

Box 1. Provisions for mental health outside the specific legislation

- Constitutional guarantees of the promotion of human rights
- Federal Act 43 of 1992 for the right to healthcare for all citizens
- Constitutional article 19, concerning the rights of incarcerated persons to healthcare (1971)
- Federal Anti-Human Trafficking Act 51 of 2006 to combat human trafficking offences and various forms of exploitation of human beings, particularly women and children
- International Convention on the Elimination of All Forms of Racial Discrimination (1974)
- The Convention on the Rights of the Child (1997)
- The Convention on the Elimination of All Forms of Discrimination Against Women (2004)
- The Geneva Convention on international humanitarian law (1972)
- Cooperation agreement with UNICEF in 2005 to provide for the social and psychological rehabilitation, repatriation and local integration of child camel jockeys

Source: Working Group on the Universal Periodic Review (2008).

Other laws with provisions for mental health

The numerous constitutional guarantees of the promotion of human rights and guarantees in international treaties and programmes as they relate to the UAE are detailed in Box 1.

Discussion

The UAE's present mental health law regulates compulsory admissions to mental health facilities. However, there is currently no unified procedure for its consistent implementation. The language of the law needs to be updated to incorporate modern, internationally used terminology (e.g. the term 'legal guardian' instead of 'legal custodian', 'interpersonal' instead of 'interactive'). A new comprehensive draft Federal Mental Health Act is in its final review and approval stages. The hope is to produce consistent and sustainable changes in mental health practices throughout the UAE.

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Emirati girl who died from abuse and torture suffered at the hands of her father and his partner, a crime that shocked Emirati society. In November 2012, the draft law was approved by the Cabinet. Its 72 articles cover all children's rights guaranteed by international conventions, the rules of Islamic law (Sharia) and the principles of the Emirati Constitution. It will ensure children's physical, ethical and psychological safety.



Mental health and psychosocial support for children in areas of armed conflict: call for a systems approach

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This paper focuses on the question of whether separate attention to children who have faced specific conflict-related events is justified, or whether the scarce resources for mental health should be spent on the development of services for children more broadly in low- and middle-income countries (where most contemporary armed conflicts are taking place). It is argued that a systems approach to mental health and psychosocial support for children is warranted.

Mental health problems affect 10–20% of children and adolescents worldwide (Kieling *et al*, 2011). Especially in low- and middle-income countries (LMICs), there is a substantial gap in the available resources to meet the mental health needs of children (Belfer, 2008). Among these LMICs, there are

currently 23 countries where armed conflict results in grave acts committed against children (United Nations, 2014). Armed conflicts have a negative impact on the mental health and psychosocial well-being of individuals, including psychological distress and mental disorders, as well as negative impacts on the families and communities in which children grow up (Barenbaum *et al*, 2004).

In response, psychosocial and mental health interventions for children affected by armed conflict have been developed. Types of interventions vary widely, with respect to both aim (from promotion, prevention and treatment approaches) and modality (spanning creative and recreational group activities; dance and movement therapy; parental support; individual psychotherapy) (Jordans *et al*, 2009b). School-based interventions are most often represented in the literature

(Betancourt *et al.*, 2013). Research on resilience in children and adolescents affected by armed conflict converges on the importance of supports across socio-ecological levels, of which parental support and parental monitoring are most consistently associated with desired mental health outcomes (Tol *et al.*, 2013b). Recent years have seen a rise in the number of trials for interventions targeting young people in humanitarian settings, but the evidence base is still weak, with mixed results (Tol *et al.*, 2011).

Given the range of potential stressors that children in areas of armed conflict in LMICs are exposed to, a pertinent question is whether separate attention to children who have faced specific conflict-related events is justified, or whether the scarce resources for mental health should be spent on the development of services for children more broadly in LMICs (where most contemporary armed conflicts are taking place). This paper focuses on this question, starting with giving arguments for and against such special attention.

Whether and how to target services

The most compelling and most straightforward reason to argue in favour for services specific to conflict-affected children concerns their increased risk of mental health problems as a result of the exposure to violence. Studies suggest there are higher prevalence rates of mental disorders among children exposed to conflict compared with the general population, including post-traumatic stress disorder, anxiety and depression (Kohrt *et al.*, 2008; Attanayake *et al.*, 2009). In addition, exposure to violence affects children's views of the world, their social networks and relationships, and family functioning (Stichick, 2001; Williams, 2006). Furthermore, one could argue that precisely because of the limited resources it is better to target a smaller at-risk group rather than watering down resources by spreading them over the entire population. This pragmatic argument is based on the notion that a well defined sub-population is easier to cover. In addition, because of the obvious urgency of needs, funding specifically for children affected by armed conflict is commonly more readily available. Finally, psychotherapies targeting traumatic stress are among the few in LMICs that have a relatively strong evidence base.

