Sommet mondial sur la santé mentale

« Mind Our Rights, Now! »

Workshop 4

Vulnerable groups and health crises

How to respond to inequalities?

Co-organizers:

* **Cecilie ALESSANDRI**
Head of Mental Health and Psychosocial for international department, French Red Cross (FRC)
cecilie.alessandri@croix-rouge.fr
+33 674 01 09 38

* **Guglielmo SCHININA**
Head of the Mental Health, Psychosocial Response and Intercultural Communication Global Section, International Office of Migration (IOM)
contactpss@iom.int
+32 472 81 28 21

Main findings and recommendations

This workshop focuses on the mental health of vulnerable populations in the context of health crises and beyond. The panels aim to shed light on how and why the mental wellbeing of people in vulnerable situations can be asymmetrically affected in terms of stressors, clinical outcomes and limitations of the right to access mental health care and other forms of support, during a pandemic such as COVID-19 and beyond.

Multiple forms of vulnerability can affect the mental health and psychosocial well-being of concerned individuals and communities, making access to services and other forms of support, where available, more complex. In addition, mental disorders can generate vulnerabilities or exacerbate pre-existing ones. This session aims to illustrate some of these vulnerabilities and how they relate to mental health, in particular to:

- Highlight the specific needs of individuals and groups according to the vulnerabilities they face
- Identify possible actions to mitigate the insurgence of disorders and propose accessible services adapted to the specific situations in which the people concerned find themselves
- Propose operational and effective actions to strengthen the rights of vulnerable people in terms of mental health and psychosocial support, whether in terms of prevention, treatment or social inclusion

The workshop presents the challenges encountered by the actors and stakeholders working with these people and the actions implemented worldwide to address the protection of the right to mental health care. It does so through discussing vulnerability and rights along two axes. The first addresses the mental health and psychosocial needs and resources of people on the move, and the approaches to mental health care provision for people on the move in various contexts, from those impacted by emergencies to countries of resettlement or transit. The second focuses on different types of vulnerabilities relating to illness, age, and gender, and of their specific impacts on mental wellbeing and access to mental health care.

In this workshop, vulnerability is understood as both a process and outcome of social, political, and economic marginalization, which can affect mental health and psychosocial wellbeing; and as a potentially aggravating factor of negative mental health outcomes, at times causing greater precarity. A human rights approach to service provision should thus seek to address the mental health needs of individuals and communities within their larger social environments by contributing to redressing the structural conditions of marginalization, as well as their impacts on mental wellbeing.

The following recommendations provide guidance for policy makers and practitioners on establishing more equitable, inclusive, and rights-based mental health care and psychosocial support for vulnerable groups in low and high-resource settings.

» *Equitable policies*

- Mainstream the right to mental health into health, poverty-reduction and development strategies and interventions, and explicitly include it in general and priority health and social policies and plans;
- Develop health policies based on response to basic needs (housing, food, rights, health) in order to prevent mental suffering and disorders;
- Mobilize ministries and actors from different sectors, including health, protection, education, the law enforcement, social care, culture, gender ones to provide holistic and comprehensive support to diverse individuals and groups' mental health and psychosocial well-being and thus ensure access to various services that meet their needs in a complementary approach within all government parts;

- Integrate mental health care, including psychosocial interventions and community-based care, into primary health care systems, as well as cultural diversity considerations;
- Develop psychosocial and community-based interventions to provide an appropriate local response and facilitate referral to specialist services when necessary;
- Ensure service users are meaningfully involved, and their lived experiences inform, health systems strengthening processes and mental health policy formation, with respect for their rights and dignity.

