COSTA RICA INTERNATIONAL
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CRIMUN

WORLD HEALTH ORGANIZATION

"Addressing Mental Health in Emergencies"

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Leadership Network

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WELCOME LETTER FROM SECRETARY GENERALS

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Dear delegates, facilitators and guests,

It is with the utmost pleasure that we welcome you to the fifth annual Costa Rica International Model United Nations conference at the Radisson hotel. This year, we have the pleasure of sharing this event with participants from around the world. CRIMUN 2019 has been a process that our staff has been working arduously on for 10 months, and we cannot wait to watch it culminate in a successful and educational conference.

From its inception, CRIMUN has strived to be a conference of high educational value and deep personal development, where young people like us can find ourselves in positions of leadership and power that allow us to incite global action. This all happens in an environment where cultural exchange and diplomacy is key to unlocking one's full potential in furthering one's knowledge. By attending this conference, you are inserting yourself into a platform of global leaders and exchanging ideas with some of the world's greatest young minds. With so many of us coming from different backgrounds and experiences, it is inevitable for this conference to become an opportunity for you to learn about global perspectives through first-hand experiences.

Your choice to participate in Model United Nations is not untelling of your character as a global citizen. Activities like these bring together those of us that, despite current conflicts and injustices, believe that we can forge a peaceful world through dialogue and empathy towards others. The personal passion that each and every one of you shows towards your respective topics is a testament to how much you truly care about making this world better for everyone. At the end of the day, the future of the globe is in our hands. It is up to us to find our voices and stand up for each other.

In the three days that you will be accompanying us at the Radisson, you will engage in productive, and at times difficult, debate with your peers. While this may prove to be challenging, you must remember that the committee's sole objective is to unify and not divide, to come together and reach a solution to the situation at hand. Your speaking, writing, negotiation and listening skills will prove to be the greatest tools in constructing plausible solutions that may, one day, become a reality. Embrace the responsibility that this entails, as we are building our future, one step at a time.

We hope that you enjoy this conference and gain life long lessons from it.

Kind regards,

The Costa Rica International Model United Nations 2019 Secretariat

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INTRODUCTION LETTER FROM DIRECTORS

Hello delegates,

My name is Santiago Villa and I will be one of your directors for the World Health Organization (WHO) committee this year. I am a sophomore at La Salle High School and I have been participating in Model UN for 3 years now. Through doing MUN, I have learned a lot and have improved my oratory skills, drafting and writing for resolution papers, cooperation, leadership, and research skills. Apart from having harnessed these skills, I have also acquired the possibility to someday make a change in this world for the betterment of our society. In MUN conferences, you will access tools that allow you to bring about change in your lives and in others, where you become the leaders of our future, and incentivize participation in your communities by thinking of solutions and cooperating with one another to reach a middle ground. I will be looking forward to seeing everybody sharing their positions and, adding to the debate, and working together to reach a common goal. It is my pleasure to welcome you to this committee, where we will be discussing many important subjects regarding mental health and emergency responses. If you have any questions about the topic or have any request, don't hesitate to reach out to us.

Thank you, and I am eager to see you this CRIMUN 2019,

Santiago Villa Hidalgo

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INTRODUCTION TO THE COMMITTEE

In 1851 the first International Sanitary Conference was convened in Paris was held in response to cholera epidemics that had begun in the 1830s. This first conference lead to the development and creation of an organization known today as the World Health Organization (WHO).

The World Health Organization was established in 1948 for the purpose of maintaining and improving mental health on a global scale. It operates on over 150 countries with 7000 staff members comprised of doctors, public health specialists, scientists, epidemiologists, and people trained for the management of administrative, financial, and information systems, experts in health statistics, economics and emergency reliefs. Currently, the WHO focuses on combating communicable diseases, including HIV/ AIDS, Ebola, Malaria, and Tuberculosis. It also works to improve sexual and reproductive health; aging; nutrition, food security, and healthy eating; occupational health; substance abuse; and mental health. The WHO is responsible for the World Health Report, the worldwide World Health Survey, and World Health Day.

TOPIC INTRODUCTION

Throughout history, mental health has been a prevalent subject that until the 20th century began to be addressed. It is in situations of extreme stress and pressure that people face, where problems can arise, like wars, famine, and disease that affect any population. One of those problems is how the mental health of people can be affected in emergency situations. Illnesses like post traumatic stress disorder (PTSD), anxiety, and depression can rise after the events.

The impact that these illnesses have cripple a communities' ability to develop. That's why it is important to establish a first response system to emergency situations, to further prevent the repercussions that traumatic events have on citizens and other parties involved. Economic and social problems can further add to the pressure that people face when confronted by traumatic situations, which leads to suicide, addiction to drugs or alcohol, or abandoning the community. Intervention systems in emergencies for mental health can often be ineffective as they are underfunded and seen as a lesser priority when faced with other problems. Emergency response systems that effectively deal with social, physical and emotional problems for people and are able to find ways to help themselves, will be capable of recovering from long term

mental health effects.

KEY TERMS

Targeted (vertical) programmes - These are programmes that are targeted to one specific disease or health condition. Health systems, on the other hand, are not vertical programmes because they provide general services.

