OxfordMUN

Asia Conference 2021

World Health Organisation (WHO)

#BACKGROUND GUIDE

OxfordMUN
by Oxford Global

World Health Organisation (WHO)

Background Guide

Cover Letter

Hi everyone, welcome to Oxford Global. I am Angela, your chair for the WHO committee.

I have just graduated from reading Biomedical Sciences at St Hilda's College of the University of Oxford and this is my second time taking part in an Oxford Global conference. My interest in MUN stems from an ambition to contribute to solving some the most pressing problems that challenge our world today. I have been to national and international MUN conferences and was the Vice President for MUN at my school. As a delegate, I always enjoyed the heated intellectual debate and, in particular, the collaborative atmosphere to improve public health and save lives in the WHO. I have debated about solutions for the 2014 Ebola outbreak, Zika virus outbreak, non-communicable diseases management, etc. Outside of MUN, I enjoy college life very much: I was the Treasurer and Vice President of my college's Junior Common Room and rowed for the college boat club.

I very much look forward to meeting you all at the conference. This will be my fourth time chairing and I hope I can make this experience as enjoyable as possible for you.

Human health and diseases are central to well-being and economic development, as you probably have learned from the unforgettable COVID-19 pandemic this year. While in most countries the curve is now flattened and research has boomed in the scientific community, it is important to think about how we can do better in the future. Meanwhile, mental health problems, which are regarded as the silent killer, have also caused significant morbidity and mortality. With a significant proportion of the population suffering from these long-term illnesses, it is important to raise awareness and address them nationally and internationally.

I am excited to hear your ideas and discussions on these two topics and hope that in doing so, we will be able to contribute constructively to a common interest. I really hope that everyone can participate and fully engage in the debates, no matter if you are an MUN expert or a first timer.

Topic: Combatting the Emerging Mental Health Crisis Worldwide

Statement of the Problem

We draw attention to a key issue that has only recently become more recognised globally, which is mental health problems. Health has been defined by the WHO as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. Mental health promotion has become a central focus of WHO’s six main addressed areas. The WHO estimated that around 450 million people currently suffer from mental health disorders, affecting one in four people. Mental health disorders can begin at any age and can have temporary or lasting effect in life. Although various treatments are available, nearly two-thirds of people affected never seek help from health professionals, largely due to associated stigma and neglect. The WHO has a comprehensive mental health action plan from 2013–2020 that outlined major objectives including: (1) strengthen effective leadership and governance for mental health, (2) provide comprehensive mental health and social care services in community-based settings, (3) implement strategies for promotion and prevention in mental health and (4) strengthen research for mental health disorders. However, the current efforts are far from enough. Modern lifestyle, to some extent, can exacerbate the worsening of mental health and current treatments do not adequately address the complex challenges in mental illnesses. In addition, national health policies regarding mental health vary hugely between countries and access to mental health services is limited in low-resource settings. To stop mental illness claiming more morbidity and mortality, we must act now.

History of the Problem

Mental health is defined as a person's condition with regard to their psychological and emotional well-being. It affects our thoughts, feelings and actions and plays a central role in our everyday life including stress handling, empathy, and decision making. Because of this, mental health is connected to human health and its disease state requires intervention, much like diseases of the body. Common mental disorders include anxiety, depression, eating disorders, personality disorders, etc. Evidence of mental illness can be found throughout history and the phenotypic abnormal behaviours were attempted to be explained and treated. Three theories of aetiology were proposed, respectively: supernatural, somatogenic[4], and psychogenic.

Supernatural theories

During the classical antiquity, due to the lack of systematic medical research, people attributed mental illness to possession of supernatural causes such as evil or demonic spirits, displeasure of gods, eclipses, planetary gravitation, curses, and sin (Farreras). In 6,500 B.C., it was believed that the evil spirits were trapped inside of the skull to cause pathologies and hence corresponding treatment was trephination. Rudimentary surgical tools were used to drill holes into the skull, which often caused death. However, by coincidence, the non-fatal cases showed signs of improvement and the complementary infections and

[4]Arising from physical causes rather than purely psychological or spiritual.

swelling was relieved. This further encouraged trephination in the coming centuries even for a wider range of diseases (Restak). By 2,700 B.C. traditional Chinese medicine based on the concept of balancing Yin and Yang inside the human body was used to treat mental illness by re-achieving a harmonious state in China and other neighbouring Asian countries (Tseng).

Later, in 400 B.C. with the initial formation of medical concepts of the body, mental disorders began to be viewed as somatogenic. However, in the late Middle Ages, economic and political disturbances that undermined the power of the Roman Catholic church and natural disasters resulted in a revival of supernatural theories of mental disorders in Europe. Supernatural concepts of mental disorders dominated with the famous witch-hunting, where women, showing abnormal behaviours indicative of mental illness were persecuted and burnt to death. In fact, witch-hunting continued until the 18th centuries, causing more than 100,000 deaths. Other treatment at this stage included praying, relic touching, confessions, and atonement, which were mostly spiritually based (Schoeneman).

