



SALZBURG
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New Paradigms for Behavioral and Mental Health Care

SESSION REPORT

536



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THE
Dartmouth
CENTER
for HEALTH CARE
DELIVERY SCIENCE

Session 536

Salzburg, December 7 to 12, 2014

New Paradigms for Behavioral and Mental Health Care

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Abstract

The history of Western psychiatry is replete with mistakes as well as successes. Currently, high-income countries desperately need reforms to enhance the effectiveness, efficiency and availability of behavioral health care (relating to mental functioning and substance use). Meanwhile, developing behavioral health systems in low- and middle-income countries presents major challenges to policy makers. Unmet behavioral health needs and burdens are enormous, but as change occurs, there is the danger that Western mistakes will be repeated.

We need to review bio-psycho-social understandings and see how these may be implemented most effectively in the context of diverse cultures, beliefs and values. Innovations in service delivery, taking advantage of upcoming and adapted technologies, offer opportunities which should be assessed in ways appropriate to those different contexts. We also need to explore how patients' interests, rights and preferences may be best elicited, protected and acted upon, consistent with institutional and legal norms informed by health care delivery science. Both aspects are key to determining how health systems' capacity can be built most economically and effectively, and how "patients" can be "agents" in their own behavioral health care.

In December 2014, Salzburg Global Seminar, together in partnership with the Dartmouth Center for Health Care Delivery Science at Dartmouth College, and with support from the Robert Wood Johnson Foundation and the Robert Bosch Stiftung, convened the program *New Paradigms for Behavioral and Mental Health Care* to help countries design their future behavioral health care systems in full knowledge of the successes and mistakes of the West, as well as cutting-edge developments in human rights, health care delivery science, and behavioral health technologies.



Albert G. Mulley Jr.,
The Dartmouth Center for
Health Care Delivery Science



Susan Mende,
Robert Wood Johnson Foundation

The highly participatory week-long program had a strong focus on building new insights, aggregating perspectives and experiences from different sectors, areas of expertise and regions.

The program brought together mental health experts and policy makers from a variety of countries, including low- and middle-income countries; people with the lived experience of recovery from mental disorders; experts in health care delivery science; and experts in behavioral health technologies. Together, they tackled the following key questions:

Key Questions

1. **Human rights:** Some institutional or traditional practices can be abusive or fail to give voice and agency to people with behavioral health problems. How can competing behavioral health care practices be aligned with basic human rights and patients' rights?
2. **Patient-centeredness:** How can countries build behavioral health care systems based on the needs and wishes of service users and families rather than those of professionals and industries?
3. **New systems:** Existing Western behavioral health systems are in need of reform and fit poorly in other countries for many reasons. But how can low- and middle-income countries develop affordable and culturally relevant systems without suitable precedents?
4. **Existing resources and cultures:** How can new systems best leverage existing behavioral health resources, models, and cultures?
5. **New technologies:** Information technologies (which leverage the Internet and mobile devices) may allow countries to skip over many unhelpful steps and develop more effective and efficient models, but how do they proceed?



Bernadette Klapper,
Robert Bosch Stiftung



John Lotherington,
Salzburg Global Seminar



1. A cross-country working group meets in the Meierhof Library

2. Panelists (l-r) Graham Thornicroft, Ilirjana Bajraktari and Peter Bartlett

3. Trina Dutta delivers her "memo to the Minister" in a role play exercise

4. Fellows and speakers gather in Parker Hall, the main conference room of Salzburg Global Seminar

5. Angela Ofori-Atta plays the role of the Minister of Health in "memo to the Minister"

6. Tina Ntoli

7. Merritt Partidge and Walter Humberto Castillo

New Paradigms for Behavioral and Mental Health Care

A Fellow's Perspective

Manish Mishra

Clinical Fellow, Dartmouth Center for Health Care Delivery Science; Assistant Professor, Geisel Medical School, Dartmouth College, Hanover, NH, USA

Program collaborations between Salzburg Global Seminar and the Dartmouth Center for Health Care Delivery Science in the *Health and Health Care Innovation in the 21st Century* multi-year series:

Innovating for Value in Health Care Delivery: Better Cross-Border Learning, Smarter Adaptation and Adoption

[SalzburgGlobal.org/go/481](https://salzburgglobal.org/go/481)

(September 25 to October 1, 2011)

Realizing the Right to Health: How can a rights-based approach best contribute to the strengthening, sustainability and equity of access to medicines and health systems?

[SalzburgGlobal.org/go/500](https://salzburgglobal.org/go/500)

(November 9 to 14, 2012)

The Drive for Universal Health Coverage: Health Care Delivery Science and the Right to High-Value Health Care

[SalzburgGlobal.org/go/507](https://salzburgglobal.org/go/507)

(December 8 to 13, 2013)

New Paradigms for Behavioral and Mental Health Care

[SalzburgGlobal.org/go/536](https://salzburgglobal.org/go/536)

(December 7 to 12, 2014)

Introduction

On December 7, 2014, Salzburg Global Seminar opened its 536th session, *New Paradigms for Behavioral and Mental Health Care*. This was the fourth collaboration in the *Health and Health Care Innovation in the 21st Century* series with the Dartmouth Center for Health Care Delivery Science [SEE SIDEBAR], and it also benefited from the support of the Robert Wood Johnson Foundation and the Robert Bosch Stiftung.

The program brought together service users, advocates, educators, health care practitioners, and politicians to create a broad picture of what the current state of mental health care looks like across global contexts. Sixty-eight participants arrived at Schloss Leopoldskron, home to Salzburg Global, from seventeen nations to bring their observations to this forum.

