

ADVOCACY BRIEF

MENTAL HEALTH IN THE TIME OF COVID-19

BACKGROUND

Mental health plays a key role in efforts to achieve social inclusion and equity, universal health coverage, access to justice and human rights, and sustainable economic development. The ongoing COVID-19 pandemic has overwhelmed and caused havoc on already fragile health systems in most countries in our region. Even prior to the outbreak, global statistics on mental health conditions were already bleak. An ongoing, long standing issue is that responses to mental health has always been heavily underfunded. Countries spend on average only 2% of their health budgets on mental health. A significant proportion of mental health needs in our region is unmet, and this has substantial effects on the social ecology and economic stability of communities.

This advocacy brief, done in partnership between APCASO, UNFPA APRO and country focal points who convened an expert group from the region that formulated policy recommendations in framing pandemic and post-pandemic responses that are community-centered, rights-affirmative, and

gender-transformative. A virtual dialogue was conducted on 4th December 2020 with relevant stakeholders to generate discussion and recommendations that are reflected in this advocacy brief.

THE IMPACT OF COVID-19 ON MENTAL HEALTH

The mental health effects of COVID-19 result not only from trauma exposure but may also arise from the implementation of public health response strategies such as quarantine, physical and social distancing. This is further exacerbated by economic insecurity, unemployment, school closures and the shutdown of existing infrastructures with devastating effects on the mental health of the general population. While many people demonstrate tremendous resilience during emergencies and in the immediate aftermath, the long-term psychological effects of pandemics are often debilitating with far fetching consequences. Key, vulnerable and marginalized communities with layered social and economic vulnerabilities are at the center of these synergistic epidemics, or syndemics, which have interacting effects that amplify disease burden in the populations they affect.¹

Health emergencies, in spite of their tragic nature and adverse effects on mental health, are also unparalleled opportunities to improve the lives of large numbers of people through reforms. The pandemic has inevitably brought discussions and awareness of mental health to the forefront. This is especially pertinent for a region like



JIP team providing health services to local communities in Indonesia. Photo: Jaringan Indonesia Positif (JIP).

Rapid assessment on the needs of people living with HIV (PLHIV) in Indonesia.

In March 2020, the Positive Indonesia Network or Jaringan Indonesia Positif (JIP) conducted a rapid survey among 1,000 respondents to assess the needs of PLHIV at the start of the COVID-19 pandemic. JIP, with support from UNAIDS and WHO, then conducted a follow up survey in August 2020 with 1,035 respondents. Specifically related to mental health, 41% respondents disclosed undergoing 'heavy anxiety' in both the surveys with 26% in the first survey disclosing experiences of 'high anxiety' which increased to 27% in the second survey. Respondents expressed the need for psychosocial support and counselling for anxiety and depression as health services needed during this time. Findings from the rapid survey was seen as a strong tool and evidence base for advocacy to the government as well as to create recommendations on how to strengthen the HIV programme in the future including the integration of services available to PLHIV.

A more specific rapid assessment to measure the impact of COVID-19 on the socio-economic situation, and gender-based violence (GBV) and sexual and reproductive health (SRH) experiences among women living with HIV and women who are partners of PLHIV was also conducted by JIP with support from UNFPA. Of the 260 respondents, 16.9% reported 'severe anxiety', and 16.4% reported 'very severe anxiety' due to th-19 outbreak. The assessment recommends access to information and mental health services that are integrated with HIV as essential in dealing with the pandemic and concrete efforts to ensure information and referral for mental health services can be accessed easily.

Asia-Pacific - where stigma, taboo, and discrimination still heavily surround mental health - wherein an opportune moment is at hand to normalize the narrative of mental health. The pandemic presents a critical opportunity to reimagine and re-strategize mental health care. Positive coping mechanisms and good practices are reported to be emerging in different countries and communities. Actions are being taken and organizations are introducing innovative initiatives to help overcome challenges and working to help meet mental health needs during these extraordinary times. However, to sustain this and to reduce overall stigma regarding mental health will require sustained effort over months and years as the full impact of the pandemic is felt by communities across the world.

HOLISTIC APPROACH TO MENTAL HEALTH

WHO defines health as "A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."⁴ It further defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

These definitions link health explicitly with well-being, and conceptualizes health as a human right requiring physical and social resources to achieve and maintain. Thus 'well-being' refers to a positive rather than neutral state, framing health as a positive aspiration. This is consistent with the biopsychosocial model of health, which considers physiological, psychological and social factors in health and illness, and interactions between these factors. It differs from the traditional biomedical model, which defines health as the absence of illness or disease and emphasizes the role of clinical diagnosis and intervention. Despite these assertions, an approach that focuses on well-being has and continues to be a challenge as most mental health interventions are illness-oriented instead of wellbeing-oriented.

In order to realize the full definition of health, there needs to be more emphasis on well-being in a broader sense, one that pays sufficient attention to the numerous determinants of mental health. Mental healthcare in public health needs to focus on a holistic approach which is characterized by the treatment of the whole person, taking into consideration environmental and social factors, rather than just the symptoms of a disease thus adopting a patient-centered instead of a disease-centered approach.