Somatogenic theories

In 400 BC, Greek physicians Hippocrates (460–370 BC) rejected the classical supernatural theories. He believed that mental illnesses were 'natural occurrences in the body' instead of the results of evil or God's wrath. He proposed the 'humors theory' which remained central until the 19th century and stated: blood, yellow bile, black bile, and phlegm are four essential factors that keep balance in the human body. They control the characteristics and personalities of individuals, and physical or mental illness occur if the humors are out of balance. For example, depression was believed to be caused by too much black bile entering the brain and disrupting brain activity. Galen (AD 130–201) inherited the humors theory and advocated cutting open veins and releasing excess black bile for treatment. He also suggested psychological stress as a potential cause of abnormality and laid the foundation of psychogenic explanations (Farreras).

The somatogenic theories and treatments dominated in the field of mental disorders for many centuries. From the 16th century, many monasteries and churches were transformed to mental hospitals and asylums to house and manage psychiatric patients (such as St. Mary of Bethlehem in London). Patients were often physically constrained and treated by purges, bleedings, and emetics based on the humors theory. Institutions also exhibited them as animals to the public with two-penny tickets to raise income.

It was also commonly believed that extreme conditions could help mental disorder patients restore rationality by instilling fear. 'Water therapy', by immersing patients in extreme hot- or cold-water baths for several days depending on their emotional states, was popular. Between the 18th and 19th centuries, the 'gyrating chair' and 'swing bed' were developed to shake patients at high frequencies to dredge blood vessels in the brain and restore humors balance. However, this method did not show extensive curative effects and instead caused adverse effects, such as artificially induced seizures and deprivation of physical activity.

In the 1870's Franz Anton Mesmer proposed the theory of 'animal magnetism': natural energy transference occurring between all animate and inanimate objects. He advocated for patients to drink liquid containing high doses of iron, followed by placing patients in a circle of magnets to reset the body's magnetic field. In the 19th century, electroshock therapy started to gain popularity in Italy but severe convulsions and abuse from unscrupulous doctors limited its wider application. From the 1930s, psychosurgery, by cutting the nerves connecting the frontal lobes (which regulate behaviour and personality) to the inner brain limbic systems (which regulate emotions), was widely adopted around the world to treat mental disorders. While some people experienced symptomatic improvement with the operation (such as docile temper), the improvements were achieved at the cost of creating other impairments (e.g. personality change). Hence, lobotomy and other psychosurgeries became controversial and banned after the 1970s.

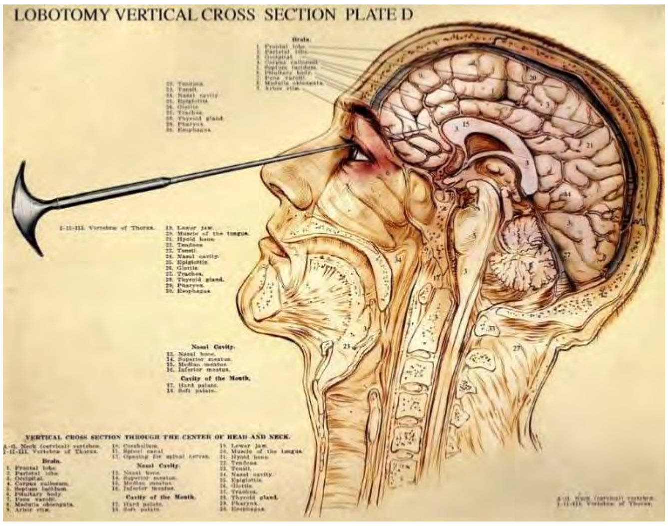

Figure 2 | An illustration of psychosurgery, lobotomy

Psychogenic

The cornerstone of the psychogenic theory was laid by Galen. Although the concepts were formed early on, they were overlooked until the 17th century when medicine gradually separated from theology with the rise of the bourgeoisie. Later after the French Revolution, the French doctor Philippe Pinel (1745–1826) protested against the terrible living conditions of patients with mental illnesses and advocated humanitarianism as 'moral treatment'. He allowed patients to move freely in the hospital whilst providing a comfortable environment, and encouraged communication and care to each individual. This promoted humanitarian treatment in England and America, where doctors encouraged their patients to participate in manual labour and intellectual conversations, effectively ‘training’ them to adapt to healthy states and contribute to society again.

However, in the second half of the 19th century, moral treatments were criticised for merely relying on the sympathy of medical staff, instead of treating the pathologies systematically, and were then abandoned, despite previously demonstrated therapeutic effects. During the first half of the 20th century, am Austrian neurologist Sigmund Freud（1856–1939）developed a breakthrough in psychogenic treatment with the theory of psychoanalysis. He advocated hypnosis to understand the thought processes and the unconscious mind of hysterical patients, which enabled psychoanalysis for a more targeted consultation. However, since Freud followed the moral treatment his theory was heavily criticised. Nonetheless, psychoanalysis was then proven to be an effective treatment of mental illness.

