., Cardozo, BL., Osofsky, HJ., Raphael, B., Ager, A. & Salama, P. (2004). Mental health in complex emergencies. *Lancet, 365*(9462), 842-843.

Munir, K., Ergene, T., Tunaligil, V. & Erol, N. (2004). A window of opportunity for the transformation of national mental health policy in Turkey following two major earthquakes. *Harvard Review of Psychiatry, 12*(4), 238/251.

Pandu Setiawan, G. & Viora, E. (2006). Disaster mental health preparedness plan in Indonesia. *International Review of Psychiatry, 18*(6), 563-566.

Pérez-Sales, P. (2004). Mental health in disasters: the psychosocial approach. In T. Baubet, K. Le Rouch, D. Bitar & M. Moro (Eds.), *Soigner malgré tout. Trauma, cultures et soins* Paris: Pensée Sauvage.

Pérez-Sales, P., Férnandez-Liria, A., Baingana, F., & Ventevogel, P. (2011). Integrating mental health into existing systems of care during and after complex humanitarian emergencies: Rethinking the experience. *Intervention, 9*, this issue.

Prince, M., Patel, V., Saxena, S., Maj, M., Maselko, J., Phillips, MR. & Rahman, A. (2007). No health without mental health. *Lancet, 370*(9590), 859-877.

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

Rodin, D. & van Ommeren, M. (2009). Commentary: explaining enormous variations in rates of disorder in trauma-focused psychiatric epidemiology after major emergencies. *International Journal of Epidemiology, 38*(4), 1045-1048.

Ryscavage, R. (2003). The transition from conflict to peace. In K. M. Cahill (Ed.), *Emergency relief operations* (pp. 284–294). New York: Fordham University Press /Center for International Health and Cooperation.

Sadik, S., Abdulrahman, S., Bradley, M. & Jenkins, R. (2011). Integrating mental health into primary health care in Iraq. *Mental Health in Family Medicine, 8*, 39-49.

Salama, P., Spiegel, P., Talley, L. & Waldman, R. (2004). Lessons learned from complex emergencies over past decade. *Lancet, 364*(9447), 1801-1813.

Saraceno, B. & van Ommeren, M. (2003). *Five year mental health plan for northeast Sri Lanka*. Geneva, World Health Organization, Department of Mental Health and Substance Dependence (Unpublished report).

Saraceno, B. (2005). The WHO's mental health response to the Asian tsunami. *World Psychiatry, 4*(2), 66-67.

Saxena, S., Thornicroft, G., Knapp, M. & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet, 370*, 878-889.

Silove, D. (2004a). The challenges facing mental health programs for post-conflict and refugee communities. *Prehospital & Disaster Medicine, 19*(1), 90-96.

Silove, D. (2004b). Considerations in Planning Mental Health Services in Conflict-Affected Countries in the Developing World In R. F. Mollica, R. Guerra, R. Bhasin & J. Lavelle (Eds.), *Book of best practices.Trauma and the role of mental health in post-conflict recover.* (pp. 124–152). Retrieved from http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172610662358/Proj1Billion.pdf.

Silove, D., Rees, S., Tam, N., Liddell, B. & Zwi, A. (2011). Staff management and capacity building under conditions of insecurity: lessons from developing mental health service and research programs in post-conflict Timor-Leste. *Australasian Psychiatry, 19*(Suppl 1), S90-S94.

Somasundaram, DJ., van de Put, WA., Eisenbruch, M. & de Jong, JT. (1999). Starting mental health services in Cambodia. *Social Science & Medicine, 48*(8), 1029-1046.

Souza, R., Yasuda, S. & Cristofani, S. (2009). Mental health treatment outcomes in a humanitarian emergency: a pilot model for the integration of mental health into primary care in Habilla, Darfur. *International Journal of Mental Health Systems, 3*(1), 17.

Summerfield, D. (1999). A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Science & Medicine, 48*(10), 1449-1462.

The Sphere Project. (2011). *Humanitarian Charter and Minimum Standards in Disaster Response - 2011 Edition*. Geneva, Switzerland: The Sphere Project.

Tol, W. A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T. S., Souza, R., van Ommeren, M. (2011). Mental health and psychosocial support in humanitarian settings: linking practice and research. *Lancet, 378*, in press.

