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IFMSA Policy Document Mental Health

Proposed by the Team of Officials

Adopted at the IFMSA General Assembly August Meeting 2019, in Taipei, Taiwan.

Policy Statement

Introduction:

Mental health is a principal element of WHO's definition of health, and yet mental health services and care remain a hugely neglected area of health worldwide. Mental illnesses constitute the highest cause of global disability. Hence, mental health is fundamental to achieve health for all. Access to treatment is still limited by under-diagnosis, the availability and affordability of services, as well as the stigma attached to mental disorders and psychosocial disabilities.

IFMSA position:

The IFMSA, as future healthcare professionals, strongly affirms the necessity to provide comprehensive mental health services and improve its integration in health and social sectors. IFMSA recognizes the global burden of mental disorders and calls for the implementation of effective strategies to promote mental health and end the discrimination against people who experience mental health conditions. We support the call by the World Health Organization (WHO) for countries to acknowledge people with mental health conditions as a vulnerable group, and support the WHO's Mental Health Action Plan 2013-2020. Finally IFMSA firmly believes, in line with WHO, that there can be no health without mental health, and asserts this as an area of priority and need.

Call to Action:

IFMSA calls on:

Governments to:

1. Provide inclusive and integrated mental health services and treatment facilities in community-based settings;
2. Adhere to SDG target 3.4 to by 2030 and reduce by one third premature mortality from non-communicable diseases through prevention and treatment of mental disorders while promoting mental well-being;
3. Strengthen national and multinational capacities to provide information system and research for mental health;
4. Adopt a multidisciplinary response for mental health in collaboration with public sectors such as health, education, employment, social and other relevant sectors as well as the private sector;
5. Formulate and implement mental health policies and strategies compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions;
6. Ensure the integration of mental health strategies at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age;
7. Promote the provision of funds in mental health services and psychiatric research in particular to the most vulnerable including youth and adolescents;



IFMSA

International Federation of
Medical Students' Associations

8. Integrate mental health into general health care settings, and through maternal, sexual, reproductive and child health programs;
9. Develop mental health interventions that address social and economic determinants related to mental health such as poverty reduction and community development strategies;
10. Improve access for people with or at risk of mental disorders to social welfare services and opportunities for education and employment.

Hospitals and Healthcare providers to:

1. Ensure equitable accessibility to mental health services by persons with mental disorders to reach the highest attainable quality of health;
2. Integrate mental health care and treatment into general hospitals and primary care with efficient continuity of care between different providers;
3. Train healthcare providers with the knowledge and skills to provide human rights-oriented and evidence-based mental health services;
4. Remain mindful of the rights-infringement imposed on individuals who are subjected to institutionalization as a result of mental illness and ensure humane treatment of these patients
5. Establish healthy work environments that promote the mental health of medical staff with respect to the provision of safe rosters and fair work contracts;
6. Promote mental wellbeing and advocate for improved mental health services and funding, according to the increasing burden of mental illness.
7. Eliminate stigmatization and human rights violations against persons who suffer from mental disorders.

Universities, including medical schools to:

1. Mainstream mental health into medical curriculum including school-based mental health promotion programs that focus on targeting risk taking behaviors, impact of stigma as well as developing coping skills within the young population;
2. Establish capacities for evidence and research programs in mental health disorders;
3. Provide accessible, confidential and effective mental health support services for all students including low-threshold counseling that aim to eliminate the barriers to seek help when struggling with mental health issues;
4. Provide mandatory clerkships in psychiatry for all medical students.

IFMSA National Member Organizations (NMOs) and medical students to:

1. Take the lead in the promotion of mental health and prevention of mental disorders through advocacy campaigns and initiatives;
2. Collaborate with universities and other providers of education to improve the education on mental health and disorders in curricula;
3. Advocate to faculty members regarding the establishment and/or improvement of mental health services for students in the university;
4. Safeguarding the mental health of their members, by having specific safeguarding mechanisms in place, both for prevention and intervention.



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Medical Students' Associations

Position Paper

Background information:

Mental health affects many crucial areas of the IFMSA's mandate – including the health of children and youth, public health, and human rights. The burden of mental health issues among medical students and doctors is also a significant problem, which clearly must be addressed if we are to guarantee the future of our healthcare workforce. Finally, we support the role medical students can play as international advocates for mental health.

