SECONDARY SCHOOLS' UNITED NATIONS SYMPOSIUM 2015

NGO Committee On Mental Health

Co-Chairs:
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Vice Chairs:
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NGO Committee on Mental Health

Dear Delegates,

We, your Co-Chairs Aravind Addepalli and Mahathi Ramesh, would love to extend a warm SSUNS welcome to all of you on behalf of the NGO Committee on Mental Health Dais. Aravind is a senior at McGill University pursuing a joint degree in Anatomy & Cell Biology and Economics. Aravind was born in the beautiful United States of America but has lived and studied around the world most recently ending up in Mississauga, Ontario. He is extremely passionate about international issues and strives to bridge the gap between science and international development in a sustainable manner. Mahathi is a junior at McGill University hailing from Mumbai, India. She is a Psychology major who found a passion for international relations through MUN. When not leading delegates from the dais, she models for charity showcases and has the honour of being an intermediate level belly dancer.

Joining us are our exceptional vice-chairs, Alex Petit-Thorne and Henry Yu. Alex is a fourth year student pursuing a double major in International Development Studies and Anthropology and a minor in Political Science. She is originally from Saint John, New Brunswick. She is very passionate about mental health and has participated in a number of mental health initiatives here at McGill including sitting on the Secretariat of MonWHO 2015 – Mental Health and Neurological Disorders. Henry is a senior here at McGill majoring in Neuroscience and Minoring in Finance. He first heard about MUN through a friend just this year and decided to try it out; so far the experience has been amazing. On his downtime he enjoys PC gaming, swimming, and, as all Scottish-born lads do, a fine glass of scotch. We all look forward to meeting you and spending what we are sure will be a most illuminating weekend together with fierce debate!

In true Specialized Agency form this year's simulation will be a comfortably small committee of 60 delegates. The importance of mental health care and the role of the NGO Committee on Mental Health cannot be more evident than it is in this day and age. Just a few weeks ago it was announced that John Nash, the famous American mathematician who struggled with and showed how one can triumph over issues of mental health, passed away in a motor vehicle accident. Despite his lead in tackling schizophrenia, it is unfortunate that even today, the mention of mental illness and disorders is often greeted with knee-jerk stigma and distaste. It is our responsibility to not only overcome this opprobrium, but also to create provisions to ensure that mental health care resources are available to all who require them regardless of age, gender, and socio-economic background.

We are all enthusiastic about the topics selected for this year's debate and this background guide provides a general overview of what we hope to deliberate. However,

do keep in mind that further research into any branch of the given topics would definitely help you make the most of your time at SSUNS and is most certainly suggested. Given our careful selection, we welcome you to delve into any aspect of these thought provoking and fascinating topics to further your research and prepare yourself. We are confident that you will definitely give this committee your best effort and have no doubt that come November we will be impressed with all of your work!

Finally, if you have any questions or remarks between now and the conference, or if you just want to say hello, please don't hesitate to reach out to any one of us and we'll make sure to reply as soon as possible! Thank you for choosing our conference and we hope to see you soon.

Warm Regards,

Mahathi Ramesh
Aravind Addepalli
Co-Chairs, NGO Committee on Mental Health

Introduction

Founded in 1996, the NGO Committee on Mental Health was created to foster collaboration among NGOs worldwide to bring mental health concerns to the forefront of global consideration. With the epidemic of mental illness affecting 1 out of 4 individuals worldwide, this committee is increasingly more relevant, with its mission of promoting psychosocial wellbeing and improving mental health services being at the crux of international healthcare.

Over the years, as has been the tradition with mental illness, the NGO Committee on Mental Health has had to contend with cultural stigma and a lack of recognition in the global community. Today this committee finds itself in a position of immense responsibility to ensure that crucial mental health topics are addressed and the nebulous boundaries of mental health care reach a degree of international standardization.

When debating on topics pertinent to mental health such as global access to mental healthcare as well as trauma and mental health, delegates will need to lobby to find innovative and peaceful solutions and methods while simultaneously keeping in mind the contentious history of the global reception of mental health advances.

While maintaining traditional specialized agency procedures, this committee will push the boundaries of conventional MUN through incorporation of novel working environments. How can we as a modern society address such pervasive problems? What advances are needed in our inflexible system? Where does one begin to tackle such an issue? Join the NGO Committee on Mental Health and be a part of the revolution.

Topic 1: Global Access to Mental Health Care

Introduction

The World Health Organization (WHO) as well as leading trend analysts worldwide estimate that a substantial proportion of the leading causes of disability worldwide are due to mental and neurological disorders.[1] Access, in this day and age, is the aspect of mental health care that is least prioritized by nations worldwide[2]. There are still regions in many nations where

[1] Chambers, Andrew. "Mental Illness and the Developing World." Theguardian. May 10, 2010. Accessed May 30, 2015. http://www.theguardian.com/commentisfree/2010/may/10/mental-illness-developing-world.
[2] Moller, Hans-Jurgen, and Florian Seemuller. "Time and Depression Treatment: The Value of Early Treatment Response." Medicographia RSS. 2010. Accessed May 30, 2015. http://www.medicographia.com/2010/10/time-and-depression-treatment-the-value-of-early-treatment-response.

individuals with mental disorders are thought to be possessed by paranormal entities and are thus reluctant to come forward. Laying aside developing countries, even in relatively more developed nations such as the USA and Canada, there is widespread ignorance and reluctance with regards to addressing mental disorders such as depression, schizophrenia and psychosis.

