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

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This concluding paper of the Intervention Special Issue on integrating mental health care into health systems during and after complex emergencies summarises the main findings and conclusions of each of the programmes presented. This paper further integrates these findings into a common framework in order to extract key factors and recommendations on actions that can be taken, and those to avoid, to enable humanitarian emergencies to be transformed into opportunities in the psychosocial field. The main guiding principle to create such opportunities appears to require taking the post emergency context into consideration, from the first moments of any intervention. It is important that interventions in emergencies are conceptualised as part of the continuum of rehabilitation, construction and reconstruction. As a result, unique opportunities to rethink existing models and to introduce changes and new developments in the provision of mental health care and psychosocial support are created.

Keywords: complex humanitarian emergencies, lessons learned, mental health care in general health care

In the introduction paper of this issue, emergencies and disasters were defined as isolated or repeated situations that overwhelm the response capacity of a group or a community. Furthermore, they cause major disruption and disintegration of the social fabric by preventing the affected population from functioning normally (Pérez-Sales, 2004). In the aftermath of an emergency, the need to rebuild offers unique opportunities for change: new leaderships may emerge, unconventional approaches may become a necessity and there might be a questioning of the status quo by parts of the society. Rebuilding from a disaster can also create a new way of thinking and an opportunity to redefine how the general and public services have been working. Additionally, there may be an influx of local and foreign qualified professionals, that also bring a new availability of aid funds. This combination of factors can turn a disaster into a unique opportunity for change that can truly stop the downward spiral of vulnerability associated with certain groups and communities (Anderson & Woodrow, 1998; Ventevogel, Pérez-Sales, Férnandez-Liria, & Baingana, 2011).

In order to realise these potential benefits, it is important that mental health programmes in complex humanitarian emergencies have, from their onset, a clear focus on medium and long term development of community

based, primary mental health care services and social interventions. This is in contrast to the traditional focus on provision of immediate, short term relief of psychological distress during the acute phase of an emergency. This is also a key point in the brief published by the World Health Organization on mental health (MH) in emergencies (WHO, 2003). The same is true for other key points in this document: 1) The need for consultation and collaboration between governmental and nongovernmental organizations (NGOs) working in the area; 2) Continuous involvement, preferably of the government or local organisations is essential to ensure sustainability; 3) Encourage integration of mental health interventions in general primary health care (PHC); 4) Ensure access to services for all and avoid setting up separate, vertical mental health services for special population; 5) Make training and supervision a continuous process, by mental health specialists with sufficient clinical on-the-job training and thorough supervision and support of PHC-workers; and 6) start monitoring from the start of the activity.

This long term view implies a priority to initially develop a situation analysis of the existing (mental/psychosocial) health services in the area of the emergency. Such analysis needs to be sufficiently broad, and to include an exploration of how people cope, and what resources (not only material, but existing public services, community based organisations, religious institutions, traditional healers and other social institutions) are being used. This may assist the interventions in the first phase of the response to articulate a joint response, but will also help in laying the groundwork for a participatory process of reflection among local stakeholders about how the emergency can also be an opportunity for change.

Major international policy documents on MH in emergency settings by the Inter-Agency Standing Committee (IASC-RG., 2010; IASC, 2007), The Sphere Project (2004) and the World Health Organization (WHO & Wonca, 2008) advocate for the integration of mental health services within general health care services. Primary health care is defined as the first level of contact of the population with the health care system, carrying out tasks of health promotion, illness prevention, care for common illnesses, and management of ongoing health problems. Primary health care (PHC) services are usually the principal point of consultation for patients within a health care system, and depending on country conditions and the type of structure, can be carried out by a doctor, nurse, midwife, health worker, traditional healer, even members of the group or the community (WHO, 2005). In settings of complex humanitarian emergencies, a public health approach will often seek to transform the existing health system; aiming for increased access to services and social health protection, mitigation of the health effects of war (including social and environmental hazards), and increased and institutionalised participation of civil society in policy dialogue and accountability mechanisms. In displacement settings, it is often aimed at providing access to same level of care as the host population. There is a need for a global framework that requires reforms, in order to ensure that health care systems contribute to health equity and social justice. General hospital based MH services or community mental health centres are in an excellent position to provide the leadership, training and supervision that are essential for the successful integration of MH into PHC. However, these recommendations are not the reality in most countries.