The World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) - This document serves as a tool to collect crucial information regarding the mental healthcare systems of each participating nation.

mhGAP Intervention Guide (mhGAP-IG) - This is a guide written by the WHO regarding mental, neurological, and substance abuse disorders in non-specialist health settings. It is used by doctors, nurses, health workers, health planners and managers worldwide in order to strengthen national and international healthcare systems.

HISTORICAL BACKGROUND

Earliest Forms of Mental Health Treatment

The first forms of mental health treatment, known as trephination, began taking place around 4000 C.E. This process consisted of the removal of certain parts of the skull and was believed to have treated headaches, mental illnesses, and even demonic possession. However, little has been discovered of mental health treatments until the 1600s.

Mental Health Treatment in the 17th Century

During the 1600s, the concepts of mental health, or better known at the time as "insanity", depended solely on public opinion and social concepts, rather than medical or scientific research. Individuals with mental health issues at the time were handled and treated by family members, and governments had absolutely no involvement in their medication or analysis. Popular treatments for mental illnesses during this time period included bloodletting and purging, which consisted of draining blood out of a patient's body in order to rid them of demons or evil spirits. This practice was most notably endorsed by English physician Thomas Willis who used the teachings of ancient Greek philosophers and doctors to support this medical practice. Additionally, Willis stated that "an internal biochemical relationship was behind mental disorders. Bleeding, purging, and even vomiting were thought to help correct those imbalances and help heal physical and mental illness,". It is also important to note that bloodletting and purging were also used to cure a variety of physical diseases, including diabetes,

asthma, cancer, cholera, smallpox, and stroke, so the practice was not limited to the mental health field.

Another form of treatment that became common during the 17th century was the use of isolation and asylums. Although the use of isolation and asylums were claimed to be for the treatment of patients, it's real purpose was to hide mental health patients from their societies. Asylums introduced a variety of health threats, including overcrowding and poor sanitation. Additionally, cruel and physical tactics were used; including ice water baths and restraints.

Mental Health Treatment in the 19th Century

Prior to 1891, there had not been much conversation regarding mental health worldwide. Before the 1890s, discussing topics surrounding mental health was shunned upon, and patients with mental illnesses were treated through inhumane methods. Besides conversation on mental health being "taboo", there also was an extensive lack of medical and scientific research on the matter, which meant patients who were being treated were often being treated incorrectly. Throughout the 18th century and up to the mid to late 19th-century, treatment of mental disorders was cruel and archaic, conducted in what was called at the time "insane asylums". Treatments were drastic, ranging from electroshock therapy to lobotomies.

Mental Health Treatment in the 20th Century

In the 20th century, influential publishings were made analyzing mental health, which in turn changed worldwide perspectives about these illnesses and the treatment patients were receiving in mental hospitals, and therefore sparking the mental hygiene movement. Mental hygiene, now referred to as mental health, is a movement that can be attributed to the work of Clifford Beers. After graduating from college, Clifford was admitted into a mental hospital after suffering his first episode of bipolar disorder following the death of his brother in the year 1900. It was during that time that he witnessed and was subjected to the horrors of how psychiatric wards treated their patients. In 1908, he published a book that recounted his experience during his stay at 3 mental institutions and later founded the National Committee for Mental Hygiene. In 1919, the internationalization of the committee's activities led to the creation of other national associations in other countries such as France, South Africa, Italy, and Hungary, which later became the International Committee on Mental Hygiene, superseded by the World Federation of Mental Health in 1948.

However, it is important to note that many treatments for mental health patients were inhuman and violent during the 1900s. Tactics that were used during this time period included:

- Insulin Coma Therapy (1927-1960s) - Patients were placed under low blood sugar comas for a period of one to four hours. Doctors at the time believed that changing a patient's glucose levels would alter their cerebral functions. However, this treatment was later deemed extremely unsafe and ineffective, and mortality rates varied from 1 to 10 percent.

- Metrazol Therapy (1930s-1982) - The form of treatment consisted of using stimulant medication to prompt patients into having seizures. Metrazol therapy was often conducted on patients several times a week and in many cases, resulted in broken muscle tissue, bones, and a variety of other injuries. Although metrazol therapy was discontinued in 1982 by the FDA, it progressed into a different form of treatment known as electroconvulsive therapy, which is still used today in extreme cases.

- Lobotomy (1930s-1950s) - Lobotomies were the surgical process of cutting or removing the connections between the prefrontal cortex and frontal lobes of the brain. Due to the fact that they came with severe risks, they were only allowed to be administered by physicians in severe cases. Notably, the procedure won the Nobel Prize in Physiology and Medicine in 1949, before it was later discontinued in the 1950s due to the introduction of psychiatric medications.

History of Mental Health in Emergency Situations

The early history of mental health being affected in emergency situations are exemplified in events such as the U.S. Civil War during the 1860's, where cases of "nostalgia", now described as PTSD, were seen as signs of cowardice or feeble will. This concept became more prevalent during World War I, where cases of 'shell shock' became commonplace. Shell shock was described as lesions on brain tissue by shockwaves, however, this definition failed to explain how symptoms were showing up in those who were nowhere near exploding munitions and were dismissed as being a nervous breakdown.

In 1952, the American Psychiatric Association created its first Diagnostic and Statistical Manual of Mental Disorders, or DSM-I, which established the base for future diagnosis for mental illnesses and facilitate its treatment.