Discussion:

Global burden of mental health

Mental health is included in the World Health Organisation (WHO) definition of health: “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity”. (1) However, mental health remains a neglected area of health worldwide. The WHO reports that mental, neurological and substance use disorders constitute 13% of the global burden of disease, however treatment of these conditions is severely under-resourced. (2) Prevention of psychiatric disorders is also essential. The social determinants of health and inequality play a key role in mental health and well-being. Advances in the field of mental health need to target these social determinants of mental health, as well as further accessibility and affordability of psychiatric treatment. (5)

Access to treatment

The Sustainable Development Goals seek to address this, with target 3.4 for Goal 3 (Health) stating that by 2030, we will “reduce by one third premature mortality from non-communicable diseases (NCDs) through prevention and treatment and promote mental health and well-being”. (4) There is much to be done before this is achieved.

1) Financial and physical resources

450 million worldwide suffer from a mental health condition, yet resources for treatment remain insufficient and inequitably distributed. Most of the global burden of mental health conditions lies in low & middle income countries (LMIC), but these countries have the least financial and human resources with on average US \$1.53 spent on mental health per year. (5) High-income countries have more available facilities, higher allocation of resources (almost US \$60 per capita) and higher demand for and use of services. (5)

The median number of mental health beds is less than 5 per 100,000 population in LMIC in contrast to over 50 in high income countries. (5) Access to treatment is limited by the availability of services, affordability of services and treatment, and the stigma attached to mental health conditions.

2) Legislation and policy

Legislation and policy regarding mental health conditions is also inequitably distributed. In general, 68% of WHO Member States have a stand-alone policy or plan for mental health. 92% of citizens in high-income countries are covered by mental health legislation, yet this percentage



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International Federation of
Medical Students' Associations

in low-income countries is only 36%. (5) In addition, many policies and laws are not in congruence with human rights, implementation can be weak and the involvement of persons with mental illness is generally variable and incomplete. (5)

3) Stigma and its effect on accessing treatment

Stigma against mental illness can be defined as negative attitudes including rejection and discrimination triggered by a label which sets the labeled individual apart from others and may link them to undesirable characteristics. Mental health is stigmatized for many reasons, including its 'intangibility'. Stigma is a common and significant inhibitor in progressing the rights of those with mental illness. Additionally, stigma attached to mental illness impedes initiation, continuation and outcomes of treatment and mental health programs. (6)

Many individuals and groups contribute to the development and reinforcement of stigma including government, the media and healthcare workers. (6) Psychiatrists and mental health healthcare workers are no exception. (7)

Stigma can lead to the denial of opportunities and social and cultural rights as well as restrictions on civil, political and reproductive rights as well as education and employment. (2) Removal of these rights may restrict access to healthcare and conversely the right to make their own healthcare decisions. Stigma can lead to societal acceptance of maltreatment, abuse and other unacceptable practices within health services. In many countries, with particular prominence in LMIC, institutionalization is utilized for mental illness in ways that seriously violate and degrade human rights including forced treatment. (5) Living in vulnerable situations such as homelessness and inappropriate incarceration is more common in those with mental illness, perpetuating stigma. The Convention on the Rights of Persons with Disabilities, which has been signed by 114 countries, protects and promotes the rights of individuals with disabilities including mental illness. (8) Countries should ratify and adhere to this agreement. (2) Additionally, fighting against stigma should be considered a long-term endeavor incorporated into health and other social programs by getting all stakeholders on board.

Treatment of mental disorders

Health workforce

Well-trained and supervised lay health workers have a critical part to play in the scaling-up of a mental health workforce (9). There is a global shortage of psychiatrists and other non-medical mental health clinicians, including community psychiatric nurses. These human resources are also inequitably distributed, with less than 1 mental health worker in low-income countries per 100,000 population as compared to over 50 in high income countries. The global median is less than 1 practitioner per 10,000 people. (4)

From a governmental perspective, barriers to training as a mental health worker include a lack of resources particularly in low income countries and insufficient evidence on workforce planning for effective scaling up of mental health services. (9)

From a practitioner perspective, factors including misconceptions regarding mental illness, fears, perceived low status regarding mental health professionals and inadequate training contribute to the reluctance of some health workers to provide mental healthcare in select LMIC. Emigration from LMIC, largely due to better training and career opportunities, is another barrier to a sufficient health workforce. Educational interventions to improve attitudes towards mental illness and recruitment and retention strategies are key in maintaining an effective workforce (9).