According to the Mental Health Atlas, around 62% of countries in the world have mental health policies, 70% have some form of national mental health programme, 76% of low income countries provide some support of mental health in PHC, 55% have some treatment facilities for severe mental disorders in primary care, and 62% have some kind of community care facilities for mental health problems (WHO, 2005). It must be taken into account that simply having a policy plan, or a facility, does not automatically mean funding is available or that implementation occurs. Treatment in low income countries is often concentrated in a small number of places in the country, usually connected to, or around, large psychiatric hospitals. As a result, the vast majority of populations, living in low and middle income countries, do not have regular access to mental health care (WHO, 2005). International nongovernmental organizations (INGOs) and local NGOs operating in emergencies cannot ignore this reality, and should not pretend that their immediate relief efforts are aimed at restoring a '*normal*', pre-disaster situation.

There are some preliminary studies on the effectiveness of primary care mental health services in low income countries (Cohen et al., 2011) and in the decade that passed since these studies, more research has been done (Petersen, Lund, & Stein, 2011) and intervention packages for the treatment of mental, neurological and substance use disorders have been developed (Patel & Thornicroft, 2009). There have also been a number of important experiences of integrating MH in PHC during emergencies. Many of them have not been documented. There is an urgent need to document and evaluate what service models can deliver effective treatments and care, in a systemic fashion. This *Intervention Special Issue* aims to take the first few steps to answer this need.

The widely diverging contexts in which humanitarian emergencies take place make it difficult to find common strategies, and to draw lessons learned that will be valid for all contexts. However, the experiences included in this issue refer to different situations that do have a common fact: that the community itself cannot cope and the resources to provide psychosocial support or mental health care to the population have become insufficient. Examples examined here include: the occurrence of natural disasters (such as in Sri Lanka, Peru or Haiti), the effects of chronic armed conflict on health care systems (such as in Uganda, Burundi, Peru, the occupied Palestinian territory or Lebanon), the influx of hundreds of thousands of refugees (such as in Syria and Lebanon) or a military rule and extreme inequality that hinders development (such as in Equatorial Guinea). The state of the existing mental health care system in these countries, described in this issue, is variable, as are the levels of human resources. For example some African countries, such as Equatorial Guinea, do not have a local psychiatrist, or very few in cases such as in Burundi with one psychiatrist for eight million people. In contrast, Lebanon (in the Middle East), has a much more developed mental health work force with one psychiatrist for 50,000 people. The functioning of general health services in which the mental health component needs to be integrated is also variable. There are countries in which the network of primary health care centres is very poorly developed (such as in Equatorial Guinea, Haiti or Burundi), and others where there is a reasonably functioning system for primary health care (such as in Uganda or the occupied Palestinian territory). Some projects occur

in countries with policies or mental health plans in different stages of development, and in others, without any pre-existing policies or plans. There are countries where there is an administrative system, such as a Ministry of Health, actively engaged as a partner with NGOs (Uganda), while in other countries the commitment of the government is much less strong (Burundi, Haiti). There are countries that have seen a huge influx of INGOs (Sri Lanka, Haiti, and the occupied Palestinian territory), while in other settings (Peru and Equatorial Guinea) there is far less support from the international community. In some settings coordinated plans of action have been developed between national and international actors (occupied Palestinian territory, Iraq, and Sri Lanka), while in others this is not the case (Equatorial Guinea and Burundi), or it has proven to be very difficult to coordinate (Haiti).

The first and second author (PPS and AFL) of this paper independently read the manuscripts contained here, and compiled a list of main components and key actions. They then collated their lists and compiled a draft list that was sent to the corresponding authors of all papers, with request to make corrections. The revised list was then verified by the last author (PV). The main components of each of the nine programmes in the eight countries described are summarised in Table 1. The two field reports in this issue (Ganesan, 2011; Jones, 2011) do not contain systematic descriptions of projects but reflect personal experiences of practitioners. These, and the mental health policy analysis of Iraq (Sharma & Piachaud, 2011), are not included in Table 1.

Beyond the differences, the experiences documented in this *Intervention Special Issue* have significant similarities. Although most articles do not report on outcome measures, they do contain useful observations and lessons learned that allow an outline of some of the key components to create a successful programme for MH in general health care in complex humanitarian emergency settings.