Many aspects such as lack of awareness and an insufficient legal framework culminate as a severe deficiency in access to mental health care. The NGO Committee on Mental Health recognizes that addressing this topic is essential to progress in the field of mental health care. This background guide will attempt to describe all these problems and present an overview of why the global community needs to ensure access to mental healthcare for individuals and what are the reasons that we have been short of successful so far.

Importance of Mental Health

The Rhode Island Psychological Association states, "when we are free of depression, anxiety, addictions and other psychological problems, we are more able to live our lives to the fullest"[3]. Mental health not only affects how one thinks but also subsequently how one feels and acts. Mental health problems have been hypothesized to arise majorly due to the interaction of biological and environmental factors, in what is commonly known as a stress-diathesis interaction.[4] Mental disorders are thought to represent an overwhelming 14% of the global burden of disease with most experts agreeing this is an underestimation due to cases being undiagnosed and/or mistreated[5].

The Global Burden of Disease study measures burden in "disability adjusted life years" (DALYs), which is a way of quantifying the gap between current and ideal health status. One DALY equates to one lost year of healthy life. In 2010, mental health and related disorders accounted for 183,292,000 DALYs globally.[6] These lost years represent an enormous personal as well as economic burden on a global scale. Mental health is not just a medical concern, it is a part of the larger problem of development. Low-resource settings, found mostly in less developed countries (LDCs) are settings where the resources are scarce as well as where the probability of extreme hardship is increased. These circumstances of extreme poverty, lack of nutrition and lack of access to education enhance the vulnerability to develop and misdiagnose mental disorders[7].

Moreover, the importance of mental health in today's youth cannot be overemphasized. Mental health is an indispensable cog in the development of a child and disturbance tends to interact with a child's physical health as well as academic performance. There is a pronounced unmet need for mental healthcare in this specific population, even

[3] "Useful Psychology Information: Importance of Mental Health." Rhode Island Psychological Association. Accessed May 31, 2015. http://www.ripsych.org/importance-of-mental-health.
[4] "Glossary of Psychological Terms." American Psychological Association. 2002. Accessed May 31, 2015. http://www.apa.org/research/action/glossary.aspx?tab=4.
[5] Kanellis, Pamela. "Mental Health Challenges in Developing Countries." TVO. Accessed May 31, 2015. http://theagenda.tvo.org/story/mental-health-challenges-developing-countries.
[6] "Global Burden of Neurological and Mental Disorders." Brainfacts.org. November 10, 2014. Accessed June 1, 2015. http://www.brainfacts.org/policymakers/global-burden-of-neurological-and-mental-disorders/.
[7] Brooks, Megan. "Proposed Rule to Increase Access to Mental Health Care." Medscape Medical News, April 8, 2015. Accessed May 26, 2015. http://www.medscape.com/viewarticle/842825.

more so in children from low-income backgrounds.[8] A WHO report from 2003 titled 'Caring for Children and Adolescents with Mental Disorders' states that nearly 20% of children and adolescents worldwide suffer a disabling mental illness[9] and numbers have been steadily rising.

History

Attempts to treat mental illness date back as early as 5000BCE with ancient world cultures believing the illness was due to supernatural phenomena such as demonic possession. These beliefs cultivated a taboo culture around the illness with families and friends often concealing the fact and/or abandoning the individual.[10] The first attribution of mental illness with natural physiological occurrences in the brain appeared with early European physicians such as Hippocrates in 5 BCE. Regardless, two thousand years later the social stigma associated with mental illness is still prevalent in many countries.

As recent as in 2010 Nora Mweemba, who works for the WHO in Zambia, explains how people suffering from mental disorders do not seek treatment because the issue is still considered to be a curse or punishment from God; people rely on traditional healers to cure the possession instead of approaching psychiatric or psychological institutions.[11] In a recent Centre for Addiction and Mental Health (CAMH) report, it was observed that only 50% of Canadians would tell co-workers or family members about suffering from mental disorders and 42% Canadians would be hesitant and unsure to socialize with individuals that are suffering from mental disorders.[12] These concerning figures highlight the nature of an illness that has been stagnating in the depths of stigma for thousands of years.

Barriers to Access

Worldwide, timely access to required mental health services is a critical issue facing individuals. Although the statistics on the treatment gap (the number of persons in need of help vs. those receiving help) are estimates, there are clearly apparent barriers to mental health services around the world.

1. Stigmatization and stereotyping

First and foremost is the stigmatization of the issue around the world. Social stigma is perpetuated by a lack of information about the issue. The key problem with the stigmatization of those affected by mental disorders is that it perpetuates misinformation and forces the

[8] "Children's Mental Health." American Psychological Association. 2015. Accessed July 1, 2015. http://www.apa.org/pi/families/children-mental-health.aspx.
[9] Remschmidt, Helmut, and Myron Belfer. "Mental Health Care for Children and Adolescents Worldwide: A Review." World Psychiatry. October 4, 2005. Accessed July 1, 2015. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414760/#B1.
[10] Foerschner, Allison. "The History of Mental Illness: From "Skull Drills" to "Happy Pills"" Student Pulse. 2010. Accessed May 31, 2015. (Foerschner 2010)-.
[11] Chambers, Andrew. "Mental Illness and the Developing World." Theguardian. May 10, 2010. Accessed May 30, 2015. http://www.theguardian.com/commentisfree/2010/may/10/mental-illness-developing-world.
[12] "Mental Illness and Addictions: Facts and Statistics." CAMH: Centre for Addiction and Mental Health. Accessed May 30, 2015. http://www.camh.ca/en/hospital/about_camh/newsroom/for_reporters/Pages/addictionmentalhealthstatistics.aspx.