Current Situation

Causes of mental health disorders

While many people have ‘down’ moments and mental health concerns from time to time, a mental illness is when these ongoing signs and symptoms cause frequent stress and affect the individual’s ability to function. A variety of genetic and environmental factors may contribute to the development of mental health disorders. (1) Inherited traits: certain genes increase the risk of developing a mental illness, such as schizophrenia. These genes can be passed on in the family and may be triggered by life situations. (2) Environmental exposures before birth: exposures to environmental stressors including inflammatory conditions (during infections), toxins, alcohol, drugs, etc. while in the womb may increase the person’s chance of developing mental illness later in life (as well as diseases of the body, such as diabetes). (3) Brain pathways and neurotransmitters: neurotransmitters are endogenous chemicals in the brain that transmit signals between different parts of the brain and the body. When the neural network is impaired or the neurotransmitters are depleted, the function of receptors and nervous systems may change, leading to depression and other emotional disorders. (4) Environmental: certain factors in life can act as stressors and induce mental health problems, such as stressful life situations, bereavement, brain damage, traumatic experiences, loneliness, etc (Mayo clinic). Most mental health disorders have some predisposition, either from genetic causes or stressors from the environment.

Classes of mental illness

Neurodevelopmental disorders cover a wide range of problems, often with some association to physical neurodevelopment during infancy or childhood. This class of diseases are typically lifetime disorders, but can be mitigated. Examples include autism spectrum disorder (ASD), attention deficit/hyperactivity disorder (ADHD) and other learning difficulties. Another class of these disorders mainly affect emotional *feelings* of individuals. Depression and anxiety disorders are both in this category. Depression describes a low mood that lasts for an extended period of time and can impact the ability to carry out daily activities and functions. Anxiety is characterised by excessive worrying for future events. Common symptoms of anxiety disorders include sleeplessness, tremors, phobias and panic attacks.

Personality disorders is a unique class that describes a lasting pattern of emotional instability and unhealthy behaviour that cause problems in life and relationships, including borderline, antisocial and narcissistic personality disorders. *Psychotic disorders* result in detachment from reality, forming delusions and hallucinations and disorganised thinking and speech. The most well-known is schizophrenia, characterised by relapses of psychosis. For patients with dissociative identity disorder (DID), the sense of self is disrupted, and multiple personalities may form with completely different tempers and identifiers. Obsessive-compulsive and related disorders manifest in repetitive thoughts, actions and addiction, such as hoarding, binge eating, drug addiction, etc. *Neurocognitive disorders* affect someone's ability to think and reason. The acquired cognitive problems include delirium[5], as well as neurocognitive disorders due to diseases, such as traumatic brain injury and Alzheimer's disease (Mayo clinic).

Diagnosis

An accurate diagnosis is vital for the determination of corresponding treatment regimens. The establishment of a standardised diagnostic classification system greatly contributed to the progress in treatment of mental illnesses. In 1883, Emil Krapelin published a comprehensive system of psychological disorders that centred around a pattern of symptoms suggestive of an underlying physiological cause. In 1952, the American Psychiatric Association first published the Diagnostic and Statistical Manual (DSM) (American Psychiatric Association). The DSM has undergone various revisions and by 1980, the third version took into account the entire individual circumstances and behaviour, instead of just the specific problem behaviour. Axes I and II contain clinical diagnosis, including intellectual ability assessment and personality disorders. Axes III and IV entails a list of relevant medical conditions or psychosocial or environmental stressors. Axis V provides a global assessment of the individual's level of functioning.

The most recent version 5 combined the first three axes and removed the last two axes. These revisions reflect an attempt to help clinicians streamline diagnosis and categorise patients so they can be treated accordingly. The standardisation of the classification system has contributed to better

[5]A sudden change in the brain that causes mental confusion and emotional disruption, including impairment to memory, cognitive functions, attention span and so on.

categorisation of mental disorders and since the first publication of DSM, the number of diagnosable disorders tripled (Farreras). Now, doctors and other medical professionals base diagnosis mainly according to the current version of the manual, DSM-5.

There are usually three steps to confirm a psychological disorder. The first is a physical exam, in which the doctor will try to rule out physical problems that could have been the cause of the symptom, e.g. brain tumour. Secondly, lab tests would be conducted to eliminate the possibility of alcohol- or drug-induced symptoms. Lastly, a medical professional would ask for a description of the symptoms, thoughts, feelings and behaviour patterns. A questionnaire may be used to evaluate psychological state and the assessment is reliant on subjective responses. Because multiple disorders may show similar symptoms, more information provided helps medical professionals to differentiate between disorders.

Current treatment

There is currently a wide variety of treatment available for mental disorders, including medication, lifestyle changes and behavioural therapy. The treatment depends on the type of mental illness diagnosed, its severity and individual circumstances. If the mental illness is at early stages with mild symptoms, counselling and lifestyle changes are likely to be sufficient. However, for more severe illnesses, drugs are often prescribed to improve symptoms (Healy et al.).