The **general components and key actions** that can be found in one or more of the programmes examined, and which are associated with success by the authors, are described briefly below.

Coordination and collaboration

- It is important to establish a coordination group for mental health and psychosocial support (Sri Lanka, Lebanon and occupied Palestinian territories).

Assessment

- Interventions must be based on proper assessment of local needs. It is important to ensure participation of the local communities in participatory needs assessments to identify the main problems, how they have coped with these problems in the past, and how project intervention may help them to cope better with these problems in the future (Peru, Burundi).
- In the assessment, various kinds of stakeholders should participate to ensure that different perspectives are taken into account. This includes the participation of local authorities, the affected communities, future service users (people with mental disorders) and especially local health personnel (Syria, occupied Palestinian territory, Lebanon, Peru).
- Where there are no valid epidemiological data, conducting studies to determine the overall situation, and living conditions of special targeted groups, and provide rough estimates of prevalence. For example, people with severe mental disorder, people affected by political

Table 1. Summary of main components of each of the programmes

Aspects addressed by the intervention	Syria (Quosh, 2011)	Lebanon (Hijazi, Weissbecker & Chammay, 2011)	occupied Palestinian territory (de Val D'Espaux et al., 2011)	Equatorial Guinea (Morón-Nozaleda et al., 2011)	Haiti-1 (Budosan & Bruno, 2011)	Haiti-2 (Rose et al., 2011)	Uganda (Baingana & Onyango Mangen, 2011)	Burundi (Ventevogel, Ndayisaba, van de Put, 2011)	Peru (Kohan et al., 2011)
	INGO	UN	INGO	INGO	INGO	INGO	Local NGO	INGO	INGO
Event that triggered the emergency situation	Refugee crisis	Refugee crisis	Ongoing occupation	Military Rule	Earthquake	Earthquake	Post conflict	Post conflict	Earthquake
Project duration (years)	4/On going	5/On Going	5/Finished	1/On Going	2/On Going	2/On Going	3/Finished	8/Follow Up	4/On Going
Involvement in national MH policy development	Not initially Being done	Being done	✓	✓	Intended	✓	✓	✓	✓
Establishment of MHPSS Coordination Group	✓	✓	Sub-cluster	✓	Sub-cluster	Sub-cluster			
Level of government involvement and commitment	High	Medium	High	High	Low	Medium	High	Low	High
Participatory Assessment	✓		✓	✓	✓		✓	✓	✓
Advocacy for MH/PHC Policy Plans	Being done	Being done	✓	Being done	Being done	✓	✓	✓	✓
Training of local human resources	✓	✓	✓	✓	✓	✓	✓	✓	✓
Training of trainers	✓							✓	
Learning through practice/on the job	✓		✓			✓	✓	✓	Planned
Network of volunteers	✓			✓			✓	✓	
Strengthening community systems	✓						✓	✓	Planned
Support for community mental health centre			✓						✓
Establish referral systems		✓	✓	Planned	Intended	Intended	Intended	Intended	✓

(*continued overleaf*)

Table 1. (Continued)

Aspects addressed by the intervention	Syria (Quosh, 2011)	Lebanon (Hijazi, Weissbecker & Chammay, 2011)	occupied Palestinian territory (de Val D'Espaux et al., 2011)	Equatorial Guinea (Morón-Nozaleda et al., 2011)	Haiti-1 (Budosan & Bruno, 2011)	Haiti-2 (Rose et al., 2011)	Uganda (Baingana & Onyango Mangen, 2011)	Burundi (Ventevogel, Ndayisaba, van de Put, 2011)	Peru (Kohan et al., 2011)
Adaptation of Health Information System			✓	Planned			Intended	✓	✓
Support to secondary/ tertiary mental health care			✓	Planned		✓	✓	✓	✓
Case detection in community				✓		✓	✓	✓	✓
Case management	✓	Planned		Planned				✓	✓
Monitoring and research								✓	✓
Providing access to psychotropic medication (or advocacy for it)		✓	✓	Planned		Planned	✓	✓	✓
De-institutionalisation			✓						✓
Agreements for handover to local authorities		✓	✓			Intended	Intended	Intended	✓
Stigma reducing activities	✓		✓	✓			✓	✓	
Collaboration with traditional/ religious healers				intended					
Output	Increased knowledge	Increased knowledge	Improved functioning health staff		Increased knowledge		Improved functioning health staff		Improved functioning health staff
Impact (according to authors)	Not assessed	Not assessed	High	Too early	Low	Low	Mixed results	Mixed results	Too early

MH = Mental health, MHPSS = mental health and psychosocial support, PHC = primary health care. INGO = International NGO, UN = United Nations Agency.

violence (Peru), and suicide in the community.
- It is important not only to identify the problems that should be tackled by the programme, but also discuss indicators of success with the community.