MENTAL HEALTH AND THE SDGs

Goal 3 of the SDGs: Ensure healthy lives and promote well-being for all at all ages. Within Goal 3, mental health is referred to three times, directly in the target to ‘reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being’ (target 3.4); in the further target to ‘strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol’ (target 3.5); and is also implicitly included in universal health coverage to ‘achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all’ (target 3.8) (United Nations, 2015).

The nexus between mental health and development had finally been acknowledged at an unprecedented level and scale through the SDGs, the first time that a major global development instrument included the promotion of mental health and well-being as an objective. This further emphasized the point that achieving the goals of promoting good mental health and wellbeing for all, and providing good and dignified treatment for those in need, requires a multidisciplinary action as mental health intersects with and influences most of the other SDGs. The solution will not only be found in the health sector. The Lancet Commission on global mental health and sustainable development too proposes a dramatic reframing of mental health as not just a health issue, but as a crosscutting development issue relevant to virtually all of the SDGs.⁶

The approach ensures that support and comfort are provided to the individual, their family and community. Mental health services are also increasingly being encouraged to adopt a recovery-based approach; the recovery approach respects that mental health is about more than symptom reduction; it is about people deciding what outcomes are important for them to live a more meaningful and satisfying life.⁵

KEY POPULATIONS, VULNERABILITY AND MENTAL HEALTH

The right to health contains the core obligation to ensure the “right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups”.⁷ Vulnerability is dynamic, and an individual’s level of vulnerability in a time like this is dependent on a range of contextual factors, resulting in resilience at times and vulnerability at others. The burden of mental disorders does not uniformly affect all sections of society. Groups with pre-existing vulnerabilities, adverse circumstances and the least resources often face the highest burden of vulnerability.

The relationship between HIV, TB, and mental health issues is bi-directional – poor mental health is a risk factor for HIV and TB exposure which complicates both the course of the disease and treatment. In addition, living

with HIV and/or TB is a significant risk factor for a decline in the individual’s mental health, and developing psychiatric illness.⁸ Key populations (KPs) are particularly vulnerable to service interruptions and additional harm during the COVID-19 pandemic. Stigma, discrimination, violence and other human rights violations routinely experienced by key populations will likely worsen, as will other obstacles key populations face in accessing services, perhaps making it more likely they will be denied assistance when they seek care.⁹ Other important services, like opioid substitution and gender-affirming hormone therapies, may be deprioritized as non-essential. In addition to disruptions in access to essential medicines, commodities and health services, some key populations are at increased risk of indirect impacts arising from responses to COVID-19, particularly physical distancing measures and lockdowns.

The negative consequences of these measures on general population health and well-being, such as mental health issues arising from isolation, loss of income and residential instability, will be exacerbated in vulnerable KPs who lack the resources to physically distance or who do not have access to social safety nets or the option of working from home.¹⁰

Mental health is closely related to TB, depression often coexists with TB, and this comorbidity is associated with poor adherence to TB treatment and higher mortality. Lack of adherence to anti-TB regimens may lead to higher risk for drug resistance, morbidity, and mortality, as well as



Key population network and groups during capacity building workshop in Sri Lanka. Photo: APCASO.

Community-led rapid survey: COVID-19 impact on key populations in Sri Lanka.

In SRI LANKA, a rapid assessment¹² (with about 329 participants) was carried out by CARE Consortium (a KP network) with support from APCASO to assess the immediate impact of the curfew and other COVID-19 pandemic control measures on KPs and PLHIV communities. The community-led assessment was aimed at forging a working relationship with relevant stakeholders in the HIV response in the country to collectively address the needs of the key populations, including mental health. The survey revealed that 75% of the respondents experienced mental health related conditions (stress, helplessness, anxiety and depression). A majority of them were not aware of any mental health services available to them and mental health support that are usually provided faced the additional challenge of curfews and lockdowns.

The assessment recommends that further research in collaborations with KP organizations should be conducted to understand the mental health conditions and needs of the KPs; KP-led and serving organizations should integrate addressing mental health issues among KPs in their organizational mandates and implement concrete interventions targeting mental health issues; mental health services should be integrated into HIV services as a key component of comprehensive HIV prevention, testing, treatment and care packages and that partnerships need to be developed between KP-led and serving organization and organizations that provide mental health support to provide sensitive and comprehensive mental health services to KPs.

community exposure to TB. Coping with a TB diagnosis itself and the related treatment can be difficult and cause a lot of worries. On top of that, the changes and uncertainty due to COVID-19 have created anxiety, stress, depression and fear among communities and people affected by TB. Collectively, these experiences will have far-reaching consequences on the mental health of KPs and needs to be addressed as part of the pandemic response.

