



SALZBURG  
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# New Paradigms in Behavioral and Mental Health

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## New Technologies

New technological tools – along with the growing ubiquity of phone access worldwide – are providing both health care practitioners and patients unprecedented abilities.

Doctors can treat people remotely, decreasing costs and allowing them to treat more patients. Meanwhile, some new mobile applications allow patients in-the-moment support, like one self-management tool for schizophrenic patients that provides coping functions that help them avoid the escalation of symptoms.

Thara Rangaswamy's organization SCARF – Schizophrenia Research Foundation – created one of the world's first mobile psychiatric treatment buses, which treats patients and dispenses medication remotely. It travels to many poor regions of India and allows psychiatric patients to talk with doctors in Chennai through a video screen. The company also leverages mobile technology with appointment reminders, alarms for taking medication, and provides emergency contact information.

Some concerns about mobile health technology include questions about confidentiality, the potential for mobile apps to replace doctors and nurses, the validity of information, fighting tenuous connectivity in many regions, and the potential for mobile consultations to lead to over-medicating.

## Get involved online!

You can join in the conversation on Twitter with the hashtag #SGShealth and find other Tweeting Fellows via the list: [www.twitter.com/salzburgglobal/lists/SGS-536](http://www.twitter.com/salzburgglobal/lists/SGS-536)

We are also posting all our session photos on our Facebook page: [www.facebook.com/SalzburgGlobal](http://www.facebook.com/SalzburgGlobal) day-by-day and will post hi-res images for use in publications on Flickr: [www.flickr.com/SalzburgGlobal](http://www.flickr.com/SalzburgGlobal)



You can download the group photo from the Yammer group

## “Nothing about me without me” Mental health patient-centeredness

**“Treat the person in front of you and not the schizophrenic!”** – wise words from the floor during a discussion on patient-centeredness on the second day of the Salzburg Global session *New Paradigms in Behavioral and Mental Health*.

All too often in health care provision, patients are merely seen as their diagnosis, especially when treating mental health issues.

While shared decision making has been embraced in some areas of medicine, especially when considering aggressive treatments versus palliative care for terminal patients, it is poorly applied in mental health care provision. Patients might be the best placed people to determine what would be the most effective treatment for them, but they are often assumed to have a diminished sense of responsibility and thus are denied personal agency.

“Every time you relapse, you learn something,” insisted one Fellow who had been diagnosed as bipolar. Another Fellow who is in recovery from a teenage-diagnosis

of schizophrenia told the audience, primarily of clinicians, advocates and policy-makers, that over several years, they had come to learn what can trigger their episodes, thus formulating coping mechanisms and better informing their doctors of what medication does and does not work for them.

For many of the service users in the room who generously shared their own experiences, their families and communities had proven to be valuable assets in their recovery. Mental health services in many countries now strongly advocate for “care in the community.” But much like the fact that not all medications work for all people, not all patients are “lucky” enough to have supportive families and communities; in fact for some patients, these people can be a great hindrance to their recovery.

Clinicians need to have the time and resources necessary to adequately consider each of their patients’ individual circumstances – a huge challenge for GPs who might only have ten minutes per consultation.





## Hot Topic

### What are the best (and worst) practices in mental health service provision?

“Our best practice in **India** is that we are involving basic community health workers, and also the opinion leaders from the community in mental health management. For example, we involve teachers, faith-healers, and the families in mental health treatment.

One of the biggest handicaps is that still, most of the people are unaware of the mental health issues. They have many false beliefs, that the mental conditions are due to black magic or evil spirits. They are taken to religious places, and subjected

to all kinds of treatments, and often victimized with human rights violations. Valuable time is lost and some illnesses become incurable.”

**Ramasubramanian Chellamuthu**

*Founder of M.S. Chellamuthu Trust and Research Foundation, India*

“In Croatia, we have a universal health care system. Every person can approach the system and receive health care. What I also find good is the movement toward community mental health care, which is at its very beginning, but gives people more control and makes them feel they are the captains of their ship.

People believe more in institutions than in the community and community support. It's something from previous years, from the socialist way of thinking, that whatever problem you have there is an institution for that. We should

break the walls and bring people back to the community.”

**Radmila Stojanovic Babic**

*President of the Association for Psychosocial Support, Croatia*

“One of the best things is that we have good quality acute care in the [American] Indian health service programs. They've done a tremendous job treating communicable diseases like tuberculosis.

The downside of that program is that about 70 percent of the **American Indian** population lives in big, urban areas where access to services is limited... It's a changing population in terms of geography, and that system doesn't address that geography adequately.”

**Pat Walker**

*Research Assistant Professor in Public Health and Preventative Medicine, Oregon Health & Science University, USA*