Programme design

- Programmes need to be designed with an *human rights perspective* (occupied Palestinian territory, Peru, Syria) and give specific attention to survivors of political violence (occupied Palestinian territory, Peru), and people displaced by violence and armed conflict (Lebanon, Iraq, Syria).
- In project design it is recommend using international consensus standards and guidelines, such as the *Sphere Handbook* (Sphere Project, 2004) and documents produced by the IASC taskforce and reference group for *Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007, IASC RG, 2010) to guide project activities (Haiti, Lebanon, Syria, Peru), but it is also important to build on local agreements and locally produced materials (Uganda, Lebanon, Syria, Peru, Burundi) that take cultural and religious aspects into account.
- It is important to have, *from the beginning*, a strategy for the *transfer* of responsibility to local stakeholders (occupied Palestinian territory, Peru, Equatorial Guinea, Uganda). It is also important to have specific agreements with the authorities about this transfer, although this is not always a guarantee that the handover will be successful (Burundi).
- MH interventions should be linked to other health and non-health interventions, such as nutrition programmes, livelihood activities, programmes for child wellbeing and protection, empowerment programmes for women, etc. (occupied Palestinian territory, Syria, Burundi).

Structure of service delivery

- MH activities need to be installed on different levels of the health care system. Integration of MH into PHC is an essential element of such a multi-leveled system of MH services, but cannot stand alone. A coordinated network is required to make MH services accessible at the first points of access to the health care system, with ensuring appropriate referral systems between primary and secondary services (Lebanon, Syria, Burundi, occupied Palestinan territory, Uganda). Focusing only on the primary care level can lead trained general health workers to feel isolated, and it may discourage long term commitment.
- Access to health care for the *seriously mentally ill* should be guaranteed (occupied Palestinian territories, Peru, Burundi). This includes access to general (non psychiatric) health care services.
- Creation of community mental health centres, or other similar secondary health care resources, can be very useful. They act either as reference point for clinical attention, (i.e. occupied Palestinian territory) or as a technical point of referral, training and supervision of the network (i.e. Lebanon, occupied Palestinian territory, Peru, Uganda, Sri Lanka).
- It is essential to create or reinforce systems of referral and back referral (i.e. Lebanon, occupied Palestinian territory).
- Decentralisation from large hospitals is important. The World Health Organization recommends the de-institutionalisation of patients from psychiatric hospitals to community services. This often requires

the provision of beds in general hospitals (Lebanon, Peru, Iraq).

- Prescription of psychiatric drugs can be problematic. Some projects described how difficult it proved to change prescribing habits of primary care physicians (Haiti, Lebanon). This requires a strategy to avoid prescribing medication to those who could be feasibly helped with psychosocial interventions, and to ensure that for those with severe mental disorders and epilepsy, a continuous supply of medication is guaranteed (i.e. Lebanon, occupied Palestinian territory, Burundi).
- Proactive strategies of case finding and case management are important to ensure that patients with mental disorders are identified, and encouraged to comply to treatment. Case detection based on community networks is efficient and feasible (Peru, Burundi, Uganda). Case finding can be a problem in places where there are strong prejudices associated with mental health problems. Stigma, lack of knowledge of resources, geographical isolation, poverty and other factors can prevent the most severe patients from looking for care (Peru). Case detection should only be done when access to essential psychopharmacology and other forms of aid is ensured. *It is unethical to create expectations without guaranteeing conditions for treatment.*

