



All-Party Parliamentary Group on Global Health  
All-Party Parliamentary Group on Mental Health

# Mental Health for Sustainable Development

A line art illustration of several diverse human faces, rendered in a teal color, overlapping each other. The faces are shown in profile and three-quarter views, representing a variety of ethnicities and ages.

**MENTAL ILLNESSES  
DISABLE MILLIONS  
DISRUPT AND DESTROY LIVES  
CAUSE EARLY DEATHS  
LEAD TO HUMAN RIGHTS ABUSE  
DAMAGE THE ECONOMY**

Dr Mary De Silva & Jonty Roland, on behalf of the Global Health  
and Mental Health All-Party Parliamentary Groups

## Abbreviations

APPG	All-Party Parliamentary Group
BME	Black and Ethnic Minority
DALY	Disability Adjusted Life Year
DFID	Department for International Development
EMERALD	Emerging mental health systems in low- and middle-income countries
MDG	Millennium Development Goal
mhGAP	Mental Health Gap Action Programme
NGO	Non-Governmental Organisation
NHS	National Health Service
PCAF	Peter C. Alderman Foundation
PRIME	PRogramme for Improving Mental health carE
THET	Tropical Health and Education Trust
SDGs	Sustainable Development Goals
WHO	World Health Organization
YLD	Year Lived with Disability

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All of the projects and organisations highlighted in this report and on the map on page 20 are profiled on the [Mental Health Innovation Network](#) in a growing database which currently hosts more than 85 innovative examples of best practice in mental health promotion, prevention and treatment from around the world.



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# Preface

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The simple message of this report is that progress in development will not be made without improvements in mental health.

The reasons are equally straightforward. Mental illnesses cause more disability than any other health condition; bring enormous pain and suffering to individuals and their families and communities; and can lead to early death, human rights abuses and damage to the economy. Improving mental health is therefore a vital part of a successful development programme.

Yet mental health is generally given a very low priority – and often neglected altogether – in both national and international policy.

The UK government can give a powerful lead to correct this through DFID and its work with other international bodies; however, it also needs to develop its own policies and practices to give mental health greater priority and, crucially, parity with physical health. Mental health needs to move from being an afterthought to an essential part of social policy, health system strengthening and health improvement.

Change is also needed in the UK's vibrant voluntary sector which, with a few notable exceptions, does little in this area. Moreover, the negotiations on the forthcoming Sustainable Development Goals present the opportunity for real change. As the report says, we know what needs to be done. What is needed now is a change in mindset as well as in policy and practice.

We would like to thank all those who contributed ideas, evidence and case studies. In particular, we would like to thank the report's two authors, Dr Mary De Silva and Jonty Roland, as well as the team which supported them consisting of Vanessa Halipi, Lisa Townsend, Grace Ryan, Lucy Lee, Catherine Rushworth and Will Burch.



**Lord Crisp**  
APPG on Global Health



**Meg Hillier MP**  
APPG on Global Health



**James Morris MP**  
APPG Mental Health

# Executive summary

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The scale of the problem is better understood than ever. Cost-effective solutions for addressing it exist. It is becoming increasingly apparent that successful development will not take place without addressing mental health. The time is right to consider what the UK is currently doing to improve mental health globally and whether UK expertise and resources could be more effectively used to meet this challenge.

Mental health problems account for almost 13 per cent of the world's total disease burden, affect up to 10 per cent of people across the life course at any one time, and make up over a quarter of the years people live with disability globally.<sup>1</sup> This costs the world some US\$2.5 trillion per year,<sup>2</sup> yet the amount invested in treating mental health problems is barely a fraction of this – less than two per cent of the health spending in most low and lower-middle income countries.<sup>3</sup>

Depression, substance abuse, schizophrenia, learning disabilities and other common conditions are not simply 'Western issues'. Almost three quarters of people with mental health problems live in low and middle income countries<sup>4</sup> and receive little or no evidence-based treatment. This report sets out three important arguments why mental health matters globally and why development activity will not be truly successful without tackling mental health issues:

## The health case

People with mental health problems have shorter lives and worse health than others. This is due to suicide, mental health problems worsening the course and interfering with appropriate care and self-management of physical health problems, and poorer treatment of those problems by the health system

## The social and economic case

Mental health problems are a brake on development as they cause (and are caused by) poverty. This fuels social failures including poor parenting and school failure, domestic violence, and toxic stress, preventing people with problems and their families from earning a living

## The human rights case

People with mental health problems are often subjected to serious abuse, such as chaining, and in many countries are denied fundamental human rights and protections through discriminatory laws.