The pre-session assignment invited people to define what the term “global mental health” means. The range of responses, from spiritual peace to neurochemical variation, indicated that precision in language would be an important part of the week. This push for clarity led to a corollary exercise in more generally defining “mental health.” Perhaps the most useful frame is psychiatrist George Engel’s biological-psychological-sociological model. This approach allowed for a variety of perspectives to be heard generously and opened enough space for alternatives in treatment modalities to be thoughtfully weighted.



Session Chair Robert Drake opens the session, in conversation with John Lotherington

Mental health is such an expansive term, it is difficult to maintain coherence in conversation using only generalizations. There are obvious differences between a teenager struggling with addiction and a senior struggling with dementia, yet both lie under the same umbrella term. Diagnoses are changing too; new categories are emerging, old criteria are being revised and more children are being identified as mentally ill.

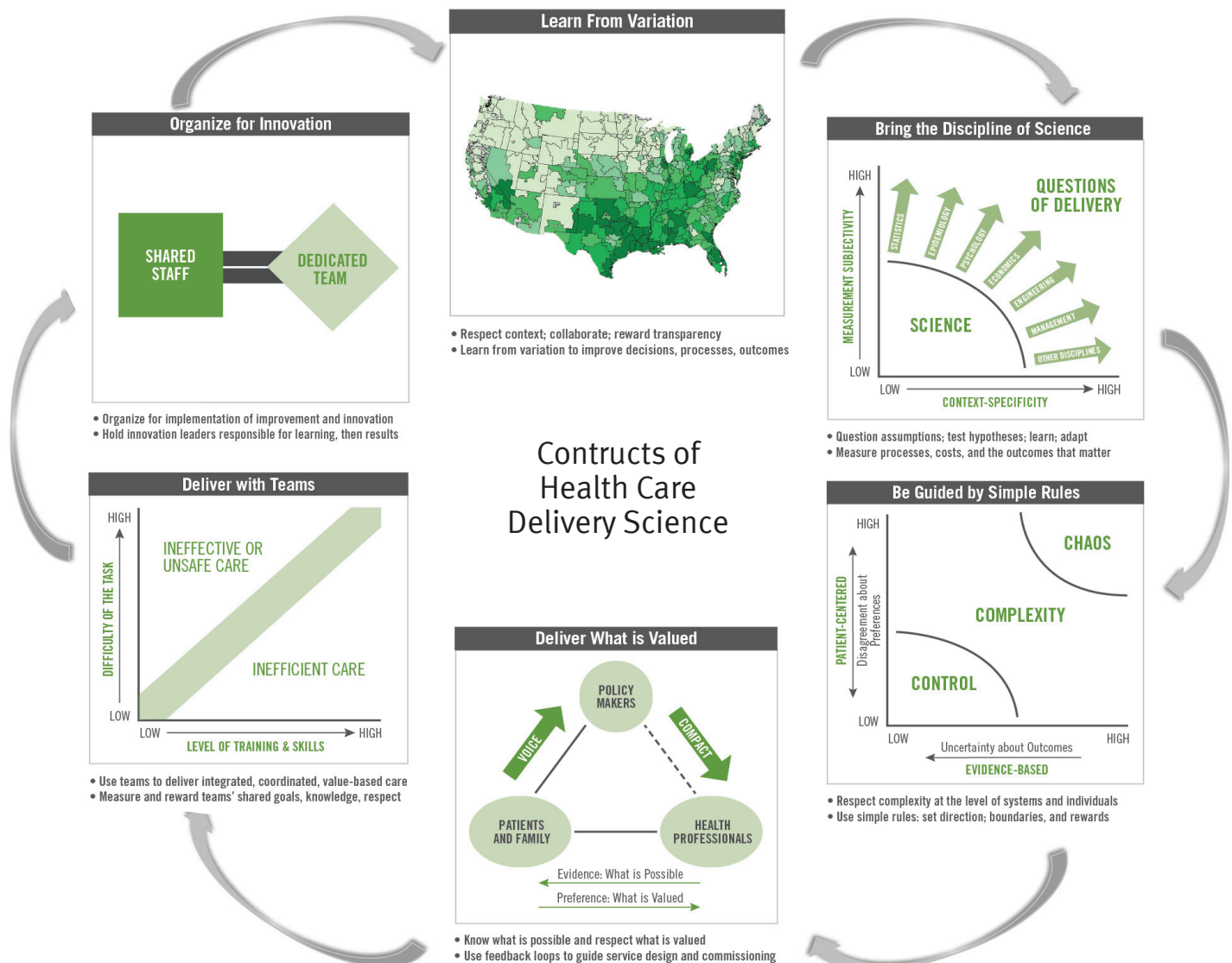
Like the diagnostic criteria, mental health care continues forward on a dynamic landscape. The general concern is that its evolution is not meeting the needs of the population. Resources are not being maximized, and quality of care varies with sub-optimal outcomes for many. Care systems are often not designed to support recovery, enable independence and engage the people that they intend to serve. The existing structures that guide mental health do not seem to incentivize optimal care.

Although there are parts of particular care models that work well, on the whole, no nation represented in Salzburg claimed to have an exemplary model. A combination of these observations led to the resultant question that framed the week: How can we reliably get people the care that they need and want in a way that is possible and sustainable?

