THE BURDEN OF AN UNRECOGNIZED EPIDEMIC

BY BRUCE COMPTON

"But then the Good Samaritan came by, and he reversed the question:
'If I do not stop to help this man, what will happen to him?'"

— The Rev. Martin Luther King Jr.: "I've Been to the Mountaintop,"
speech delivered on April 3, 1968, Memphis, Tenn.

Mental health, according to the World Health Organization, is not just the absence of mental disorder. It is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to her or his community.

Church social teaching tells us that respect for human life — shielding life from threat and assault, doing everything that can be done to enhance this gift and make life flourish — is part of our responsibility as stewards of creation.[1]

In the United States we may not be satisfied with the mental health services available to everyone or with the strictures experienced by those who suffer mental illness. We must admit, though, that we have much broader options here than are available to our many brothers and sisters in the developing world.

It takes only minutes in Haiti to find people suffering with mental illness and left at the margins of society. During the several years I was living there, I must admit that it shocked me to see the conditions of these men, women and children. But because I was there to focus on so many needs, I also must admit I did not specifically act on any one person's behalf.

Though I was there to carry on the mission and be like the Samaritan, might I have been like the priest or the Levite who crossed to the other side of the street, who did not ask the question posed by the Rev. Martin Luther King, Jr., in the speech he presented the day before he died?

This is troubling to consider, and it also reflects the burden of an often unrecognized epidemic, that of mental illness. As part of the Catholic Health Association's partnership with Catholic Relief Services (CRS) in building and strengthening the faith-based health network in Haiti, I can report there is potential for hope and for the Catholic health ministry to help.

The epidemic is global, however, and with that in mind, I asked colleagues from CRS to give us an overview. As you read, please join us in continuing to reverse the question and ask, as Dr. King did, what will happen to those who suffer this illness if we do nothing?

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NOTE
1. From "To Be a Christian Steward: A Summary of the U.S. Bishops' Pastoral Letter on Stewardship," www.usccb.org/beliefs-and-teachings/what-we-believe/stewardship/.

Global Mental Health and Well-Being: Best Practices from U.S. Catholic Health Care

GUEST COLUMN BY ROBIN CONTINO, LCSW-C, SHANNON SENEFELD, PSY.D. AND KATIE JANUARIO

Mental health and well-being is an integral part of everyone's core existence. It is the part of our being that allows us to realize our own potential; to lead a fulfilling life; to form positive relationships; to engage in healthy coping strategies and to contribute to society through productive work and positive community contributions.[1]

However the ups and downs of life — loss of a loved one, exposure to trauma or disaster, poverty or diagnosis of a severe disease — as well as genetics (that is, diagnosable mental health disorders) can lead to impairment in our mental health and well-being. A 2011 report by the World Economic Forum and the Harvard School of Public Health names mental health conditions among the dominant contributors to the global economic burden of non-communicable diseases.[2]

In August 2012, the World Health Organization (WHO) released its "zero draft" of the Global Mental Health Action Plan, the first comprehensive effort to address the mental health needs of the global population. The draft action plan, which has been developed through consultation with WHO member states, civil society and international partners, proposes actions to address the health, social and economic burden of mental disorders by adopting a comprehensive approach involving coordinated services from the health and social sectors. Emphasis is placed on promotion, prevention, treatment, care and recovery, and with due attention to the principles of equity, human rights, evidence and user empowerment. It also sets out clear roles for member states, WHO secretariat and international, regional and national level partners, and it proposes key indicators and targets that can be used to evaluate levels of implementation and impact.

DRAFT GLOBAL MENTAL HEALTH ACTION PLAN OBJECTIVES:[3]
■ To strengthen effective leadership and governance for mental health
■ To provide comprehensive, integrated and responsive mental health and social care services in community-based settings
■ To implement strategies for mental health promotion and protection, including actions to prevent mental disorders and suicides
■ To strengthen information systems, evidence and research for mental health

The Global Mental Health Action Plan has close conceptual and strategic links to other global action plans and strategies, and it acknowledges how current health systems have not adequately addressed or integrated the full burden of mental health. Findings from a WHO study reveal that between 76 percent and 85 percent of people with severe mental disorders receive no treatment for their disorder in low- and middle-income countries; the corresponding range for high-income countries is also high: between 35 percent and 50 percent.[4]

Catholic health care in the U.S. and Catholic Relief Services (CRS) around the world have directly taken action to address the mental health and well-being needs of the populations they serve. CHA and its members have recognized mental health as an area that is underserved and poorly funded in the U.S. and have demonstrated creative ways to address those needs. Some examples — all of which also parallel the objectives in the Global Mental Health Action Plan — include:

Advocacy: San Francisco-based Dignity Health's Office of Public Policy actively engages in advocacy efforts towards health reform to provide coverage for the most vulnerable and poor populations.[5]

