Mental health in all policies in contexts of war and conflict

Mental health is shaped by social and political determinants, including health-related knowledge and behaviours and upstream factors such as political violence, social disadvantage, inequity and discrimination. Improving these determinants requires commitment to strengthening mental health care provision and necessitates policies and actions that go beyond the mental health sector to include economic and social factors and improved living and working conditions.[1,2] In conflict-affected settings, such upstream determinants of mental health are rarely addressed. Interventions typically promote downstream and midstream trauma-focused and psychosocial approaches, despite the fact that research highlights how mental health in such settings is powerfully impacted by political violence, social position, and the scale of social and economic differences.[3,4,5]

To improve mental health care and equity in contexts of conflict requires a radically new approach that builds and sustains collaboration across sectors to address the upstream determinants of mental health. Intervention at the following four levels is required: at the national level to include the protection of human rights, poverty reduction, improvement of infrastructure, and implementation of national policies that ensure access to education, employment, decent wages, health care, and housing; at the service level to include provision of health care with attention to existing pluralistic medical traditions and creation of a referral system that connects medical, psychosocial, and social services; at the community level to include the creation of information systems, development of community needs assessments, and enabling community involvement; and at the household level to include strengthening support across extended families, attending to loss of family members, and provision of a decent living wage.[6]

Such interventions are challenging, as they occur in volatile contexts and thus produce unpredictable outcomes that lead to uncertainty. Health in All Policies (HiAP), a policy agenda rooted in science and promoted by WHO, is attuned to such challenges. This strategy promotes policies that "systematically [take] into account the health implications of decisions, [seek] synergies, and [avoid] harmful health impacts in order to improve population health and health equity."[7] If adapted to the context of mental health, HiAP must fulfill the following three core premises: provide political, rather than clinical, responses to social determinants; develop strong partnerships and cooperation based on solidarity between national and international institutions; and generate best practice evidence as part of the interventions, with a focus on local relevance and changing contexts.

First, public policies and practices in sectors other than health must make a concerted effort to address social determinants that affect the mental health of war survivors. These sectors must adopt policies that enable them to systematically cooperate by accessing mental health expertise, develop shared goals, make informed decisions, and establish constructive communication and flexible working strategies, while taking into account how the objectives of various sectors might be in conflict with one another.[8] Implementation of these policies is not negligible, as action in conflict-affected settings is driven, not only by local, but also by global decision makers. Besides governments, there are multiple non-governmental organisations that deliver humanitarian and development aid outside state parameters. Therefore, tapping into the right policy moments can be almost impossible if decisions are made speedily and behind closed doors. Furthermore, mental health harbours specific challenges, for example, low government priority translating into a severe lack of funding, staff, medication, and facilities.[9]

Second, to overcome these intractable challenges and enable integrative governance, mental HiAP requires a vision rooted in solidarity. Solidarity, as Prainsack and Buyx argued, is a relational practice and an "enacted commitment to carry 'costs' (financial, social, emotional or otherwise) to assist others within whom a person or persons recognise similarity in relevant respect."[10] On a legal level, solidarity has the potential to improve mental health by generating legal provision and contractual norms between local and global actors and international declarations or treaties. To convince stakeholders not directly involved in mental health to share costs when resources are lacking is complex. One method is by combining so-called inclusive deliberation with a pragmatic, problem-oriented approach that develops policies and actions that benefit all parties involved (a win–win strategy).[8]

Third, evaluating the mental health impact of a solidarity-based approach is crucial to ensure sustained commitment by local and global actors, and to capture other knock-on effects of solidaristic exchanges between institutions. Such evaluation must be long-term, as it is predicted that the lag between action and effect takes time, and direct links between action and effect might be impossible to establish retrospectively, particularly as practices take place in complex, radically shifting, and unstable contexts. Therefore, to capture and improve actual reform processes and the provision of mental health care, through so-called evolutionary learning, is paramount.[11]

Finally, for mental HiAP to be effective, it is crucial for policy development and mental health practice to be locally specific and led by local, rather than international, investors and interventionists. This strategy requires a radical reshaping of existing global structures, including funding agendas, research programmes, methods of sharing mental health information, and capacity building at institutional and community levels, and can only be achieved through solidaristic practices that dismantle current power structures, colonial legacies, and exploitative practices.

Hanna Kienzler
Department of Global Health and Social Medicine, King's College London, London WC2B 4BG, UK
hanna.kienzler@kcl.ac.uk

I declare no competing interests. I would like to thank Barbara Prainsack, Carrie Friese, and Claire Marris for their valuable feedback and discussions.

1 Braveman P, Egerter S, Williams DR. The social determinants of health: coming of age. *Annu Rev Public Health* 2011; **32:** 381–98.
2 Hinchliffe S, Jackson MA, Wyatt K, et al. Healthy publics: enabling cultures and environments for health. *Palgrave Commun* 2018; **4:** 57.
3 Kienzler H, Locke P. The effects of societal violence in war and post-war contexts. In: White R, Orr D, Jain A, Read U, eds. The Palgrave handbook of global mental health: socio-cultural perspectives. London: Palgrave Macmillan UK, 2017: 285–305.
4 Miller KE, Rasmussen A. War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. *Soc Sci Med* 2010; **70:** 7–16.
5 Pedersen D. Political violence, ethnic conflict, and contemporary wars: broad implications for health and social well-being. *Soc Sci Med* 2002; **55:** 175–90.
6 Wahlbeck K, Cresswell-Smith J, Haaramo P, Parkkonen J. Interventions to mitigate the effects of poverty and inequality on mental health. *Soc Psychiatry Psychiatr Epidemiol* 2017; **52:** 505–14.
7 WHO. Helsinki statement on health in all policies. https://www.who.int/healthpromotion/conferences/8gchp/8gchp_helsinki_statement.pdf (accessed Oct 11, 2019).
8 Ollila E. Health in all policies: from rhetoric to action. *Scand J Public Health* 2011; **39** (6 suppl)**:** 11–18.
9 Saxena S, Thornicroft G, Knapp M, Whiteford H. Resources for mental health: scarcity, inequity, and inefficiency. *Lancet* 2007; **370:** 878–89.
10 Prainsack B, Buyx A. Solidarity in biomedicine and beyond. Cambridge: Cambridge University Press, 2017.
11 Noam Cook SD, Hendrik Wagenaar. Navigating the eternally unfolding present: toward an epistemology of practice. *Am Rev Public Adm* 2012; **42:** 3–38.