Some of the commonly used prescribed psychiatric medications include: (1) antidepressants for depression and anxiety. They are used based on the monoamine hypothesis (traced back to 1950s), which attributes depression to a lack of monoamine neurotransmitters (namely serotonin, noradrenaline and dopamine). Supplementing these neurotransmitters can relieve the symptoms of sadness, hopelessness, lack of energy, difficulty concentrating and lack of interest in activities. This class of drugs is not addictive and does not cause dependency. Nonetheless, common side effects include dry mouth, weight gain, dizziness, headaches and sexual dysfunction. (2) Mood stabilising medications, mostly commonly used to treat bipolar disorders, which involves alternating episodes of mania and depression. These drugs do not have a strong basis as anti-depressants and are described by their effect, which is to stabilise mood. Lithium was the first to be approved by the US Food and Drug Administration and is still popular in treatment. However, it requires close monitoring to avoid toxication at high concentrations (Marmol). Another popular class of mood stabilisers are anticonvulsant, including Valproate, Lamotrigine and Carbamazepine. (3) Antipsychotic medications describe drugs that are used to treat psychotic disorders, such as schizophrenia, by altering the neurotransmitter levels in the brain. Haloperidol and chlorpromazine tend to block dopamine receptors in the mesolimbic, tuberoinfundibular and nigrostriatal pathways, which are linked to psychotic experiences. Other antipsychotics also antagonises serotonin receptor variants.

Alternatively, or simultaneously, psychotherapy is also used to treat psychotics. Most psychotherapies are based on talking about the condition and related issues with a medical professional. The problems and issues (whether current or in the past) that affect the patient’s mood, feeling, thoughts or behaviour are often confronted and discussed. Cognitive behaviour therapy (CBT) is a specific type of talking therapy that can help patients manage the root problems of their disorders by changing their thinking processes and behaviours. CBT is commonly used to treat anxiety and depression. The basis of CBT is that thoughts, feelings, physical sensations and actions are interconnected, so negative feelings and thoughts can be trapped in a vicious cycle.

CBT helps to break down large, overwhelming problems into smaller parts for patients to deal with in a more manageable way, in order to improve the state of the mind on a daily basis. Unlike other talking therapies, the centre of the focus is the current problems rather than long-standing problems in the past. However, the success of CBT depends heavily on patient's commitment and cooperation. The confrontation to stressors and problems also produces a brief period of anxiety or emotional discomfort (NHS). These therapies rely on the professionalism and expertise of the therapists to empathise with the patients and direct the patients out of their current mental states.

Disparity in mental health in society and across nations

Inequalities in mental health, defined as differences in health status or in the distribution of health determinants between different population groups, is strongly correlated with the socioeconomic status within a society. Mental illness and poverty can be viewed as a vicious cycle where mental illnesses impairs an individual's ability to work and undertake social interactions, whereas unemployment and poverty are both stressors that make individuals more prone to mental health disorders. People growing up in lower income neighbourhoods are more likely to have more severe (but not more frequent) stress and to incur traumatic events in their childhood (American Psychological Association).

Another factor that contributes to disparities in mental health is race. It was found that Britons of Black Caribbean origin have a seven times higher risk to develop psychosis compared to their white counterparts (Mental Health Foundation). This is likely because of more social pressure and discrimination that ethnic minorities are likely to face in their lifetime, which is stressful and can have a negative impact on overall health and mental health. In addition, in some communities, mental health is rarely discussed and is stigmatised. This also poses as a barrier for people from minority communities to engage with health services and treat the disorders at early stages.

Moreover, it was found that rural areas in both developed and developing countries suffered from a higher burden of mental health disparities. This may be surprising at first, because urban lifestyle is commonly perceived as more stressful. This may be attributed to more general healthcare disparities between rural and urban areas. As more health resources are concentrated in urban areas, including the more limited access to mental health care facilities in rural areas. In addition, the awareness of mental health problems may be little in rural areas, and even stigmatised in relatively close rural communities. In developing countries which lack basic hygiene and medical resources, children may suffer from malnutrition, infection and stress from prebirth, which predisposes to the development of mental health disorders. Lastly, there is often a socioeconomic gradient between urban and rural residents, which exacerbates the disparities in mental health.

In many developing countries with mental health policies, scarce resources, unestablished infrastructure, ineffective advocacy and lack of political will, limits effective mental legislations and interventions. As a result, people with mental health problems are often marginalised and limited to their own ability to combat these disorders, while facing stigma associated with their disorders. In fact, over 80% of people suffering from mental health problems live in developing countries. The portion of untreated cases also range from 32.2% for schizophrenia to 56.3% for depression and 78.1% for alcohol and drug use disorders (Kohn et al.). There is likely also a large number of unidentified cases in developing countries due to a lack of awareness. For example, in Kenya, it is estimated that unidentified cases of depression from attendance to district hospitals is around 40% and almost 25% of patients have undiagnosed alcohol abuse problems (Ndetei et al.).