CHALLENGES TO ACHIEVING HOLISTIC, COMPREHENSIVE AND INTEGRATED MENTAL HEALTH CARE

I. NARROW BIOMEDICAL APPROACH TO MENTAL HEALTHCARE

A narrow biomedical approach to mental healthcare is limiting as it cannot fully or sufficiently capture the reality, nature, and causes of mental disorder or illness in all their forms. Medicalization occurs when a diversity of behaviors, feelings, conditions or health problems are “defined in medical terms, described using medical language, understood through the adoption of a medical framework, or treated through medical intervention”.¹³ This approach is often associated with social control as it serves to enforce boundaries between what is defined as normal or acceptable behaviors and experiences. When experiences and problems are seen as purely medical, responses are then centered around individual-level interventions that aim to return an individual to a level of functioning within a social system rather than addressing the systemic failures and the changes required to counter the faults at the societal level. A purely biomedical approach promotes a “disease” model of mental health that rely heavily on diagnostic criteria and views mental health challenges as monolithic in terms of their effects on individuals.¹⁴ The approach is also potentially risky of legitimizing coercive practices that violate human rights and may further entrench discrimination against groups already marginalized.

On the other hand, the biopsychosocial approach introduced by Engel¹⁵ considers biological, psychological, and social factors and their complex interactions in understanding mental health, illness, and mental health care delivery. It provides important opportunities to link mental health outcomes to development approaches that address systemic faults, like poverty eradication,

employment opportunities, improving inequities and inequalities. However despite having been introduced since the 1970s, the integration of the biopsychosocial approach into mental health care has still not fully materialized. Addressing the overemphasis on a purely biomedical view and a shift towards the comprehensive nature of the biopsychosocial approach requires a shift in views, a re-look at established mental health systems as well as re-strategizing our efforts to build new systems.

II. STIGMA AND DISCRIMINATION

People with mental health issues face the dual challenge of the disease along with the stigma and discrimination that comes with it. In the context of mental health, stigma can be defined as a distinguishing demarcation between the people with and without psychiatric illnesses, attributing negative characteristics of psychiatric illnesses to this person.¹⁶ Stigma is a major cause of discrimination and social exclusion that leads to low self-esteem, psychological burden, and ultimately interfere and lead to a negative impact on adherence and attitude towards psychiatric treatment. Discrimination against people diagnosed with mental health issues may lead to delays and avoidance of psychiatric treatments. Stigma associated with seeking mental health support is highly prevalent in the region. The culture of seeking the support of a counsellor or a therapists is not usual and even if it is done, it is usually done discreetly. This is especially so for key populations who are often considered to be psychologically challenged which makes seeking mental health support a way of confirming this stereotype, hence the reluctance to seek support even when going through a mental health crisis.

Besides public stigma there is also the self-stigmatization when a person with a mental health diagnosis becomes aware of public stigma, agrees with those stereotypes, and internalizes them by applying them to the self.¹⁷ Stigma and discrimination are further perpetuated by inaccurate information about mental disorders, such as the notion that people with mental disorders are often violent or bewitched in some way, or that mental disorders are untreatable. Lack of access to effective treatments, and provision of care in isolated mental asylums serve to prolong these misperceptions. Stigma and discrimination are the most significant challenges that people living with chronic diseases face, leading to a negative quality of life. Holistic mental health interventions require specific efforts to address and remove barriers linked to stigma and discrimination.



Asian woman during lockdown. Photo: MIA Studio/Shutterstock.

III. LOW MENTAL HEALTH LITERACY

Mental health literacy is defined as the knowledge and beliefs about mental disorders which aid recognition, management or prevention.¹⁸ Recent definitions include four distinct but related components: understanding how to obtain and maintain good mental health, understanding mental disorders and their treatments, reducing the stigma related to mental disorders, and enhancing help-seeking efficacy.¹⁹ This broader definition advances previous perceptions and includes not only knowledge and beliefs about mental ill-health, but also the promotion of mental health.

Mental health literacy remains relatively low in countries in our region. Mental health literacy which often translates to public knowledge about mental health is a necessary prerequisite for positive public attitudes towards mental health. The attitudes of the public towards mental health issues are important factors in the stigma experienced by people with mental illness and attitudes are generally shaped by knowledge or the lack of it. Improved knowledge about mental health and mental disorders, better awareness of how to seek help and treatment, and reduced stigma against mental illness at individual, community and institutional levels may promote early identification of mental disorders, improve mental health outcomes, increase the use of mental health services.

IV. LACK OF SPACE AND OPPORTUNITY FOR PARTICIPATION

Everyone is entitled to active and informed participation in issues relating to their mental health, at all levels. However the ‘nothing about us without us’ maxim seems to have been largely overlooked in the mental health sphere. In theory, participation of persons with mental health conditions, in the planning, monitoring and evaluation of services, in system strengthening and in research, is now more widely recognized as a way to improve the quality, accessibility and availability of services and the strengthening of mental health systems. However there is little evidence available to show where and how this has been done especially in countries in our region, particularly at the systems or policy level.

For many, being “listened to” is therapeutic thus pivotal to healing in crisis and this requires a rights-based support that ensures diverse, participatory, multifaceted communication methods and networks are developed and available. The absence of the participation of affected individuals and communities is most evident in the decision-making spaces.²⁰ Participatory decision-making in the planning of health funding mechanisms, and the



Community voice in Mental Health National Strategic Plan development process in Nepal.