Despite strong economic, social, humanitarian and epidemiological arguments for tackling mental health in low and middle income countries, mental health is disproportionately poorly funded around the world. In low income countries, as few as one in 50 people with a serious mental health problem ever receives treatment.

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**“Mental illnesses are killer diseases. They need to take their place among the other killer diseases for investment and priority”**

Graham Thornicroft,  
Professor of Community  
Psychiatry, King's College  
London

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Fortunately, a growing body of research is showing that – even in the poorest countries – cost-effective solutions to this global challenge exist. These include:

- Improving social and economic environments as part of sustainable development so that mental health problems are less likely to occur
- Integrating mental health into generic primary health care
- Using trained and supervised community and non-specialist health workers to provide culturally appropriate care and treatment in the community
- Harnessing technology to build workforce capacity, connect people with specialist help, and increase access to self-help
- Empowering people with mental health problems to support and advocate for themselves and for each other
- Improving the physical health care of people with mental health problems
- Advocating for greater rights and representation for people with mental health problems

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**“ We have such good cost-effective interventions. Treatments for mental disorders are as cost-effective as those for other chronic diseases like diabetes”**

Vikram Patel, Wellcome Trust Senior Research Fellow, London School of Hygiene & Tropical Medicine

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This report contains practical examples of all of these approaches, many of which hold lessons for highly developed health systems as well – such as how to integrate mental health into existing physical health services and how to adapt mental health interventions to work across different cultures.

These solutions are beginning to raise global mental health up the international agenda. A year ago, member states of the World Health Organization (WHO) unanimously supported the adoption of the Comprehensive Mental Health Action Plan 2013 – 2020. This recognises the importance of mental health as a global health priority, and commits to four key objectives by 2020:

- Strengthen effective leadership and governance for mental health
- Provide comprehensive, integrated and responsive mental health and social care services in community-based settings
- Implement strategies for promotion and prevention in mental health
- Strengthen information systems, evidence and research for mental health

The UK was an important supporter of this global agreement and has much to contribute but as yet does not have a clear strategy for what its role in achieving the Action Plan will be.

Although the British Government and other institutions are doing more than most to improve mental health in low and middle income countries, these initiatives are few in number and are often isolated. This report gives a number of practical recommendations for ‘doing more’ and ‘doing differently’.

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**“ The challenge is we have in the order of a billion people on the planet who will have a mental health problem in their lifetime and not get evidence-based care for it. A response to that sort of problem needs action at a global level. It needs the sorts of global structures we’ve created for malaria and HIV to be created for mental health as well”**

Gary Belkin, Executive Deputy Commissioner,  
New York City Department of Health and Mental Hygiene

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# Recommendations

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## Recommendation 1

The Department for International Development (DFID) to ‘integrate’, ‘evaluate’ and ‘replicate’ global mental health in its programmes in order to support countries to implement the WHO Action Plan:

- ‘Integrate’ by conducting a ‘mental health in all policies’ review to strategically consider its role in achieving the WHO Mental Health Action Plan objectives
- ‘Evaluate’ by incorporating mental health impact metrics into its existing programmes
- ‘Replicate’ by committing to programme funding to scale up mental health projects that prove successful as part of DFID-funded research

## Recommendation 2

NGOs and others working in international development should support staff to understand the needs and capacities of people with mental health problems, encourage the inclusion of people with mental disorders in their general development programmes, set up new mental health specific programmes, and measure the impact of their programmes on mental health

## Recommendation 3

Professional bodies and mental health providers, with the support of government, should establish and expand training and research partnerships with low and middle income countries – seeking to teach and to learn about professional skills, tackling discrimination and policy reform

## Recommendation 4

The UK should lobby for the inclusion of the following mental health target within the Health Goal in the Sustainable Development Goals

“The provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health and working towards universal coverage”

# 1. Why mental health matters globally

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There are powerful reasons why improving mental health in low and middle income countries should be a key global concern. Mental disorders are responsible for a significant proportion of the disease burden in developing countries. They impede social and economic development. They impair community fabric and impair crucial collective needs such as parenting, child development, and school success.<sup>5</sup> They are also associated with some of the world's most pervasive human rights abuses. Despite a compelling case, mental health is disproportionately poorly funded around the world - especially in low and middle income countries.

