WORKING GROUP MENTAL HEALTH

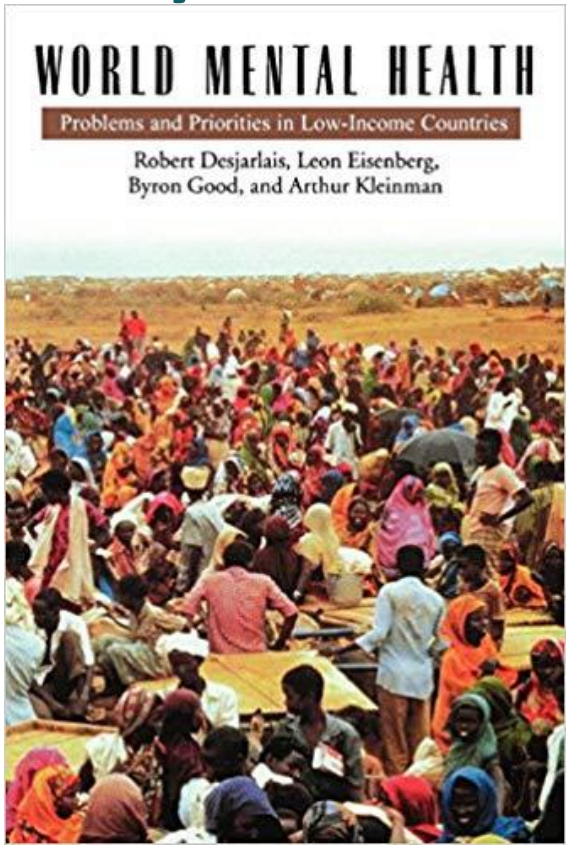
1 FEBRUARY 2019

KICK OFF MEETING

1. SHORT ‘LOOK BACK’
2. CURRENT SITUATION, LESSONS LEARNED?
3. QUESTIONS, CHALLENGES TO ORGANIZE THE WG

Mental Health field: attention since early 1990's

- Mental, neurological, and substance use (MNS) disorders are highly prevalent and are responsible for 14% of the global burden of disease expressed in disability-adjusted life years (DALYs) [1]. The resources in countries to tackle the burden are insufficient, inequitably distributed, and inefficiently used, which results in a large majority of people with these disorders receiving no care at all [2]–[7]. The result is a large treatment gap.



Growing attention through the years, needs still huge

- ‘Normal’ mental health needs unmet;
- Refugee situation adds to that: 65 m displaced by conflict
- Half of these in “protracted situations”
- ‘New field’ of MHPSS

SPECIAL ARTICLE

The contemporary refugee crisis: an overview of mental health challenges

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There has been an unprecedented upsurge in the number of refugees worldwide, the majority being located in low-income countries wit ited resources in mental health care. This paper considers contemporary issues in the refugee mental health field, including developme research, conceptual models, social and psychological interventions, and policy. Prevalence data yielded by cross-sectional epidemiol studies do not allow a clear distinction to be made between situational forms of distress and frank mental disorder, a shortcoming tha be addressed by longitudinal studies. An evolving ecological model of research focuses on the dynamic inter-relationship of past trau experiences, ongoing daily stressors and the background disruptions of core psychosocial systems, the scope extending beyond the individ the conjugal couple and the family. Although brief, structured psychotherapies administered by lay counsellors have been shown to be ef in the short term for a range of traumatic stress responses, questions remain whether these interventions can be sustained in low-resour tings and whether they meet the needs of complex cases. In the ideal circumstance, a comprehensive array of programs should be pro including social and psychotherapeutic interventions, generic mental health services, rehabilitation, and special programs for vuln groups. Sustainability of services, ensuring best practice, evidence-based approaches, and promoting equity of access must remain the g future developments, a daunting challenge given that most refugees reside in settings where skills and resources in mental health care shortest supply.

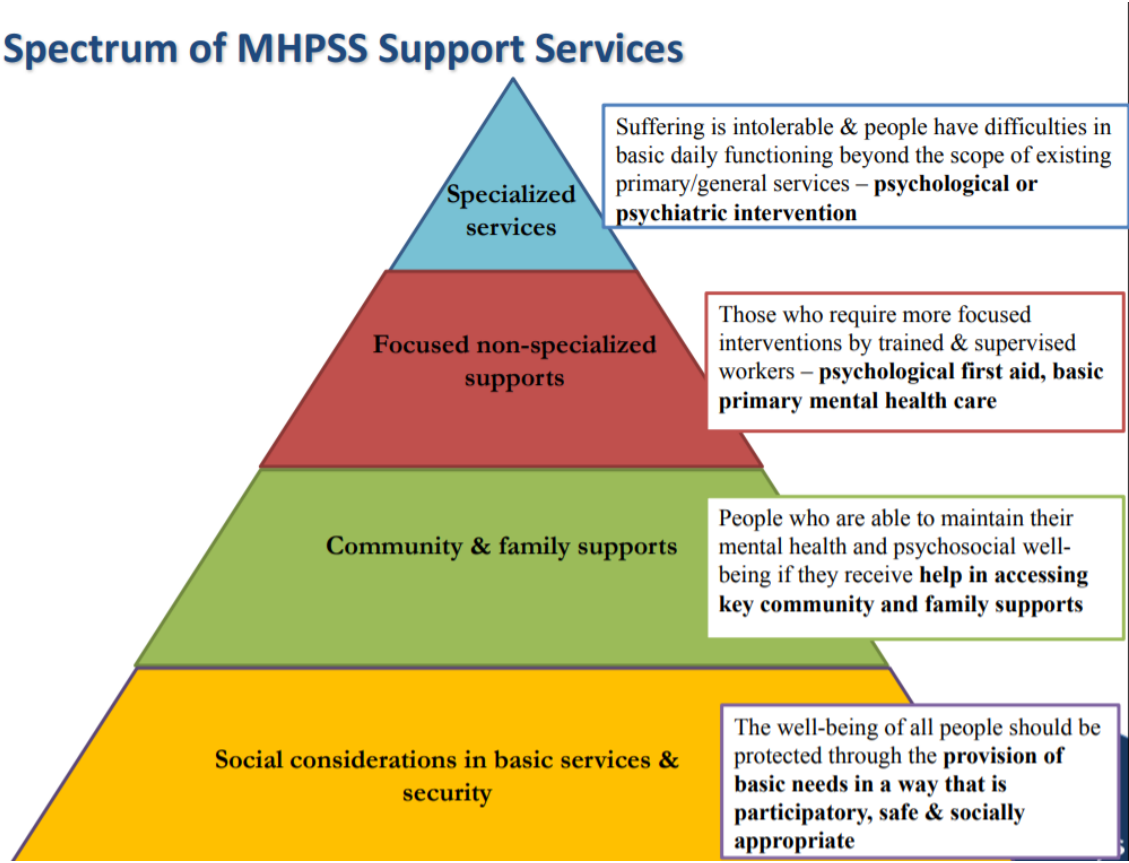
Key words: Refugees, displacement, asylum seekers, ecological models, trauma, stress, mental health, post-traumatic stress disorder, depre social interventions, brief psychotherapy