Many developing nations have no policy to address the basic needs and rights of individuals with mental illnesses. In addition, the burden of mental illness is often compounded by high levels of stigma and discrimination, which also pose as an obstacle in the provision and utilisation of mental health services. Social distancing, misconceptions and stigmatisation of patients living with mental disorders contribute to discrimination and violation of human rights, experienced by people with mental disorders, even by mental health providers (Ndetei et al.). Limited knowledge of the causes, symptoms and treatment of mental illness often leads to false beliefs that these conditions are caused by supernatural powers or punishment to the individuals or their family, much similar to the historical account in the Western world.

The consequences of mental disorders extend beyond immediate effects on health. The economic burden of mental disorder is great. In the US, the indirect costs attributed to mental disorders was estimated to be over 79 billion USD, with about 63 billion reflecting the loss of productivity because of illness (Ngui et al.). A similarly high loss is observed in Canada, and mental health conditions cost 3–4% of the GDP in European Union member countries (Ngui et al.).

Relevant UN Actions

The UN pays great attention to mental health, as mental health is included in the Millennium Development Goal 3 'ensure healthy lives and promote well-being'. Mental health is in fact interconnected with other Millennium Development Goals (eradicating extreme poverty and hunger, reduce child mortality and improve maternal health) and has been previously largely neglected by world leaders beforehand. Since the incorporation of promotion of mental health and well-being into the global development agenda, progress had been made in a decline of global suicide rate (from 12.9 per 100,000 in 2000 to 10.6 per 100,000 in 2016). However, suicide remains the second highest cause of death among younger adults and the rate is much higher in low- and middle-income countries (WHO, 'Sustainable Development Goal 3'). Nonetheless, the UN has successfully raised awareness of the importance of mental health in the international community. To guide countries to protect the vulnerable with mental disorders, the WHO established a QualityRights Toolkit with practical information to assess and improve the quality and human rights in mental health and social care facilities (United Nations, *Mental Health and*

Development). This can be used in developing and developed countries, as well as many institutional settings.

Amidst the current COVID-19 pandemic, the UN also addresses mental health needs. The UN Secretary General launched the UN policy brief and The Need For Action on Mental Health to urge international communities to attend and protect those vulnerable with mental diseases or facing increasing mental pressures. The most at risk groups identified are frontline healthcare workers, older people, adolescents and young people and those with pre-existing mental health conditions. The UN paper further warned that new cases of mental disorders are likely to arise in coping with COVID-19 and lack of social interactions (United Nations, 'UN Leads Call to Protect Most Vulnerable from Mental Health Crisis during and after COVID-19').

Proposed Solutions

Despite the great start by the UN and some progresses in the diagnosis and treatment of mental health problems, much can be done to improve prevention strategies and further support the people suffering.

Reduce stressors and improve quality of life

It is vital to establish the infrastructures that promote mental health and treat people with mental disorders. Research suggests that loneliness is a risk factor for many mental disorders, hence encouragement of social interactions, such as building community centres, may be beneficial for the maintenance of good mental state in community networks. Fostering a sense of ownership and social responsibility with community members, as exemplified in the Communities That Care (CTC) Programme in the US, also replicated in Europe, which activates communities to prevent violence and aggression.

As previously discussed, some mental problems are attributed to adverse environment before birth or early in childhood. Improving nutrition and housing conditions in socioeconomically disadvantaged families can, to some extent, avoid these stressors and contribute to prevention of mental illnesses. In addition, iodine was found to play a key role in preventing mental and physical retardation and impairment in learning ability. In addition, addressing factors such as maternal smoking, poor social sport and early child-parent interactions have shown great health, social and economic outcomes, namely long-term improvement in mental health of both the mothers and the babies. Reducing child abuse and neglect by home visiting programmes for high risk families and building resilience in children of parents with mental illness or substance abuse can also reduce the children's risk of developing mental illnesses later in life.

Low literacy and low levels of educations have been recognised as major social problems in many middle- and low-income countries. Lack of education is strongly associated with less disposable income, leading to financial problems being identified as a stressor in mental health problems. Hence, through improving literacy, tangible benefits may be achieved by reducing psychological strain and promotion of mental health. Another method to reduce economic insecurity is through programmes that promote entrepreneurships in low-income settings.

Increase awareness and destigmatization

The first step towards better prevention and treatment of mental illnesses is to increase awareness among the general public. This can be achieved by mass campaigns and documentaries that introduce the types, causes and symptoms of mental illnesses, and more importantly the steps to follow in order to seek help. The main points should be centred around clearing up misconceptions and explaining the underlying basis of the mental illnesses. Especially in communities that have attributed mental disorders to supernatural powers or punishment of the family lineages, the campaigns promoted by the authorities should clarify these misbeliefs. In addition, the campaigns should be designed to air on TV, radio and on the internet to achieve high coverage across age groups. In addition, the campaigns can be combined with community-based programmes to further discuss the messages, similar to anti-tobacco campaigns. Additionally, education programmes can be initiated at school so that future generations will have an awareness of mental disorders growing up, learning to take care of their own mental health and also support those suffering from mental disorders. To ensure that the rights of people with mental illnesses are not violated and to prevent marginalisation, legislation may be passed to protect them. For example, care environments should be well maintained to keep them clean and comfortable, and people with a history of mental disorders should not be discriminated against when seeking employment. Sufficient supervision and enforcement is required.