labelling of individuals. Such labelling hinders successful management of mental disorders and propagates stereotypes that then go on to increase stigma. This vicious cycle has proven very challenging to overcome and the perseverance of stigma in the global community leads to long-term consequences for the individuals at the receiving end, such as limited opportunities for housing, employment and education.[13] Moreover, increased belief in the stereotypes of mental illness being the prominent cause of violent behaviour has led to a drastic increase in the incarceration of individuals suffering from a mental disorder as opposed to hospitalization.[14] These findings were illustrated in the Northwestern Project conducted by the Feinberg School of Medicine at Northwestern University, where it was found that an individual was 2 to 3 times more likely to be arrested if they were suffering from a mental disorder.[15]

The most effective way to combat stigma is through spreading knowledge and awareness about the reality of mental illness. In a study across nine predominantly LDCs, it was found that providing adequate knowledge about mental health problems to parents, teachers and students resulted in improved awareness about and detection of mental health disorders in school children.[16]

2. Lack of legal framework

A second equally important issue is the gross human rights violations of those who are suffering from mental illness. Many countries lack a basic legal framework to protect those with a disability. Human rights violations are extremely common around the world with patients physically restrained, isolated and denied basic rights[17].

In many countries, a lack of community-based mental health care system forces individuals with mental illness into psychiatric institutions where, even today, there are gross human rights violations and poor living conditions. Many such affected individuals are even denied the right to vote, marry and have children.[18] For example, the inability to marry exists in Bulgaria, Russia, Thailand and India (among other nations), applications of nationality are denied in Switzerland if the individual is struggling with intellectual disability, violations such as denial of food, restriction of movement, unexplained physical restraints have been observed in Zambia, wrongful and unnecessary administering of antipsychotics have been observed in Hungary and unmodified Electroconvulsive Therapy (ECT) is continuing to be administered in Turkey and Peru.[19] This widespread problem leads to discrimination and

[13] "Topics: Stigma." Mental Health Commission of Canada. Accessed May 31, 2015. http://www.mentalhealthcommission.ca/English/issues/stigma.
[14] "More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States." May 1, 2010. Accessed May 31, 2015. (E Fuller Torrey 2010).
[15] Teplin, Linda. "Health Disparities & Public Policy." Department of Psychiatry and Behavioral Sciences. Accessed May 31, 2015. http://psychiatry.northwestern.edu/research/health-disparities/.
[16] Hoven CW, Doan T, Musa GJ, et al. Worldwide child and adolescent mental health begins with awareness: a preliminary assessment in nine countries. Int Rev Psychiatry 2008;20:261–70.
[17] Chambers, Andrew. "Mental Illness and the Developing World." Theguardian. May 10, 2010. Accessed May 30, 2015. http://www.theguardian.com/commentisfree/2010/may/10/mental-illness-developing-world.
[18] "Mental Health, Human Rights & Legislation." World Health Organization. Accessed June 1, 2015. http://www.who.int/mental_health/policy/legislation/en/.
[19] Mfoafo-M'Carthy, Magnus, and Stephanie Huls. "Human Rights Violations and Mental Illness: Implications for Engagement and Adherence." Sage Journals. March 10, 2014. Accessed June 1, 2015. http://sgo.sagepub.com/content/4/1/2158244014526209.

exclusion from society, which only serves to further alienate individuals suffering from mental illness and reduce their chance at a good prognosis.

The need for comprehensive legislation to protect affected individuals is of paramount importance because mental illness affects the way people think, act and behave and diminishes their capacity to protect their own interests. Furthermore, the economic and social marginalization of people with mental disorders could be monitored and curbed with a binding legal structure. In the WHO report on Mental Health Legislation and Human Rights of 2003 it was observed that about 25% of nations, consisting of approximately 31% of the global population, have no mental health legislation. The most concerning region is the Eastern Mediterranean region where only 57% nations have protective legal frameworks.[20]

The recommended measure for nations to adopt to combat this issue is a combination of consolidated and dispersed legislation. Consolidated legislation ensures an overarching combined legislative literature that addresses all issues related to mental illness and mental health care in a single instrument while dispersed legislation incorporates different facets concerning mental health care in the pre-existing legislative systems. By assimilating both methods, the legal framework of mental health care would not only be easy to enact and adopt but would also assist in the removal of stigma and integration of individuals suffering from mental illness into the community.[21]

3. Inequitable distribution of mental health resources

Next, perhaps one of the most significant barriers of all is the shortage of mental health professionals addressing these disorders in most regions of the world. Mental health resources are very inequitably distributed around the world, with 95% of specialized human resources concentrated in high-income countries.[22] A 2014 assessment of the available mental health workforce in 144 low-income and middle-income nations yielded the results that approximately 93% of low income nations and 59% middle income nations have been experiencing a shortage of mental health professionals such as psychiatrists and nurses, totalling a deficiency of circa 239,000 mental health workers. Population analysis shows us that unless we attempt to actively solve this problem, the mental health care gap will continue to increase and will hinder economic productivity and drain resources from other developmental programs in the process.[23]

Furthermore, the population within a nation is also subject to the influence of a disparity in mental health care resources among levels of socio-economic standing. In developed nations too, the general pattern observed has been that the lower the net income of

