Mr President, chief guest of the day, chairman, distinguished delegates, ladies and gentlemen, at the outset we extend the warm greetings to you all from the people of New Zealand, a fellow Commonwealth country with whom India has very many close links in terms of diaspora, education, sport and tourism.

May we offer congratulations to the new President for his insightful and inspirational comments just delivered. His comments would be apt in any Commonwealth country and is a reflection of his enormous grasp of what needs to happen in the mental health space globally.

It is a matter of considerable regret that my colleague and friend, Sir Anand Satyanand, has been prevented from being with you today to deliver this plenary address. This has been occasioned by a temporary illness resulting in medical advice not to travel for a few weeks.

The address I shall now deliver can be described as a joint production of Sir Anand Satyanand’s work with some input from myself based on my own background in social policy and social work, human rights, public policy, as a parliamentarian, and most recently as a Commonwealth Special Envoy to Lesotho in Southern Africa.

Since Sir Anand Satyanand and I are not medical doctors, we are intrigued, humbled, and very appreciative of the fact that you would include us in your deliberations at this conference. You administer in an arena that is vast in its geography, extensive in its historical time frame, populous, diverse, and with a very large diaspora of which Sir Anand and I are but two. We trust that the perspective we bring satisfies our brief and provides some challenge to your thinking.

The brief in this address is to identify some contemporary issues for the delivery of mental health services in Commonwealth countries. As a peak organization of psychiatrists, your interest is in change, change to the way in which mental health is perceived and in the range of services that are offered to your patients. What this address advances is a broad framework for considering contemporary issues in the delivery of mental health services that may be useful as you individually and collectively review your priorities for advocacy and take on new challenges for the future.

We start with a description of the contemporary international context of mental health. We then follow a simple organizing framework for our discussion. First, we address overarching issues (macro dimensions of mental health). They are the place in medical and community consciousness of mental health and second, the ever-present threat of corruption of systems and practices which thwart efforts of improvement. We then discuss the policy context of the delivery of mental health services, the community context, and finally the family context. While we focus primarily on the macro challenges we have included the other challenges for the sake of completeness and to acknowledge that practitioners and organizations like yours have the ability to take effective action at many levels concurrently.

We want to begin by setting out the broad context in which mental health is practiced. The world’s population today is more than 7 billion. In the year 2005, it was 6.5 billion and in 10 years’ time in 2025, it will have reached 8 billion. All of you as medical practitioners in the psychiatric field will know that in all countries, people with mental disabilities represent a significant proportion of this number. It will be accepted that mental health conditions apply worldwide and that one in four people will experience a mental health condition in their lifetime. Globally, the World Health Organization estimates 450 million people suffer from mental disorders. Dementia, schizophrenia, depression, and addiction make up the bulk of this. One million people die due to suicide each year. Suicide is the third leading cause of death among young people. Depression is the leading cause of years lost due to disability. Mental health problems including alcohol abuse are among the ten leading causes of disability. Depression is ranked third in the global burden of diseases. Mental health unhappily results in stigma and discrimination and abuse.
Professor Mark Tomlinson of the Centre for Public Mental Health, Department of Psychology, at Stellenbosch University, in South Africa, says that it has been estimated that in low- and middle-income countries, as many as four out of five people with a severe mental disorder will not receive any form of treatment. This is known as the “treatment gap.”

There have been many examples from around the Commonwealth of inhumane treatments for mental health patients including being chained, being isolated in cells, and physically abused and ostracized. The World Economic Forum has estimated that the global impact of mental disorders in the next 20 years due to lost economic output is likely to exceed US$16 trillion.

When your work touches the most vulnerable in society, and you wish to make a long-term difference, then it usually requires that something special from practitioners that is scientifically evidenced, unrelenting, highly competent, and courageous. That is the burden of choice of an organization like the Indian Psychiatric Society.

Let us reflect now on the first challenge. Despite an awareness of the prevalence I have cited, today there is an insufficient acknowledgment of this nationally in many cases, as well as internationally.

A reflection of the acknowledgment of mental health today is the way the United Nations has dealt with the issue. Article 25 (1) of the Universal Declaration of Human Rights states that: “(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.”

As to this fundamental document of the modern era, we make the comment that although there may be a global reference to the right of people to receive medical care, there is no specific mention of mental health care.

It will be recalled that the Universal Declaration of Human Rights was promulgated in 1948 and that at the millennium in 2000, much attention was focused on setting goals to alleviate disparity and inequality. The Millennium Development Goals (MDGs) decided upon by United Nations’ resolution in 2000 focused international attention on primary needs at that time. The eight chapters of the MDG were stated as follows: (1) eradicate poverty and hunger, (2) achieve universal primary education, (3) promote gender equality and empower women, (4) reduce child mortality rate, (5) improve maternal health, (6) combat HIV/AIDS and other diseases, (7) ensure environmental sustainability, and (8) develop a global partnership for development.