Session Summary

One of the host teams for the session, the Dartmouth Center of Health Care Delivery Science, offered a frame that helped bring some cohesion to varying themes that developed. The constructs of health care delivery science [SEE BELOW] that were shared are a six-part proposition intended to bring a unifying lens through which one can understand health systems. The intellectual underpinnings behind each construct are deeply rooted in thinking from across disciplines including, public health, economics, and the management sciences. They can be used as a starting point in a variety of ways, clarifying the links between the issues we focused on and the mechanics of a health system. For the sake of organization, it may be helpful to invoke this model as we reflect on what took place.

The Constructs of Health Care Delivery Science, courtesy of The Dartmouth Center for Health Care Delivery Science



Learn from variation

The week began by looking at models of care in the **USA**. Many topics including pathologizing normal behavior, over-diagnosis, overtreatment, and poor treatment were all raised. There were data driven reviews of the huge expenses for a health service that is not meeting population needs. In contrast to the US approach, lower income nations appeared to have a heavy burden as well, but for opposite reasons, where no diagnosis and no treatment seem to be equally troubling. The broader concern is that in looking to address these issues regarding lack of provision, nations will look to replicate the existing, expensive models – some of which do not deliver significantly better outcomes for the resources available.

Mental illness manifests in harrowing ways across all cultures. Without sufficient numbers of trained specialists, many developing communities have organized services to address the most pressing issues: depression, psychosis, learning disabilities, dementia and substance abuse. As the conversation took shape, there seemed to be a consensus that biology is relatively similar and context is what needs to be addressed. Tailoring mental health care to particular contexts became an important landmark for subsequent explorations.

In light of the resource polarity in global health, the conversation moved towards possibilities that could offer relief in either extreme. Instead of waiting for more specialists to arrive, both contexts could



The USA team in the Reinhardt Library



July Caballero



Wayne Cannon



Panelists Thara Rangaswamy and Lisa Marsch with program director, John Lotherington

benefit from training a different type of workforce: one that identifies and manages health taking a needs based approach. The roles of a new skills-based health team were postulated and imagination was captured. We explored how the approach could to reduce harm and ensure the greatest value by delivering preference sensitive care, whatever the resource base. This same intervention would add value to very different health care climates, for very different reasons. Only by looking at variations did this similarity emerge.

Deliver what is valued

There was a focus on the role of technology-based approaches to behavioral healthcare. Strategies for leveraging the ubiquity of mobile technology in ways that would be advantageous for mental health service users were discussed. More specifically, the call was to look at and assess the landscape of how technology is used in particular regions. Resistance to adopting these strategies was then discussed in the spirit of sustainability.



Dawn Carey



Byron Good

A lasting example of understanding context came from the **Uganda** country team where alcohol and marijuana abuse are overwhelmingly prevalent in some areas. An attitude that was shared resonated with the group: “What is the point of getting better, if I am stuck with the same everyday problems?” As the percentage of people living below the poverty line in Uganda increases, substance abuse, depression and suicide become more common.

In Uganda, there are 33 trained psychiatrists for a population of 33 million people. This has led to a care structure that does not allow for

many follow-up visits, leaving patients with a tendency to take any help that is available. Attitudes in this system have leaned towards nihilism with regards to seeking formal care. The model of waiting to train more specialists is not a viable option when the disparity is this large.

Out of necessity, a system resulted in training citizens to be the community mental health workers. Some areas of Uganda have two representatives in every village that report to a central community health office. As this approach is getting stronger, movement towards adapting technology-based interventions is starting to gain traction. Cell phone check-ins using text messaging for advice and accountability has begun. Service users and clinicians have been very active in providing feedback to refine the process. Although data has not been collected, reactions have been overwhelmingly positive. What made this system so appealing was that it minimized the separation between the service user and the clinician, articulated the voices of service users in determining what they need and when, and created greater parity for service users, as well as a sense of social capital – each of which is therapeutic in itself. Mental health workers could provide support when it mattered most – during the actual time of discomfort. The overall blueprint seemed to value the creation of an infrastructure that can support mobile technology, before establishing its role as a hallmark modality of care delivery. This could deliver true value in delivering what patients want and need.



Members of the Uganda team, Tina Ntolu and Sheila Zaramba Ndyabangi



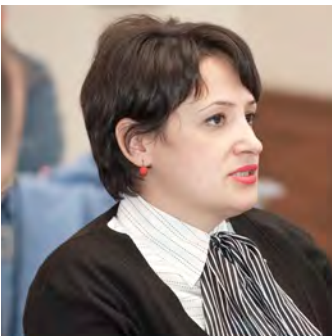
Hafsa Lukwata Sentongo



Rashid Male



Shpend Haxhibeqiri



Jonida Haxhiu



Native American team member Dale Walker

Bring the discipline of science

Another theme that developed was how the difficulty in addressing global mental health needs extends far beyond the study of psychiatry. In 2007, *The Lancet* published an article titled “No health without mental health.” This phrase echoed throughout the session and was used in a variety of ways. If we were to take this at face value, the implication runs well beyond health and healthcare. That is exactly what we heard from our colleagues representing the **Native American** population.

In a presentation examining the current difficulties experienced by Native Americans, the issues of reach and advocacy drew considerable attention. The lack of parity in allocating health care resources to mental health issues was introduced. It was postulated that the lack of presence and accurate representation in legislation was a major contributing factor. Many laws in existence not only create obstacles for people to access care, but may actually discriminate against them. Statistics indicate that mental illness, including substance abuse, depression and suicide, occurs at disproportionately high rates in this indigenous group and it would be reductive to attribute this observation solely to biological variation. Advocacy teams find it difficult to make wide-reaching gains based on limited expertise in critical disciplines. In order to create systems that support the scale of what needs to happen to move towards parity, there is a call for alignment across a variety of disciplines.