On the other hand, there are many groups vulnerable to higher rates of mental health problems (e.g. children in caregiver roles; children facing child abuse and neglect; trafficked children; children with chronic physical illnesses or disabilities). Instead of focused attention on one group, a population-wide mental healthcare system can encompass multiple vulnerable groups – rather than having them compete for the scarce resources. Also, the simple argument that mental health problems are present in any child population, regardless of the presence or absence of armed conflict, supports such a broad approach. An additional argument for broader targeting comes from epidemiological research. Recent

studies with conflict-affected populations have shown the importance of chronic daily stressors for mental health that most children in all LMICs are exposed to (i.e. poverty, social exclusion, domestic violence), in addition to past exposure to specific conflict events (Betancourt *et al.*, 2010; Miller & Rasmussen, 2010; Jordans *et al.*, 2012). Such data further complicate tough questions on targeting.

Maybe the more appropriate question is how these two positions can be combined. A two-pronged approach that works towards a population-wide mental healthcare system, within which the special needs of conflict-affected children are explicitly addressed, may reconcile these positions. This principle, also called *proportionate universalism*, entails that actions to support mental health should be universal yet calibrated proportionally to the level of vulnerability, because an exclusive focus on the most vulnerable will fail to receive the support of the whole population. An exclusive focus on one group will also fail to reduce the magnitude of social determinants of mental ill-health, which are felt across a gradient of vulnerability (World Health Organization & Calouste Gulbenkian Foundation, 2014). This two-pronged approach should build on the evidence that is available, and combine a universal approach geared towards promoting resilience within families and communities (Tol *et al.*, 2013b) with more targeted attention to families and individuals with specific vulnerabilities (Jordans *et al.*, 2011).

A comprehensive systems-of-care approach

In addition to prevention, such systems should focus on community-based mental health treatments for a range of mental disorders. This is based on the widely advocated idea that the best way to provide population-wide mental health services in LMICs is by integrating them into non-specialised health settings. Evidence-based guidelines have been drawn up that cover a spectrum of psychological and pharmacological treatments (World Health Organization, 2010). Specific attention to violence-affected children can be embedded, for example by including psychological treatments with proven efficacy to deal with post-traumatic stress disorder (e.g. cognitive-behavioural therapy with a trauma focus, eye movement and desensitisation reprocessing) (Catani *et al.*, 2009; Betancourt *et al.*, 2013; Tol *et al.*, 2013a), or by population-based community screening for at-risk children (Jordans *et al.*, 2009a).

Merging such approaches into one service-delivery framework is critical in order to address both preventive and treatment needs in humanitarian settings (Inter-Agency Standing Committee, 2007). Promoting resilience at different ecological levels to address long-term damaged social fabric as a result of conflict can be best achieved by targeting locally identified risk and protective factors, at the family, peer-group and community levels (Tol *et al.*, 2013b). Families may be particularly relevant for selective preventive interventions, such

as parenting support, whereas schools have been shown to be promising venues for mental health promotion and universal prevention (Barry *et al.*, 2013), for example classroom management support for teachers. The integration of mental health within non-specialised healthcare is a possible strategy to make targeted interventions sustainable. Overall, prevention and treatment should take into account a life-course approach that responds to the risk and protective factors for the overall well-being of children in a way that is sensitive to their developmental stage. Armed conflict clearly poses additional stressors for children and their environment, necessitating adjustments at all parts of the spectrum, which include promoting a sense of safety, calming, a sense of self-efficacy and community efficacy, connectedness and hope (Hobfoll *et al.*, 2007) (e.g. normalising daily life by re-initiating safe schooling, strengthening parent-child relations, stress management).