Service user and community involvement has become an increasingly common strategy to enhance mental health outcomes, and has been incorporated in the mental health policies of many developed nations. In countries like Nepal, while attempts have been made for increased participation, the involvement of communities affiliated to mental health in policy development is still reported to be ‘tokenistic’.²¹ Perceived barriers to greater involvement included lack of awareness, stigma and discrimination, poor economic conditions, the centralized health system, and lack of strong leadership and unity among user organizations.

mainstreaming of mental health and well-being into existing mechanisms, can be a useful tool to recognize the cross-cutting nature of mental health and well-being and the importance of a plurality of approaches to address resource gaps and under-prioritization.

V. RESOURCES – FINANCIAL, HUMAN AND CAPACITY

Even prior to COVID-19, the world was not equipped to deal with mental health needs of its population. Untreated mental disorders exact a high toll, accounting for 13% of the total global burden of disease.²² Prior to COVID-19 there were an estimated 264 million people with anxiety, and 322 million with depression worldwide. In addition, there are nearly 800,000 suicides per year globally, and suicide is the second leading cause of death in young people aged 15-29. However most people who need treatment in most countries in our region do not receive it. Even if service does exist, it can sometimes be of poor quality, or abusive and does not respect autonomy or choice. Recent research has shown that potentially as few as 1 in 27 people in LMICs receive minimally adequate treatment for depression.²³

In many countries in our region, the rate of mental health workers can be as low as 2 per 100,000 population, compared with more than 70 in high-income countries. This is in stark contrast with needs, given that 1 in every 10 person is estimated to need mental health care at any one time.²⁴ National health budgets also show a deficit in spending, less than 2% of national health budgets globally are spent on mental health. In LMICs, the majority, over 80%, goes towards running inpatient psychiatric institutions which serve a small proportion of those who need care.

*Trisuli Plus mobilising communities for capacity building workshop in Nepal.
Photo: Trisuli Plus.*

Against this backdrop, Trisuli Plus Community Action Group, a community based action group in Nepal led by People Living with HIV/AIDS, have successfully advocated to be included in the Ministry of Public Health convened Technical Working Group working on Mental Health National Strategic Plan. This representation is crucial as it allows for the voices, lived realities and needs of effected communities to be heard and reflected in the strategic plan that will be soon rolled out.



Girl wearing protective face mask. Photo: Chansom Pantip/Shutterstock.

Research and consultations conducted by Overseas Development Institute²⁵ found that a synthesis of how much and how to spend money on mental health policies and programmes missing in most LMICs. Decision-makers cited a lack of understanding of how much and how to spend money on mental health. This was cited as a major barrier to moving forward, particularly in prioritizing national budgets (and therefore delivering effective services) and leveraging further funding. It was also found that policy-makers need to prioritize funding for mental health in their own national health budgets before seeking external resources.

With regard to international aid for mental health, there is a significant challenge in getting a complete picture of the funding landscape for mental health. Another report by the Overseas Development Institute “highlights how little information there is on what donors are spending on mental health globally, [and] what types of activities are funded”.²⁶ The COVID-19 pandemic has also served to further highlight the substantial need for resourcing for mental health, as the public health crisis, social isolation, and economic hardship pose significant challenges for individual and community well-being.

VI. HIGH OUT-OF-POCKET EXPENDITURE

Mental health is frequently left out of the package of services covered by national insurance schemes in LMICs. WHO’s Mental Health Atlas 2017²⁷ shows more than two-third of countries globally report that care and treatment of persons with severe mental disorders is not included in national health insurance or reimbursement schemes. The biggest rate for out-of-pocket expenditures on mental health (besides the African region) was the South East Asian regions where in 40% of countries people pay

mostly or entirely out of pocket towards the cost of mental health services. This makes the need to push towards universal health coverage that includes mental health all the more important, to ensure that everyone, everywhere, can access the care they need, including mental health care.

VII. GAPS IN POLICY EXISTENCE OR IMPLEMENTATION

79% of WHO Member States do have a stand-alone mental health policy or plan, but most have not fully implemented it, partly due to failure to allocate adequate resources for implementation. Only about half of Member States with a mental health policy or plan have estimates of the resources required to implement it, and of those, only half have allocated those resources. Monitoring of policy implementation is especially weak in most LMICs, and policies are frequently outdated and out of step with international human rights standards. Observance of human rights standards in mental health policy formulation is lowest in the Southeast Asian and Eastern Mediterranean regions.

VIII. LACK OF ALTERNATIVES TO INSTITUTIONALIZATION OR FACILITY BASED SERVICES

While there are increased calls for promoting deinstitutionalization and community-based care, mental hospitals or specialized hospital-based facilities continue to consume the majority of mental health budgets in the 80% of countries that have them.²⁹ This leaves a small portion of an already scarce human and financial resources for all other forms of mental health interventions and services.