(World Psychiatry 2017;16:130–139)

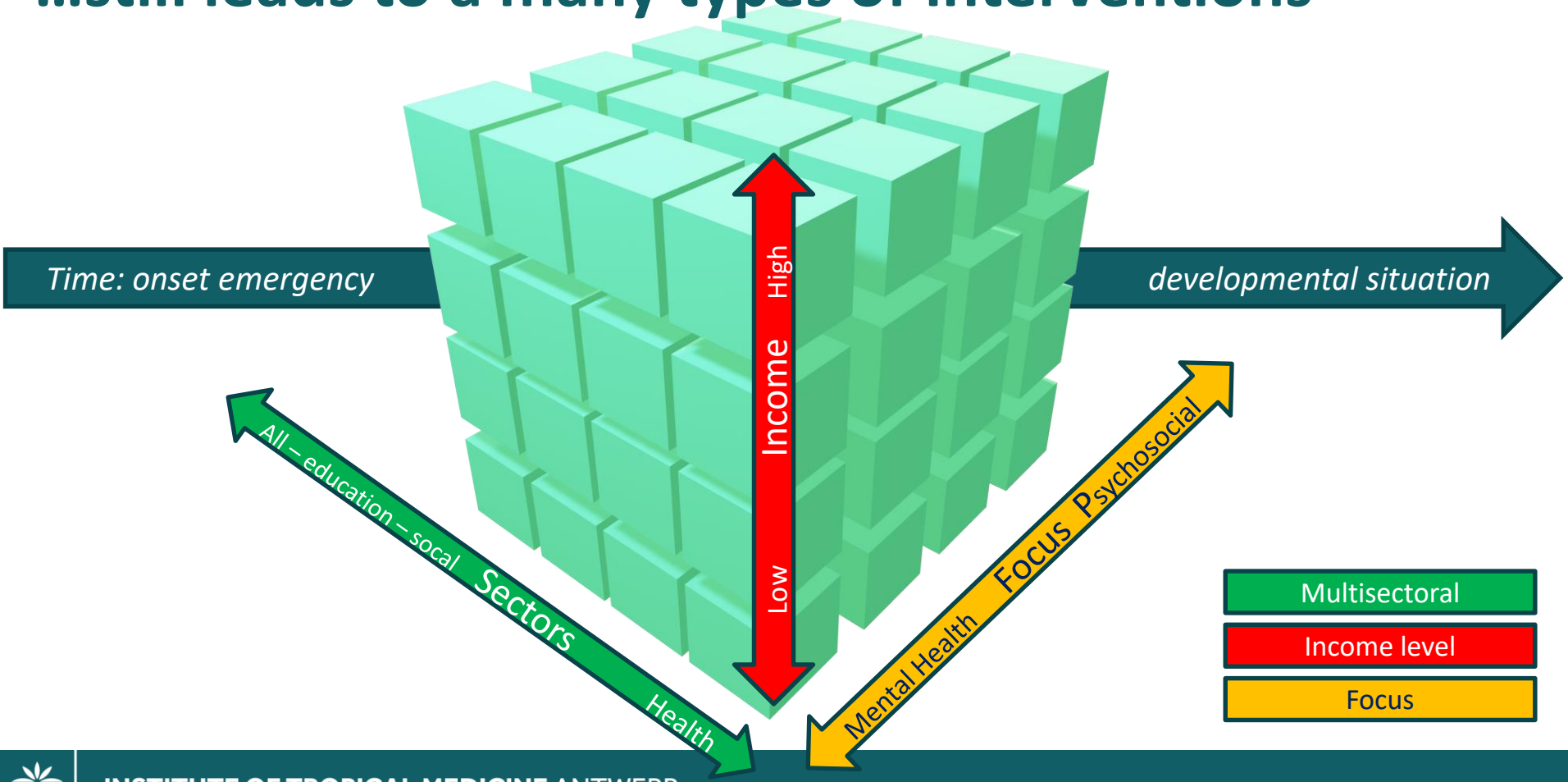
The current ‘paradigm’…

The pyramid was designed by the IASC working group (2007).

The challenge was to bring some coordination and logic in a myriad of interventions that came up after ‘psychosocial care’ projects became popular in late 1990s.



…still leads to a many types of interventions



History in Guidelines…..