CURRENT SITUATION

Current Emergency Mental Health Plans

WHO has currently developed plans for the intervention in emergency situations like the "Problem Management Plus" manual or "PM+", which is a scalable psychological intervention for people exposed to calamities. The "mhGAP Humanitarian Intervention Guide" was also developed by WHO for the clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Local workers, teachers and volunteers are trained to provide psychological first aid. An intervention pyramid was developed with essential services at the bottom and more specialized services at the top that are used by countries in order to match the response to an emergency with the communities' needs.

Current Mental Health Treatments

In general, the medical community has been able to develop mental health treatments that are both effective and safe, and come from a variety of psychotherapy and biomedical treatments. Some of the most common treatments of mental health treatment include the following:

Psychotherapy - When paired with medication, this treatment is believed to be the most effective for mental health patients. Psychotherapy explores thoughts, feelings, and behaviors, and seeks to improve an individual's well-being. There are many different branches of psychotherapy, including Cognitive Behavioral Therapy, Exposure Therapy, and Dialectical Behavior Therapy. Because of the wide range of psychotherapy tactics, patients are able to receive treatment that is tailored to their needs.

Medication - Although medication is usually unable to cure mental illness, it does help to treat most symptoms. As mentioned previously, this form of treatment is most effective when paired with psychotherapy.

Case Management - Case management involves creating a plan for a patient's recovery by assessing, monitoring, and planning a strategy involving a variety of treatments. This plan is usually created by a case manager who is professionally trained in the matter.

Hospitalization - Although not as common as other treatments, hospitalization is normally used as a way to closely monitor and medicate patients whose mental illness has temporarily worsened.

Support Group - This treatment consists of meetings of people who work to support each other and attain a similar goal of recovery. Support groups usually involve

people who have suffered through similar situations or illnesses rather than professionally train therapists.

Complementary and Alternative Medicine - Also known as CAM, this rehabilitation tactic consists of therapeutics and medications that are not standardly used. CAM is usually used along with other forms of treatment.

Electroconvulsive Therapy - Electroconvulsive Therapy is a procedure where small electric currents are sent to the brain in order to cause a brief medically induced seizure, which in some cases alters the patient's cerebral chemistry. Although this procedure has been shown to be safe and successful for most patients, there is a large stigma placed on it due to a bad history of abusive treatments using large shockwaves and causing severe side effects. However, modern-day electroconvulsive therapy is performed under anesthesia and is used to treat severe depression, treatment-resistant depression, severe mania, catatonia, as well as agitation and aggression from patients with dementia.

Art Therapy - This new form of therapy began to appear around the mid-1900s, and is commonly used alongside other forms of psychotherapy, including group therapy and cognitive behavioral therapy. Art therapy comes in a variety of different forms, including drawing, painting, sculpture, and collage making. The treatment occurs usually in hospitals, private mental health offices, schools, and community organizations, and is targeted towards people who have suffered through emotional trauma, physical violence, domestic abuse, and anxiety, depression. Common patients of art therapy include children with learning disabilities, adults experiencing severe stress, children suffering from behavioral or social problems at school or at home, people experiencing mental health problems, individuals suffering from a brain injury, and children or adults who have experienced a traumatic event. According to Cathy Maldiochi, from The Art Therapy Sourcebook: "In most art therapy sessions, the focus is on your inner experience—your feelings, perceptions, and imagination. While art therapy may involve learning skills or art techniques, the emphasis is generally first on developing and expressing images that come from inside the person, rather than those he or she sees in the outside world,"

Cognitive Behavioral Therapy - This treatment, known also as CBT, is a form of targeted psychotherapy that helps patients better understand their thoughts, feelings,

and behaviors. CBT is usually used to treat patients suffering from a variety of mental illnesses, including phobias, addictions, depression, and anxiety. According to the British Association of Behavioural and Cognitive Psychotherapies, "Cognitive and behavioral psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behavior. They include a wide range of treatment approaches for emotional disorders, along with a continuum from structured individual psychotherapy to self-help material." It is also important to note that this form of treatment faces criticism and has been deemed ineffective by many due to the fact that it does tend to focus on potential underlying unconscious resistances to change as much as other approaches such as psychoanalytic psychotherapy. Cognitive behavioral therapy comes in many different variations, including:

- Rational Emotive Behavioral Therapy (REBT) - REBT focuses more on identifying and recognizing irrational beliefs.
- Cognitive Therapy - Cognitive Therapy is centered around identifying and changing distorted thinking patterns, emotional responses, and behaviors.
- Multimodal Therapy - This form of therapy studies and works to improve a person's mental health by addressing their behavior, affect, sensation, imagery, cognition, interpersonal factors, and drug/biological considerations.
- Dialectical Behavior Therapy - DBT works to address thinking patterns and behaviors and incorporates strategies such as emotional regulation and mindfulness.

MAIN ISSUES / SUBTOPICS

Lack of Funding

At the moment, global funding is going through a transition from financing targeted mental health programmes, typically provided as 'project' funds to countries, to financing 'national programmes' or health systems to improve country ownership as well as to enhance engagement and efficiency. One of the main reasons for this transition is the inefficiencies due to the funding of multiple uncoordinated projects.