In order to make a strong legal case, the evidence has to be built from ideas deeply rooted across a variety of disciplines. From there, the conversation opened a broader scheme requiring a concerted effort from sociologists, statisticians, epidemiologists, historians, politicians, marketing experts, financial experts, and engineers. A fascinating discussion ensued, as this multi-national room began to reflect on their own countries' indigenous populations. In several countries, these communities have endured similar struggles with adjusting to changes in power structures. That said, there have been some health and policy successes across a variety of disciplines that have endured in other native populations. The conversation developed and it became clear that native populations from different parts of the world could benefit greatly from a meaningful exchange. A suggestion was made to have a future Salzburg Global Seminar program on the topic of indigenous peoples and communities across the world and their health and health care.

A big lesson from this conversation was that a neglected sub-group has a very difficult time self-advocating without support. Advocacy within a heterogeneous system is a skill, one that can be learned and practiced. Mental health, especially ethnic-specific mental health, often gets lost in an overwhelmed medical ecosystem. That is not likely to change unless people lend expertise with deep resolve – in a variety of practical ways.



Christine Holden with Native American team members Patricia Walker and Gloria King



Benjamin Miller



Martha Mitrani



The Colombia team – Migeul Uribe, Carlos Gomez-Restrepo, Gloria Nieto de Cano, and Alvaro Arenas

Be guided by simple rules

The anatomy of a flexibly sustainable system became a noteworthy line of conversation. Sustainability has a resonance of reliably meeting broader needs of a community over time, while being able to adjust to the inevitable subtleties of changing need over time. Implicit in this assertion is that there must be clarity regarding the priorities of the community members. Valued outcomes are more likely to occur when process changes are unrelentingly focused on the people they are meant to honor. The team from **Columbia** brought a rich example of the curiosity and rigor required to alter an all too familiar scenario.

A group of health care professionals recognized a large gap between research and clinical practice in mental health. There was a disconnect between what international journals were publishing as evidence-based, best practices for the treatment of mental illness and what was available in Columbia. One example was in the practice of psychological therapy. Although there is strong evidence endorsing the use of cognitive behavioral therapy for a variety of conditions, only a handful of practitioners use this modality in Bogota.

If the evidence from North America and Europe were taken as imperatives, the solution would be to train as many people as possible in this form of therapy. However, that did not seem either feasible, or likely in Columbia. The line they chose to follow was to carefully study their professional capabilities and map them onto the needs of the people they served. The research team was explicit in their guiding principles, their “simple” but powerful rules: keep empathy first, increase quality, honor professional integrity, contain cost, and seek wide acceptance.

With those markers, the overall hope was that they could create a re-imagined mental health care system where Latin American values were regarded. To make something culturally relevant, they needed to understand the experience of their mental health service users. The research design was built on interviews of people who lived with severe mental illness. The simple step of keeping first-hand reports above perceived clinical expertise led to the construction of culturally sensitive tools. The Columbia-specific guidelines have been drafted and they are at the stage where they ready to begin implementation trials.

1. Country teams meet in the Robison Gallery

2 & 3. Members of the Germany team – Konrad Roehl, Katja Wimmer and Harald Kolbe





Maria Medina Mora



Sally Okun

Deliver with teams

At first blush, teamwork would appear to be an obvious, universal truism. But when time-honored cultural practices need to be challenged, seemingly insurmountable boundaries arise. Building teams across historic divisions can be difficult, but certainly possible with thoughtfulness and creativity.

A powerful narrative from the **India** team demonstrated clever problem solving around communal concerns. Faith traditions and medical practices have not always worked in tandem. In the example from India, a de-facto competition for the troubled had developed over time. A community health team noted that people struggling with mental illness were filling local temples in search for comfort. This had gone on for generations as the historical roots often intertwined medicine and religion. The holy men in ancient India were often the most educated citizens, leading to a relative mastery of several disciplines across science. That led to the assumption that the holy men were able to heal both mind and body.

The evolution of the phenomenon had been left unchecked over millennia. The community health team had knowledge of the historical developments and potential value of innovating a combined service. Considerable relationship building took place upon their first arrival, including attendance at temple services. Needs of the temple and their management of those with mental illness were explored. After enough trust had been established, the leadership



The India team – Ramasubramanian Chellamuthu, Manish Mishra, Kasi Sekar and Thara Rangaswamy



Ramasubramanian Chellamuthu

of the medical team met with the leadership of faith team and a partnership was formed. Both parties came to understand that the wellbeing of the local citizens was their primary goal. For the most part, priests were relieved when they were able to transfer some care to medical professionals and health team members took solace in offering faith-based care as a parallel treatment that generated hope. The skepticism that used to exist due to the misalignment of faith and medical services all but disappeared in this region. From this foundation, an alliance developed that was beneficial to the entire community.

The wider impacts for people who sought relief from psychiatric symptoms included no longer being left with only one option. As this notion became accepted, the previously rivaled institutions began to work in concert and marked the beginning of complementary system of care. Once the relationship was refined, this symbiotic trend spread to other religions and local places of worship. In addition, it also extended to other medical disciplines beyond mental health. An expansion of services in both health and faith was the outcome. With courage to challenge the historical overlay, clear communication, and humility, a common divide was bridged. This is paralleled in many contexts where it is important to work with the existing social and belief structure, rather than impose an abstract “rational” system, which may fail to reach or engage those who need care.