[20] "Mental Health Legislation and Human Rights." Mental Health Policy and Service Guidance Package. 2003. Accessed June 1, 2015. http://www.who.int/mental_health/resources/en/Legislation.pdf.
[21] "Mental Health Legislation and Human Rights." Mental Health Policy and Service Guidance Package. 2003. Accessed June 1, 2015. http://www.who.int/mental_health/resources/en/Legislation.pdf.
[22] Brooks, Megan. "Proposed Rule to Increase Access to Mental Health Care." Medscape Medical News, April 8, 2015. Accessed May 26, 2015. http://www.medscape.com/viewarticle/842825.
[23] Scheffler, Richard, Tim Bruckner, and Brent Fulton. "Human Resources for Mental Health: Workforce Shortages in Low- and Middle-income Countries." Human Resources for Health Observer. February 1, 2011. Accessed June 1, 2015. http://whqlibdoc.who.int/publications/2011/9789241501019_eng.pdf.

a family, the more likely they are to develop and be diagnosed with a mental illness[24]. A theorized reason for this association is that this socio-economic deprivation is the stimulus for negative emotionality and maladaptive cognition in this population. Unfavourable mental health consequences are up to two and a half times more likely in individuals that are socially disadvantaged and this effect only increases with an increase in the socio-economic disparity. Hence the primary method to overcome the mental health care gap within a nation would undoubtedly involve attempts to close the prominent socio-economic rift.

An example of the inequitable distribution of mental health resources can even be seen in a nation with a health care system that is widely recognized by the global community as one of the best. An article by the National Collaborating Centre for Aboriginal Health (NCCAH) describes the barriers to access of mental health care resources of the Aboriginal population of Canada, especially the Inuit and Metis.[25] As elucidated by the NCCAH, the 50% of the Aboriginal population of Canada that live in rural areas face tough barriers to access such as 'low population density, lack of transportation infrastructure, ability to speak only Aboriginal languages, long wait times, inadequate human resources, and northern climate conditions'. Moreover the long distances and low population density results in high service delivery cost per capita which reduces the number of health care professionals and health care services available to this population. The harshness of the climate and the rural geographical area results in low retention of mental health care professionals as well.[26]

4. Lack of standardization of mental health care

Worldwide diagnostic variations and cultural influences reduce the efficacy of standardized mental health care. Standardization of mental health care is central to the process of increasing access to mental health care. A standard system of identification, diagnosis, treatment and prevention would increase the efficiency of the process of obtaining mental health resources and so would be able to serve a higher volume of individuals and treat more illness.

Standardization involves many aspects of the mental health care system, primarily the standardization of diagnosis and the inclusion of mental health care in insurance packages. Standardization of diagnosis has been a contentious issue in the global psychological and psychiatric community since before the publication of the first Diagnostic and Statistical Manual (DSM-I) in 1952 and is yet to be resolved.[27] The matter of diagnosis and it's social, cultural, geographical and even individual variations seem to be the principal deterrent to streamlining the entire process of mental health care. The fact that subjective variation while diagnosing a patient not only arises from the patient but the practitioner too, suggests that the

[24] Goldie, Isabella, Julie Dowds, and Chris O'Sullivan. "Mental Health and Inequalities." Mental Health Foundation. Accessed July 3, 2015. http://www.mentalhealth.org.uk/content/assets/PDF/publications/starting-today-background-paper-3.pdf.
[25] "Access to Health Services as a Social Determinant of First Nations, Inuit and Metis Health." Social Determinants of Health. 2011. Accessed July 3, 2015. http://www.nccah-ccnsa.ca/docs/fact sheets/social determinates/Access to Health Services_Eng 2010.pdf. (NCCAH 2011)
[26] "Access to Health Services as a Social Determinant of First Nations, Inuit and Metis Health." Social Determinants of Health. 2011. Accessed July 3, 2015. http://www.nccah-ccnsa.ca/docs/fact sheets/social determinates/Access to Health Services_Eng 2010.pdf.
[27] "DSM: History of the Manual." American Psychiatric Association. 2015. Accessed July 2, 2015. http://www.psychiatry.org/practice/dsm/dsm-history-of-the-manual.

lack of reliability within-culture and within-nation is almost too vast to broach, let alone the matter of standardizing mental health care diagnosis for the global community as a whole. The existence of culture-bound syndromes (a local folk illness described and recognized by people of a specific culture and that is characterized by symptom presentation peculiar to the culture[28]); multiple diagnostic manuals such as the DSM by the American Psychological Association, International Classification of Diseases (ICD) by the World Health Organization, the Chinese Classification of Mental Disorders (CCMD) and culturally relative somatization of psychological symptoms are all indicators that universalizing the diagnostic system for mental illness is much more challenging that previously conceived. However, an attempt at this standardization would go a long way in increasing access to mental health care because a standard system of diagnosis would ensure the timely administration of the appropriate treatment and a scheduled and planned prognosis for the suffering individual. Such a structured process would not only reassure individuals of the efficacy of mental health care but also provide for more distressed individuals.

A second aspect of mental health care that is need of standardization is its inclusion in health insurance policies. Many nations do offer mental health coverage under health insurance but provision of mental health care isn't mandatory. Including this in health insurance policies will bring mental health care options to the forefront of health care, educate more and more individuals about its benefits and importance and ensure better prospects of mental health care for all involved. On the other hand, many developing nations have barely started to cope with general physiological health concerns and do not consider mental health issues to be a priority when even basic health care isn't being successfully provided to individuals.

