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POINT OF VIEW

Moving the Mental Health Equity Dialogue Forward: The Promise of a Social Entrepreneur Framework

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Abstract In this commentary the authors highlight the difficulties developed countries have had in generating effective means of addressing inequities in mental health. Limitations in research, policy, and service responses are discussed and the social entrepreneurship framework is suggested as a means of better understanding how mental health disparities might be addressed. The example of the Canadian Centre for Victims of Torture is provided to illustrate the points made.

Keywords Health equity · Disparities · Social entrepreneurship

Background

Despite the substantial social and economic costs of mental illness and the existence of effective evidence-based interventions, access to adequate treatment and services is a major problem. In high income countries less than half of individuals with mental health problems receive adequate treatment (e.g., 41% in the United States; Wang et al. 2005) and in many low income countries a ratio of one psychiatrist to 1 million people is the rule (Saxena et al. 2007). The scale of the problem is further highlighted by the fact that mental illness will account for 15% of the global burden of disease by 2030 (WHO 2009).

Despite a growth in awareness of mental health problems and illnesses and advances in research, policy, and advocacy, the development of services that meet the needs of people with mental illness has not been possible in the public domain. But even within this stigmatized sector there are some who are more marginalized than others. People from immigrant or ethno-cultural groups, who are lesbian, bisexual, gay or transgender or who are from low income groups have less access to mental health care (Alegría et al. 2008; Wang et al. 2005). They are less likely to get treated when they have a mental health problem, though they are at highest risk of poorer outcomes.

The social entrepreneur model may hold considerable promise in the face of these challenges. The concept of social entrepreneurship (SE), which emerged in the 1980s, has grown largely out of Bill Drayton's work in supporting individuals who are effectively addressing social problems in developing countries (Bornstein 2007). Social entrepreneurs are individuals and groups who (i) are "relentless" in their effort to address social problems, (ii) are continuously engaged in innovation and act despite adversity and resource limitations, (iv) are highly embedded in the communities related to their work, (v) generate social capital and (v) have developed sustainable and transferable solutions (Paredo and McLean 2006). As Bill Drayton and colleagues have noted, there exists an "overlooked but dramatic impact of social entrepreneurs in the health sector" and one which has the potential "add strength and utility to systems ripe for change" (Drayton et al. 2006, p. 591).

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Difficulties in Developing Effective Services

There are many examples of striking disparity in developed countries—mortality due to drug abuse and suicide among homeless youth, depression and anxiety among lesbian, gay, bisexual and transgender persons, suicide among Aboriginal peoples, and psychosis among visible minority immigrants. Developing effective solutions to these disparities, even in settings in which there is both awareness of the problems faced and a will to generate solutions, has proven tremendously difficult. This difficulty reflects challenges both in defining the problem and framing the solutions. The first area of difficulty, that of defining the problem, lies primarily in most service systems not employing a social determinants framework (WHO 2008). Mental illness is conceptualized as a circumscribed problem situated within an individual that requires an illness-focused and typically individual-level intervention, ideally one proven effective in the context of randomized trials the designs of which are optimized when interventions are narrow and circumscribed. This approach is reified by highly competitive and siloed funding streams that provide little encouragement if not active discouragement of the development of services or integrated systems that address the social determinants of health. This limitation in defining the parameters of the problem is further compounded by the inappropriateness of an individualistic illness-focused approach in many cultural contexts in which mental illness is not understood or experienced as a problem of an individual.

The second difficulty that impedes effective efforts to address mental health disparities is what appears to be a poorly coordinated approach to generating solutions. Looking to the research, it is immediately evident that for most of the communities that experience inequity (e.g., Aboriginal, homeless, immigrant, sexual and gender minorities), there is a preponderance of research documenting risk factors and rates of illness that is greatly out of proportion with investigations into effective interventions. Outcome studies are scarce and even more rare are randomized trials examining culturally grounded interventions (Aisenberg 2008; LaRoche and Christopher 2009). In most Western service provision contexts, the most common effort to address mental health equity has been the provision of "cultural competence" trainings. In such trainings providers are given broad instruction regarding ways of adapting their practice to be more appropriate to the range of cultures accessing their services. The problem with such a strategy is that, while it is likely better than providing no additional training at all, such trainings are highly variable in content and quality and there is no definitive indication that they actually impact the services received (Bhui et al. 2007).