Mental health is an indispensable component of health, defined by the WHO as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.”<sup>6</sup> ‘Mental health problems’ is a term that refers to a set of medical conditions that affect a person’s thinking, feeling, mood, ability to relate to others, and daily functioning. This includes a wide range of conditions such as depression and anxiety, drug and alcohol abuse, and schizophrenia.

In this report, and in line with guidance from the WHO, the neurological conditions dementia and epilepsy are also included, as in low and middle income countries their treatment is similar to mental health problems such as schizophrenia.<sup>7</sup> Table 1 presents definitions for the mental health and neurological problems included in this report, all of which cause a significant disease burden in low and middle income countries.

There are three compelling arguments why improving mental health should be considered a vital component of global health and development: the health case, the human rights case and the social economic case.

## **The health case: mental health problems cause more disability than any other health problem, as well as high levels of premature mortality**

Mental health problems are extremely common in all countries of the world. At any point in time, more than one in 10 people have a mental health problem:<sup>1</sup> nearly three quarters of these people live in low and middle income countries.<sup>4</sup>

Mental health problems are the most disabling of all health conditions, contributing nearly one quarter of all Years Lived with Disability (YLDs) globally (Figure 1). Importantly, though there is variability between countries in the burden of some disorders (particularly alcohol use), most do not differ significantly from the global average. Rates of mental disorders in low and middle income countries are very similar to those in high income countries.<sup>1</sup> The burden is greatest in people aged 10-29 years, reflecting the early age of onset of many substance use and common mental disorders.<sup>1</sup> This is particularly important for regions like Africa, where up to 40 per cent of the population are children.<sup>8</sup>



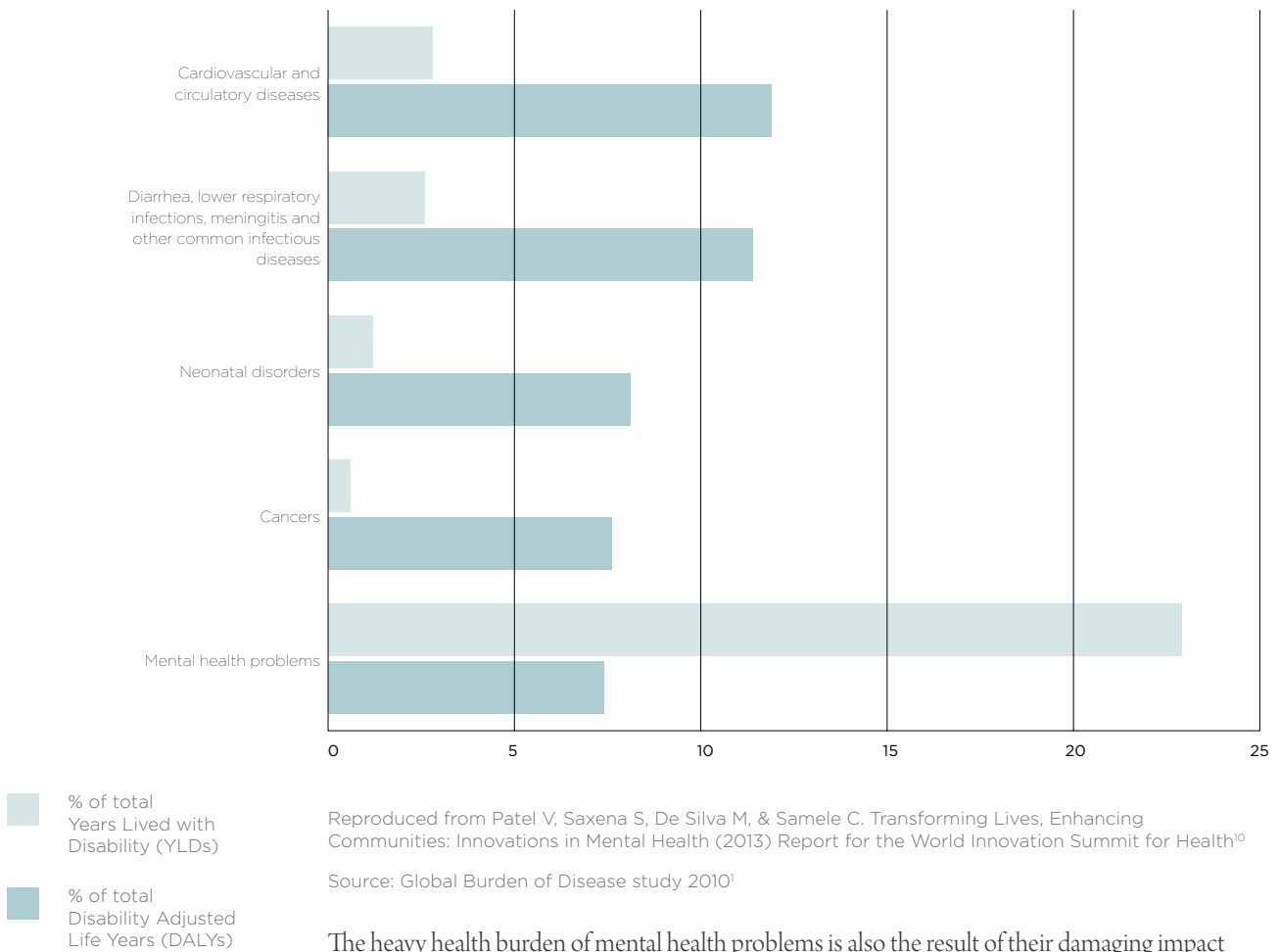
Table 1: The global burden of mental, neurological, and substance use and disorders