Even more unsettling than the resource crunch caused, is the way these facilities still operate in most countries in the region. People are confined arbitrarily to institutions against their will for months or even years. Once committed, they may be restricted to cell-like seclusion rooms or restraints.³⁰ They often live in substandard conditions and are separated from their families and communities. Many of these facilities are associated with human rights violations including unhygienic and inhumane living conditions, and often, harmful and degrading treatment practices.

The path to deinstitutionalization and moving away from facility based services is a complex process that requires political will, resources and shift in how mental health is viewed. WHO's Mental Health Action Plan for 2013 to 2020 (extended to 2030)³¹ proposes that countries shift systematically from long-stay mental hospitals towards community-based settings and using a network of linked community-based mental health services.

IX. LACK OF AN INTEGRATED RESPONSE

Mental disorders have typically been diagnosed and treated in centralized psychiatric hospitals or clinics. In this context, people with severe mental illnesses who live far from a centralized treatment facility—the majority of the population in most LMICs—are often unable to access care, and people with common mental disorders such as major depression, generalized anxiety disorder, and substance use disorders are most often left untreated.³²

Mental disorders have several features in common with those of other chronic diseases: they share several underlying causes, risk factors and consequences. Mental disorders and other chronic diseases like HIV and TB are highly interdependent and they often co-occur, but in most instances services provided are still highly fragmented. Integration of services into existing health care systems and facilities is key to ensure a person-centered approach that is responsive to patients' needs and expectations.

X. RESEARCH GAP TO SUPPORT EVIDENCE AND PRACTICE BASED ADVOCACY

There is a research gap that needs to be urgently addressed to ensure that mental health interventions and advocacy are supported by strong evidence and lived experiences. Currently mental health research represents less than 4% of all published global health literature and 94% of this literature comes from high-income countries.³³ According to The Academy of Medical Sciences,³⁴ a quarter of LMICs have no mental health researchers at all, and a further quarter of countries have five or fewer researchers in total. When they do exist, mental health researchers in LMICs are poorly funded, and have little access to resources such as research networks, fellowships, technical support, or well-resourced libraries. Most research carried out in the region also lacks

a user-led approach or those that include people with lived experiences, those who identify as service users or psychiatric survivors, or persons with psychosocial disabilities as equal partners.



Myanmar girl. Photo: szefei/Shutterstock.

THE GENDERED IMPACT OF COVID-19 ON MENTAL HEALTH

COVID-19 has exposed long standing fault lines in our societies including the entrenched gender inequalities in our societies. The pandemic has disproportionately impacted women and girls where inequalities in access to education, job opportunities, and healthcare have left women inadequately equipped to effectively protect themselves and their families against infection during an outbreak, and they are also more likely to bear secondary negative effects of prolonged crises, such as economic insecurity or challenges accessing essential health services.

Quarantine and lockdown measures as a response to the disease have also put women at heightened risk of violence at home and cutting them off from essential protection services and networks, which they had prior to the imposition. Many countries have reported an increase in domestic violence cases after the viral outbreak. In countries where lockdown is observed, home is unfortunately not always a safe space. The exacerbation of gender-based violence may not receive the attention needed in the context of the pandemic. All of these further exacerbates gender inequalities and becomes a source of stress on women's physical and as well as mental health. Women are reporting greater levels of increased anxiety and depression than men in many cases. Given that the COVID-19 is not gender-blind, intervention and response need to include a gendered lens to address systemic inequalities and the mental health needs of women and girls.

More research that is grounded on lived realities of those from the region is needed to ensure that the practice-based evidence generated is rooted in local realities, possibilities and understanding of care. The research gap is also evident in the area of stigma and discrimination. There is a lack of research and insufficient evidence to determine what interventions are effective and feasible for decreasing stigma, how best to target key groups that are most vulnerable, and how to adapt such interventions in specific contexts. Research around interventions and its effectiveness to address stigma is therefore an advocacy and programmatic priority.

WHAT DO WE NEED TO FOCUS ON?

I. A HUMAN RIGHTS-BASED APPROACH (HRBA) TO MENTAL HEALTH CARE

Any discussion on the state of mental health care requires an analysis of the history of mental health interventions. A purely biomedical approach has resulted in various rights violations such as involuntary psychiatric interventions, forced institutionalization, coercion, and unnecessary pathologization. In a report³⁵ published in 2020 by the outgoing special rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, it is stated that the combination of a dominant biomedical model, power asymmetries and the wide use of coercive practices together keep not only people with mental health conditions, but also the entire field of mental health, hostage to outdated and ineffective systems. It suggests that States and other stakeholders, should critically reflect on this situation and join forces towards abandoning the legacy of systems based on discrimination, exclusion and coercion. One effective way to do that is through a human right based approach.

When a right-based approach is not prioritized, the mental health care intervention ends up disempowering an already marginalized population. A rights-based approach would require setting aside “substitute decision-making” and offering support according to a person’s “will and preferences”, and where unknown, the “best interpretation” of her/his will, preferences and rights.³⁶ Advocates, researchers and scholars are increasingly challenging the grounds for the “exceptions” that legitimizes coercion and forced treatment in mental health care.