Equitable practices

- Prioritize community-based approaches to mental health and psychosocial support (MHPSS), in which individuals and communities are active participants in the design, implementation, monitoring and evaluation of MHPSS efforts;
- Provide inclusive and accessible mental health services through ensuring they are non-discriminatory; culturally sensitive; physically and economically affordable; well-known and advertised to all; this includes the provision of interpreters and mediators, wherever needed.
- Ensure the presence of sufficient and adequately qualified human resources and promote the training of mental health and psychosocial workers based on curricula adapted in terms of content, teaching methods and duration;
- Promote person-centered approaches, based on the idea that people have their own solutions and resources to deal with their situation, in order to strengthen their involvement and respect their autonomy and choices, while supporting and strengthening their power to act;
- Provide families and caregivers of persons with mental illness with support in how to properly provide care and complement mental health services, while offering them respite options.

Equitable research

- Mental health research priorities should promote independent, qualitative and participatory social science research and research platforms, exploring alternative service models that are non-coercive, culturally inclusive and non-discriminatory;
- Research must be strengthened at the different stages of an intervention: upstream to ensure that actions are adapted to the specific needs of the people and the context, in the analysis of current or completed practices to identify and share good practices and recommendations.

Focus on some of the issues discussed

Mental suffering of exiles in France - MDM

The exiles welcomed in by *Médecins du Monde* in their programs in France suffer from a combination of factors that can affect their mental health:

- Many have suffered multiple acts of violence, either in their country of departure or during the migration process (62% of the people received by the Committee for the Health of Exiles between 2012 and 2016 declared a history of violence);
- A significant number of these exiles are unaccompanied minors, who are particularly vulnerable and overexposed to health risks or exploitation, which are all factors in the development of post-traumatic disorders.
- The living conditions of many exiles in France, which are often undignified, as well as the difficulties in accessing their rights, exacerbate and perpetuate states of psychological suffering or traumatic disorders.

> Out of 580 cases of serious psychological disorders diagnosed by Comede between 2012 and 2016, the most common forms were psycho-traumatic syndromes (60% of patients), depressive symptoms (22%), anxiety disorders (8%) and complex traumas (8%).
>
> It is worth noting that the preponderance of psycho-traumatic syndromes was greater among asylum seekers (64%).

MDM have identified several issues to be taken into consideration in order to improve the support and/or care of these people and contribute to improving their mental health, including:

- → Promoting networking and multidisciplinary work that offered integrated responses (social, legal, somatic medical and psychological/psychiatric) from the first contact.
- → Strengthen the budget for professional interpreting and mediation in health care, as well as the training of actors involved in the care of these people.
- → Develop first-resort mechanisms as close as possible to and with the people concerned.
- → Encourage the production of knowledge, data and surveys concerning exiled people, their journey and their psychological suffering.

The clinical medical anthropology approach to promoting mental health care for migrants, asylum seekers and refugees – Minkowska centre

Migrants, asylum seekers or refugees in France have often overcome multiple ordeals, even traumas, in the country of departure, during the journey or on arrival. They may be confronted with significant alterations in their mental health. However, their situation, cultural differences and language barriers can make it difficult to access care in general, and specialized mental health care in particular.

The use of an interpreter or mediator can be indispensable. Indeed, once the linguistic problem has been solved, and by accepting the elements of clinical medical anthropology that allow the cultural representations of mental illness to be confronted, it is possible for all therapists to acquire a cultural competence that will allow them to provide the services they deliver under better conditions.

The development of interpreting as a means of contributing to the care of these people in the field of mental health is proving to be an effective but complex means. Effective because it allows non-native speakers to express themselves freely in a language in which they feel comfortable, reinforcing the indispensable bonds of trust. Complex because the configuration of care with an interpreter upsets the representations and practices of the actors involved, all the more so when the interpreter, the third person, is not familiar with the field of therapy. Interpreting cannot be limited to translating, and taking into account the culture in the discourse is essential. To this can be added the difficulties of interpreters in managing their emotional involvement. If interpreting in support of migrants, refugees or asylum seekers is now seen as an essential aspect of the access and quality of care to which these people are entitled, it is essential to invest not only in the availability of interpreters, but also in their training and supervision, as well as training to health and staff.