Mental and substance use disorders: 7.4 per cent of global disease burden (DALYs*)	
Developmental disorders	A group of conditions which develop from birth onwards, characterised by impairments in intellectual, movement, sensory, social, or communication abilities (e.g. autism, intellectual disability and cerebral palsy)
Child behavioural disorders	A group of conditions characterized by impairments of attention and disruptive behaviour (e.g. attention deficit hyperactivity disorder and conduct disorder)
Drug and alcohol use problems	A group of conditions characterised by regular use of drugs and alcohol to the level of causing harm to the person's health and social/ personal relationships
Common mental disorders	A group of conditions including depressive disorders (low mood, loss of interest and enjoyment, and fatigue) and anxiety disorders (excessive worrying, tension and fear, and physical symptoms such as palpitations, headaches and sleep disturbances)
Psychosis	A group of conditions characterized by distortions of thinking and perception (e.g. hallucinations and delusions), behavioural abnormalities and emotional disturbance, including schizophrenia
Self-harm and suicide: 1.5 per cent of global disease burden (DALYs)	
Self-harm and suicide	Intentional self-inflicted poisoning or injury which may lead to death.
Dementia and Epilepsy: 1.15 per cent of global disease burden (DALYs)	
Dementia	Organic brain diseases characterized by a progressive deterioration in mental functions, such as memory and orientation, leading to behavioural problems and loss of the ability to care for oneself and ultimately death
Epilepsy	Neurological condition where there is a tendency to have seizures that start in the brain. Repeated seizures without treatment can result in permanent brain damage

\* Disability Adjusted Life Years: A measure of the number of years lost due to death, disability and ill health.

Source: 2010 Global Burden of Disease estimates<sup>9</sup>

Figure 1: Top five contributors to the global health burden (DALYs and YLDs)



Reproduced from Patel V, Saxena S, De Silva M, & Samele C. Transforming Lives, Enhancing Communities: Innovations in Mental Health (2013) Report for the World Innovation Summit for Health<sup>9</sup>  
 Source: Global Burden of Disease study 2010<sup>1</sup>

