The toll of effectiveness studies on mental health interventions in the global south

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Increasing focus on evidence-based interventions in global development has led to a neglect of root causes and systemic failures; this same criticism should be applied to the implementation of mental health and psychosocial support (MHPSS) programs in the global south.

A RECENT joint letter written by leading economists in global development cites the obsession with 'aid effectiveness' as a major stumbling block in reducing poverty (*The Guardian*, 2018). In particular, they criticize the increasing use of randomised control trials (RCTs) to determine how best to use aid money, drawing on examples such as micro-credit schemes and water purification tablets. The criticism rests on the consequences of using RCTs; the interventions are discrete and structured, they are testable, and implemented in a controlled and systematic way. The authors refer to these interventions as micro-interventions with micro-results. They rarely reflect the reality of implementation in real life, the impact of changing and moving populations, of corruption, and of political will. They also ignore the root cause of problems and the systems maintaining them. As one author, Professor Harriss-White (2018) from Oxford University describes in an interview, water purification tablets may be effective in cleaning water, but they won't tackle why the water is contaminated or scarce, nor the systems that failed in the first place.

These criticisms can and should be applied to mental health and psychosocial support (MHPSS) in low and middle income countries (LMIC), and arguably in disadvantaged communities in high income countries too. Most interventions implemented by state and non-governmental organisations (NGOs) in LMIC reflect the same obstacle. There is an increasing focus from donors, governments and NGOs on evidence-based interventions to address mental ill health and psychological distress. For example, Lebanon, home to an estimated 1.5 million refugees, a middle income country affected by political instability, widespread corruption and ongoing sectarianism, is investing in training healthcare workers in evidence-based interventions as part of a National Mental Health Program, such as interpersonal psychotherapy (IPT) and the World Health Organization's (WHO) Problem Management Plus programme (Karam et al., 2016). NGOs in the country are also offering a host of other evidence-based interventions for populations unable to access the predominantly private healthcare system, from cognitive behavioural therapy (CBT) to narrative exposure therapy (NET).

This focus on evidence-based interventions is not unreasonable, in that it attempts to improve the effectiveness, cost-effectiveness and acceptability of delivered interventions, and reduce ad hoc and eclectic interventions that are assumed to work but may be ineffective, or worse, harmful. Indeed, the damaging effects of debriefing for victims of acute emergencies, which was found to increase the risk of developing posttraumatic stress disorder rather than decrease it (Rose et al., 2002), demonstrates why interventions need testing, and that any intervention is not necessarily better than no intervention. However, the letter on poverty alleviation highlights the same two problems in evidence-based MHPSS.

The first is that the evidence base is biased. The nature of scientific testing favours neat individualised interventions with a clear manual and structure. Meta-analyses continuously churn out the same results: interventions that lend themselves to this kind of testing, CBT in particular, are effective; other interventions do not have enough evidence to draw conclusions (Betancourt et al., 2013; O'Sullivan et al., 2016; Tol et al., 2011). Rarely are such studies able to comment on efficacy, on the real world application of interventions in contexts with poor infrastructure, limited training and staff, and heavy stigma. The literature also focuses on psychiatric diagnoses and on individuals – equally neglecting the wide scale need for more general community-based mental health support, and the normality of psychiatric symptoms in chronically unstable environments and of diverse cultural and socio-political norms.

The second problem is that in the context of many LMIC, and certainly in the case of war and mass displacement, these structured interventions only treat the symptoms of mental ill health. Treating symptoms in this context ignores the root cause of the suffering: the violence, instability, poverty and inequality. A child in a tented settlement in Lebanon presenting with anxiety may gain some relief with an individualised symptoms-based intervention, but it will do little to change the systemic failures causing it. Research highlights again and again the impact of poor socio-economic status (Reiss, 2013), of exposure to violence (Stansfeld, 2017), of unemployment (Karsten & Klaus, 2009), and of inequality on mental health (Layte, 2012). Yet our interventions remain constrained to addressing individual cognitions, behaviours or interpersonal patterns.

As with poverty alleviation, the suggestion is not necessarily to cease treating symptoms, but to increase focus on systemic public health and policy-based interventions, using longitudinal designs that do not rely exclusively on quantifiable short-term outcomes, that can have lasting and real world impacts on the wellbeing of disadvantaged populations. We would do well to follow the advice for poverty alleviation and think long term, multi-level and systemically about the way to address mental illness and psychosocial distress in LMIC and beyond.

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