UNITED NATIONS CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITIES (CRPD)³⁷

Is an important international legal instrument specifically tailored to stipulate the rights of persons with disabilities. Ratified by 177 countries, the CRPD represents a shift from a medical and charitable model towards a rights-based approach. It entitles people with disabilities to the full spectrum of human rights without discrimination. While the whole of the CRPD is relevant to those with psychosocial disabilities, certain articles are particularly significant : Article 12 on legal capacity, Article 15 on freedom from torture or inhuman or degrading treatment, Article 19 on the right to live independently and be included in the community. A General Comment on Article 12 by the CRPD Committee establishes that people with psychosocial disabilities must be guaranteed legal capacity on an equal basis with others, and therefore cannot be detained against their will, even with consent from a substitute decision maker.

The directive of the CRPD to embrace a social or “human rights” model of disability and move away from a “medical model” of disability has strategic advantages, including shining a light on the many social, political and economic factors that create grave disparities for people with mental health conditions or psychosocial disability.³⁸ The CRPD specifies how the principles of human dignity, equality, non-discrimination, autonomy and full social participation and inclusion apply in the case of persons with disabilities. It aims to ensure that such persons are treated on an equal basis with others.

HRBA to mental health care is normatively based on international human rights standards and operationally directed to promoting and protecting human rights.³⁹ In the context of mental health care, it means placing emphasis not only on avoiding human rights violations but making sure that human rights principles are at the center of a service-providing organization.⁴⁰ HRBA becomes a useful tool with a set of universally accepted values and principles which can guide countries in the design, implementation, monitoring, and evaluation of mental health policies, laws, and programmes. There are no easy or simple solutions to achieving a rights-based approach. While continued and nuanced discourse is needed, applying the core principles of human rights of

universality and non-negotiable standards for all people will act as powerful catalysts for change to mental health care responses and interventions.

II. UNIVERSAL HEALTH COVERAGE (UHC) THAT INCLUDES MENTAL HEALTH CARE

Universal health coverage (UHC) has human rights and equity at its core, which makes access to affordable health a fundamental human right, not a privilege, while mental health is an inalienable part of the right to health. Various conventions and human rights framework cements this right. The International Covenant on Economic, Social and Cultural Rights (ICESCR) through Article 12.1 affirmed “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.

The availability of high quality, rights-based mental health care to those who need and want it is a critical part of ensuring that their right to health is met. UHC for all cannot be realized without the inclusion of mental health and this was acknowledged in the 2019 Political Declaration of the High-level Meeting on Universal Health Coverage. Provision 36 asserts that measures to promote and improve mental health and well-being as an essential component of universal health coverage, including by scaling up comprehensive and integrated services for the prevention, including suicide prevention, as well as treatment for people with mental disorders and other mental health conditions as well as neurological disorders, providing psychosocial support, promoting well-being, strengthening the prevention and treatment of substance abuse, addressing social determinants and other health needs, and fully respecting their human rights, noting that mental disorders and other mental health conditions as well as neurological disorders are an important cause of morbidity and contribute to the non-communicable diseases burden worldwide.⁴¹

III. INTEGRATION OF MENTAL HEALTH INTO PRIMARY HEALTH CARE (PHC)

Calls to integrate core mental health services into primary healthcare systems is not new. It has been the push from way back in the 1970s to address the high prevalence of mental disorders and the very low numbers of specialist mental health resources in most countries. But the call resonates a lot more strongly now as the world grapples with an increase in mental health needs and an overburdened healthcare system caused by COVID-19.

The integration of mental health interventions within primary care systems has the advantage of being more accessible and recognizes that people with mental disorders also often have other significant acute and chronic physical health problems that may lead to worse health outcomes if not addressed.⁴³ Additionally, many people with undetected mental disorders will initially visit primary healthcare providers as a gateway to care. As a result, integrating mental healthcare into non-specialized healthcare can optimize both mental health and physical health outcomes, and avoid fragmentation of health services.⁴⁴

Stigma and taboo around mental health also has the potential to be addressed by integrating care of mental health needs into the context of general care settings which is often more acceptable to patients and family members.⁴⁵ While integration of mental health into primary care is a key element to reach this goal, it is clear that this is not a cheap or quick solution. It needs to move beyond a technocratic approach and be embedded into a multilevel approach that includes policy-makers, mental health specialists, general health workers and community members.

The idea of inclusive primary healthcare services, in which psychological and social aspects of health are considered side by side with somatic aspects, has been enshrined in various landmark documents such as the 1977 Declaration of Alma Ata on primary healthcare and publications of the World Health Organization (WHO, 1990, 2001; WHO & WONCA, 2008).

In 2008, WHO launched the mental health gap action program (mhGAP) in primary health care to scale-up

cost-effective interventions for MNS disorders through the training and supervision of primary health care workers based on a task-sharing approach.⁴² This task-sharing approach (mobilizing primary health workers in the diagnosis and treatment of common mental disorders) is perceived to be feasible to implement when other components of service delivery such as supply of drugs, continued clinical supervision by specialists, and clear administrative and governance procedures are put in place.

