was made explicit in the DSM-5 for schizophrenia spectrum disorders. The influence on clinical trials methodology will be profound. Many therapeutic and management approaches must be developed without commercial finance and it will be challenging for funders of public science to adequately address the need for knowledge acquisition in the range of psychopathology essential for broadly integrative care.

This report would be valid if addressing schizophrenia rather than primary psychosis. The authors have given emphasis to transdiagnostic conceptualization of psychopathology related to psychosis. This advance has been unnecessarily slow. A personal milestone is our 1974 paper[2] summarizing data that made clear, to us, that schizophrenia was a clinical syndrome rather than a disease entity. Six aspects of psychopathology were viewed as separate targets for discovery not unique to schizophrenia. However, in 1983, the DSM-III viewed schizophrenia as a disease based on the belief that heterogeneity would be addressed when clinicians used specified symptoms for the diagnosis and gave prominence to Schneiderian first-rank symptoms. It was three decades later that the DSM-5 made explicit the syndrome status and identified dimensions of psychopathology relevant for psychotic illnesses.

A turn to transdiagnostic psychiatry is being supported by the US National Institute of Mental Health's Research Domain Criteria[3]. Very controversial at the outset, the view that dimensions of psychopathology can be investigated across diagnostic boundaries has taken hold. The comparison of schizophrenia patients versus non-ill controls is gradually giving ground to paradigms involving specific aspects of psychopathology with potential relevance across diagnostic boundaries. A nosology with specific diagnoses is necessary for many reasons, and schizophrenia is not an exception. The key is understanding the implications of the diagnosis and the need for a further clinical characterization in order to personalize management.

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From exception to the norm: how mental health interventions have become part and parcel of the humanitarian response

Humanitarian psychiatry is the provision of services for mental health and psychosocial support in a humanitarian context – that is, to populations exposed to collective violence, forced displacement or natural disasters. Unfortunately, humanitarian needs have grown: nearly 80 million are forcibly displaced in the world today, that is one in a hundred people, with diminishing numbers returning home. These figures do not include those with humanitarian needs who are not displaced, but who are also in danger, as for example in Yemen at this time.

When the first author of this paper began her career in humanitarian psychiatry 30 years ago, during the Balkan wars, psychiatry in humanitarian settings focused largely on one diagnosis (post-traumatic stress disorder, PTSD) and individualized medical interventions to prevent and/or address it. She encountered the same approaches in Iraq in 2003, and after the 2004 South-East Asian tsunami[1].

The publication in 2007 of the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings heralded a new understanding and a new approach. Namely, that tightly defined psychiatric problems are only part of a spectrum of mental health and psychosocial needs. These may be prevented or mitigated if people's basic needs for food, shelter and security, and their social needs for connection and justice, are addressed in a dignified and equitable manner that respects human rights (see Silove[2] in this issue of the journal).

This requires multi-sectoral action, with different levels of intensity and specialization. Clinical services constitute a modest part of the pyramid of multi-layered mental health and psychosocial services and supports, the others being: a) focused non-specialized psychosocial support, b) strengthening the capacity of individuals, families and communities to support themselves, and c) embedding social and psychological considerations into the way basic needs and security are delivered.

That is not to say that clinical needs are insignificant. The latest World Health Organization (WHO) figures show that more than one in five people in post-conflict settings have depression, anxiety disorder, PTSD, bipolar disorder or schizophrenia[3]. Fortunately, certain barriers to addressing psychiatric disorders in emergency settings have been removed. Prior to 2009, mental health problems were not included in the health information system of the United Nations High Commissioner for Refugees (UNHCR), which meant they were invisible. Since then, the inclusion of seven, and currently nine, mental and neurological categories has highlighted the significance of these conditions[4]. Another problem was that only three psychiatric medications were included in WHO essential drug kits for emergencies. The increase to five in 2011, continued in 2017, has meant that pharmacological treatments are now available in emergencies[5].

The first most significant development of the last decade is the recognition that the provision of essential mental health services is not the exclusive realm of mental health specialists. It can be done by non-specialized health workers, particularly in primary care, if they are well trained and supervised. The development

and rollout, by the WHO and UNHCR, of the Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG) for clinical management of mental, neurological and substance use conditions in humanitarian emergencies has played a pivotal role in making non-specialized, community-based delivery possible[6].

The other main development has been the emergence of a range of brief psychological interventions that can be easily taught to non-specialized staff and community volunteers. These have the potential to be rapidly brought to scale in a relatively cost-effective manner[7]. Many of these interventions have been purposely developed for, and tested in, humanitarian contexts rather than simply being superficial adaptations of existing tools from high-income settings[8].

In addition, other actors and sectors now recognize that addressing mental health is a major component of humanitarian response. In the last decade, mental health has become increasingly engrained within policy documents and guidelines. For example, the Sexual and Gender-Based Violence Clinical Guide now includes a chapter on mental health needs; the UN Children's Fund (UNICEF) emphasizes the need for infant stimulation in food emergencies, and the Child Protection Minimum Standards include mental health and psychosocial support.

The Sphere Handbook, the most authoritative guide for emergency responses, has mental health and psychosocial support integrated throughout. Moreover, the IASC Principals, the highest decision makers for emergencies, in their meeting of December 5, 2019, agreed to "treat mental health and psychosocial support as a cross-cutting issue that has relevance within health, protection, nutrition, education and Camp Coordination and Camp Management sectors/clusters, in all emergencies". The recent UN Global Humanitarian Response Plan for the COVID-19 pandemic contains multiple references to mental health and psychosocial support throughout the document[9]. Three UN agencies (WHO, UNICEF and UNHCR) are developing a Minimum Service Package for mental health and psychosocial support which will include interventions in health and protection for children and adults.

But there are continuing challenges**.** Those with severe pre-existing disorders and learning disabilities are still among the most neglected and underserved groups in emergencies, often languishing in horrifying conditions within asylums or still chained at home or in camps. Humanitarian interventions are still on many occasions only short term and fail to build back better.

Meanwhile, the recent climate related fires and floods and the global COVID-19 pandemic have allowed many people in high-income countries to learn first-hand what it feels like to live in continual stress and have lives turned upside down. This has perhaps created greater understanding of how emergencies affect mental health. Paradoxically, lockdown in the global North has also helped us realize the strengths and abilities of local actors, a point emphasized by a growing international Black Lives Matter movement, that is calling for the decolonizing of humanitarian aid.

Where do we go from here? Our immediate priorities are to improve the care for people with severe mental disorders and learning disabilities through a combination of recovery-oriented community interventions and decent medical treatment; to address the neglected domains of alcohol/substance use and prevention/response to suicidal behaviour; and to foster community-based psychosocial methods that focus on social connectedness and interpersonal "healing". Underpinning all of this is continued support and empowerment of local actors on the ground, including affected persons themselves, and a commitment to listen and learn from them.

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