Improving diagnosis and treatment

As well as reducing the risk factors and prevention of mental health disorders, it is also important to manage and improve the quality of life for patients with mental disorders. Currently, although the diagnosis assessment is updated regularly by the American Psychological Association and is relatively accurate at identifying mental disorders, the questionnaire-based assessment is largely subjective to patient's responses. In addition, for some diseases that may have some neurodevelopmental associations, such as autism spectrum disorder, no direct aetiologies have been identified.

Moreover, most medications for psychological disorders are based on empirical observations of improvement in symptoms rather than with the traditional target-based therapeutics. The current drugs often come with strong side effects, including nausea, weight loss/gain, sexual dysfunction, etc. The precise mechanisms of actions of the drugs should be elucidated. Hence, more research into mental health and diseases that can improve diagnosis, help our understanding of the treatments and broaden the range of treatments available, which is highly desirable. For example, in 2017, Yuen et al. applied genome wide sequencing[6] to families with autism spectrum disorder in a large-scale study (5205 samples) and identified 18 new candidate autism risk genes. These gene loci may be applied to diagnostics and their encoded protein products may also become drug targets (C Yuen et al.).

[6]Determining the complete sequence of a person, including non-coding regions, at a single time.

Establishment of mental health infrastructure and facilities

In countries that are currently prioritising the provision of primary healthcare, it is vital to incorporate mental health facilities and promotion in primary healthcare. It is possible to adopt an already established mental health network piloted in other countries, although the financial aspects need to be taken into consideration as well. Community-based approaches are commonly successful in low resource settings. The development of low-cost drugs for treatment is also vital to improve access, as people with mental illnesses are often among the most financially deprived. Training of medical staff to be able to conduct psychotherapy is also vital for the establishment of mental health recourses. More realistically, as the situation is often confined by the number of qualified medical doctors available, it might be more beneficial to give general mental health training to nurses and community leaders so that they can undertake the first assessments and refer people to doctors if needed. The location of mental health services and infrastructure should also be sensibly spaced so that no significant disparities exist throughout the country. However, it may be unavoidable that cities have more services than rural areas, as with most healthcare facilities. Access to mental healthcare in this setting would rely on external factors, such as public transportation.

Questions a Resolution Must Answer

- What are the determinants of mental health?
- How to destigmatise and prevent discrimination against mental health issues in society?
- How should mental health be promoted in remote communities?

- How can governments and non-government institutions help to care for people with mental health problems?
- How can countries promote and protect mental health in emergencies/crises/disasters?

It would be good for delegates to come up with both short-term and long-term solutions to promote and maintain mental health in normal state and in crises.

Bloc Positions

The division of bloc positions is entirely up to you, so here are just some suggestions:

Countries with some degree of mental health awareness and resources: As previously discussed, there are disparities in mental health awareness and promotion across countries. Generally speaking, the US has conducted the most research in mental health disorders, as the APA initially published the criteria for mental illness assessment. In some western countries such as the US and UK, there are some existing awareness for mental disorders and the society is already progressing through destigmatization of mental disorders. More systematic approach and greater effort is required to reduce the disparities in mental health, further prevent mental illnesses and improve the rights and treatment options for the affected.

Countries with limited knowledge or strong stigma surrounding mental health: In many South-East Asian countries (such as China and Japan), mental health problems are viewed as taboo, associated with weakness of personality. As a result, a large number of mental health disorders are undiagnosed every year, leading to high suicide rates and other negative consequences. In these countries, the key to improvement of mental health is first destigmatization and education. It is important to raise awareness of these issues, and increase societal inclusivity of those suffering from them, in order to address the neglected issue of mental health problems.

Countries where mental health is currently not a priority in healthcare: Many developing countries (especially those with low-income) lack basic healthcare infrastructures and resources. As they are in the progress of implementing primary healthcare systems and facilities, it is vital to incorporate mental health services. In low resource settings, it is also important to focus on community-based approaches. Other countries and the WHO may assist these countries to improve their healthcare infrastructure and train medical staff to better treat patients with mental health problems.

Suggestions for Further Research

A first start to the scope of mental health problems may be the WHO website on Mental Health and Development that defines mental health and provides up-to-date information with mental health disorders. Also consider how mental wellbeing interlinks (affects and is affected by) with other Millennium Sustainable Development Goals. It is definitely worth reading about the history of mental health perceptions and treatment. During my own research, I found this webpage particularly useful: https://nobaproject.com/modules/history-of-mental-illness#content. For the current policies on mental health promotion and prevention of these illnesses, the situation varies hugely across countries, so I would suggest you read up on your delegation and have an awareness of systems in other blocs. To think of solutions, a summary report published by the WHO named '*Prevention of mental disorders: effective interventions and policy options*' provides a comprehensive list of prevention strategies that countries can employ. You do not have to list all the ways suggested in this report but maybe incorporate them into your own ideas.