Feasibility and sustainability

The comprehensive systems-of-care approach we propose clearly raises questions with regard to feasibility and sustainability. Especially in post-conflict settings where systems are devastated and weak, the development and continuation of a system of care will be challenging. However, this lack of a care infrastructure also provides opportunities. Experience has shown that mental health reform is realistic as part of post-emergency recovery, because of the increased recognition of donors and governments of the importance of mental health in humanitarian settings. Initiatives to (re)build mental health services are successful when they address the broad mental health needs of the population rather than set up vertical programmes (World Health Organization, 2013). This entails that psychosocial and mental health programmes in conflict-affected countries, which are often brief and consist of single-intervention approaches funded outside of existing health and social systems, need to systematically integrate a longer-term perspective into their work and employ multi-level or stepped-care packages with entry points in community and non-specialised healthcare settings (Jordans *et al.*, 2009b; Betancourt *et al.*, 2013). The feasibility of a multi-layered care system for children has been demonstrated in several conflict-affected settings, with schools as the entry point (Jordans *et al.*, 2011). At the healthcare level, task-sharing mental healthcare with primary healthcare workers appears a feasible strategy based on existing studies (van Ginneken *et al.*, 2011), also in post-conflict settings (Mendenhall *et al.*, 2014).

Calls to widen the focus of treatment to a broader group of mental disorders seem daunting. However, a promising direction in this regard is a trans-diagnostic modular approach, in which different components of evidence-based treatments for specific disorders are combined to cater for a variety of mental health problems (e.g. rather than only addressing post-traumatic stress disorder,

especially given the very high comorbidity rates). These different components can subsequently be combined to form the building blocks of a larger care package.

Conclusion

Clearly, this paper is not a call to neglect the potentially devastating impact of ongoing political violence on children in areas of armed conflict. In contrast, we argue that a broader systems approach is better capable of addressing the variety of needs of *both* this group of children and other vulnerable groups in LMICs affected by armed conflict. With millions of children living in areas of war, continued attention to their plight and mental health needs has to continue, and subsequently be channelled to establishing a mental healthcare approach that has the ability to address specific psychosocial sequelae of conflict-affected children and families. This can be achieved within a multi-level system that promotes mental health, prevents mental ill-health and strengthens access to evidence-based treatments in the population at large.

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Pandora searches the world literature for evidence, news and other sources on matters of interest (doesn't shy away from controversy) to bring to the reader. She welcomes comments and suggestions (via ip@rcpsych.ac.uk)

BJPsych International – Research Supplement

Pandora is pleased to announce the publication of the first Research Supplement of *BJPsych International* (May 2015), which is available (as is every issue of the journal) for free download at <http://www.rcpsych.ac.uk/publications/journals/ipinfol.aspx>.

The journal's mission is to address matters of practical relevance to patients' care with a focus (although not exclusively so) on the mental health needs of low- and middle-income countries as well as the socially excluded in higher-income countries. The Research Supplement covers a wide range of subjects, including service developments, undergraduate training, the use of guidelines from the National Institute for Health and Care Excellence and the World Health Organization's Mental Health Gap Action Programme (mhGAP) in various parts of the world, and an examination of research productivity in Arab countries.

Healthy gut fauna for healthy brain

Have you ever imagined that bacteria living in your gut could have 'conversations' with your brain? The gut microbiome and its role in the function of body and brain have been the focus of research in recent years. S. R. Dash's summary of the evidence on Medscape makes interesting reading. The gut microbiota are established at birth and alterations in their composition appear to play a role in a range of body and brain disorders. There is bidirectional communication between the gut and the brain, which can be direct or indirect,

via the enteric nervous system, neurotransmitter modulation, endocrine and immunoinflammatory systems. The gut microbes have been implicated in conditions such as type 2 diabetes, cardiovascular disorders, multiple sclerosis, anxiety and depression. A healthy balanced diet and good lifestyle encouraging growth of the right bacteria, living in harmony in the gut, are the road to good physical and mental health!

S. R. Dash (2015) The microbiome and brain health: what's the connection? Medscape, 24 March.

Precision medicine comes to psychiatry!

Are you disillusioned with successive diagnostic classification systems based on symptom categories? Like other medical disciplines, psychiatry is calling out for 'precision medicine'. Cancer research has led the way, with molecular diagnosis leading to better-defined treatments and improved outcomes. Could this be achieved in psychiatry? Modern biology, in particular cognitive, affective and social neuroscience, are producing new insights and 'mental' disorders are soon to be recognised as 'brain' disorders caused by disruptions to neural, cognitive and behavioural systems.

The National Institute for Mental Health has launched a 'precision medicine for psychiatry' project, the Research Domain Criteria (RDoC) initiative, with the aim of rethinking research into psychopathology. This has gained momentum, with over 1000 papers in the last year and with similar initiatives emerging in Europe, such as the Roadmap for Mental Health Research funded by the European Commission and a call from the European Union's Innovative Medicines Initiative