Emmanuel Owusu-Ansah



Henry Rebaza Iparraguirre



The UK team – Paul Burstow, Peter Barlett, Kevin O’Neill, Albert G. Mulley Jr., Elizabeth Mortimer, Anna Moore and Josh Chauvin

Organize for innovation

The working group sessions of the program have become an important feature of the week. Multi-disciplinary teams form that combine stakeholders from different population sectors. The goal is to explore a more defined issue that is specific to a particular region. Many countries send delegates to Salzburg with a clear topic in mind. Other Salzburg Global Fellows join the working groups and look to either enhance or add novelty to the proposition. The **UK** team was one of the groups that mobilized this opportunity in important ways.

In the fall of 2014, the National Health Service (NHS) of the UK published a strategy and planning document called the “Five Year Forward View”. It included a commitment to develop new models to meet the challenges of modern health care. The “Thrive Model of Care” was one approach in rethinking how mental health services could be redesigned to maximize benefit, in this case particularly in child and adolescent mental health services. It seeks to replace the tiered system of increasing specialism matching severity of the problem with a focus on groups of children and young people and the sort of help they may need, aiming for a clearer distinction between treatment on the one hand and support on the other. The model has

been developed in line with payment systems and ensures patients' preferences are central to determining the care provided by ensuring shared decision-making is systematically implemented. To enable rapid improvement and the implementation of feedback loops, clinical outcomes are routinely collected at every contact. Given the recent developments in NHS, combined with the spirit of the conversation in Salzburg – new partnerships emerged that continue to work on implementing and evaluating this new way of working. An enhancement to the Thrive model was the notion of building healthcare capacities to patient preferences in mental health, and the routine measurement of patient preferences, as well as measuring the quality of the shared decision-making process, have now been incorporated into the approach.

The UK team presented their context with an openness that allowed for others to synergistically participate in significant ways. Many stakeholders from a variety of regional teams continue to augment their local agendas based on the relationships that developed from this work.

1. Hong Ma

2. Anna Moore and Josh Chauvin with Albert G. Mulley Jr.

3. CJ Peek, Ericka Zimmerman and Ronald Stock





Manish Mishra

A Closing Thought

The Salzburg Global Vision calls for “Imagination, Sustainability and Justice.” This week could be seen as a focused meditation on those three programmatic clusters. This report only touches on some of the major themes that were seeded over the session. In addition to the summary above, we thought deeply about many stories that were very hard to hear. There were detailed accounts regarding sex workers, child soldiers, profiteering, drug-trade, exorcisms, suicides, homicides, genocides, post-conflict nations, post-disaster populations, and mass casualty survivors.

This report summarizes much of the collective deliberation that took place in the session. It is also worthwhile to reflect upon the changes that have taken place at the level of the individual. The people who assembled in Salzburg for Session 536 are deeply committed to the working with mental illness in important ways. Taking some time to reflect on how this experience changed personal perspectives and practices can be a valuable exercise.

I am a fellowship-trained psychiatrist, in both addiction and geriatrics. My time-tested frames were deeply challenged over the week in Salzburg. I most often approach patient care by using three distinct axes: self-respect, self-efficacy, and continuity. Paraphrased, it has been a helpful starting point for patients to articulate a sense of: why I matter, how I am a capable, and recognition that although I am changing, I remain the same person from one day to the next. If these basic needs are addressed, resilience can be conferred in a way that serves as a protective ally against mental illness. This operates cleanly on an individual level of care. However, in thinking about how to deliver care at a population level facing extreme hardship may be a different proposition. The six constructs of health care delivery science has been a helpful frame in thinking about broadening this approach. One important conclusion from this program is that we need a framework to even start thinking about these soul-shaking questions. You may not need *the* framework, but *a* framework is essential. Only after being comfortable with a starting point can we begin to diagnose and treat disease at this scale.

The six constructs of delivery science helped tease out some truths that cut across contexts. It seemed to be universal that individual



Jong Hye Ra



Ezra Susser

voices and day-to-day negotiations often get lost when relevant policy is being designed. Keeping the spirit of the individual service-user at the core of the design is critical to a sustained effort. After all, who knows more about dis-ease of disease than the folks who live with it? Another important theme is the importance of minimizing the separation of clinicians, patients, and policy makers. We have seen small examples of potency when these contingencies align – and we look forward to seeing what this looks like at scale.

Although we are working on systems-level care with contexts that reach across the planet, maybe this all is built on one simple premise: every single person matters. None of this is possible unless people rigorously care about the wellbeing of relative strangers. Perhaps this is the guiding theme that emerged from this week and will help inform the upcoming health care sessions in this Salzburg Global series.



Fellows of the Salzburg Global Seminar program *New Paradigms for Behavioral and Mental Health Care*



1. The Rwanda team – Marie-Josée Maliboli, John Bosco Kanani, Clare Nancy Misago and Franciose Murekatete with Dawn Carey

2. The Chile team – Cynthia Zavala, Rodrigo Salinas, Paulina Bravo and Alvaro Aravena with Robert Drake

3. Cynthia Zavala

4. Veronique Roger

5. Ronald Stock

6. Alvaro Aravena

Salzburg Statement

Fellows of the Salzburg Global session *New Paradigms for Behavioral and Mental Health* called on the United Nation to make a “renewed global commitment to mental health.”