Currently, mental health is represented in 8% of the disease burden in high-mortality low- and middle-income countries. For example, even where mental health is identified as a priority, mental health does not receive any specific budget in most of Africa. In fact, in 70% of African nations, less than 1% of the health budget is allocated to mental health. When it comes to funding from NGOs, it is easy to say that not enough

funding is provided to health programs in order to address the mental health support of a whole country on a sustainable basis, due to the fact that there is no well-functioning public health system in place.

On average, the WHO offers US $ 50,000 to low-income countries twice a year. However, most of this funding is used by countries for advocacy events such as World Mental Health Day, consultation events, or office equipment for the ministry of health. Although this funding does benefit the ministries of health, it does not create a meaningful change in the current services offered to patients with mental health problems in developing countries.

All in all, the lack of international investment in mental health infrastructure, information systems and research not only hampers the ability of Ministries of Health to make an effective case to Ministries of Finance, but also prevents necessary treatments from reaching patients in dire need.

Lack of International Response and Involvement

One obstacle that is faced when trying to address this problem is that policymakers do not see mental health as an easily approachable subject due to the complex nature that it holds and the difficulties that come when trying to fund programs to further improve the understanding of what mental health means and the ways to treat different illnesses. There is an important economic justification for mental health investment. Medications like psychotropic treatments, to give an example, are fundamental in the proper addressing of mental health problems and they are, in fact, among the treatments most used by developing countries due to their low cost and high effectiveness.

This subject cannot be simply approached from the necessity of medications, but it must be supported by the general population, which could deter reform of the health sector because of the social mechanisms on which our society is built upon. This makes it difficult for mental health to be targeted, as often it is seen as a lesser priority.

Social Stigmas

Mental health disorders are socially tied to many stigmas such as the idea that mentally-ill people are weak, 'crazy' or are unable to take care of themselves and complete tasks. These stigmas are extremely detrimental to a person's self image and the opportunities that they might have in terms of work or social relationships. Additionally, they may also prevent patients from asking for help or

speaking about their experiences with mental health, therefore leading to cases of isolation, self harm and suicide. In lieu of this, it is important that the committee addresses these stereotypes and works to educate the general public in order to eliminate them and shine a light on the truth of mental health.

Suicides

The health of refugees is affected adversely after being displaced from their homes and put into camps, as seen in the infamous Greek camp in Lesbos. Fights between Arabs and Afghans, the dirtiness, and the lack of food and water have lead to children contemplating suicide in this camp and young men auto-mutilating after being rejected for asylum and facing other hardships.

This indicates the harrowing reality that refugee camps can be; cramped and uncomfortable places with people who have faced adversity and, many times, has scarred them and changed them. This points towards the lack of resources that exist in order to help those afflicted with mental health disorders in emergency situations which leads to further long term problems. Depression, PTSD, and anxiety, are significantly higher in refugee camps that in the general population. For instance, depression and anxiety rates had percentages in the low 40s in the Karenni refugee camps of Thailand, with a significant difference to the anxiety and depression rates of the general US population, 7%, and 10% respectively.

Anxiety Disorders

Anxiety disorders are those that involve an extreme feeling of fear or worry and therefore interfere with the mental function of refugees on a daily basis. Anxiety conditions are often disabling and can lead towards behaviours that isolate and ultimately hurt a refugee's ability to reintegrate into society.

There are various subcategories of anxiety disorders, of which the most prone to affect refugees are Post-Traumatic Stress Disorder (PTSD), General Anxiety Disorder (GAD), panic disorders and separation anxiety. These can all be triggered and caused by the extremely traumatic events that refugees go through such as conflicts, violence and natural disasters.

General Anxiety Disorder - causes extreme and constant feelings of worry about a myriad of topics, usually linked to money, family, safety, etc. People that suffer from this disorder may be anticipating the worst outcomes possible from a situation with seemingly no logical explanation. They also

might find the thought of getting through the day completely unbearable and develop an unhealthy need for control.

It is important to note that GAD is characterized by repeated and illogical feelings that exceed the normal amount of stress that a person goes through. This means that a person's body is not made to handle such a large amount of mental pressure and serious physical and emotional trauma may ensue. Therefore, delegates must not confuse this disorder as normal worry, and should rather treat it with the seriousness that it entails during debate.

Post-Traumatic Stress Disorder (PTSD) - happens after a person has experienced a traumatic event and therefore experiences symptoms up to months or even years later. These symptoms can be categorized into three different types:

-The re-experiencing of the traumatic event through psicosis, nightmares or night terrors and flashbacks.
-The avoidance of places, people, smells or other factors that remind the patient of the trauma, as well as emotional numbness.
-Having a hard time concentrating or sleeping, being sensitive to your environment and feelings of anger or irritability.

After emergency situations, refugees may experience PTSD due to the distressing nature of war, natural disasters, leaving behind their homes and loved ones or entering completely new environments, amongst others. This makes them especially vulnerable to this type of disorder, and therefore PTSD should be a major area of discussion for delegates.

Panic Disorders - are characterized by spontaneous and irrational panic attacks as well as deep recurring feelings of fear that interfere with daily functions. Panic attacks may be triggered by an array of events or be brought on in a seemingly out of the blue manner. These may even occur as a person is waking up from sleep. The symptoms of an attack are:

-Trembling
-Accelerated heart rate and palpitations
-Sweating
-Difficulty breathing
-Shortness of breath and sensations of smothering
-Feelings of dizziness or faintness
-Nausea or abdominal pain
-Numbing
-Chills
-Derealization or depersonalization
-Fear of death
-Fear of losing control

The intensity of these attacks may vary, as

well as their symptoms. Usually, they reach their peak after 10 minutes, after which they start to subside. They are also not exclusive to people with panic disorders and many refugees may experience them after situations of trauma, even if they aren't diagnosed with a mental illness.