Closing Remarks

Hopefully after exploring these issues, you have gained a better idea of the problems that need addressing and you have thought of creative solutions. The WHO may seem like a technical committee with all the scientific jargon. However, you do not need advanced knowledge of the science itself, and ultimately the focus of debate will be on policy design and international cooperation. It may at first seem daunting with information overload, but if you work through the topics step-by-step systematically, you will find yourself comfortable with them very soon.

Remember that this study guide is by no means comprehensive but only an introduction to the topics. Please do not limit yourself by the scope of this guide, as you are encouraged to do further research on the topics based on your interest. It is also strongly recommended to do research on your country in the specific areas discussed.

Again, I am very excited to meet you all at the conference. I can't wait to hear your ideas on how to solve these pressing health issues. As ever, if you are feeling lost or need help, we are always willing to help and provide direction or guidance. Hence, do not hesitate to reach out at any point. Good luck and I look forward to seeing all of you at OxfordMUN soon.

Bibliography

Abutaleb, Yasmeen, et al. ‘The U.S. Was Beset by Denial and Dysfunction as the Coronavirus Raged’. *The Washington Post*, 2020.

American Psychiatric Association. *Diagnostic and Statistical Measurement*.

American Psychological Association. *Higher Stress among Minority and Low-Income Populations Can Lead to Health Disparities, Says Report*. 2018.

Bojkova, Denisa, et al. ‘Proteomics of SARS-CoV-2-Infected Host Cells Reveals Therapy Targets’. *Nature*, 2020, doi:10.1038/s41586-020-2332-7.

Broughton, James P., et al. ‘CRISPR–Cas12-Based Detection of SARS-CoV-2’. *Nature Biotechnology*, 2020, doi:10.1038/s41587-020-0513-4.

Brundage, John F., and G. Dennis Shanks. ‘What Really Happened during the 1918 Influenza Pandemic? The Importance of Bacterial Secondary Infections’. *The Journal of Infectious Diseases*, vol. 196, no. 11, Dec. 2007, pp. 1717–18, doi:10.1086/522355.

C Yuen, Ryan K., et al. ‘Whole Genome Sequencing Resource Identifies 18 New Candidate Genes for Autism Spectrum Disorder’. *Nature Neuroscience*, 2017/03/06, vol. 20, no. 4, Apr. 2017, pp. 602–11, doi:10.1038/nn.4524.

Callaway, Ewen. ‘Coronavirus Vaccine Trials Have Delivered Their First Results—but Their Promise Is Still Unclear’. *Nature News*, 2020.

Cao, Yunlong, et al. ‘Potent Neutralizing Antibodies against SARS-CoV-2 Identified by High-Throughput Single-Cell Sequencing of Convalescent Patients’ B Cells’. *Cell*, 2020, pp. 1–12, doi:10.1016/j.cell.2020.05.025.

Centers for Disease Control and Prevention. *1918 Pandemic Influenza Historic Timeline*. 2018.

---. *2014-2016 Ebola Outbreak in West Africa*. 2019.

---. *Prevention Strategies for Seasonal Influenza in Healthcare Settings*. 2019.

Chico, Harlan, et al. 'Coronavirus Infections Haven't Spiked since Europe Loosened Lockdowns. There Are Many Theories about Why'. *The Washington Post*, 2020.

Farreras, Ingrid. 'History of Mental Illness'. *NOBA*, 2013.

Gagnon, Alain, et al. 'Age-Specific Mortality during the 1918 Influenza Pandemic: Unravelling the Mystery of High Young Adult Mortality'. *PloS One*, vol. 8, no. 8, Public Library of Science, Aug. 2013, pp. e69586–e69586, doi:10.1371/journal.pone.0069586.

Giuffrida, Angela. 'Italy's Lockdown Has Taken Heavy Toll on Mental Health, Say Psychologists'. *The Guardian*, 2020.

Grein, Jonathan, et al. 'Compassionate Use of Remdesivir for Patients with Severe Covid-19'. *New England Journal of Medicine*, Massachusetts Medical Society, Apr. 2020, doi:10.1056/NEJMoa2007016.

Healy, David, et al. 'Enduring Sexual Dysfunction after Treatment with Antidepressants, 5α-Reductase Inhibitors and Isotretinoin: 300 Cases'. *The International Journal of Risk & Safety in Medicine*, vol. 29, no. 3–4, IOS Press, 2018, pp. 125–34, doi:10.3233/JRS-180744.

Kohn, Robert, et al. 'The Treatment Gap in Mental Health Care'. *Bulletin of the World Health Organization*, 2004/12/14, vol. 82, no. 11, World Health Organization, Nov. 2004, pp. 858–66, https://pubmed.ncbi.nlm.nih.gov/15640922.

Last, JM, editor. *A Dictionary of Epidemiology*. 4th ed., Oxford University Press, 2001.