Case Study: mhGAP

The WHO Mental Health Gap Action Programme (mhGAP) has been the most successful and concerted effort to reduce the gap between the resources required in relation to mental health care and the resources available. mhGAP aims to scale up services in low and middle income nations for mental, neurological and substance use disorders and recommends interventions for prevention and management of these conditions. It plans to enable direct mental health care access to the individual suffering from mental illness in a timely and efficient manner.[29]

This action programme includes many useful tools such as protocols for clinical decision-making for priority mental health conditions such as depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm/suicide and other significant emotional or medically unexplained complaints. The most beneficial aspect of the programme is that it can be adapted by health-care providers and workers in specialized or

[28] Simons, MD, Ronald. "Introduction to Culture-Bound Syndromes." Psychiatric Times. November 1, 2001. Accessed June 3, 2015. http://www.psychiatrictimes.com/cultural-psychiatry/introduction-culture-bound-syndromes-0.
[29] "MhGAP Mental Health Gap Action Programme." World Health Organization. Accessed June 1, 2015. http://www.who.int/mental_health/evidence/mhGAP/en/.

non-specialized settings to suit the local needs of the community it has been implemented in.[30]

The World Health Organization partnered with the European Commission and the Ministries of Health of Ethiopia and Nigeria to support the implementation of mhGAP in the two nations. The aim of the project is to decentralize and integrate mental health care into the central health care system and this is in line with the mhGAP policy to scale up care. The WHO Global Mental Health Action Plan of 2013-2020 includes the mhGAP implementation in the WHO African Region, mainly concentrated in Ethiopia and Nigeria.

Currently the project is in its Proof of Concept phase wherein analysts are devising a method to integrate requisite policies from mhGAP into the existing health care infrastructure and in four pilot sites of implementation 2,730 people benefitted from the entire project. The fundamental measures that the project is basing the scaling up of services on are the training of mental as well as non-mental health care professionals, increasing the involvement of Regional Health Bureaus and ensuring the continuous availability of psychotropic medication at a health facility level. [31] A notable achievement since the start of the project has been the training of more than 400 psychiatric nurses and their deployment to various health care facilities in increasingly inaccessible regions, which has spread the project to the periphery of the nation.

The mhGAP tool has been modified into many forms over the years to better suit specialized situations where mental health care has been compromised in order to increase its versatility and increase access to mental health care. The WHO and United Nations High Commissioner for Refugees (UNHCR) issued a guide on mental health in humanitarian emergencies called the mhGAP-HIG (Mental Health Gap Action Programme-Humanitarian Intervention Programme) so that non-specialist health workers in in regions with humanitarian emergencies arising from natural disaster and armed conflict, such as Central African Republic, South Sudan, Syrian Arab Republic, Yemen and very recently, Nepal. The guide focuses on modules that help assess and manage conditions such as acute stress, grief, moderate to severe major depressive disorder and post-traumatic stress disorder.[32]

Conclusion

Mental health is an aspect of life that is of utmost importance to everyone in the population regardless of age, sex, race or creed. Problems pertaining to mental health are thus pervasive and affect populations without discrimination. Throughout history the face of the mental health paradigm has shifted immensely with the elusive nature of conditions such as schizophrenia and psychosis being misinterpreted time and time again. Though we have

[30] "MhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings." National Center for Biotechnology Information. 2010. Accessed June 1, 2015. http://www.ncbi.nlm.nih.gov/books/NBK138690/.
[31] "MhGAP in Ethiopia: Proof of Concept." 2013. Accessed June 1, 2015. http://www.who.int/mental_health/mhgap/mhgap_ethiopia_proof_of_concept_2013.pdf?ua=1.
[32] "MhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies." ReliefWeb. May 5, 2015. Accessed June 1, 2015. http://reliefweb.int/report/world/mhgap-humanitarian-intervention-guide-mhgap-hig-clinical-management-mental-neurological.

come a long way in terms of understanding mental health issues, in an era of daily scientific progress and medical breakthroughs, the effort behind addressing these conditions is unfortunately lackluster.

This is an issue that can be attended to from both sides of the spectrum; starting from an individual as well as population level. As can be observed from the WHO mhGAP, a dedicated effort to increase access of mental health care even in developing and less developed nations can be a very successful endeavor. At the very least, an exploration into the requirements of people suffering from mental illness can give the global community a sense of the potential problems as well as the innovative solutions that can be implemented worldwide in relation to mental health and access to care.

The foremost problem to deal with is access to mental health care. By acknowledging and much more significantly spearheading initiatives tackling barriers such as stigmatization, subpar legal frameworks, inequitable resource allocation, and lacking regulatory standardization, we as a modern society can turn the tides of ignorance with regards to mental health. While leading nations such as the United States propose to address lacking access to mental health care in less developed countries, there are many issues within these developed areas that require improvement as well. Simple discussion about the problems facing mental health around the world is a small yet significant step in the right direction as a society, however we must make sure to make the conversations a reality in step with our developing society.

Questions to Consider

1. What are the basic steps a developing nation could take to increase access to mental health care? (For example, a simple 5-step plan to be implemented in institutions offering mental health care such as a national helpline, reallocation of resources around the nation, inclusion of mental health care in insurance policies etc.)
2. What are the foremost problems with regards to access to mental health care to address in developed countries?
3. How can access to mental health care during emergencies be increased and made more efficient?
4. What can individuals do to help facilitate greater access to mental health care?
5. How can children be involved in the control and prevention of stigmatization and stereotyping of those with mental illness?

Topic 2: Trauma

This committee will focus primarily on two types of trauma: man-made trauma, including war and violence, and natural disaster related trauma.

What is trauma?

According to the American Psychological Association, trauma is an emotional response to a traumatic event, typically including immediate shock and denial and long term psychological and physical symptoms[33]. A traumatic event requires a stressor, as per DSM-IV criterion, that induces a response of intense fear, helplessness or horror in the face of trauma[34]. Traumatic events can include sexual abuse, physical abuse, emotional abuse, neglect, serious accidents or illnesses, domestic violence, community violence, school violence, natural or manmade disasters, forced displacement, war and terrorism, extreme interpersonal violence, and system-induced trauma[35]. Symptoms relating to traumatic experiences can manifest themselves physically, emotionally, and psychologically – this can include developing a variety of psychiatric conditions, including anxiety, depression, post-traumatic stress disorder, substance abuse, and suicidal ideation among others[36].