Depressive Disorders

Depression is the most common mental illness around the world and one of the most seen in refugee areas. It affects how you feel, act and think in a serious and negative way. Depressive disorders are commonly characterized by feelings of sadness, emotional numbing, loss of interest in daily activities and various physical symptoms, amongst others. As it is, depression can gravely injure a person's ability to work or function, and refugees can be impacted greatly by this disorder when looking to reintegrate into society or move on with their lives after a traumatic experience.

Physically, depression can have a concerning impact on people's health. People in refugee status that live with this illness may experience drastic changes in weight, severe insomnia or unhealthy sleeping patterns and restlessness. Energy levels may completely plummet and consequently migrants may not be able to work or maintain their social networks, let alone expand them and lead a healthy lifestyle. Medically, this may pose a threat to their health, and depression has been linked to an array of disorders or physical illnesses in the past.

Acts of recklessness and feelings of worthlessness are also predominant in patients with this disorder. Suicide may also be a consequence of depression, and this is not an uncommon happening in refugee camps. The committee must come to an agreement that fights to help protect and ensure the wellbeing of migrants that have experienced trauma around the world.

Mental Health in Refugee Camps

Refugees are faced with extreme hardships before, during, and after their displacement, including oppression, discrimination, sexual violence, genocide, torture, political persecution, and the loss of loved ones while being forced to flee conflict. Because of the atrocities that refugees witness throughout their lives, many suffer from a variety of mental health issues, most notably post-traumatic stress disorder (PTSD). Many symptoms of PTSD can occur when refugees arrive at camps and are not provided with enough food, shelter, or safety. The amount of refugees suffering from PTSD varies between regions, past historical trauma, and refugee camps. However, the average percentage

of refugees suffering from PTSD is between 10-40%. Sadly, children are more likely to suffer from PTSD, with and an average of 50-90% experiencing symptoms.

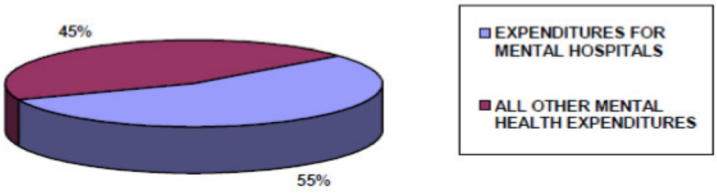
Refugees might not receive the mental help they need due to a variety of reasons, including language barriers, belief systems, cultural expectations, and trust. Many refugees might refuse to seek help, such as therapy and counseling, they need due to their belief systems, leading to a lack of support. Sadly, individuals who have faced violence and discrimination do tend to have a sense of distrust towards staff members working in refugee camps. Because of this, training must be given to healthcare professional in order to exercise proper techniques that gain trust of refugee patients and work well with communities and families.

BLOC POSITIONS

Uganda

Mental health was allocated just 0.7% of an overall health budget ($8 USD per person) under their first Ugandan Health Sector Strategic Plan. In Uganda, the government has declared mental health as a major priority and focal point in the upcoming years, and they have recently planned several reforms to improve their mental health care system. Research conducted by the WHO and the Assessment Instrument for Mental Health Systems (AIMS) in Uganda showed that only 0.8% of the medical doctors and 4% of the nurses were specialized in psychiatry. Currently, Uganda has several organizations that work to improve mental healthcare, including Mental Health Uganda (MHU), which works to build partnerships, raise awareness, advocate for rights, capacity build, and provide psycho rehabilitation.

Uganda's National Spending on Mental Health:



United States of America

The United States has several programs focused on addressing mental health, such as the US Center for Mental Health Services and the National Institute of Mental Health. Nonetheless, the human services funding each state gives its counties hasn't increased since before the Great Recession (circa 2009), causing many small children, outpatient, and peer-support programs to be shut down. Abroad, the United States Agency for International Development (USAID) has encouraged public-private

alliances and proposals focused on integrating mental health services for women into primary care in eastern Europe and Eurasia. USAID has also funded a two-year project in Kosovo to support community integration and full participation of people with mental disabilities into society. In the West Bank and Gaza, it has supported child and adult mental health programmes and projects, while in Africa it has recently been supporting efforts to rebuild national mental health policy in Liberia.

United Kingdom

The UK Department for International Development (DFID) had an expenditure of £6.3 billion (0.43% of the UK's gross national income) in the year 2008. Of total overseas aid, 41% went to multilateral organizations, such as the European Commission, the World Bank, and the UN. The rest of international funding went towards bilateral assistance to countries (47% of bilateral assistance was allocated to Africa and 33% to Asia). The DFID has also invested in a number of mental health projects around the world, including the Knowledge Fund. They also funded NGO development projects in Eastern Europe and support for mental health reform in the Sverdlovsk region of Russia, which included health and social welfare system development as well as NGO capacity building.