Training

- Mental health training of primary health personnel is an essential tool for capacity building (this was described in all projects). It is important to use the principles and methods of adult learning and participatory training. It is important to acknowledge what participants already know, and to build on their experience. Training per se, without a framework and a global plan, creates frustration and discourage people in the short term.
- Processes of training should ideally:
  - Use appropriate methods, including observation of standard practice, to identify training needs (Peru, occupied Palestinian territory, Haiti).
  - Be practice oriented.
  - Be related not only to transfer of knowledge, but also to accepted attitudes and approaches at all levels.
  - Provide training tailored to the recipient (often with different professional backgrounds, and who will work in multi-professional teams) (Syria, Lebanon).
  - Include on the job training and supervision. This is essential to instill clinical skills (Lebanon, Haiti, occupied Palestinian territory, Burundi).
  - Cascade training (training of trainers) can be considered if there is longer term support, monitoring and evaluation provided (Syria, Uganda, Burundi). However cascade training poses important difficulties for assessment, supervision and quality control.
  - Existing training materials such as the *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings* (World Health Organization, 2010) can be used in complex humanitarian emergencies (Haiti), but before that local materials should be made which are tailored to the local context, with attention to culture and idioms of distress (Syria, Lebanon, Haiti, occupied Palestinian territory, Burundi). Such locally produced materials are still valuable.

Working with the community

- Mental health professionals should understand and respect local coping

mechanisms for mental and psychosocial problems, and strengthen initiatives that foster mutual social support and self-help within the community (Haiti, Burundi). Projects can reinforce traditional ways of mutual self-help, but should also be careful not to ignore or undermine traditional systems by trying to introduce new ones with the idea of empowering the community.

- Locally designed psycho-educational materials, and workshops for the general population, are pivotal for success. Such interventions may target mental illness, stigma and discrimination, health habits (alcohol use, domestic violence, intellectual disability, severe mental disorder, epilepsy) and strengthen available resources for people affected with mental health problems (Uganda, Burundi, Equatorial Guinea).
- Collaboration with traditional and religious healers is a contentious issue. It is essential to learn where they are active, and what they do, and where appropriate to explore options of collaboration (Equatorial Guinea).
- Community and grassroots organisations should be seen as existing resources for collaboration (Burundi, Sri Lanka). Working with local authorities, natural or spontaneous leaders, community health workers, and psychosocial workers can be all be important to the sharing and support of activities (Burundi, Peru).
- Community based psychosocial workers or trained volunteers can be utilised for awareness raising and case identification, referral and follow up (Burundi, Uganda). However, volunteers need continuous support and supervision. On their own, they cannot provide the basis of a mental health system. Issues related to sustainability need to be considered, such as financial remuneration of volunteers, ensuring of minimum quality, cultural acceptability, efficiency and coverage (staff attrition).

Lessons learned

These papers have made clear that the main, key component to create lasting and sustainable change across all projects and programmes is to include a long term perspective of inclusion of MH into PHC from the very start of any intervention. Several authors of articles in this issue expressed some dissatisfaction with the final results of the interventions. Table 2 summarises possible lessons learned, covering a wide range of issues, and includes key actions considered successful.

There are many sources of dissatisfaction, but the main one may possibly be related to the perhaps limited long term impact of some of the interventions. Unfortunately, this is something that cannot be assessed properly as the experiences documented here are primarily focused on satisfaction and activity/output indicators (like improvement in the level of knowledge of the staff that received training). There is a lack of outcome indicators in terms of the impact on the real life of people. Measures such as pre/post intervention indicators of the number of new cases properly detected and treated, measures of community and individual emotional wellness, number of cases properly included in case management strategies, or properly referred to other levels in a long term follow up, number of community cohesion activities or decrease in levels of violence or conflict in the community, are not routinely addressed. These measures are impacted by time or budget constraints, and they are key for scaling up or replicating effective programmes and interventions. A major challenge for all programming in