Trauma and its effects

Post-traumatic stress disorder is a condition resulting from exposure to a traumatic or life-threatening event that is processed in such a way that there is a psychological continuation of the sense of threat beyond the event itself.[37] The diagnosis of post-traumatic stress disorder (PTSD) was first applied to Vietnam veterans and has since been applied to a range of traumas.[38] An individual's psychiatric and medical history is consistently found to a risk factor in the development of trauma related psychiatric conditions.[39] Post-traumatic stress disorder is often linked to a number of other psychiatric conditions, including anxiety, depression, and substance abuse – it is important to note that the correlation between these conditions in a variety of patients does not prove a causal link between psychiatric conditions. PTSD can occur as a primary disorder or secondarily as a result of an existing disorder. Generally, other psychiatric disorders increase the risk of exposure to trauma and increase the risk of developing PTSD.[40] Women tend to have a higher rate of exposure to trauma, as will be touched upon in the case studies to follow, as thus a higher risk of developing PTSD.[41]

[33] American Psychological Association, 2015
[34] Hapke et al., 2006: 299
[35] Center for Early Childhood Mental Health Consultation, Georgetown University, 2015
[36] Johnson and Thompson, 2007
[37] Ibid.
[38] Hapke et al, 2006; 299
[39] Hapke et al, 2006; 300
[40] Ibid
[41] Ibid

Man-Made Trauma

Case study: Humanitarian aid workers in Uganda

A study of humanitarian aid workers in Northern Uganda examined the mental health of aid workers and examined correlations between working environments, exposure to stressors and traumatic events, and the prevalence of post-traumatic stress disorder, depression, and anxiety disorders. The major stressors for aid workers included financial and economic problems, high workload, and workplace tensions due to the disparity of treatment between international and local staff.[42]

This study found a negative correlation between the availability of group support systems within the workplace and the reporting of symptoms. For example, United Nations humanitarian workers enjoyed much better work place cohesion and systems of social support and also reported significantly fewer instances of workers presenting symptoms of PTSD, depression or anxiety. United Nations workers also had, on average, fewer incidences of exposure to chronic stressors.[43]

Nationals were at a higher risk than their foreign colleagues of suffering adverse mental health effects.[44] The researchers attribute this to a variety of factors, including a difference in the way local and international workers are treated as well as a higher prevalence for re-exposure to stressors and traumatic events in local workers. They also found that, in general, female workers reported more symptoms than their male colleagues and experienced higher levels of distress.[45] Overall, there is generally a lack of mental health data in Uganda to compare with the data taken from humanitarian workers.

Case study: Group mental health in Lebanese civilians post-civil war

This study was conducted to examine the effects of cognitive behavioural group therapy in civilian populations that were exposed to conflict and violence.[46] Cognitive behaviour therapy (CBT) was adapted to fit a group setting for this pilot project and was further adapted to Lebanese culture. The majority of participants in this pilot used the group CBT as an opportunity to build more social connections and a support network while sharing their experiences. The majority of participants were satisfied with the experience of group CBT, experienced a general decreased in symptoms of trauma related disorders, and benefitted from positive group interactions of therapeutic and social benefit.[47]

The group setting also allowed for psychoeducation. Participants generally lacked knowledge regarding general mental health issues, particularly psychiatric symptoms and the potential effects of trauma. Psychoeducation was introduced in appropriate amounts as it was relevant to the group therapy. Following this, many participants were able to

[42] Ager et al., 2012
[43] Ibid.
[44] Ibid.
[45] Ibid.
[46] Farhood et al., 2014
[47] Ibid.

identify symptoms they had previously experienced and were generally receptive to both the physical and psychological ways in which these symptoms may present themselves.[48]

The participants perceived the group as a potential support network and a safe space to share their experiences,[49] which would encourage the expansion of this pilot program. Despite the positive affect of psychoeducation, stigma surrounding mental health acted as the greatest barrier to attendance and participation in group CBT.[50] The rural communities in which this pilot was conducted was tight-knit – this could be utilized in forming a strong support system if further group CBT is implemented. However, as it stands, the structure of these communities reinforces stigma and poses a significant challenge to progress in the field of mental health.[51]

Natural Disasters

Case Study: 2004 Indian Ocean Tsunami

In this case study, adult Thai survivors were psychologically assessed at 2 weeks and 6 month following the 2004 Indian Ocean tsunami. According to this study, 22% of survivors reported traumatic stress symptoms at the 2 week assessment, while a total of 30% reported symptoms in the 6 month assessment.[52] Tang identified four trajectories in which traumatic stress symptoms presented themselves: 12% of survivors showed symptoms of chronic stress, 18% experienced a delayed onset of symptoms, 10% showed an improvement over time, and the remaining 60% of survivors studied maintained emotional stability. Tang (2007) also noted the following trends among survivors expressing symptoms of traumatic stress: chronic stress was experienced primarily by the oldest group of the population, delayed onset of traumatic stress was experienced by groups who received the lowest amount of government support in the recovery period, and those that maintained stability were exposed to the fewest post-disaster stressors.