Lazzerini, Marzia, and Giovanni Putoto. 'COVID-19 in Italy: Momentous Decisions and Many Uncertainties'. *The Lancet Global Health*, vol. 8, no. 5, Elsevier, May 2020, pp. e641–42, doi:10.1016/S2214-109X(20)30110-8.

Marmol, Frederic. 'Lithium: Bipolar Disorder and Neurodegenerative Diseases Possible Cellular Mechanisms of the Therapeutic Effects of Lithium'. *Progress in Neuro-Psychopharmacology and Biological Psychiatry*, vol. 32, no. 8, 2008, pp. 1761–71, doi:https://doi.org/10.1016/j.pnpbp.2008.08.012.

Mayo clinic. *Mental Illness*. 2019.

McCarthy, Michael. *A Brief History of the World Health Organization d ' Hygiene International Sanitary Conference Was Held in Paris in 1938 For Personal Use. Only Reproduce with Permission from The Lancet Publishing Group. WHO Regional Offices at a Glance*. Vol. 360, 2002, pp. 1111–12.

Medicins sans frontiers. 'Crisis Update—June 2020'. *DRC Ebola Outbreaks*, 2020, https://www.msf.org/drc-ebola-outbreak-crisis-update.

Mental Health Foundation. *Black, Asian and Minority Ethnics (BAME) Communities*. 2019, https://www.mentalhealth.org.uk/a-to-z/b/black-asian-and-minority-ethnic-bame-communities.

Ndetei, David M., et al. 'The Prevalence of Mental Disorders in Adults in Different Level General Medical Facilities in Kenya: A Cross-Sectional Study'. *Annals of General Psychiatry*, vol. 8, no. 1, 2009, p. 1, doi:10.1186/1744-859X-8-1.

Ngui, Emmanuel M., et al. ‘Mental Disorders, Health Inequalities and Ethics: A Global Perspective’. *International Review of Psychiatry (Abingdon, England)*, vol. 22, no. 3, 2010, pp. 235–44, doi:10.3109/09540261.2010.485273.

NHS. *Cognitive Behaviour Therapy*. 2019.

Organization, World Health. *Key Events in the WHO Response to the Ebola Outbreak*. 2015.

Restak, R. *Mysteries of the Mind*. National Geographic Society, 2000.

Schoeneman, Thomas J. ‘The Role of Mental Illness in the European Witch Hunts of the Sixteenth and Seventeenth Centuries: An Assessment’. *Journal of the History of the Behavioral Sciences*, vol. 13, no. 4, John Wiley & Sons, Ltd, Oct. 1977, pp. 337–51, doi:10.1002/1520-6696(197710)13:4<337::AID-JHBS2300130406>3.0.CO;2-G.

Think Global Health. *Timeline of the Coronavirus*. 2020.

Tseng, Wen-Shing. ‘The Development of Psychiatric Concepts in Traditional Chinese Medicine’. *Archives of General Psychiatry*, vol. 29, no. 4, American Medical Association, 1973, pp. 569–75, doi:10.1001/archpsyc.1973.04200040109018.

United Nations. *Mental Health and Development*.

---. ‘UN Leads Call to Protect Most Vulnerable from Mental Health Crisis during and after COVID-19’. *UN News*, 2020.

Wang, Yeming, et al. ‘Remdesivir in Adults with Severe COVID-19: A Randomised, Double-Blind, Placebo-Controlled, Multicentre Trial’. *The Lancet*, vol. 395, no. 10236, Elsevier, May 2020, pp. 1569–78, doi:10.1016/S0140-6736(20)31022-9.

WHO. ‘Interim Infection Prevention and Control Guidance for Care of

Patients with Suspected or Confirmed Filovirus Haemorrhagic Fever in Health-Care Settings, with Focus on Ebola'. *World Health Organization*, no. December, 2014, pp. 1–27, http://apps.who.int/iris/bitstream/10665/130596/1/WHO_HIS_SDS_2014.4_eng.pdf?ua=1&ua=1&ua=1.

---. 'Sustainable Development Goal 3'. *Progress of Goal 3 in 2019*, 2019.

World Health Organization. *Ebola Virus Disease*. 2020.

---. 'Ebola Virus Disease—Democratic Republic of the Congo'. *Emergencies Preparedness, Response*, 2020.

---. *Global Influenza Strategy 2019-2030*. World Health Organization, 2019, https://apps.who.int/iris/handle/10665/311184.

---. *Pandemic Influenza Preparedness (PIP) Framework*. 2020.

---. *Preventing Epidemics and Pandemics*.

---. 'WHO Timeline—COVID-19'. *Newsroom*, 2020.

Zhu, Feng-Cai, et al. 'Safety, Tolerability, and Immunogenicity of a Recombinant Adenovirus Type-5 Vectored COVID-19 Vaccine: A Dose-Escalation, Open-Label, Non-Randomised, First-in-Human Trial'. *The Lancet*, Elsevier, June 2020, doi:10.1016/S0140-6736(20)31208-3.