IV. STRENGTHENING COMMUNITY SYSTEMS IN MENTAL HEALTH CARE

The Mental Health Action Plan 2013–2020 (extended to 2030) of WHO⁴⁶ calls for the provision of comprehensive, integrated and responsive mental health and social care services in community-based settings. The action plan uses ‘community-based settings’ as the focus instead of the more restrictive term ‘primary healthcare settings’. It is also of critical importance that the action plan explicitly favors social options such as prevention and health promotion for addressing the burden of mental health.

Community-driven and community-supported responses recognize the community as valued authorities on their own lived experience. Listening to and incorporating diverse knowledge and multiple perspectives are essential to ensure that mental health services and psychosocial initiatives designed for any community are accessible, acceptable, culturally secure and developmentally appropriate. Emerging evidence suggests that mutual reinforcement of public health messages and actions among community members has positive implications for health-related behaviors and compliance with public health directives during pandemics. Restoring connections to the natural environment will have additional mental health benefits. Working within existing community social structures and across a broad cross section of the community—with elders, youth, local faith leaders and community groups—helps to establish respectful and collaborative relationships.

Improvements in provision of mental health services through primary health system therefore needs to be supported by investments in strengthening community systems including community health workers (CHWs). Studies in low income-countries have shown how training community health workers (volunteers with a brief training of usually of 4 – 12 weeks who assist in case-finding, health education, follow-ups) has led to a significant increase in self-referrals to primary mental health services. Community-based self-help groups can be powerful tools to enable people with mental disorders, and their families, to become stakeholders with clout and be less dependent on formal service providers thus dealing with the situation of scarcity in resources that many countries face.

Studies have found that successful community-based interventions did not use medical language, such as ‘depression’, ‘post-traumatic stress disorder’ or other psychiatric jargon.⁴⁷ This is crucial as most people who could be diagnosed with a common mental disorder



Motorcyclists wear face masks for protection.
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DRIVE-Mind project - innovative community-based access to psychiatric care for people who inject drugs (PWID) in Haiphong, Vietnam.

Hai Phong city, the 4th largest city in Vietnam, has a population of around 2 million people with an estimate of 10,000 people who use drugs with 5,000 PWIDs and is known for an HIV epidemic driven by drug injection. The DRIVE⁴⁸ project, supported by ANRS (French Agency for Research on AIDS) and SCDI aims to ‘end’ the HIV epidemic among PWID in Haiphong through multiple interventions. In the course of the project,⁴⁹ mental health assessment uncovered that one third of the participants reported constant worry, constantly feel hopeless. As many as 31% of all participants - 47% of women and 29% of men - reportedly had depression. More notably, over 22% reported suicidal thoughts, and 11% reported a history of suicidal attempts. Data showed that among PWID suffering from psychiatric disorders, none sought treatment or follow-up due to stigma, lack of knowledge, administrative barriers and the cost of the treatment.

There was a gap in the psychiatric care for PWID, the DRIVE-MIND project⁵⁰ addressed this gap by developing several mental health interventions. These include raising awareness among the PWID for knowledge building in order to reduce stigma on mental health through peer educators; conducting research on the link between HIV and mental health; developing COQST (Community Quick Screening Tool) for screening psychiatric disorders among PWIDs; training CBOs to carry out the screening and make referrals as needed. Additionally the project also addressed the stigma among mental health providers in Vietnam of PWIDs by engaging and organizing training sessions for them on mental health issues usually faced by PWIDs including the development of certificate programmes in collaboration with local universities. The success of DRIVE-MIND shows that successful and feasible community-based psychiatric intervention for PWID needs comprehensive interventions and coordination of psychiatrists, CBOs, families and communities.

(e.g. depression, anxiety disorder, or harmful use of substances or alcohol), would not conceptualize their problem as a medical disease, but rather frame their problem in non-medical terms linked to life experiences or circumstances – this approach is highly effective in

communities where there is still such much stigma and taboo attached to mental health. It allows for those who need help to get it in a safe setting that does not alienate them and further exacerbate their mental states.