During the Salzburg Global program, it was recognized that the United Nations post-2015 Sustainable Development Goals (SDGs) have a critical part to play in setting priorities for the development and investment in healthcare systems, prompting the 70 international healthcare policy experts, practitioners and service users, who attended the December 2014 session, to collectively draft their Salzburg Statement.

The Statement calls on the UN and its Member States to make *“a renewed global commitment to mental health, with clear and specific targets and indicators, particularly with a focus on mental health treatment coverage, strengthening community health, outreach and peer support.”*



Radmila Stojanovic Babic



Heeseok Yang



Paul Burstow



Peter Badimak Yaro



Boris Zernikow

Upon the issuing of the Statement, session participant and professor of community psychiatry at the Institute of Psychiatry, King's College London, Graham Thornicroft said: "As mental health problems contribute so much towards disability and mortality worldwide, it is right that the United Nations fully recognises this by agreeing strong mental health targets and indicators in the new Sustainable Development Goals."

Paul Burstow, then-UK Member of Parliament and author of the UK government's mental health strategy added: "Now is the time for the United Nations to fully reflect the impact of mental health problems worldwide by agreeing to clear and challenging mental health targets and indicators in the new Sustainable Development Goals."

Since publication in January 2015, the Statement has been shared with policy-makers and practitioners around the world.

As well as on the following page, the Statement is available to view and download here: www.SalzburgGlobal.org/go/536/statement



Graham Thornicroft



Salzburg Global Statement

New Paradigms for Behavioral and Mental Health Care

RECOMMENDATIONS OF SALZBURG GLOBAL FELLOWS

In December 2014 a group of more than 70 international healthcare policy experts, practitioners and service users, under the leadership of Professor Robert Drake, attended the Salzburg Global session

New Paradigms for Behavioral and Mental Health Care (December 7-12, 2014).

During the seminar it was recognized that the United Nations post-2015 Sustainable Development Goals (SDGs) have a critical part to play in setting priorities for the development and investment in healthcare systems.

Signatories: Alvaro Aravena Molina, Community Mental Health Center Rinconada, Chile; Alvaro Arenas Borrero, Clinica La Inmaculada, Colombia; Ilirjana Bajraktari, Kosovo; Peter Bartlett, University of Nottingham, UK; Paulina Bravo, Pontificia Universidad Catolica de Chile, Chile; Paul Burstow, House of Parliament, UK; July Caballero, Peruvian National Institute of Mental Health, Peru; Dawn Carey, Dartmouth Center for Health Care Delivery Science, USA; Joshua Chauvin, Canada; R. Chellamuthu, M.S.Chellamuthu Trust and Research Foundation, India; Trina Dutta, USA; Byron Good, Harvard University, USA; Shpend Haxhibeqiri, University Clinical Centre of Kosovo, Kosovo; Jonida Haxhiu, Institute of Public Health of Albania, Albania; Prince Bosco Kanani, Rwanda NGO's Forum on AIDS and Health Promotion, Rwanda; Gloria King, Rainbow Healing, USA; Bernadette Klapper, Germany; John Lotherington, Salzburg Global Seminar, UK; Hafsa Lukwata, Ministry of Health, Uganda; Marie-Josée Maliboli, Rwanda Biomedical Center, Rwanda; Lisa Marsch, Dartmouth Center for Health Care Delivery Science, USA; Maria Elena Medina Mora, National Institute on Psychiatry Ramon de la Fuente Muniz, Mexico; Susan Mende, USA; Nancy Misago, Rwanda Biomedical Center / Ministry of Health, Rwanda; Martha Mitrani Gonzales, National Institute of Mental Health HD-HN, Peru; Anna Moore, UCL Partners, UK; Albert G. Mulley Jr., Dartmouth Center for Health Care Delivery Science, USA; Gloria Nieto De Cano, Asociacion Colombiana Personas con Esquizofrenia y Familias, Colombia; Angela Ofori-Atta, University of Ghana School of Medicine & Dentistry, Ghana; Sally Okun, PatientsLikeMe, USA; Emmanuel Owusu Ansah, The Ministry of Health of Ghana, Ghana; Merritt Patridge, Dartmouth Center for Health Care Delivery Science, USA; Thara Rangaswamy, Schizophrenia Research Foundation (SCARF), India; Veronique Roger, USA; Rodrigo Salinas, Universidad de Chile, Chile; Ronald Stock, USA; Ezra Susser, Columbia University, USA; Graham Thornicroft, Kings College London, UK; Chris Underhill, BasicNeeds UK, UK; Jose Miguel Uribe, Colombia; Dale Walker, Oregon Health & Science University, USA; Peter Yaro, BasicNeeds Ghana, Ghana; Cynthia Zavala, Pontificia Universidad Catolica de Chile, Chile; Ericka Zimmerman, University of Charleston, USA

We, the participants of the Salzburg Global session

New Paradigms for Behavioral and Mental Health Care

(listed in this document):

- I. *Recognize* the central importance of mental health in the United Nations post-2015 Sustainable Development Goals (SDGs);
- II. *Accept* the case for fully including mental health in the SDGs given:
 - i. The global prevalence of mental disorders and psychosocial disabilities, with 1 in 4 people experiencing mental health problems in their lifetime;
 - ii. The excessive treatment gap in low- and middle-income countries, where often over 90% of people with mental disorders receive no effective treatment
 - iii. The global under-financing of the mental health sector, and the critical shortage of mental health services;
 - iv. The breach of the universal right to health for up to 600 million people with mental illness across the world each year;
 - v. The growing global impact of mental disorders and psychosocial disabilities, which contribute 23% of the total global burden of disease;
 - vi. The often long-lasting disability caused by mental disorders and psychosocial disabilities, and the high impact of the excess mortality, and suicide;
 - vii. The global crisis, of human rights violations, social exclusion, stigma and discrimination of persons with mental disorders and psychosocial disabilities;
- III. *Accept* the importance of fully including mental health in the SDG targets and indicators, which will be necessary to provide reliable information, and measurable and comparable data, for policy makers, service providers, and service users, to enhance mental health systems and services worldwide;
- IV. *Regret* that, despite growing global awareness, until now there has been a lack of substantial progress in fully including mental health in the United Nations SDGs.