The question faced by many service providers in this context is how can they develop service systems that are based in communities, endure over time, effectively address the needs as expressed by communities and are nimble enough to respond to the changing requirements of diverse populations. These would most likely be the types of service falling in 'informal community care' sector of a mental health system—a sector that in the WHO recommendations for mental health service systems (WHO 2009) should be the second largest after self-care, yet in high income countries is often the least developed and most poorly defined. Furthermore, these would be services that operate within a social justice framework, catalyzing communities in the fundamental challenge of changing steeply graded distributions of social resources.

Social Entrepreneurship as a Promising Approach

It is in such a context that models of social entrepreneurism would seem to have the potential to move the mental health equity dialogue forward. In each area of shortcoming described above social entrepreneurs have clear strengths: (i) they are highly effective in connecting multiple sectors and creating linkages across systems that do not normally communicate with one another. (ii) Their solutions are fundamentally community based and create social capital. (iii) By offering highly effective and engaging solutions they are able to generate change in contexts characterized by long histories of apathy and adversity. (iv) They operate effectively with very limited material resources. Additionally, as Bill Drayton noted with respect to healthcare in a broad sense (Drayton et al. 2006), there exist many examples of social entrepreneurs in the area of mental health equity. The problem is that the models of care underlying their work are not well known or articulated within mainstream service sectors. In a recent project to identify social entrepreneurs in mental health equity the authors located several organizations that meet all of the criteria of social entrepreneurism which were widely regarded as being highly effective in addressing mental health equity. One example is the Canadian Centre for Victims of Torture (CCVT). Using social entrepreneurial principles, this organization has several characteristics that have allowed it to very effectively meet the needs of a wide range of immigrants and refugees who have experienced torture and political oppression in their home countries. It is fundamentally grounded in a model of community involvement and they rapidly implement programming that matches the needs of community members, making it highly reflexive to the shifting needs and demographics of their clients. CCVT conceptualizes interventions at all levels, individual, family, social, cultural, and political

with no predominant emphasis on one area. This approach better addresses the determinants of mental illness for this group and better matches the perspectives on illness of the many communities they serve. CCVT also does not operate within what might be considered the obstinately 'face valid' approach that characterizes much of mainstream mental healthcare. From their perspective, providing single Somali women with self-defense classes *is* mental healthcare as is offering a volunteer-based homework program for their children. Such approaches receive the same amount of attention as evidence-based pharmacotherapy for post traumatic stress disorder.

Conclusions

A social entrepreneur framework would seem to hold considerable promise in moving the dialogue forward on developing effective solutions to mental health inequity. Mental health services in western developed nations, employing narrow, individualistic conceptualizations of illness and treatment, with few answers found in a research literature characterized primarily by analyses of risk factors, and offering superficial solutions such as "cultural competence" workshops, need to take a step back and learn from individuals and groups who are making inroads in providing culturally-responsive care. Direct service providers could benefit from incorporating social entrepreneurial approaches to the care they provide and administrators and policy makers could benefit from being better able to recognize and support social entrepreneurs. Policy makers might also begin to address the need to rethink the programs and deliverables tied to healthcare dollars, recognizing that in some contexts homework assistance for teenagers is as important to community mental health as cognitive behaviour therapy. Drawing from the extensive knowledge base on social entrepreneurism developed in the past 30 years by organizations such as Ashoka (www.ashoka.org), this framework represents an opportunity to have a meaningful impact on mental illness among minority groups in a broad range of contexts.

For more information on social entrepreneurship and mental health equity and the project referenced in this paper go to: www.camh.net/semh.

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