Partnership and Collaboration: Alegent Health, now Alegent Creighton Health, based in Omaha, Neb., played a key role in the planning process to ensure continued care following the closing of Omaha's largest provider of inpatient mental health care. A positive public and private partnership resulted, with the state of Nebraska announcing Lasting Hope Recovery Center, a new 64-bed, community-based behavioral health center.[6]

Service Reorganization: Amid times of economic difficulty, PeaceHealth St. John Medical Center in Longview, Wash., was able to expand its mental health services across target populations, which include expanding services to high-functioning mental health patients and improving care for people with significant mental health needs but no means to pay for services. The Peace of Mind clinic, part of St. John's behavioral health department, was opened to serve high-functioning patients who may benefit from a brief period of outpatient therapy for a particular need, such as a depressive episode related to a problem at the workplace. Other campuses of the main hospital operate an inpatient mental health unit,

while an affiliated campus has an outpatient behavioral health clinic for adults. Children's and adolescents' needs are served at A Child's Place.[7]

Integrated and Responsive Care: CHRISTUS Health, headquartered in Irving, Texas, is using community health workers to stretch limited mental health resources in Texas, the state with the highest number of uninsured residents and one of the smallest per capita public investments in mental health services in the nation. The goal is to integrate care through increasing collaboration between hospitals, community-based mental health care service providers and other nonprofits that provide mental health services, housing and job search assistance to people with chronic, debilitating mental illness. By using paraprofessional community health workers for outreach, CHRISTUS is working to design a cost-effective program that will lower barriers to care, decrease the stigma of mental health issues and direct people to the most appropriate level of care.[8]

Similarly, CRS works to empower the poor, vulnerable and marginalized around the globe and has vast experience working in mental health and well-being globally, both in its development and emergency response programming. For example, in 2008, CRS released the Orphans and Vulnerable Children Well-Being Tool with the goal of improving both the quality and responsiveness of programs by identifying and responding to unmet needs and evolving circumstances that affect the well-being of vulnerable children. The tool was an immediate success. In the past five years, CRS has facilitated training in the tool's proper use and has assessed thousands of young people globally, ultimately improving their well-being through improved programming promoting better health, sanitation, nutrition, education and livelihoods.

In emergency situations, CRS has significant experience creating child-friendly spaces for displaced and refugee populations following natural and man-made disasters. These spaces are intended to create a safe place where children can play and engage in psychosocial activities that allow them to better cope with the challenges compounding their already complicated life circumstances. Following the devastating 2010 earthquake in Haiti and more recently on the border of Syria, CRS has partnered with a non-profit to develop short films using puppets to address trauma, healing and resiliency as well as to raise awareness on normal stress and trauma reactions to extraordinary events.

One of CRS' largest programs to date was AIDSRelief, a five-agency consortium that provided HIV care and treatment to more than 700,000 people in 10 countries in Africa, Latin America and the Caribbean. During the nine-year project, CRS recognized the lack of psychosocial care and counseling services for HIV-infected children and adolescents. In particular, there was an urgent need for training of health care workers to provide appropriate, high-quality counseling. Therefore, in 2009 AIDSRelief created a training manual that focused on improving the skills of facility-based health care staff. The course materials may be delivered as a complete package or stand-alone modules, and trainers can tailor the course according to participants' needs. The training has been rolled out to hundreds of providers and was adopted as a national curriculum by Zambia's Ministry of Health.

In summary, CHA and Catholic Relief Services have vast resources and experience in adequately addressing mental health and well-being in challenging economic times and for poor populations. By building on existing work in the developing world, the opportunity for CHA and Catholic Relief Services to collaborate and advance best practices, strategies and programs further demonstrates their importance in improving global mental health services.

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NOTES
1. World Health Organization, "Mental Health: A State of Well-being," www.who.int/features/factfiles/mental_health/en/index.html.
2. David E. Bloom, et al., *The Global Economic Burden of Non-communicable Diseases* (Geneva: World Economic Forum, 2011).
3. World Health Organization, *Zero Draft Global Mental Health Action Plan 2013-2020* (Geneva: World Health Organization, 2012), 6.
4. World Health Organization, *Action Plan*, 10.
5. Eileen L. Barsi, "Dignity Sets Strategies to Better Serve the Poor," *Health Progress* 93, no. 6 (2012): 26-31.
6. Catholic Health Association, "Partnership Fills Mental Health Service Gap in Omaha," *Catholic Health World*, June 1, 2008.
7. Catholic Health Association, "St. John Expands Access to Mental Health Services in Challenging Economy," *Catholic Health World*, March 15, 2010.
8. Catholic Health Association, "CHRISTUS Stretches Mental Health Resources in Texas," *Catholic Health World*, Oct. 15, 2008.

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