The point to be made is that despite the prevalence of mental health in every part of the world, it is a matter of record and surprise that there was a lack of mention of mental health as something needing urgent and timely attention.

We have a background with the Commonwealth, which is a grouping of 53 countries bound by common ties of language and a commitment to the rule of law and democracy. In the year 2013, a new Commonwealth Charter was drawn up and promulgated which gave new direction and purpose to the 53 member State Commonwealth contained the following excerpt about health: “access to health, education, food, and shelter. We recognize the necessity of access to affordable health care, education, clean drinking water, sanitation and housing for all citizens, and emphasize the importance of promoting health and well-being in combating communicable and noncommunicable diseases. We recognize the right of everyone to have access to safe, sufficient, and nutritious food, consistent with the progressive realization of the right to adequate food in the context of national food security.”

Again, while this is a laudable modern view about achieving equity and justice, there was no specific mention of mental health.

Based on the absence of reference to mental health specifically in these two major international instruments, it is our view that there is an urgent need for its inclusion in its own right. Many notable experts have made the same point.

The focus and funding driven by the MDGs between 2000 and 2015 had effected a number of positive changes such as in increased school enrollment and decreased mortality among children. Things such as access to drinkable water and combating HIV, malaria, and tuberculosis also registered progress. It is thus pleasing to report that in article three of the newly adopted sustainable development goals, in September, there is an important clause which reads: “3.4 By 2030, reduce by one-third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.”

It can therefore be stated, with some satisfaction, that the matter of mental health and its alleviation has received new impetus and that attention to mental health can take its place alongside environmental sustainability and human development more generally and more forcefully.

It is however nothing more than a “work in progress” waypoint because more than a few of those who advocated...
for a separate sustainable development goal on mental health were disappointed that this separate goal was not achieved. However, they are able to take the inclusion of mental health as a starting point for another chapter of advocacy.

That chapter is possible because indicators on mental health have not as yet been agreed to or included in the list of indicators. This matter of indicators will be important because when agreed to, data will be collected and published on progress that countries are making on mental health. Advocates argue that data on mental health must be included in the final indicators that are developed. This is something that we feel sure the Indian Psychiatric Society may well want to monitor and make a contribution to.

This occasion in Bhopal is one of the larger gatherings of professionals in the mental health field, anywhere in the world since September 2015 (when the sustainable development goals were agreed to by world leaders) and this conference offers the possibility of considering preliminary action in support of the newly calibrated goal and what remains to be done.

There is then potential for smaller groups of nations within the United Nations to develop a strategy to deal with this and to offer what may be done as a benchmark. One such group could be the Commonwealth with its 53 countries, 31 small states, 2.2 billion people, 60% of whom are under 30, comprising some of the world’s richest – for example, the United Kingdom and Canada and the world’s poorest countries, such as Malawi and Uganda. There is already talk of a Commonwealth Convention on Mental Health.

Commonwealth Health Ministers, in their own separate meeting, have agreed that the post-2015 development agenda could include universal health coverage, address the unfinished business of the MDGs, cognizant of the need to accelerate progress on reducing maternal, newborn and child mortality, and incorporate a life-course approach to health, with a focus on morbidity, noncommunicable diseases, strengthening health systems, equitable access to medicines, and links health to other development goals. It is our earnest suggestion that attention to mental health will fit with this admirably.

If you are persuaded that a case has been advanced for mental health to be more prominent as an issue affecting countries throughout the world, one might then ask, how is this to be done?

As outsiders to your number, we hope that the following suggestions may find some degree of acceptance.

First, to advance the case to the United Nations, it would seem desirable to advocate, appoint, and/or join a task force, whose task it would be to maintain the importance of mental health in the United Nations. It seems to me that India could play a leading role in this.

Second, if it were thought desirable, submissions of this kind could be made to a forthcoming meeting of Health Ministers of the Commonwealth. That group of Ministers meets regularly, and the same task force might be empowered to work on a specific convention regarding mental health within the Commonwealth. India is an important and respected member of the Commonwealth whose voice carries considerable weight.

Third, at an operational level, there is much work to be done in clarification and achieving harmony in mental health terminology and documentation. This requires attention in many areas and the education of professionals and those who assist them in their work. A Commonwealth Task Force, perhaps suggested from India, might be one way toward achieving this.

Addressing chronic and serious mental health issues for patients is a complex and demanding challenge for any health system. Alleviation of this, even slightly, would be in the eventual interest of the consumer, the person or persons who at the end of the day need and desire relief in their quest for wellness. There is much work to be done and it is hugely worthwhile because the end result will be to create a level playing field for the 21st century mental health patient.