In East Asia, post-traumatic stress disorder in natural disaster survivors is associates with negative physical outcomes and a variety of comorbid psychiatric disturbances, including anxiety, depression, and suicidal ideation. The percentage of natural disaster survivors that present traumatic stress symptoms in East Asia range from 3-25%, depending on the country. Comparatively, in Western countries, the prevalence rates of trauma related symptoms range as high as 85% of survivors.[53] Tang and other researchers have noted that Asian disaster survivors face a cultural stigma regarding mental health and may be uncomfortable with reporting traumatic stress symptoms. They also noted that in many survivors, these symptoms may have been expressed somatically rather than psychologically.[54]

[48] Farhood et al., 2014
[49] Ibid.
[50] Ibid.
[51] Ibid.
[52] Tang, 2007
[53] Ibid.
[54] Ibid.

Case Study: 2010 Haitian Earthquake

In Cerda et al.'s 2013[55] study of survivors of the 2010 Haiti earthquake, a population-based study of survivors was conducted to determine the incidence of post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) in the 2-4 months following the earthquake. This study assessed social, culture, and demographic factors that influenced the mental health of survivors in the pre-, peri-, and post-earthquake periods as well as the post-earthquake social support system. The sample of participants in this study included members from the Port-au-Prince community, internally displaced persons camps, and a variety of clinics.

The study found that there was a high burden of traumatic events and associated stressors experienced by the Port-au-Prince population after the earthquake. The prevalence of PTSD and MDD was exceptionally high in the 2 months following the earthquake, particularly in survivors with a history of violent trauma. The study also found a significant gender difference.[56]

[55] Cerda et al., 2013
[56] Ibid.

Topic 3: Crisis

Introduction

In modern times, the World Health Organization (WHO), various non-profit organizations and government entities all recognize the legitimacy of mental illness. These organizations strive to provide treatment and services to help those with metal and neurological disorders[57]. From a historical perspective however, it is not until the last 100 years that society changed their long-held negativity towards mental and physical deformities. Persons with mental disabilities were historically mistreated. They were seen as burdens towards society, symbols of shame to the family and were usually hidden away in asylums and mental institutions. In current times, we have made strides to improve their quality of life and to provide products and services to accommodate their needs. However, certain regions throughout the world, especially in undeveloped countries, mental illness is not regarded as a legitimate disorder and there are little social/medical infrastructure to accommodate these persons[58].

To understand factors in improving the quality of care for persons with mental illnesses, this background guide will influential historical events that have caused major paradigm shifts. When decisions are made for the care of the mentally disabled, many conflicting factors are present. These include protecting the mentally disabled from harm, protecting the general public from harm, maintaining the human rights and dignity of these people, providing the research and treatment facilities necessary to provide therapies and treatments, and ensuring that the plans are financially feasible. Historically, funding for mental illness research and for the care of mentally ill patients are deplorable, which left few resources and horrid treatment of patients. The lack of research ethics and a governing body for patient treatment and care left mentally ill patients subjected to inhumane studies. These historical events and blunders have dictated a large portion of research ethics and treatment of care quality for patients. The two that we are focusing on are the Willowbrook State School affair of the 1950's and the eugenics movement of the early 1900's. These two examples highlight some of the horrific treatment that were present in a previous era, and provides some food for thought on some issues still prevalent in today's era.

Willowbrook State School

In previous generations, research ethics laws and regulations concerning human experimentations were very lax and self-regulated. As a result, questionable human experimentation, usually without participant consent, is conducted with little or no regard of the safety of the participant in question. Usually, human experimentation was conducted on marginalized populations; the homeless, the frail, the weak, and the mentally challenged. For example, the Tuskegee syphilis in the mid 1900's recruited only African American males for a research study for the symptoms of untreated syphilis.

[57] "WHO | Global Health Atlas." WHO | Global Health Atlas.
[58] Collins, Pamela. "Grand Challenges in Global Mental Health." *Nature* Vol.475 (2011).

These clean recruits were under the impression that they were receiving free health care, but were injected and infected with syphilis. While a cure for the symptoms of syphilis was already invented at this time, these types of unethical studies were still performed by well-known institutions like the US Public Health Services[59]. The same scenario exists for persons with mental illnesses; they were usually the subjects for inhumane research tests due to their incapacity to object to treatment and that they were in state institutions where secrets are not easily let loose.

Willowbrooke State State School was an institution for mentally challenged children located in New York City. As the largest state-run mental institution in the 1950's, it housed 6000 children while only having a designed capacity of 4000. Due to the over population and lack of nurses and caretakers, the facilities were unsanitary and the mentally ill children were severely mistreated and abused[60]. First-person testimony of the space deemed "[the children] living in filth and dirt, their clothes and rags, in rooms less comfortable and cheerful than cages"[61], similar to a garbage dump to store and keep the mentally ill children hidden away from society's eyes. This problem stemmed from many factors. First was the low funding received from the state government, which prevented the directors from hiring an adequate number of nurses and from maintaining proper equipment and food supplies. Second, at that time, many parents with mentally ill children wanted to institutionalize them, creating excess demand that cramped the institutions. Lastly, ongoings within the institutions were kept secret with no oversight into the types of experiments conducted there. A tip given to a local news station from a disgruntled employee eventually brought this entire situation to light.

On top of the appalling conditions at Willowbrook, Dr. Saul Krugman of New York University and Robert W. McCollum of Yale University conducted a series of controversial medical tests on the children that eventually lead to the shutdown of the institution. Krugman and his colleague studied the human immune response to hepatitis through the gamma globulin[62]. This was done through injecting the hepatitis virus onto the healthy mentally challenged children, rendering them nothing more than "human guinea pigs"[63]. The unsanitary conditions lead to outbreaks of hepatitis throughout the institution, and many of the children became ill and passed away.