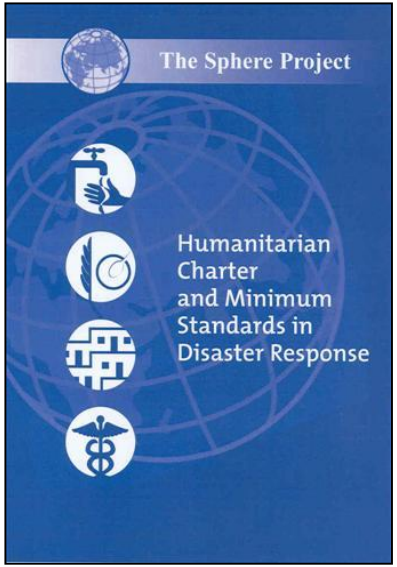
1990: Integrate psychiatry in PHC

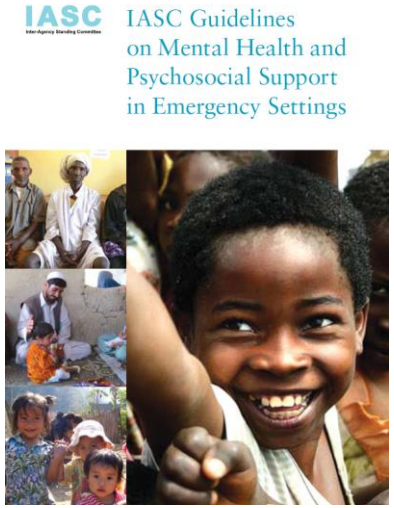
1998 Sphere Min Standards

2007 IASC Guidelines (MHPSS)

2008 mhGAP

Primary Care-Mental Health Integration

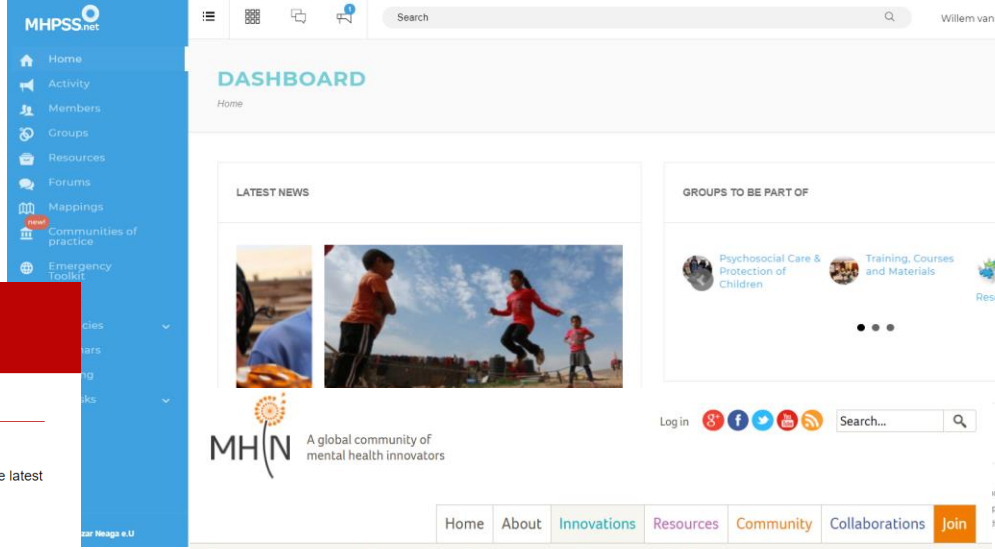


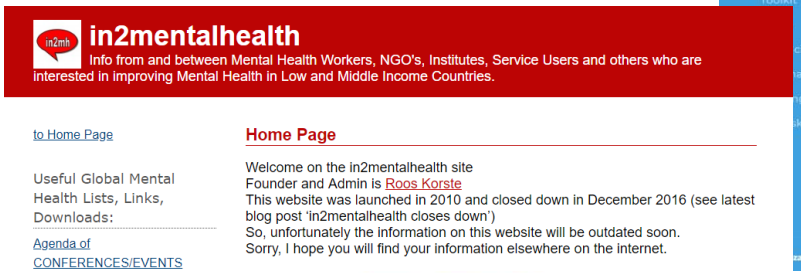


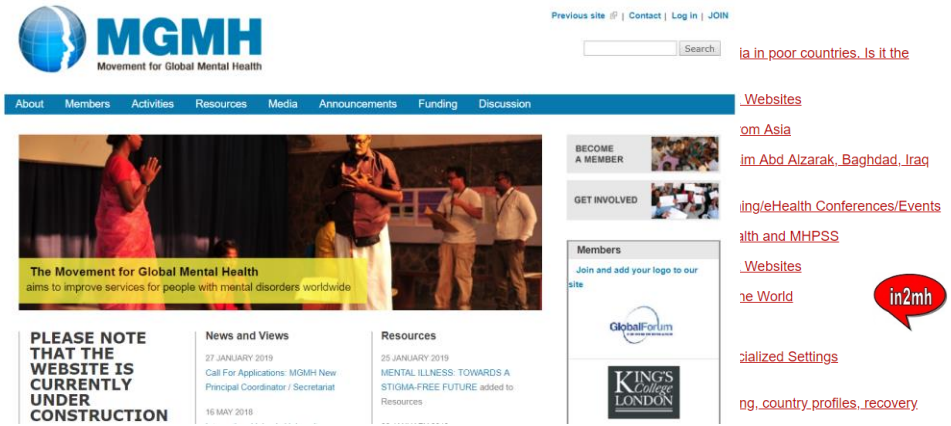
The current situation

- More actors
- More needs
- More competition
- Not much more ideas….?
- But some lessons learned