Thus far we have discussed what we see at the major contemporary macro level challenge for the delivery of mental health services in the Commonwealth.

We turn now to a second macro level challenge that stands in the way of progress and that is, unhappily, the specter of corruption. Reduced to its essence, corruption is the misuse of power for gain. It can be paraphrased to saying “yes” or “no” for money.

Across the world, corruption occurs at many levels, in every day-to-day transaction between common people, all the way up to the topmost levels of business and government, more so in some places than others and the delivery of health care and pharmaceuticals are not immune from this. If the figure means anything, the World Bank estimates that more than 1 trillion dollars are paid in bribes each year.

Like many things, corruption has a supply side and a demand side – the supply coming from unethical business people, greedy corporate enterprises, and the hapless common man who is either prepared to pay or who has no choice about doing so. The demand side comes from wrongheaded politicians, equally wrongheaded bureaucrats, and those in business who are prepared to exercise discretion in an improper manner.
We are pleased to note that one of the other major outcomes of the same UN Sustainable Development Goals meeting at the end of September was Goal 16, dedicated to the promotion of peaceful and inclusive societies for sustainable development, the provision of access to justice for all, and building effective, accountable institutions at all levels. The Conference recognized that much had been achieved during the 15 years since the MDGs were put in place, in the alleviation of poverty and mismanagement. At the same time, the finger was pointed at corruption being a scourge and sadly present in many countries inclusive of being present in the police and the judiciary. In the detail of the expression of Goal 16, some crucial items are covered. For example 16.5 says, “Substantially reduce corruption and bribery in all their forms” and 16.6 says “Develop effective, accountable, and transparent institutions at all levels.” The importance of quoting these is that corruption and its reduction have achieved expression in direct terms at the highest level.

It led British Prime Minister, David Cameron, to say at the conclusion of the conference that “the world must tackle corruption to end poverty” and he urged adoption of simple and inspiring goals to end poverty in 15 years including one that targets bribery and corruption.

If it all works, there will be a hugely powerful way for justice and equity to prevail. The provision of effective accountable institutions and thereby justice for all is something which calls for the actions of governments and also civil society.

Ladies and gentlemen, in your role, leading your profession in this country and its efforts in the 21st century, you are in a unique position to offer support for the recognition of corruption and its eradication, alongside the advancement of mental health.

Addressing macro level issues requires a reconfiguration of the most powerful influences on mental health. At the first tier, elevating consideration of mental health in its own right as a sustainable development goal will require the creation of specific indicators, and the collection of data to enable periodic reviews of progress made over time. Ensuring mental health services are not affected by corruption will also increase the effectiveness of efforts and extend the reach of services.

Adopting mental health as a sustainable development goal and resolving to eliminate corruption will not in themselves lead to addressing the challenges currently inherent in the delivery of mental health services. However, they will reorientate the focus specifically on the plight of the mentally disabled. The mechanism for translation of any broad direction is the development of specific policies on the delivery of evidence-based services. This requires specific policies that constitute the second level of challenges we want to discuss briefly.

Mental health policies need to be tailor made to the demands of a particular society, but they need to be based on the best evidence available. For example, contemporary policies in many countries now set aside funds for public education and the use of modern medicines for the treatment of mental disorders.

There is every opportunity for a working group in the Psychiatric Society to review current legislation impacting on the delivery of mental health services and recommend changes that would better address the concerns.

A third tier of work is around actions at the community level where civil society can be encouraged to discuss, debate, and reach a new level of understanding about mental health that is modern, knowledge-based, and proactive. In some countries, New Zealand being one of them, a successful media campaign has been implemented to raise awareness of mental health, to encourage people to seek help and shape public opinion that is more positive, and less judgmental about mental health.

Finally, the fourth tier of action that can be undertaken is to do work with families coping themselves with mental health issues. Thus, external intervention is extended beyond medical treatment to shape and harness the resources of the entire family that may be affected by it.

Ladies and gentlemen, there is plenty for ANCIPS to do to address the issues we have identified in this paper. There is plenty for community leaders to do and there is plenty for practitioners to do.

Effective change occurs when actions are comprehensively designed, competently implemented, carefully reviewed, and actions reformulated in keeping with local experiences and opportunities. There is plenty to do, and we wish you well in your search for answers.

As we reach the end of our paper, we hope that we have adequately addressed the brief to examine some of the contemporary issues in the delivery of mental health services and some practical action that an illustrious group like you can take.

We end with quoting what we hope it will be agreed are some apt words of the well-known South African cleric, Archbishop Desmond Tutu “Hope is being able to see that there is light despite all of the darkness.”

Thank you for your courteous attention.
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