With this experiment, Krugman made strides in understanding the transmission of hepatitis and the human immune response. These discoveries would help prevent many people from contracting hepatitis in the future. Krugment even obtained parental consent forms of all of the participants. Despite all are the lives and safety of thousands of

[59] Brandt, Allan M. "Racism and research: the case of the Tuskegee Syphilis Study." *Hastings Center Report* 8, no. 6 (1978): 21-29.
[60] Rivera, Geraldo, prod. *Willowbrook: The Last Great Disgrace*. WABC-TV Channel 7. Staten Island, New York(1972).
[61] Rothman, David J., and Sheila M. Rothman. *The Willowbrook Wars: Bringing the Mentally Disabled into the Community* (2005).
[62] Stephen Goldby, Saul Krugman, M. H. Pappworth, and Geoffrey Edsall: The Willowbrook Letters, "Criticism and Defense". The Lancet(1971)
[63] Rothman, David J., and Sheila M. Rothman. *The Willowbrook Wars: Bringing the Mentally Disabled into the Community* (2005).

mentally challenged children worth the sacrifice? Is it morally correct to conduct experiments on this vulnerable population, even if it was consented by their legal guardian or parent? Do the mentally challenged or children have the capacity to consent to experimentation, and should it matter, if they receive little or no direct benefit from it? Should the mentally challenged be forced into institutions, as in this case, or should they be integrated into the same schools as other children?

In conclusion, an expose lead by reporter Gerardo Rivera brought the Willowbrook experiments into the public eye, and social outcry shut down the state school and leads to a lawsuit against the institution. This lead to new federal legislation, which protects the mentally ill from unethical or dangerous human experimentations.

Eugenics

In the early 1900's, Charles Darwin's cousin, Francis Galton, created the concept of eugenics[64]. Eugenics compasses the desire to improve the genetic quality of the human population through selectively reproducing those with desirable qualities. Eugenics was a very popular idea that stemmed from the recent conceptualization of genetics by Mendelson. Eugenics reached a height in the 1920's and was taught in esteemed universities and the American eugenics movement received extensive funding from esteemed foundations such as the Rockefeller Foundation and the Carnegie Institution. The eugenics movement provided the scientific rational for Americans to implement immigration restrictions, compulsory sterilization, euthanasia programs and family eugenics competitions.

The unfortunate by-product of the eugenics movement was that people used it as an excuse for xenophobic and discriminatory agendas. This includes racial discrimination, people with physical and mental deformities and the poor. This was an extremely unfortunate time for persons with mental disabilities as the eugenics movement portrayed them as inferior and unfit individuals within the population. Within this era, persons labelled as mentally retarded had their rights gradually stripped from them, preventing them from living a normal and fruitful life. It began with laws that prevented marriage for persons who were "epileptic, imbecile and feeble-minded", enacted in 27 states. From there, feminists groups and women's clubs set up eugenics institutions for the feebleminded to segregate them from the rest of society.

The worst actions from the Eugenics movement came in the form of forced sterilizations. Mentally retarded males and females were subjected to forced sterilizations to prohibit them from reproducing and passing on what people considered "bad blood". While compulsory sterilization was initially a frowned upon idea and was vetoed in many states, the Supreme Court case of Buck vs. Bell made the idea popular in many states[65]. By the 1930's, forced sterilizations were the common practice in state mental institutions,

[64] Susan Currell. Popular eugenics: national efficiency and American mass culture in the 1930s. *Ohio University Press*(2006).
[65] Lombardo, Paul A. "Three generations, no imbeciles: New light on Buck v. Bell." *NYUL Rev.* 60 (1985): 30.

along with criminals and poor ethnic minorities. In total, around 64,000 individuals underwent compulsory sterilization, the majority of which were mentally retarded women.

It is important to note, that although the intention of forced sterilization was to create a "better" human race, it only resulted in marginalizing the mentally handicapped[66]. Most of the mentally ill were seen as a burden to society as they are wards placed into state institutions. Preliminary and mostly questionable scientific evidence at the time pointed to genes as the cause of these "feeblemindedness". However, how doctors and psychologists classified people as "feebleminded" was not standardized nor overseen. As a result, people without any mental disorders underwent forced sterilizations for "oversexuality", being poor, and as victims of abuse. In all cases, sterilizations occurred without any patient consent, such as the case where black women on welfare were forced on sterilizations to remain under welfare[67].

Eugenics faded from popularity after the Second World War and after the extent of euthanasia and compulsory sterilization was brought to the public eye. However, before eugenics' decline in America, it gained lots of traction in California, a state that authorized the most sterilization[68]. California eugenicists gave brochures advocating eugenics to German officials, along with grants provided by Carnegie and Rockefeller into German eugenics experiments. These measures began the German ideology of a "pure race" and the Anti-semantic movement.

The Eugenics movement of the early 20th century provides a good historical example of how not to treat persons with mental disorders. They should not been seen as burdens to society that need to be segregated and prevented from reproducing. Their access to basic human rights should not be violated under any circumstance. This brings up questions regarding mental illness such as what role does the mentally disabled have in society. How do we remove the stigma that they are "inferior" members of society? Whose responsibility is it to care for them? Is it the state, individual families, and how can we ensure that no harm falls against them?

[66] Black, Edwin. "War against the weak: Eugenics and America's campaign to create a master race." *New York* (2003).
[67] Dikötter, Frank. "Race culture: recent perspectives on the history of eugenics." *American Historical Review* (1998): 467-478.
[68] Kühl, Stefan. *Nazi Connection: Eugenics, American Racism, and German National Socialism*. Oxford University Press, 2002.

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