> Access to public mental health services for migrants, asylum seekers and refugees in France is made difficult for cultural and linguistic reasons.
>
> Working with interpreters and using video tele-interpreting facilitates access to mental health services.
>
> The clinical medical anthropology approach enables care to be adapted to the specific needs of people in migratory or exile situations.
>
> Training of medical and social professionals for these people is necessary to guarantee their right to access quality and respectful care.

Minority groups: more vulnerable to mental health disorders and impairment of psychosocial well-being – Dinesh Bhugra

In countries around the world, there are countless examples of discrimination against certain groups in society. Too often, people suffer marginalization, abuse and persecution because of their ethnicity, nationality, religion, belief, sex, gender identity, age, physical disability or other arbitrary characteristic. People from these minority groups may be particularly vulnerable to mental health problems, both because their situation may make them more vulnerable and because their situation may make access to services more complex. For example:

- Laws in 62% of countries explicitly mention mental disability/impairment/illness in the definition of disability; in 64% of countries, laws prohibit discrimination against people with mental disorders in recruitment; in one third of countries, laws prohibit discrimination in employment for people with mental disabilities. Yet, almost 50 years after the adoption of the International Covenant on Economic, Social and Cultural Rights and 10 years after the adoption of the CRPD by the UN General Assembly, discrimination against people with mental disorders continues to exist worldwide.
- Research on health, including mental health, over the past five decades in the UK has revealed high rates of various physical and mental illnesses among Black, Asian and minority ethnic groups. Some Black, Asian and minority ethnic groups have high rates of schizophrenia (3-7 times), while others have high rates of depression and self-harm (2-3 times) compared to the indigenous white population. Racism and racial discrimination have shown fairly clear links to rates of mental illness, particularly in black minority groups. This has been attributed to poor opportunities and other social factors, including disparities in aspiration and achievement. Such institutionalized discrimination leads to further alienation, increased inequality, and higher rates of mental illness.

> Citizens expect the state to provide a quality system that is accessible, equitable, adequately resourced and reliable.
>
> Countries and policy makers should implement legislative measures to ensure non-discrimination of people with mental disorders.
>
> By contributing to the development of evidence-based health and welfare policies, the Minority Health Bureau can help achieve health equity between mental and physical health and between ethnic groups.

Keeping social connection to protecting the health and welbeing of vulnerable children and young people – CORESZON

The majority of literature on child and adolescent mental health in the context of flight and migration examines risk and protective factors through a pathology-focused lens. While justifiably highlighting the urgency of addressing the well-documented barriers to equitable care, age-appropriate developmental processes and participation in social and civic life, it can simultaneously perpetuate bias and stigma. This side-effect not only exacerbates “otherness” and isolation, but can also impede the sustainable development of integrative, community-based approaches.

This is particularly reflected in practices that address mental health in refugee children and young people. The dominant perspective on refugee child mental health is pre-occupied by a focus on trauma and symptom reduction that often lacks consideration of social ecology and the vital role of caregivers, teachers and social/medical service providers with regard to ecology-related influences that promote mental health throughout developmental trajectories, e.g. social capital.

Interventions that take ecology into account have a level of complexity that necessitates multisystemic cooperation. This is easier said than done, as current policies and practices tend to reinforce silo dynamics among service providers and other essential actors, e.g. school, vocational training and employment programs.

CORESZON addresses this problem with a prevention and capacity-building program that is open to

> Relational experience in childhood influences health throughout the course of adversity and developmental trajectories.
>
> Interventions to promote refugee child mental health should facilitate protective relational factors at individual child, family and/or community level.
>
> The provision of inclusive and accessible mental health services requires targeted consideration of mechanisms that promote positive social connection as a prerequisite for trust and sustainable intervention.
>
> Refugee policies should explicitly promote intersectoral cooperation in order to allow for easier negotiation of comprehensive, holistic support by actors and refugee families.

actors and caregivers both with and without migration experience. Participants learn a skills-based method for self-care and mutual support, including the support of children. Joint participation facilitates trust and cooperation via group discussions that focus on resilience and an experiential teaching approach. Both caregivers and professionals can qualify as trainers and teach the method in their community.