Growing number of networks and groups

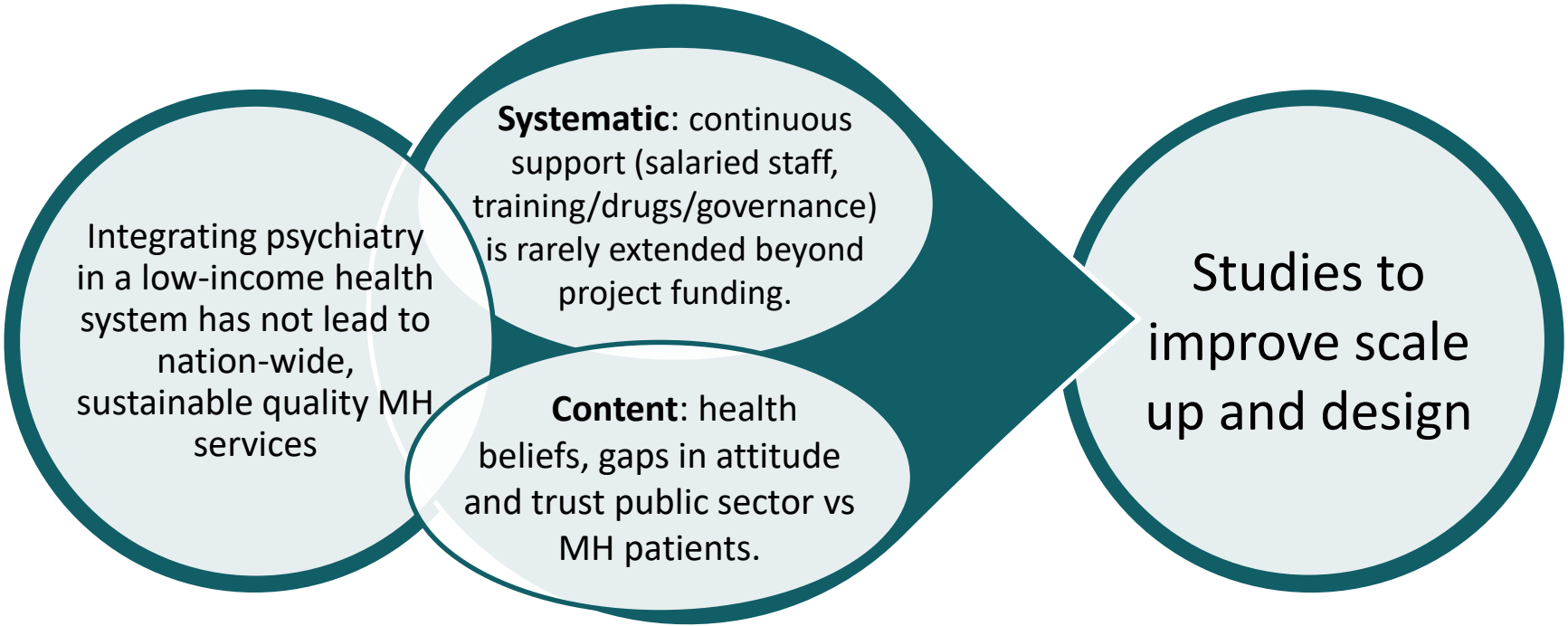






Growing number of NGOs, competition

Some lessons learned in MH integration in PHC:



Examples of recent multicountry studies

- PRogramme for Improving Mental health carE (PRIME): generate world-class research evidence on the implementation and scale up of treatment programmes for priority mental disorders in primary and maternal health care in low resource settings.
- **The Emerald Project:** aims to identify key health system barriers to, and solutions for, the scaled-up delivery of mental health services in LAMICs, and by doing so improve mental health outcomes in a fair and efficient way.
- South Asian Hub for Advocacy, Research & Education on Mental Health (SHARE): a collaborative network of institutions in South Asia, to carry out and to utilize research that answers policy relevant questions related to reducing the treatment gap for mental disorders in the region.

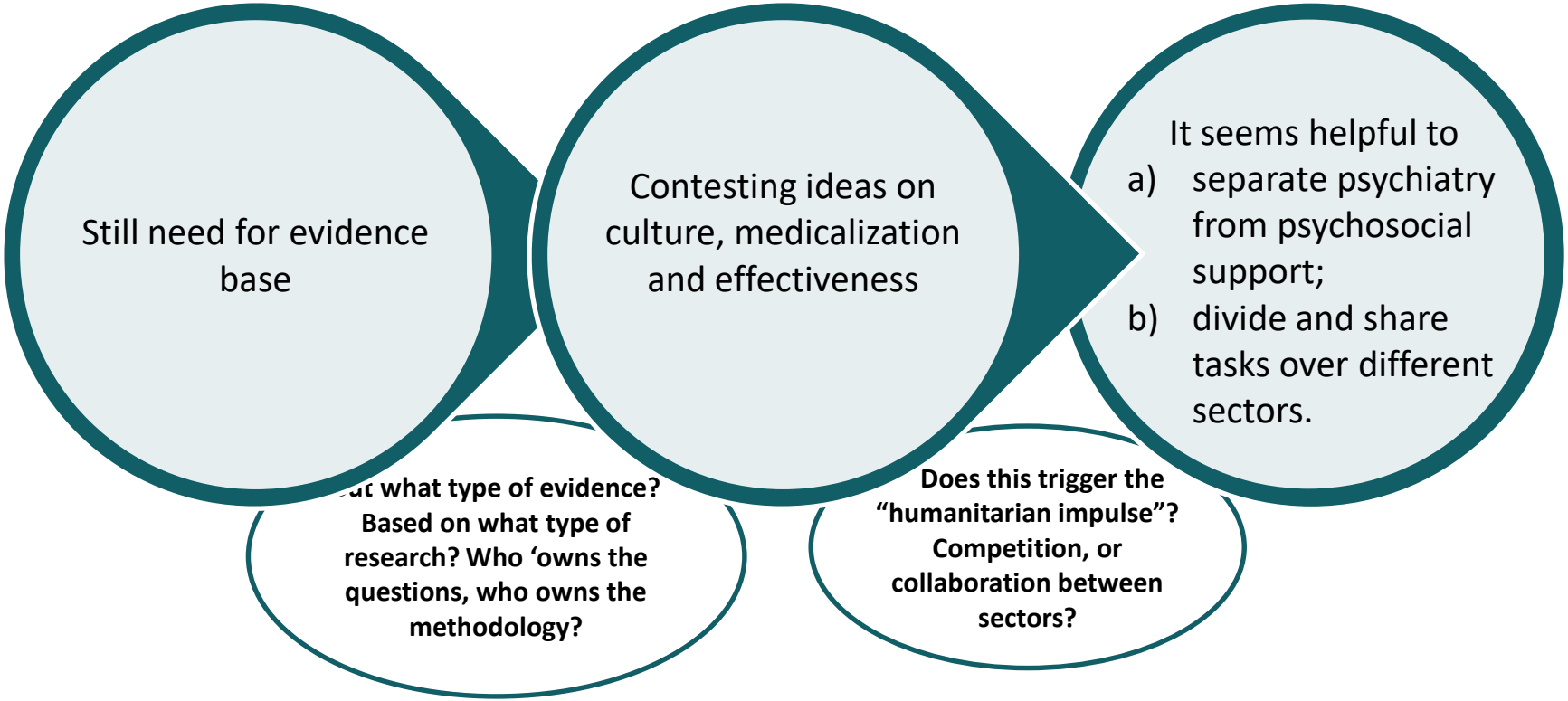
Some lessons learned in psychosocial work:

Questions on *concepts*; *medicalization* of social problems; *effectiveness* of interventions

Providing **relevant** support in terms of **acceptability** and **impact** remains a challenge

WB: priority to MHPSS projects that (a) have evidence-base; (b) improve people's daily functioning; and (c) protect most vulnerable to further adversity

So what stands out:



Perhaps: a 3-way look on MHPSS programming

1. Integration of MH in PHC services
2. MHPSS in crisis
3. Mental health *aspects* of problems

1. Integrate MH in PHC

2. MHPSS in crisis

3. MHPSS aspects across sectors

Integrate MH in PHC

Building up sustainable services requires the right resources, connection with the population, and institutional support

MHPSS in crisis

Figure 2: **Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies**[51]

Clinical Services
Example: Clinical mental health care (whether by PHC staff or by mental health professionals)

Focused Psychosocial Supports
Example: Basic emotional and practical support to selected individuals or families

Strengthening Community and Family Supports:
Example: Activating social networks
Supportive child-friendly spaces

Social Considerations in Basic Services and Security:
Example: Advocacy for good humanitarian practice: basic services that are safe, socially appropriate and that protect dignity

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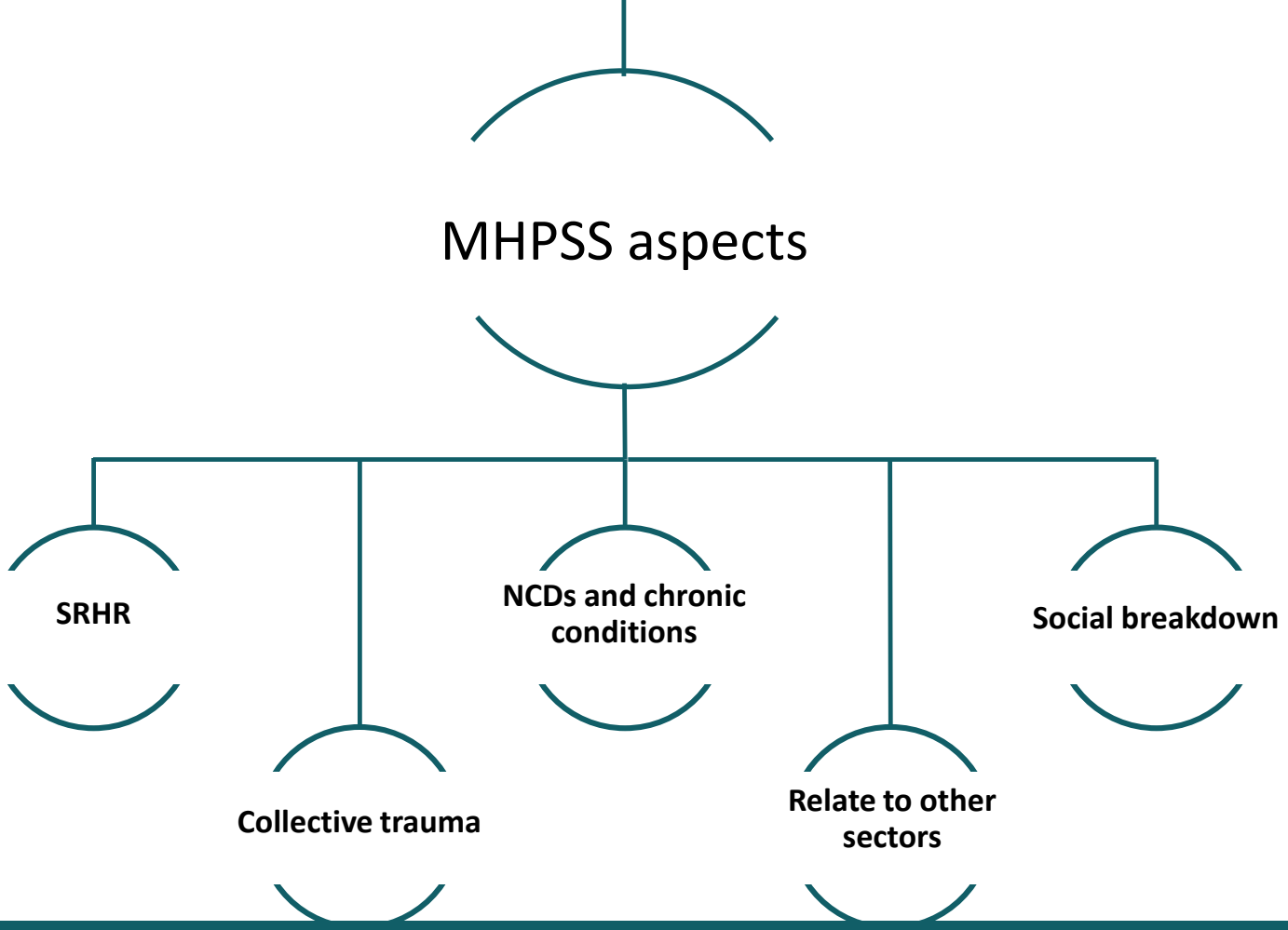
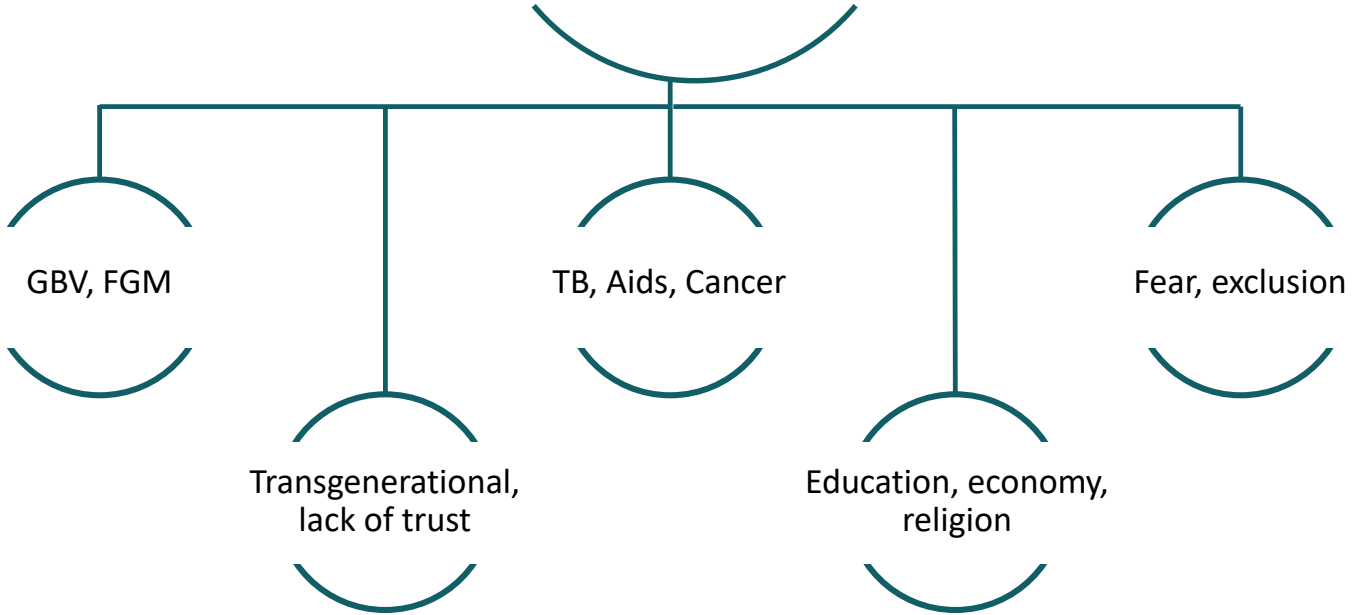
Mental Health Among Displaced People and Refugees: Making the Case for Action at The World Bank Group. January 2017