WHAT NEEDS TO BE DONE

RECOMMENDATIONS

1. The current interest and awareness on mental health that COVID-19 has particularly precipitated is an opportune time to increase mental health literacy and **advocacy to push for mental health as a political issue with a social justice consideration** that needs a holistic approach and active movement building for mental health advocacy in the region.
2. Systemic inequalities and mental health are interlinked with a causal connection. The main obstacle for the realization of the right to mental health does not rest with individuals and their global burden of mental disorders, but rather in the structural, political and global burden of obstacles being produced by archaic mental health systems. Factors such as poverty; illiteracy; income inequality; homelessness; displacement; discrimination based on ethnicity, race, gender and sexual orientation; social exclusion; stigma; disease burden and abuse all impact the mentally ill individual's ability to access services and realize full personhood within their communities. **Mental health interventions need to have an intersectoral and multidisciplinary approach that goes beyond the healthcare sector** with concerted efforts to address socioeconomic determinants of health and systemic inequalities. This additionally requires a broadening mental health perspectives to include mitigating vulnerability, resilience and risk factors especially for the most vulnerable of populations.
3. High rates of out of pocket expenditure for mental health in the region **makes the need to push towards a UHC that includes mental health, all the more important.** The inclusion of language relating to mental health in the UN Political Declaration on Universal Health Coverage is seen as a major victory for mental health to not be ignored in discussions on UHC. Advocacy efforts to push for the realization of this integration needs to be strengthened to achieve the goal of a UHC that ensures that everyone, everywhere, can access the care they need, including mental health care.
4. Mental health needs to be included in the minimum packages of care for primary care facilities and in order to **ensure a holistic mental healthcare within the primary healthcare architecture, it is essential that the supportive structures on other levels of the health systems are also strengthened.** For example, the appointment of dedicated focal points for mental health on district and provincial levels may help to coordinate mental health services and contribute to the inclusion of mental health within district and provincial strategies, training plans and resource allocation.
5. Mental health strategies, actions and interventions for treatment, prevention and promotion must be rights-based and in compliance with the CRPD, ICESCR and other related international and regional human rights instruments. In many instance, **this requires legislative reform to abolish discrimination, to outlaw abuse and exploitation, and to protect personal freedom, dignity, and autonomy.** As mentally disabled persons may not be in a position to safeguard their personal rights while unwell, there should also be mechanisms in place for active monitoring, enforcement of such rights and redress channels for rights violations.
6. **Integration of mental health care into existing healthcare systems and infrastructure needs to be advocated to ensure accessibility, acceptability, affordability and complementary with other pre-existing health conditions.** It is pragmatic for mental health interventions to use service delivery platforms that already exist for other diseases (e.g. HIV and TB) as the basis for expanding mental health services. Many commonalities exist between mental disorders, other chronic NCDs, and HIV/AIDS, and further, they tend to co-occur. It therefore makes sense that mental health services could be better integrated into service delivery platforms for these other conditions.

- 7.** In times of the ongoing pandemic, communities and community-based services will play an important role in facilitating the continuation of essential prevention, testing and treatment services for key populations and in ensuring that people are not further marginalized through stigma and discrimination. Therefore **more resources and efforts need to be channeled towards community-based mental health services.** Community-based care can be developed even within existing health care facilities. It needs to include diagnosis and treatment of both severe mental illness and common mental disorders, as well as mental health promotion and prevention.
- 8.** Efforts are needed to move away from tokenistic approaches that merely utilize civil society organizations, key populations and persons with mental disorders as implementers of projects or end users of services without recognizing the value of their participation. **There is a need for greater advocacy for the rights of people with mental health conditions and those most vulnerable and their inclusion in the development of all mental health strategies, plans, and implementation.** Persons with mental disorders and psychosocial disabilities and those most vulnerable to mental health issues should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation of interventions.
- 9. Integrate public health evidence, lived experience and rights-based research to guide decision-making on global and national public policy strategies.** That should include prioritizing a shift away from medicalization in the development of mental health, criminal justice and public welfare-related reforms. Research needs – further research to assess the impact of the pandemic; to determine effective and efficient care delivery models; and to assess the impact of COVID-19 on vulnerable populations, are needed. Another line of research will be needed to determine the mental health consequences of social isolation for vulnerable groups, and how these can be mitigated under pandemic conditions. Additionally, the neuropsychiatric impact of COVID-19 is still largely unexplored and research that evaluates the direct neuropsychiatric consequences will also be needed to improve treatment, mental health care planning and for preventive measures during potential subsequent pandemics. We need to recognize that the evidence base is still rapidly developing and needs to be captured and analyzed.
- 10.** While strategizing and reorganizing mental health systems, **it is also crucial to engage in efforts to address stigma and discrimination that often is a barrier in mental health-seeking behavior.** This needs to be done by encouraging mental health literacy, public education about mental health and creating more space for discourse on mental health to help raise and promote a better understanding. Outreach and follow-up too is an essential component that needs to be included and achieved if interventions and programmes are sensitive, responsive and grounded to local needs and realities.
- 11.** For the best outcomes, clients of mental health services and their families need to feel empowered to take ownership of the intervention measures. This requirement is arguably more important now than ever, when service access is limited and face-to-face contact is often unavailable. Mental health intervention including treatment plans might need to be rapidly renegotiated, and should be based on best practices. There is thus **a need to enhance and create robust and dynamic mechanisms and required resources to support shared decision making that is keeping with the need of the moment.**
- 12. Utilizing existing mechanisms like the SDGs, the human rights framework, and the Political Declaration on UHC to demand for accountability from governments.** The CRPD has been ratified by 181 countries while the ICESCR has been ratified by 170 states and which requires states to protect and promote the right to health, with a dedication of the “maximum available resources” to do so. As these instruments obligate states to implement policies and programs that are in keeping with principles such as dignity, autonomy, and life in the community, it needs to be used more widely to hold governments accountable in ensuring the standards set are met and followed. UN Member States have also reached consensus on the 2019 Political Declaration on Universal Health Coverage to scale-up integrated mental health services that addresses social determinants and respects the rights of those with mental health disorders and other mental health conditions.

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