Isolation of the elderly: an important factor of psychological distress – Croix-Rouge française/French Red Cross

Older people are more likely to suffer from social and emotional isolation, both at home and in the institutions that support them (such as EPHAD). The distance from their loved ones is often reinforced by the digital divide they may face. The health crisis, due to the increased fear of being infected (as people particularly at risk of developing severe forms of the disease) and due to health measures imposing social distancing and strict restrictions, has aggravated many older people's sense of isolation or loneliness.
Yet the consequences of isolation and loneliness can be serious and multiple: development of antisocial behavior, increased stress and anxiety, increased risk of depression, altered sleep patterns, altered neural functions and brain plasticity, impacts on the neurobiological architecture that favor the loss of social and cognitive capacity, increased risk of Alzheimer's disease, etc.
FRC contributes to the digital transformation of the elderly in order to fight against their isolation, by promoting the recognition and self-esteem of the elderly, by stimulating the intergenerational approach, and by innovating in adapted support solutions.

In France, a study conducted by *Petits Frères des Pauvres* in 2017 among 1,800 people over 60 showed that:

- 900,000 people aged over 60 are isolated from both family and friends
- 300,000 elderly people can be considered to be in a "state of social death", isolated from the 4 circles (family, friends, neighborhood and associations)
- 3.2 million elderly people are at risk of relational isolation
- 4.6 million French people aged 60 and over feel lonely
- More than 50% of seniors are digitally excluded

People living with HIV: stress and stigma - PNLSH in Guinea

According to the 2018 Demographic and Health Survey, HIV prevalence is estimated at 1.5% among people aged 15-49. The anxieties associated with being an HIV carrier (fear of dying, fear of infecting loved ones, fear of rejection) can lead to serious and long-lasting psychological problems. In addition, the feared or experienced consequences such as not having access to school, employment, social activities can lead PLHIV to refuse to go to health centres or to take their treatments, which can aggravate the physical and psychological impacts of the disease. All these aspects have been exacerbated by the Covid crisis.
It is essential that these aspects are taken into consideration from the moment the result is announced to those who come for testing. Understanding the situation, the prospects of effective treatment and long-term support contribute to acceptance of the status and better adherence to care. All patients who come for HIV testing should therefore receive psychosocial support from psychosocial counsellors.
The strengthening of care services, with improved therapeutic education for patients and support for compliance through accompaniment by specifically trained psychosocial workers, makes it possible to improve patients' adherence to the care programme, resulting in an improvement in their physical and mental condition.
Outreach should complement patient care to reduce risks of treatment dropout and help patients cope with discrimination, stigma and rejection from the community through peer support groups and home visits, with the support of community-based associations of people living with HIV. These interventions also include patient advocacy and community outreach to promote integration and respect for PLHIV.

- Medical care must be reinforced by quality patient education and compliance support, provided by specifically trained staff.

- Outreach and telephone support, and support groups are all ways of reducing the impact of HIV on mental health.

- The lack of specialized services adapted to PLHIV, particularly the youngest, remains a major challenge in Guinea to ensure the right to care and dignity of these people.

Gender issues in mental health - Armelle Andro

Gender inequalities and stereotypes are very important factors of vulnerability related to mental health. Some conditions are direct consequences of gender-based violence specifically experienced by women or LGBTQI+ minorities. But the gender effects are broader and more complex for all people of all sex in accessing diagnosis and care.
For example, men are under-diagnosed with depressive disorders while women are under-diagnosed with autism spectrum disorders.
On the other hand, certain sexual minorities continue to be too often pathologised from a mental health point of view, particularly "trans" people. Gender issues should be better integrated than they currently are.

- The consequences of gender-based violence, particularly sexual violence, on mental health should be better recognized;
- The consequences of gender-based violence, particularly sexual violence, on mental health should be better identified.