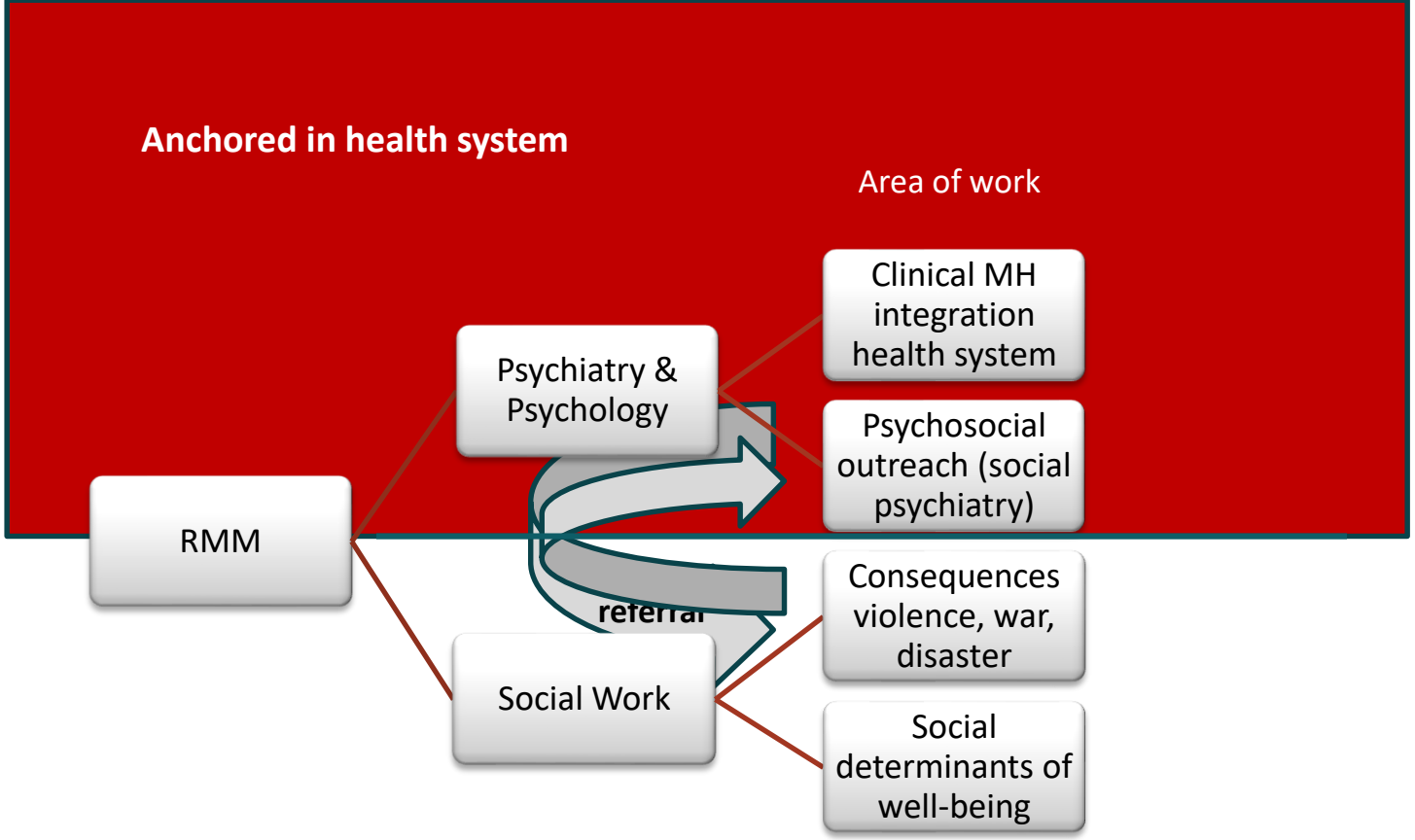
nflict settings



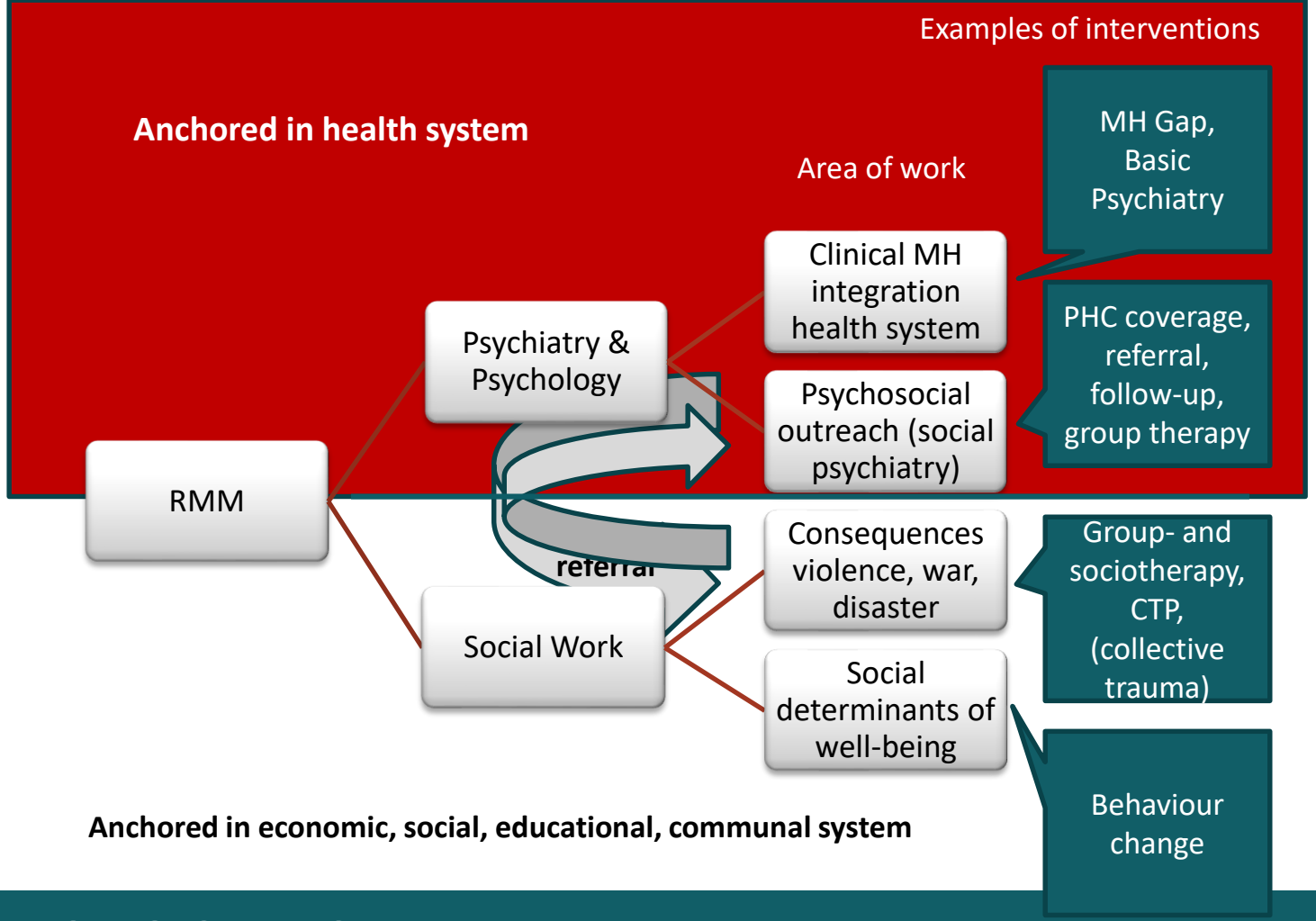
MHPSS aspects

(examples)

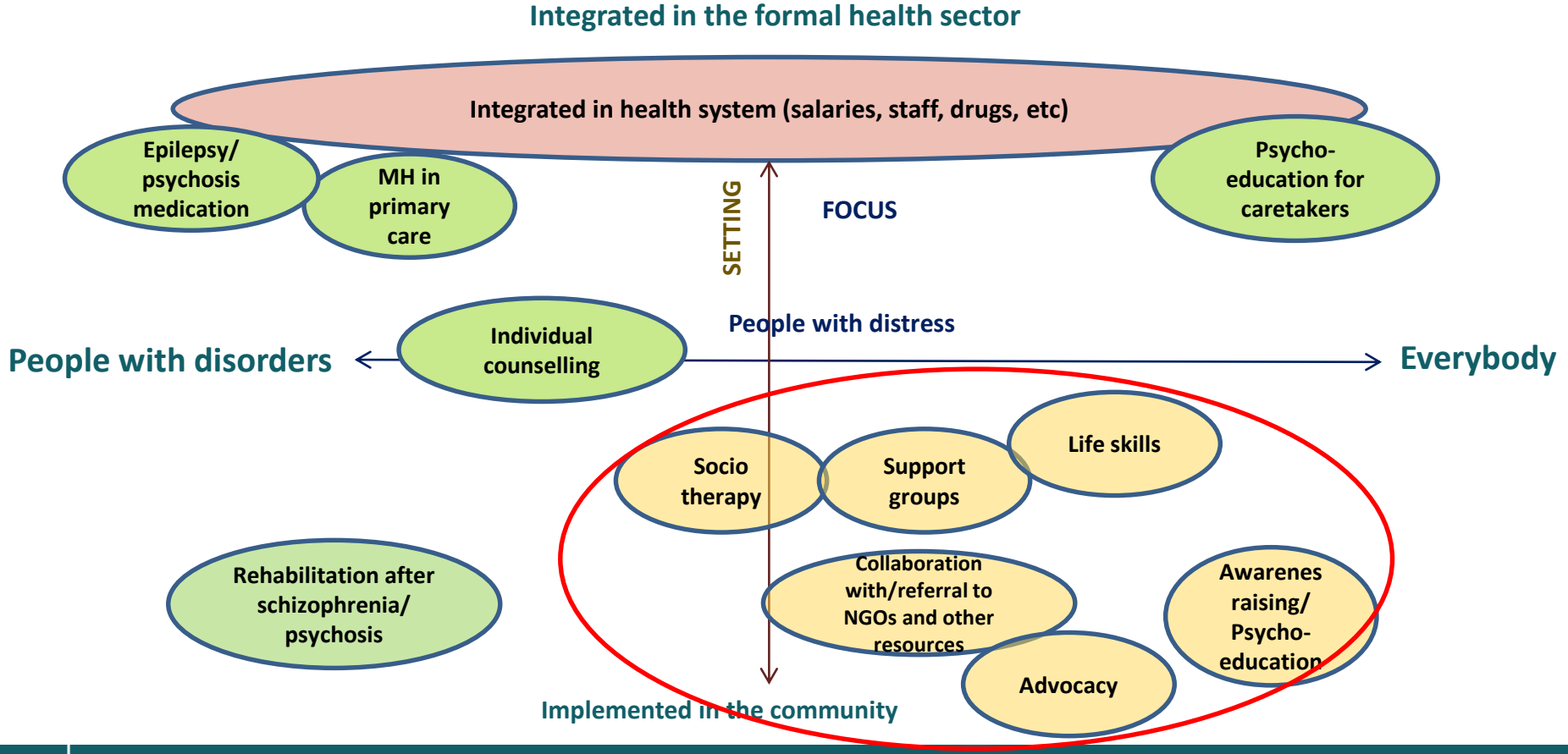




Anchored in economic, social, educational, communal system


Examples of interventions
Anchored in health system
Area of work
MH Gap, Basic Psychiatry
Clinical MH integration health system
Psychiatry & Psychology
PHC coverage, referral, follow-up, group therapy
Psychosocial outreach (social psychiatry)
RMM
referral
Consequences violence, war, disaster
Group- and sociotherapy, CTP, (collective trauma)
Social Work
Social determinants of well-being
Behaviour change
Anchored in economic, social, educational, communal system

Community versus 'Health' interventions



Issues, questions, challenges: an agenda?