Sweden

Besides funding several small-scale mental health programs, Sweden has contributed to improvements in mental health care through investments in its work more broadly in development and poverty reduction in Eastern Eastern Europe, Latin America, and Asia. The Swedish International Development Cooperation Agency (SIDA) had a budget of 16.8 billion SEK in 2009 (about half of Sweden's development aid budget), that of which has the potential to aid mental health programs. The Swedish National Association for Social and Mental Health has also been working in order to better inform politicians, authorities and care institutions, of the best actions that can be taken regarding mental health and give more influence and power to those affected over their lives. Mental health services in Sweden are given through two systems, by the county councils' mental health providers, and universal services by the municipalities' social welfare system.

Denmark

In Denmark, the first legislation regarding mental health was passed in 1938, titled the “Mental Health Act” and in 1989 a new act was passed. This new act regarded the protection of citizens that are admitted into mental institutions forcefully. The Mental Health Services of the Capital Region of

Denmark treat one-third of all patients in Denmark that suffer mental illnesses. It is also in this institution where research for depression, bipolar disorder, eating disorders, schizophrenia, etc. are researched in both adults and children. The Danish International Development Agency (DANIDA) has undertaken some mental health-specific projects in East Africa. For example, DANIDA has funded projects in Tanzania that include support for primary care training, as well as funding for psychotropic medications in Zanzibar. However, mental health programs were not included in other DANIDA country health sector support programmes prepared for Bhutan, Ghana, Mozambique, and Uganda.

European Union

The European Union (EU) has contributed greatly to health and aid development projects through the European Commission (EC), the European Council, and on behalf of member states. At a global level, the EU plays an important part in contributing to global health, as well as to the achievement of the Millenium Development Goals (MDGs). Although mental health has not been highlighted as a key priority by the EU, there is potential to allocate resources to mental health-related initiatives through the EC's support in the achievement of MDGs.

Regarding policies set by the EU, significant attention has been given to mental health through the European Union Pact on Mental Health and Well-being. Additionally, the EU has the European Structural Funding, which can serve as a source of funding to strengthen the mental health infrastructure as well as funding and monitoring efforts to promote deinstitutionalization and major system reform in member states such as Romania and Greece.

South Sudan

Shockingly, South Sudan currently only has one mental health institution, which has been described by visitors as a prison ward. As described by Dr. Inka Weissbecker, who visited the institution in 2011 (only two years after the country's independence) recalled that "Patients were sedated, living in their own filth; a traumatized young girl wandered the hallways unattended; people with schizophrenia had no medication." Due to South Sudan's violent civil war, children are suffering from post-traumatic stress disorder and there are many traumatized civilians. However, the country has received some international funding for treating mental health.

Zimbabwe

Like most developing countries, Zimbabwe treats their mental health patients by

putting them in hospitals, which usually do not meet the needs of the patients and further stigmatizes mental health issues. These asylums also use large amounts of medication and seclusion to treat their patients, and there are only 10 psychiatrists for 13 million people.

Greece

Being the gateway into Europe, Greece is currently accepting thousands of refugees from conflict zones such as Syria. Because of this, the Greek government needs to put specific focus on ensuring the mental health of all the refugees residing in their camps. For example, in the Greek Moria refugee camp, also known as the "Olive Grove", access to medical care, both physical and mental is extremely limited. In order to receive health care, refugees need to submit a form or prove that they need immediate medical attention. Currently, there is only one doctor attending refugees at the camp, and all NGOs funding the program have stated that mental health problems are the number one reason for visits to the clinic. Doctors work at the clinic for a few weeks at a time and are only able to accept patients who have persistent psychotic symptoms, who have attempted suicide, or who demonstrate significant self-neglect and inability to function. There have been many cases of suicide at the Moria camp as well as many others.

THE ROLE OF WHO

Despite its constant action in the topic, it is important to note that the WHO's main mandate is not as a donor, and so it has limited capacity to fund programs and is unable to invest in mental health service development. The WHO is also limited when it comes to working alongside ministries of health, and therefore have a minor influence on critical non-health system interventions, including housing, education, and employment, all of which have a direct link to the mental health of individuals.

Although the WHO has provided excellent technical advice and advocacy, it has yet to increase links with other major communicable and non-communicable disease programmes. Due to the fact that there is no proper communication between WHO headquarters, country and regional offices, regions, and countries act in complete independence. Because of this, priority given to mental health by WHO Headquarters may not always be reflected by regional and country offices in increased budgets for mental health. Not only this but according to independent research, the staff of the World Bank does not prioritize mental health, even where World Bank officials are aware of the importance of mental health.

PREVIOUS RESOLUTIONS BY WHO

- The World Health Organization's Mental Health Division - The MHD encouraged for there to be more research and developed a wide range of advisory documents for governments and other funding bodies.

- The World Health Report of 2001 - This document on mental health created a broad framework for the development of mental health programmes in low-income, middle-income, and high-income countries.

- WHO Suicide Prevention - On January 29th, 2019, the WHO launched their suicide prevention plan, which works as a resource and inspires governments to establish their own national suicide prevention strategy.

RESOLUTIONS

Points to consider throughout debate

1. More must be done to prevent the collapse of health systems in order to protect its citizens. Rapid response mechanisms need to become flexible, where there are situations of life or death, and further work on the humanitarian aspect.

2. There are specific problems that affect women, children, the elderly, and disabled people that are invisible to the rest. Those difficulties must be made visible and they must be approached in a specific way. Those with the greatest ability to help are local health workers that are properly trained.