Only 55% of low income countries provide training in psychiatry, 69% of lower middle income and 60% in upper middle income. (9) Just over 2% of physicians and 1.8% of nurses and midwives in primary care globally received at least 2 days of mental health training in the last two years. (4)



IFMSA

International Federation of
Medical Students' Associations

More training of primary care staff in mental health is critical in both treatment and prevention.

Vulnerable Groups

Vulnerable groups with mental illness in particular are susceptible to stigma and discrimination, violence and abuse, civil, political, educational, employment and societal restrictions, reduced access to emergency relief services as well as increased disability and premature death. (10) Societal factors and environments predispose particular groups to developing mental illness.

These include:

- People living in poverty
- Those with chronic health conditions
- Infants and children exposed to maltreatment and neglect
- Adolescents exposed to substance abuse
- Minority groups
- Indigenous populations
- Older people
- People experiencing discrimination and human rights issues, including lesbian, gay, bisexual and transgender (LGBTQIA+) individuals
- Prisoners
- People exposed to conflict, natural disaster and humanitarian emergencies
- Those exposed to domestic violence and abuse, and
- Those overworked and stressed. (2)

Many of these groups are particularly relevant to the work of the IFMSA, including but not limited to the below.

4.1 Youth and adolescents

Depression carries the largest burden of disease among youth and adolescents globally, and suicide is the third leading cause of death among this age group. (11) Among other factors, family violence, lack of education, unemployment, poverty and urban upbringing can exacerbate the risk of mental illness in youth and adolescents. (11, 12)

Most adolescents and young adults with mental illness do not receive treatment from health professionals, with a European study showing 6% of the population requiring treatment but 48% not accessing treatment. (12) Scaling up of service provision, particularly in LMIC and reduction of stigma are sorely required. Given the mixed results of current intervention programs, investment by governments into mental health innovation for youth and adolescents is required. (12)

4.2 Refugees

Refugee mental health is also a key human rights issue, and an important area of policy and action. Rates of mental illness in refugee populations can be double that of the general population, with WHO reporting rates of mild to moderate mental illness at 15-20% amongst refugees, compared with 10% in the general population. (13)

4.3 Maternal mental health

Mental health is extremely important in the perinatal period. Research and policy to date has mainly centered on postnatal depression, however there is a lack of evidence regarding the epidemiology or effectiveness of interventions for a wide spectrum of more severe perinatal mental illnesses. (14, 15) More research is required to effectively address this key issue.



4.4 People living in poverty

Substantial evidence demonstrates the relationship between low socioeconomic status and elevated incidence and prevalence of mental illness. (16) Poverty can hinder access to basic healthcare and expose individuals to stressful environments, factors predisposing to mental illness. It is the responsibility of national governments to set targets for reducing health inequalities and poverty to eventually eliminate poverty and its negative externalities such as mental illness. (17)

4.5 People living with chronic conditions

Chronic illness is an independent risk factor for mental illness. The causative link is strongest for depression and anxiety, the two most common and important mental illnesses, for both of which chronic physical illness is a major risk factor. (18)

Additionally, 79% of all deaths due to chronic disease occur in LMIC (19). As outlined, in these same regions, people are less likely to have access to adequate treatment for mental illness, strengthening the importance of chronic disease prevention for mental health.

4.6 LGBTIQ+ individuals

Globally, 5-10% of people are estimated to identify as LGBTIQ+ individuals (20). The evidence is overwhelming that LGBTIQ+ individuals are disproportionately affected by mental health issues. Same-sex attracted people have up to 14x higher rates of suicide attempts than their heterosexual peers. (21) Rates are 6x higher again for young people within this group. (21).

4.7 Medical students

The IFMSA as a body of medical students has a paramount interest in the health and well-being of medical students worldwide. Medical students have been identified as a population particularly susceptible to mental illness. (22, 23)

Students are vulnerable to being bullied in clinical scenarios with some studies showing almost three quarters have experienced teaching by humiliation. (24) Factors related to the medical education process have been shown to be contributory to burnout. Poor mental health in medical students has been shown to affect professionalism, altruism and specialty choices. (25, 26)

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IFMSA

International Federation of
Medical Students' Associations

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IFMSA

International Federation of
Medical Students' Associations

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