The heavy health burden of mental health problems is also the result of their damaging impact on physical health. In high income countries, men with severe mental health problems die up to 20 years and women 15 years earlier than people without mental health problems.<sup>11</sup> In the poorest countries this life expectancy gap is less well documented, but is likely to be much wider.<sup>12</sup> This excess mortality is due to suicide, unhealthy lifestyles (such as high smoking rates) and poorer physical healthcare for people with mental health problems.<sup>11,13</sup> Globally, nearly 1 million people take their own lives every year,<sup>14</sup> nearly double those who are killed as a result of conflict or criminal violence.<sup>15</sup> Between half and three-quarters of suicides could be averted if mental health problems were treated.<sup>16</sup> This excess and avoidable mortality has been described as a form of “lethal discrimination.”<sup>17</sup> In addition, mental health problems corrode social life, lifelong development, and overall health. For example, the effects of maternal depression on children, and exposure in early life to toxic stress, casts a long shadow on lifetime mental and physical health, and social success.<sup>18</sup>

## The social and economic case: mental health problems impose a tremendous economic and social cost to society that places a brake on development efforts

The costs of mental health problems are staggering. The World Economic Forum estimates that the global cost of mental health problems was US\$2.5 trillion in 2010, and will rise to US\$6.0 trillion by 2030.<sup>2</sup> Around two-thirds of these societal costs are due to reduced economic productivity, high rates of unemployment, and under-performance at work.<sup>2</sup> At the individual level, these costs come from loss of productivity from the affected person and their caregivers, and from often catastrophic out of pocket expenditure on health services.<sup>19</sup>

Poverty and mental health problems are intimately related to one other, with those living in poverty more likely to develop mental health problems, and mental health problems leading to a downward spiral of economic disenfranchisement.<sup>2,20</sup> This is particularly true in poorer countries, where the absence of a welfare safety net and lack of access to effective treatments accelerate the cycle of disadvantage. Breaking this vicious cycle by tackling both causes and consequences of mental health problems is key to ensuring sustainable development in all regions of the world.

## The human rights case: people with mental health problems are subject to some of the world's worst human rights abuses

People with mental health problems frequently experience stigma and discrimination which act as a barrier to participation in social and economic activities and may prevent them seeking treatment.<sup>21</sup> Rates of both anticipated and experienced discrimination are consistently high across countries from many regions of the world, and act as a barrier to seeking help, receiving successful treatment, and social and vocational integration.<sup>21,22</sup> In many countries the civil and political rights of people with mental health problems are violated, such as in Nepal where mental illness is legal grounds for divorce resulting in many women being abandoned on the streets by their husbands (see map on page 20), or in Lithuania where some people with long term mental health problems are unable to own their own home.<sup>23</sup> A review of mental health legislation in Commonwealth countries found that most legislation was outdated, was not compliant with the Convention on the Rights of Persons with Disabilities, used stigmatising terms such as 'lunatic', and did not involve people with mental disorders in the development and implementation of the legislation.<sup>24</sup>

As a result of outdated laws leading to discrimination, stigma, and poor access to services, people with mental health problems are more likely than others to experience social exclusion, violent victimization and human rights abuse.<sup>25</sup> This includes being chained to their beds or kept in isolation in psychiatric institutions, being incarcerated in prisons, being chained and caged in small cells in the community and being abused by traditional healing practices.<sup>25,26</sup> Even where psychiatric wards are included in general hospitals they are generally in much worse condition than the general medical and surgical wards. In Indonesia for example, the Ministry of Health estimates that 18,800 people with mental health problems are currently shackled in the community, a practice so common it has its own name, 'pasung' (see map on page 20).<sup>27</sup> These human rights abuses have been described as "a failure of humanity".<sup>25</sup>

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**“**When countries are setting out their health agendas, very rarely are mental health experts involved, and consequently very rarely are governments finding that mental health is a priority”