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

van der Veen, M. & Somasundaram, D. (2006). Responding to the psychosocial impact of the Tsunami in a war zone: Experiences from northern Sri Lanka. *Intervention, 4*, 53-57.

van Ommeren, M., Morris, J. & Saxena, S. (2006). Integrated programme planning and psychosocial concepts in humanitarian response: A response to Williamson and Robinson. *Intervention, 4*, 26-28.

van Ommeren, M., Saraceno, B., & Saxena, S. (2004). Role of the World Health Organisation in Mental Health Post-Conflict Recovery: Assisting Governments to Develop or Reconstruct Mental Health Services In R. F. Mollica, R. Guerra, R. Bhasin & J. Lavelle (Eds.), *Book of best practices. Trauma and the role of mental health in post-conflict recovery.* (pp. 199–215). Retrieved from http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172610662358/Proj1Billion.pdf.

van Ommeren, M., Saxena, S. & Saraceno, B. (2005). Aid after disasters. [Editorial]. *BMJ, 330*(7501), 1160-1161.

Ventevogel, P., Azimi, S., Jalal, S. & Kortmann, F. (2002). Mental health care reform in Afghanistan. *Journal of Ayub Medical College, 14*(4), 1-3.

Ventevogel, P., Faiz, H., & van Mierlo, B. (2011). Mental health in basic health care: experiences from Nangarhar Province.. In J. F. Trani (Ed.), *Development efforts in Afghanistan: Is there a will and a way? The case of disability and vulnerability.* (pp. 215–241). Paris: l'Harmattan.

Ventevogel, P. & Kortmann, F. (2004). Developing basic mental health modules for health care workers in Afghanistan. *Intervention, 2*, 43-54.

Watters, E. (2010). *Crazy like us. The globalization of the American psyche.* New York: Free Press.

Wessells, M. & van Ommeren, M. (2008). Developing inter-agency guidelines on mental health and psychosocial support in emergency settings. *Intervention, 6*(3–4), 199-218.

Williamson, J. & Robinson, M. (2006). Psychosocial interventions, or integrated programming for well-being? *Intervention, 4*, 4-25.

World Health Organization (2003). *Mental health in emergencies. Mental and social aspects of health of populations exposed to extreme stressors.* Geneva, World Health Organization.

World Health Organization (2005). *Mental Health Atlas - Revised Edition.* Geneva: World Health Organization.

World Health Organization (2008). *Kalmunai: A model on Mental Health Services Delivery* Retrieved September 24th 2011, from http://www.whosrilanka.org/LinkFiles/WHO_Sri_Lanka_Kalmunai_feature_story.pdf

World Health Organization (2010). *mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings.* Geneva, Switzerland: WHO.

World Health Organization & Wonca (2008). *Integrating mental health into primary care: a global perspective.* Geneva /London: World Health Organization and World Organization of Family Doctors (Wonca).

Zwi, A. & Ugalde, A. (1991). Political violence in the Third World: a public health issue. *Health Policy & Planning, 6*(3), 203-217.

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.

Peter Ventevogel is a psychiatrist and cultural anthropologist. He works with the international NGO HealthNet TPO as mental health advisor, with the international NGO War Trauma Foundation as the editor in chief of Intervention, and with Arq, the Dutch psychotrauma expert group, as a clinical psychiatrist. email: peter@peterventevogel.com

Pau Pérez-Sales is a psychiatrist at Hosputal La Paz (Madrid), psychosocial and mental health advidor for Médicos del Mundo – España (Doctors of the World–Spain) and initiator of of the Community Action Group (www.psicosocial.net). He has worked extensively with grassroot community organizations in context of war or political violence. email: pauperez@arrakis.esAlberto

Fernández-Liria is a psychiatrist. He works as chief of the Department of Psychiatry in University Hospital Príncipe de Asturias, Spain and is an associate professor at the University of Alcalá Alcalá de Henares, Madrid (Spain).

Florence Baingana is a psychiatrist and a public health specialist presently working as a Wellcome Trust Research Fellow with Personal Social Services Research Unit, London School of Economics and Political Science, London UK, and Makerere University School of Public Health, Kampala, Uganda.

Copyright © War Trauma Foundation. Unauthorized reproduction of this article is prohibited.