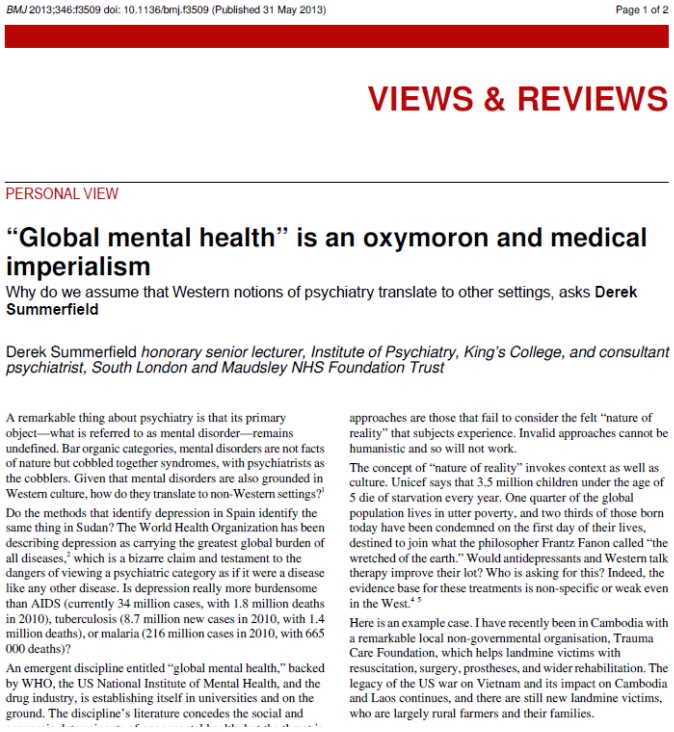
Examples MENTAL HEALTH

- Vertical programmes or integrated programmes (e.g. MH aspects of chronic disease)
- Integration of services:
  - prevalence and burden of mental health problems (what is the problem?)
  - questions on effectiveness of interventions (what works?)
  - sustainable care delivery (how can it be implemented?)
- Different settings: humanitarian settings, conflict, LMIC, crisis or no crisis
- Use of digital technology in mental health care
- Cross-cultural challenges

Examples PSYCHOSOCIAL WORK

- Cross sectoral approach, how?
- The use of diagnostic labels (PTSD debate)
- Individual or group approach
- The concept of ‘collective trauma’
- Cross-cultural challenges

Answering the critical view?



BMJ

BMJ 2013;346:f3509 doi: 10.1136/bmj.f3509 (Published 31 May 2013) Page 1 of 2

VIEWS & REVIEWS

PERSONAL VIEW

"Global mental health" is an oxymoron and medical imperialism

Why do we assume that Western notions of psychiatry translate to other settings, asks **Derek Summerfield**

Derek Summerfield *honorary senior lecturer, Institute of Psychiatry, King's College, and consultant psychiatrist, South London and Maudsley NHS Foundation Trust*

A remarkable thing about psychiatry is that its primary object—what is referred to as mental disorder—remains undefined. Bar organic categories, mental disorders are not facts of nature but cobbled together syndromes, with psychiatrists as the cobblers. Given that mental disorders are also grounded in Western culture, how do they translate to non-Western settings?[1]

Do the methods that identify depression in Spain identify the same thing in Sudan? The World Health Organization has been describing depression as carrying the greatest global burden of all diseases,[2] which is a bizarre claim and testament to the dangers of viewing a psychiatric category as if it were a disease like any other disease. Is depression really more burdensome than AIDS (currently 34 million cases, with 1.8 million deaths in 2010), tuberculosis (8.7 million new cases in 2010, with 1.4 million deaths), or malaria (216 million cases in 2010, with 665 000 deaths)?

An emergent discipline entitled "global mental health," backed by WHO, the US National Institute of Mental Health, and the drug industry, is establishing itself in universities and on the ground. The discipline's literature concedes the social and

approaches are those that fail to consider the felt "nature of reality" that subjects experience. Invalid approaches cannot be humanistic and so will not work.

The concept of "nature of reality" invokes context as well as culture. Unicef says that 3.5 million children under the age of 5 die of starvation every year. One quarter of the global population lives in utter poverty, and two thirds of those born today have been condemned on the first day of their lives, destined to join what the philosopher Frantz Fanon called "the wretched of the earth." Would antidepressants and Western talk therapy improve their lot? Who is asking for this? Indeed, the evidence base for these treatments is non-specific or weak even in the West.[4 5]

Here is an example case. I have recently been in Cambodia with a remarkable local non-governmental organisation, Trauma Care Foundation, which helps landmine victims with resuscitation, surgery, prostheses, and wider rehabilitation. The legacy of the US war on Vietnam and its impact on Cambodia and Laos continues, and there are still new landmine victims, who are largely rural farmers and their families.

- Danger of using idioms of distress to construct diagnostic labels (Kirmayer 2018)
- "Western psychiatrists, in trying to destigmatise mental illness by promoting its "medical" nature, have participated in the destruction of what attracted many of them to the profession in the first place: the chance to personally engage & heal. They have lost their souls in the quest for the 'fixable perfect brain'" (Luhrmann 2000)
- *"Pharmacracy"* (Thomas Szasz)
- Summerfield: imperialism
- Etc

A short film about the variety of ‘Global Mental Health’

Derek Summerfield: To assume that Western knowledge is universal, whereas indigenous knowledge is local, casts culture as an obstacle and ignores the plight of huge numbers of non-Western peoples mired in bare survivalist ways of life.

Thank you for your attention!

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