We therefore call upon the United Nations, and its Member States, for a renewed global commitment to mental health, with clear and specific targets and indicators, particularly with a focus on mental health treatment coverage, strengthening community health, outreach and peer support.

Appendix I

Chair

Robert Drake

Professor of Psychiatry,
Dartmouth Psychiatric
Research Center,
Lebanon, NH, USA

Co-Chair

Albert G. Mulley Jr.

Director, Dartmouth Center for
Health Care Delivery Science
(TDCHCDS), Hanover, NH, USA

Resource
Specialists**Dawn Carey**

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Dale Walker

Professor, Oregon Health & Science University; Director, Center for American Indian Health, Education, and Research; Co-founder, One Sky Center, Portland, OR, USA

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Appendix II

Daily Recaps and Interviews

Day 1

"I wouldn't start from here..."

www.salzburgglobal.org/topics/article/new-paradigms-for-behavioral-and-mental-health-day-1-i-wouldnt-start-from-here

Day 2

Patient-Centeredness and Technology

www.salzburgglobal.org/topics/article/new-paradigms-for-behavioral-and-mental-health-day-2-patient-centeredness-and-technology

Day 3

Human Rights and Overcoming Resistance

www.salzburgglobal.org/topics/article/new-paradigms-for-behavioral-and-mental-health-day-3-human-rights-and-overcoming-resistance

Day 5

Country Plans to Help Mental Health Patients

www.salzburgglobal.org/topics/article/fellows-propose-plans-to-help-mental-health-patients

Hot Topic

What are the best and worst practices in mental health care?

www.salzburgglobal.org/topics/article/what-are-the-best-and-worst-practices-in-mental-health-care

Anna Moore

"I needed a job that enabled me to work on a personal relationship with people"

UCLPartners program director and former accountant speaks to Salzburg Global about how she found her way into working in mental health care

www.salzburgglobal.org/topics/article/anna-moore-i-needed-a-job-that-enabled-me-to-work-on-a-personal-relationship-with-people

Dale Walker

"Native people need to ferret their way through the system"

Director of the One Sky Center: The American Indian/Alaska Native National Resource Center for Health, Education and Research speaks to Salzburg Global about the health care challenges facing indigenous communities in the United States

www.salzburgglobal.org/topics/article/dale-walker-native-people-need-to-ferret-their-way-through-the-system

Josh Chauvin

Video testimonials can help "transcend social barriers"

Chairman of the Mind Your Head Campaign and director of video-sharing project It Gets Brighter describes building a sense of community among mental health patients

www.salzburgglobal.org/topics/article/josh-chauvin-video-testimonials-can-help-transcend-social-barriers

Paul Burstow

Progress happens when social movements push and politicians pull in the same direction

Author of the UK government's mental health strategy gives an insider's perspective on how to make change in mental health care happen

www.salzburgglobal.org/topics/article/paul-burstow-progress-happens-when-social-movements-push-and-politicians-pull-in-the-same-direction

Program Agenda

Day 1

15:30 – Welcome

Clare Shine

Vice President & Chief Program Officer |
Salzburg Global Seminar, Austria

Albert G. Mulley Jr

Director | The Dartmouth Center for
Health Care Delivery Science, USA

Susan Mende

Senior Program Officer | The Robert
Wood Johnson Foundation, USA

Bernadette Klapper

Head of Health Section, Health and
Science Program | Robert Bosch Stiftung
GmbH, Germany

16:00 – Re-setting the Agenda
for Behavioral and Mental
Health Care

Robert E. Drake

Session Chair, and Professor of
Psychiatry | The Dartmouth Institute for
Health Policy and Clinical Practice, USA
in conversation with

John Lotherington

Program Officer | Salzburg Global
Seminar, UK

16:45 – Table Discussions

17:30 – Introductions of
Participants

18:40 – Tour of the Schloss

19:30 – Dinner

Day 2

09:15 – Patient Centeredness
and Cultural Values

How can countries build behavioral
health care systems based on the
needs and preferences of service users
and families rather than those of
professionals and industries?

Patricia Deegan (video)

Independent Consultant and Adjunct
Professor | Dartmouth College Medical
School, Department of Community and
Family Medicine, USA

Paulina Bravo

Assistant Professor | Universidad
Católica de Chile, Chile

Ramasubramanian Chellamuthu

State Nodal Officer | Mental Health
Programme, Tamil Nadu, India

Followed by a small table discussion
and Q&A

11:15 – Behavioral Health and
Integrated Primary Care

What changes in structures, funding
and engagement are necessary
to ensure integrated care is best
delivered, responding to behavioral
and physical co-morbidities?