3. The proper steps that must be taken in order to protect the systems and services that are vital and accessible to communities, must still be made.

4. It has become harder to provide an impartial service as the radicalization of religious and political ideals have expanded. It is a collision of ideas that restricts the treatment of those who follow radical ideas, which usually go against popular opinion, and to many, it would seem like a waste of resources to tend to the needs of radicals.

5. We must consider all action within the continuum of care.

6. We must increase quality support to address mental health and psychological support needs, as well as NCDs in conflict settings.

7. We must limit destruction – in urban conflict especially – and urge all parties to take feasible precautions to protect civilians and avoid the use of weapons.

Sources of Funding and Support

There are several different funding approaches and plans that can be used to fun global mental healthcare. Listed below are a few examples that the international community is currently trying to transition to in order to fund new healthcare programs.

- Sector-Wide Approaches (SWAps) - SWAps are designed to allow entire sectors to develop their own strategies. These strategies are then funded by donors who attempt to ensure their implementation.

- International Health Partnership for UHC 2030 - The IHP+ for UHC 2030 works to provide global cooperation and collective funding to strengthen global health systems.

- Health Systems Funding Platform - This platform was developed by the World Bank with the involvement of the WHO to provide existing funding for the improvement of healthcare systems and achieving the UN's Millennium Goals.

- World Bank - Mental health is not specified in its priorities but is included within some funded projects, usually in relation to post-conflict development.

- National Development Funding Programs- A couple examples of these include the UK Department for International Development (DFID), the United States Agency for International Development (USAID), the Canadian International Development Agency (CIDA), the Swedish International Development Cooperation Agency (SIDA), the Japan International Cooperation Agency (JICA), the Danish International Development Agency (DANIDA)

- Médecins Sans Frontières (MSF) - This organization works closely with the WHO regarding many health issues worldwide who hire local and foreign doctors, administrators, and health care professionals to "provide medical assistance to people affected by conflict, epidemics, disasters, or exclusion from healthcare."

- International Medical Corps - The IMC advocates for mental health through donors and governments. They work to map services, coordinate activities, and promote the proper practices and guidelines needed for a safe and efficient healthcare system.

- The Mental Health & Psychosocial Support Network (MHPSS) - As stated on

their website the MHPSS is "A growing global platform for connecting people, networks and organizations, for sharing resources and for building knowledge related to mental health and psychosocial support both in emergency settings and in situations of chronic hardship. The network functions as an online community of practice for mental health and psychosocial support in challenging humanitarian and development contexts."

- Mental Health Gap Action Programme (mhGAP) - This program was created by the WHO and works to implement services for mental, neurological, and substance abuse disorder in low and middle-income countries.

What we are looking for in working papers

1. When mentioning or using any of these funding programs in a resolution paper, it is important that mental health is included as a priority in the health policies and the health sector strategic plans (HSSP) of countries.

2. Delegates must also look for ways to find interactions and connections between mental and physical health in order to connect it to the healthcare system more easily.

3. A focus must also be made on providing both funding, infrastructural support, and training, to less developed nations in order to improve their healthcare systems.

4. Both medical and non-medical professionals must receive training in order to properly address mental health in emergency situations, particularly in refugee crises.

5. Creating and implementing community-based support groups (especially in low-income and rural areas) that offer stability and recovery for patients.

APPENDIX

Andrews, T. (2018, May 17). 097 Before After Lobotomy. Retrieved from https://www.youtube.com/watch?v=hAPicLG0Aoc

The hidden problem of mental health in refugee camps. (2019, February 20). Retrieved from https://www.centeronhumanrightseducation.org/the-hidden-problem-of-mental-health-in-refugee-camps/

Wylie, L. (2019, June 03). How to develop the mental health care that refugees really need. Retrieved from http://theconversation.com/how-to-develop-the-mental-health-care-that-refugees-really-need-106144

https://www.unhcr.org/4b4dce289.pdf

http://apps.who.int/disasters/repo/8699.pdf

BIBLIOGRAPHY

Bertolote, J. (2008). The roots of the concept of mental health. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2408392/

Cherry, K. (2018). How Does Art Therapy Work for Patients?. Retrieved from https://www.verywellmind.com/what-is-art-therapy-2795755

Cherry, K. (2019). Cognitive Behavior Therapy and How It Works. Retrieved from https://www.verywellmind.com/what-is-cognitive-behavior-therapy-2795747

Electroconvulsive therapy (ECT) - Mayo Clinic. (2018). Retrieved from https://www.mayoclinic.org/tests-procedures/electroconvulsive-therapy/about/pac-20393894

Hussung, T. (2016). A History of Mental Illness Treatment. Retrieved from https://online.csp.edu/blog/psychology/history-of-mental-illness-treatment

Jenkins, R., Baingana, F., Ahmad, R., McDaid, D., & Atun, R. (2011). International and national policy challenges in mental health. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178192/

Jenkins, R., Baingana, F., Ahmad, R., McDaid, D., & Atun, R. (2011). Mental health and the global agenda: core conceptual issues. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178188/

Mental Health Treatment: Past and Present | Introduction to Psychology. Retrieved from https://courses.lumenlearning.com/wsu-sandbox/chapter/mental-health-treatment-past-and-present/

Mental Health Treatments. Retrieved from http://www.mentalhealthamerica.net/types-mental-health-treatments

BIBLIOGRAPHY

MHA. Our History. Retrieved from http://www.mentalhealthamerica.net/our-history

MHA. Who We Are. Retrieved from http://www.mentalhealthamerica.net/who-we-are

Schimelpfening, N. (2019). What to Know About Dialectical Behavior Therapy. Retrieved from https://www.verywellmind.com/dialectical-behavior-therapy-1067402

SoulPancake. (2013). How Does Art Therapy Heal the Soul? | The Science of Happiness [Video]. https://www.youtube.com/watch?v=BN2rTaFUlxs.