Table 2. Do's and Don'ts in mental health interventions in complex emergencies

Do's	Don'ts
Advocate for using emergency funds to lay foundations for more sustainable development programmes	Do not start short term services without having plans for the post emergency period
Connect mental health projects to existing policy frameworks, such as national (mental) health policies and plans	Do not expect that the existence of mental health policies and strategies will automatically lead to increased commitment and funding by the government
Advocate for establishing or strengthening mental health policy frameworks	Do not wait for others to lobby
Ensure support from local, regional and national (health) authorities	Do not work on initiating programmes without signed agreements of the authorities
Actively promote coordination between different stakeholders (local organisations, INGOs, government)	Do not wait for others to set the parameters or first steps in coordination
Promote information sharing and equal participation of all agencies	Do not be afraid to cooperate
Promote interagency cooperation by encouraging parallel planning periods, joint assessments and pooled funding requests	Do not be naœve: sometimes there can be negative interagency dynamics and competition
Cooperate with local stakeholders such as local NGOs	Do not ignore that local stakeholders will have their own agendas
Promote local ownership and leadership in needs assessment, project design, implementation, monitoring and evaluation	Do not expect that local stakeholders can immediately take over activities without support
Ensure contextual relevance of the interventions by giving local stakeholders a real say in the kind of interventions that are developed	Do not only *'check'* cultural relevance by superficial measures that simplify local ideas
Make participatory assessment broad and relevant by 1) focus group discussion with stakeholders on perceived needs and capacities, 2) participant observation of real patient/personnel encounters, 3) including assessment of the home situation, functional impairment and support systems of people with mental health problems	Do not base interventions on pre-formulated needs described by external *'experts'*
Tailor interventions to available data on age distribution and prevalence figures of mental disorders and psychosocial problems	Do not use a *'one size fits all approach'*
Integrate mental health into non-specialised health care and refer only those cases that need more specialised treatment	Avoid separate programmes for trauma or grief at PHC level
Use a community perspective of mental health problems	Do not isolate mental disorders from the context in which they occur
Ensure that mental health care includes psychosocial concepts and practices	Do not promote the medicalisation of mental health problems
Build capacity within existing public health systems	Do not drain resources from the public health systems in order to employ them in NGO projects
To strengthen/remodel existing structures (public or traditionally, community based structures) is usually better accepted and more sustainable than introducing completely new strategies	Do not create parallel networks that compete with the general health care system
Work towards an integration of mental health care on all levels (community, primary health care, secondary care)	Do not focus on only one level of the system
Install referral systems between community, primary care and secondary care services	Do not leave workers on the primary care level overburdened with cases they cannot handle
Consider using community based psychosocial workers or community volunteers	Do not consider unpaid volunteers as the base of a mental health care system
Use participatory training methods that build on existing experiences	

Do's	Don'ts
Use broad capacity building strategies that cover knowledge, attitude and practice of trainees, and are connected to a planned supervision and follow up	Do not offer training without follow up of results, or supervision of practice
Invest in capacity building that includes training and system building	Avoid focusing on training alone, if the outcome of the training requires changes in the system
Use case detection based on identification in the community	Do not use case detection without ensuring access to treatment, including availability of essential psychiatric drugs and other forms of aid
Create awareness about mental health problems in the community	Do not underestimate the stigma and prejudices associated with mental health problems that may prevent people from seeking help
Reinforce traditional ways of mutual and self-help, and rebuilding the social fabric	Be aware of subtly ignoring or destroying traditional ways of mutual support through top-down psycho education and awareness raising
Integrate monitoring and evaluation from beginning	Do not wait to start planning for evaluation until the end of the project

post conflict or post emergency settings is analysing not only user satisfaction and process indicators, but also measures of outcome and impact (Baingana, Bannon, & Thomas, 2005; Perez Sales, 2005).

One major challenge for many of the programmes described herein has been that donors tend to use short term funding for immediate alleviation of emergency induced needs, without allowing the setting up of programmes with a longer term perspective. This is one of the reasons that the organizations such as the International Federation of Red Cross and Crescent Societies advocate for structural reallocation of humanitarian funds towards risk reduction, and community level development (IFRC, 2009). Development should not be separated from humanitarian need. Rigid separation between emergency funding and development funding makes it difficult to design sustainable programmes.

The editors have collected several experiences within this volume. Other contributions did not arrive on time, or exceeded the publishing capacity and will be included in future issues of this journal. We have also tried to summarise the main findings and conclusions of each of the programmes presented, and tried to extract key factors and recommendations to transform humanitarian emergencies into opportunities in the psychosocial field. Years after an emergency, humanitarian agencies are often confronted with the final destination of emergency funds. Appeals to the public and donors raise considerable amounts of money (Sri Lanka, Haiti). This should not be wasted on expensive short term programmes that sometimes cost much more in logistics that what it actually delivers to the population, or in well intentioned experiments which repeat errors that have already been well documented and are widely known. Emergencies can be unique opportunities to rethink existing models and to introduce changes and new developments in the provision of mental health and psychosocial support in communities. The editors and authors of this *Intervention Special Issue* hope we have managed to provide useful insights in this direction.

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