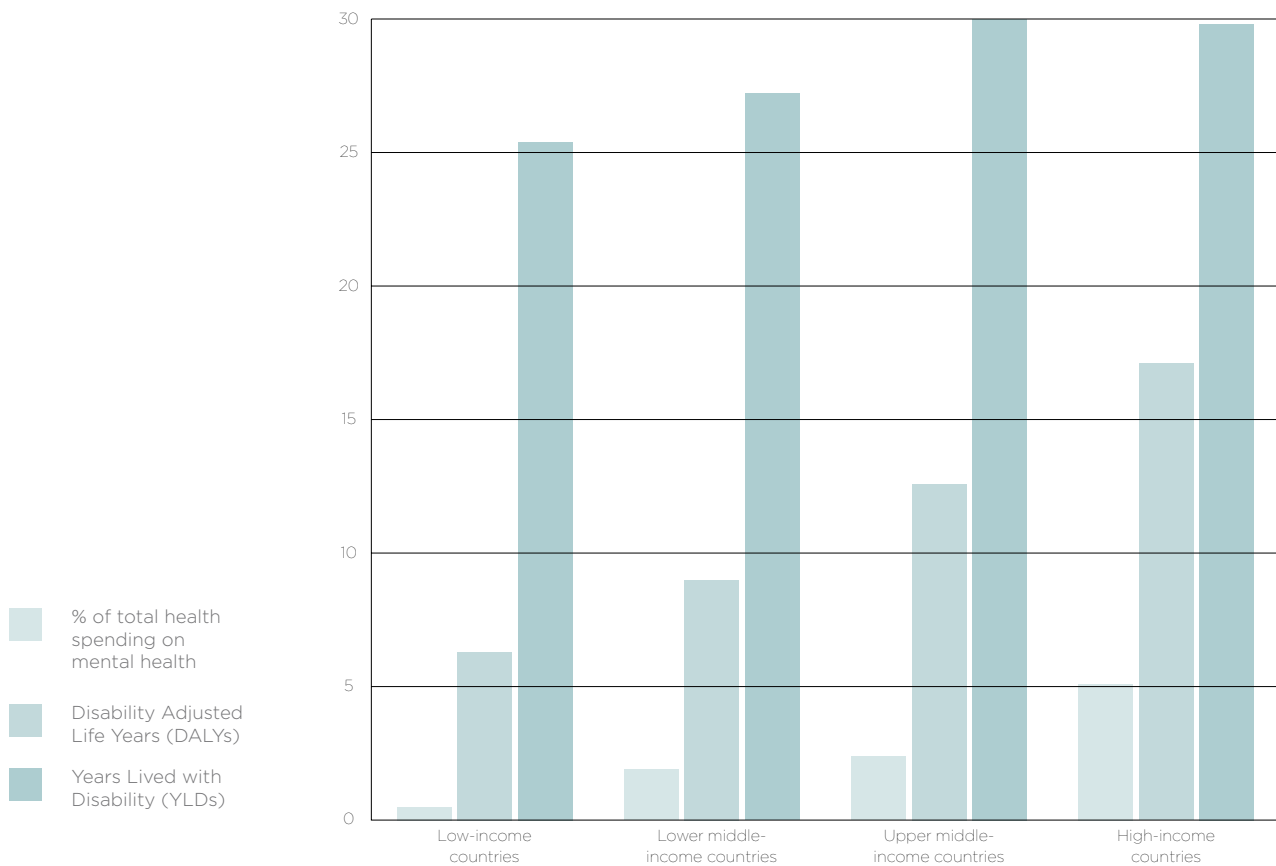
Ken Grant, Director,  
HLSP Institute

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## Global under-investment in mental health

Lack of public awareness, high levels of stigma and inadequate political attention have led to a chronic underinvestment in mental health care. Middle income countries allocate less than two per cent of their already small health budgets to the treatment and prevention of mental health problems, and low income countries less than half of one per cent<sup>3</sup> (Figure 2). More than half the world's population live in a country with fewer than one psychiatrist per 200,000 people,<sup>3</sup> with an estimated shortage of 1.18 million mental health workers in low and middle income countries.<sup>28</sup> Most of these scarce resources are allocated to a small number of psychiatric hospitals located in major cities, leaving the vast majority of the population with no access to any mental health care. This lack of investment has resulted in a situation where most people in developing countries receive no treatment whatsoever for their mental health problems. Less than one in 10 will get treatment for depression,<sup>29</sup> while in low income countries and for more severe disorders such as schizophrenia, this figures falls to one in 50.<sup>30</sup>

Figure 2: Percentage of total health spending on mental health compared to the burden of disease (DALYs and YLDs) for all mental health and neurological conditions



Reproduced from Patel V, Saxena S, De Silva M, & Samele C. Transforming Lives, Enhancing Communities: Innovations in Mental Health (2013) Report for the World Innovation Summit for Health<sup>10</sup>

Source: Global Disease Burden data 2010 (DALYs and YLDs)<sup>31</sup> and WHO Atlas 2011 (mental health spending).<sup>3</sup>

# Huzeima's story

Reproduced with the kind permission of BasicNeeds

While pursuing her studies at a teaching training college in Ghana, 25 year old Huzeima became ill. As is frequently the case, she was admitted to a traditional healer's home by her family and remained there for six months. However, a few months after returning home she became unwell again and her parents took her to hospital where she was referred to the NGO BasicNeeds.