Taylor, R. (2018). A Short History of Mental Illness Treatment. Retrieved from https://owlcation.com/humanities/A-Short-History-of-Mental-Illness-Treatment

WHO. (2017). Retrieved from https://www.who.int/en/news-room/fact-sheets/detail/mental-health-in-emergencies

https://www.uhc2030.org/news-events/uhc2030-news/universal-health-coverage-in-emergencies-a-call-to-action-at-unga-509417/

https://www.huffpost.com/entry/funding-mental-health-before-the-next-crisis_b_59e63362e4b04e9111a3e54c

https://www.internationalmedicalcorps.org.uk/

https://www.internationalmedicalcorps.org.uk/what-we-do/all-recovery/mental-health

https://www.cfr.org/blog/silent-suffering-mental-health-global-health-priority

https://www.who.int/campaigns/world-health-day/2017/en/

BIBLIOGRAPHY

https://www.who.int/mental_health/suicide-prevention/en/

https://www.hsph.harvard.edu/news/hsph-in-the-news/funding-lacking-mental-health-developing-countries/

https://www.telegraph.co.uk/news/0/invisible-crisis-developing-countries-remain-ill-equipped-tackle/

https://www.telegraph.co.uk/news/0/invisible-crisis-developing-countries-remain-ill-equipped-tackle/

https://www.who.int/bulletin/volumes/83/4/editorial10405/en/

https://papost.org/2018/12/19/state-mental-health-funding-hasnt-increased-in-years-counties-say-its-affecting-care/

https://ec.europa.eu/esf/transnationality/rsmh-261

https://www.researchgate.net/publication/12341549_The_Swedish_mental_health_system_Past_present_and_future

http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3178192/#B2

https://www.telegraph.co.uk/news/0/invisible-crisis-developing-countries-remain-ill-equipped-tackle/

https://ijmhs.biomedcentral.com/articles/10.1186/s13033-017-0154-2

BIBLIOGRAPHY

https://www.npr.org/sections/goatsandsoda/2018/10/15/656669752/report-world-support-for-mental-health-care-is-pitifully-small

https://www.theguardian.com/global-development/datablog/2015/jul/20/mental-healthcare-world-health-organisation

https://papost.org/2018/12/19/state-mental-health-funding-hasnt-increased-in-years-counties-say-its-affecting-care/

http://www.mentalhealthamerica.net/blog/how-trumps-budget-will-affect-people-mental-health-conditions

https://www.independent.co.uk/voices/mental-health-government-jeremy-hunt-theresa-may-nhs-services-suicide-self-harm-a8220661.html

https://www.who.int/about/who-we-are

https://www.msf.org.uk/article/inside-eu-refugee-camp-driving-people-suicide

https://www.nytimes.com/2018/09/25/world/europe/greece-migrant-camp-mental-health.html

https://www.psykiatri-regionh.dk/english/Sider/default.aspx

https://www.psykiatri-regionh.dk/forskning/forskningsomraader/Research-in-psychiatric-treatment-and-care-in-the-Capital-Region-of-Denmark/Sider/default.aspx

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2831025/

https://www.who.int/mental_health/uganda_who_aims_report.pdf

BIBLIOGRAPHY

https://www.mentalhealthuganda.org/

https://sustainabledevelopment.un.org/partnership/?p=11941

https://www.who.int/mental_health/emergencies/problem_management_plus/en/

https://www.who.int/mental_health/publications/mhgap_hig/en/

http://siteresources.worldbank.org/INTHSD/Resources/topics/415176-1251914777461/FAQ_HealthSystemsFundingPlatform_26August2010.pdf

https://mhpss.net/

https://www.who.int/mental_health/mhgap/en/

https://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/

https://www.who.int/mental_health/evidence/WHO-AIMS/en/

https://www.targethealth.com/post/history-of-the-world-health-organization-who

https://www.npr.org/2017/06/20/533631145/refugees-struggle-with-mental-illness-suicide-attempts-increase

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5834240/

https://www.msf.org/child-refugees-lesbos-are-increasingly-self-harming-and-attempting-suicide

BIBLIOGRAPHY

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4910138/

https://www.centeronhumanrightseducation.org/the-hidden-problem-of-mental-health-in-refugee-camps/

Understanding GAD- and the Symptoms, retrieved April 25th 2019
https://adaa.org/understanding-anxiety/generalized-anxiety-disorder-gad

Understand the Facts- Panic Disorders, retrieved April 29th 2019
https://adaa.org/understanding-anxiety/panic-disorder

Understand the Facts- Post-Traumatic Stress Disorder, retrieved April 29th 2019
https://adaa.org/understanding-anxiety/posttraumatic-stress-disorder-ptsd/symptoms

https://www.psychiatry.org/patients-families/depression/what-is-depression