Ron Stock

Health Policy Associate Professor |
Family Medicine Oregon Health &
Sciences University | Director of Clinical
Innovation Transformation Center,
Oregon Health Authority, USA

Dale Walker

Director | One Sky Center, National
Resource Center for American Indian
Health, Education and Research, USA
Followed by a small table discussion
and Q&A

13:00 – Lunch

14:30 – New Technologies

Information technologies, leveraging
the internet and mobile devices, may
allow for more effective and efficient
care. What are the most promising
models emerging, how can they best
be adapted to different contexts, and
what pitfalls may there be? In what
ways might social media enhance or
sometimes diminish social capital
relating to behavioral health?

Lisa Marsch

Director | Center for Technology and
Behavioral Health and Dartmouth
Psychiatric Research Center, USA

R Thara

Founder | SCARF (Schizophrenia
Research Foundation) | Chennai, India
Followed by a small table discussion
and Q&A

16:30 – Country/Regional Team
Meetings

To define core issues questions to
be addressed in action plans or
recommendations to providers to
ensure the highest value behavioral
and mental health care possible.

Appendix III

Day 3*09:00 – Review**09:15 – Human rights*

Some institutional or customary practices can be abusive or fail to give voice and agency to people with behavioral health problems. These issues can be aggravated by attitudes to gender relations, stigma, or civil conflict or post-conflict. How can competing behavioral health practices be aligned with basic human rights and patients' rights?

Ilirjana Bajraktari

Founder and board member | Healthcare professionals for peace and Social Responsibility of Kosovo

Peter Bartlett

Professor of Mental Health Law | University of Nottingham

Tina Ntulo

Chief Executive Officer | BasicNeeds Foundation Uganda

Graham Thornicroft

Professor of Community Psychiatry | Institute of Psychiatry, King's College London

Followed by a small table discussion and Q&A

11:00 – Role Play about Establishing New Systems: Memo to the Minister

Existing Western behavioral health systems are in need of reform and fit poorly in other countries for many reasons. But how can low- and middle-income countries develop affordable and culturally relevant systems without suitable precedents, and how can they best leverage existing behavioral health resources, models, and cultures? Participants in groups of eight will play the role of consultants to a health care minister in a country called Erewhon. There will be briefing available about the country, and the task will be to offer recommendations to the minister as to the principles, structures and priorities involved in establishing a new behavioral health care system.

Setting the Scene:

Robert E. Drake

Professor of Psychiatry | The Dartmouth Institute for Health Policy and Clinical Practice

13:00 – Lunch

Free Afternoon: Optional walk into Salzburg and Concert at Mozart's Birth-house

17:30 – Overcoming Resistance to Reforming and Improving Systems

How can existing systems of behavioral and mental health in many high income countries best be reformed? What innovations and adaptations are needed in patient and community involvement, provider education and training, clinical care and practice, and where applicable payer purchaser systems? What lessons and 'reverse innovations' can be taken from non-Western healthcare systems?

Anna Moore

UCLPartners Integrated Mental Health Program | London

Ezra Susser

Professor of Psychiatry and Epidemiology | Mailman School of Public Health, Columbia University

Trina Dutta

Special Projects Officer | Department Health Care Finance, Washington DC

Day 4

09:00 – Review

09:15 – Knowledge Café

Knowledge café with 6 stations offering specific expertise in enhancing behavioral and mental health care systems: Participants move every 30 minutes among stations. Each table has a facilitator, drawn from among the participants, who gives a brief introduction to the topic, leads the discussion, and records major points for posters.

11:15 – Cultural Framing: The Creative Process and Power of Collaboration

Byron Good

*Professor of Medical Anthropology |
Department of Global Health and Social
Medicine, Harvard Medical School*

*11:45 – Country/Regional
Groups - Developing Draft Action
Plans Recommendations to
Providers*

12:45 – Lunch

*14:30 – Country/Regional
Groups – Developing Draft
Action Plans Recommendations
to Providers contd.*

16:30 – Peer Coaching

19:00 – Dinner

*20:30 – Open Space Knowledge
Exchange Case Clinics GH*

Participants and Faculty post questions or discussions they want to have with others. People self organize into small groups around the topics they are most interested in.

Day 5

09:00 – Review

*09:15 – Rework and Finalize
Action Plans*

*14:00 – Plenary Presentations
of Action Plans*

Dr Agnes Binagwaho (in person or
by video link)
Minister of Health | Rwanda

*16:30 – Taking the Work
Forward*

18:00 – Close

18:30 – Reception

19:00 – Concert

20:00 – Farewell Banquet Dinner

Day 6

Participant Departures

Salzburg Global Seminar Staff

Senior Management

Stephen L. SALYER, *President & Chief Executive Officer*

Clare SHINE, *Vice President & Chief Program Officer*

Daniel SZLENYI, *General Manager – Hotel Schloss Leopoldskron*

George ZARUBIN, *Vice President & Chief Development Officer*

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Jemma Clerkin, *Program Associate*

Charles E. Ehrlich, *Program Director*

Jochen Fried, *Director of Education*

Marty Gecek, *Chair – Salzburg Global Seminar Studies
American Association (SSASA)*

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Klaus Mueller, *Chair – Global LGBT Forum*

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Beth Pertiller, *Director of Operations*

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Education and Genocide Prevention Initiative Director*

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Julia Stepan, *Program Associate*

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Ernst Kiesling, *Executive Chef*

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Matthias Rinnerthaler, *Maintenance Supervisor*

Karin Schiller, *Sales and Marketing Manager*

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Mladen Todorovic, *Service Manager*

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Taylor Joo, *Program*

Christina Lee, *Program*

Beth Milne, *Development*

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