As part of the BasicNeeds community based treatment, Huzeima attended an outreach clinic where she was diagnosed with psychosis and prescribed medication which helped improve her condition, bolstered by the support Huzeima and her family received from a self-help group. Huzeima said: *"The group loaned me a small amount of money and with this I was able to buy food grains during the harvest season and sell it during the lean season. I was able to repay the loan and even made a small profit. I am back to life again".*

The self-help group also approached the District Education Director requesting him to find a suitable teaching position for Huzeima. After hearing that Huzeima had dropped out of teacher training due to her illness and was dependent on her parents, the Director was able to offer her a non – professional teaching position at a local primary school.

Today, Huzeima has recovered and apart from teaching she is also Secretary of the Nanumba North District Association of mentally ill people and carers in Ghana, whose main objective is to coordinate the activities of self-help groups in the North of Ghana and champion issues of mental health and epilepsy in the district.



Huzeima at a self-help group meeting in Ghana  
Photo: BasicNeeds Ghana

## 2. What solutions exist?

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Despite the scale of the global mental health challenge, there is much that can be done to address it. Good evidence exists for a range of cost-effective, feasible interventions to improve the health and well-being of people affected by mental health problems, even in low and middle income countries.<sup>32</sup> Many of these solutions are capable of ‘turning the world upside down’ - ideas developed in resource poor settings from which the UK could learn. The problem is not what to do, but mobilising the political will, finance and human resources needed to do it.

The international community has already agreed the way forward for global mental health. In May 2013, all 194 member states of the WHO ratified the Mental Health Action Plan 2013-2020.<sup>33</sup> This committed the world to achieving four objectives, each with corresponding global targets to be reached by 2020:

1. To strengthen effective leadership and governance for mental health
2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings
3. To implement strategies for promotion and prevention in mental health
4. To strengthen information systems, evidence and research for mental health

The WHO Action Plan, along with the Convention of the Rights of Persons with Disabilities, represents a historic opportunity for Governments to act on mental health. As a signatory, the UK needs to consider what its role in meeting the Action Plan’s goals should be, and how it can equip its considerable global health and development sectors to meet these ends. One critical approach where the UK is already having an impact is working directly with governments to support them to develop effective national level mental health policies and plans.<sup>34,35</sup> Perhaps the single most important thing in ensuring that national governments and international donors prioritise mental health for investment would be to incorporate a target for mental health into the Health Goal of the forthcoming Sustainable Development Goals (SDGs). An international campaign to achieve this is already underway.<sup>36</sup>

Three broad solutions have been successfully implemented in low and middle income countries: preventing mental health problems from developing; treating them through care and support; and promoting the rights and representation of people with mental health problems. Examples of these are described below, although many programmes use a combination of all three solutions.

## **Solution 1** Foster social and economic environments that promote mental wellbeing and prevent mental disorders from developing

Action can be taken to improve the conditions of daily life, to promote mental wellbeing and prevent mental disorders developing. This requires broad interventions across multiple sectors (e.g. environment, health, education, social policy) and at multiple levels (family, community, national).<sup>37</sup> Examples include national level policy changes to restrict the availability of alcohol, such as those currently being considered in Malawi and Zambia,<sup>38</sup> and regulatory controls on the import and sale of toxic pesticides in Sri Lanka which resulted the number of suicides halving over a 10 year period.<sup>39</sup>

Some of this work is already happening through the Millennium Development Goals (MDGs). Although mental health is not explicitly mentioned in the MDGs, progress towards all of these goals (including non-health goals such as reducing extreme poverty and hunger, improving education, and promoting gender equality) will have powerful effects on promoting good mental health by acting on the social determinants of poor mental health.<sup>37</sup>

Impacts of poverty reduction programmes on mental health can be hard to predict without purposefully measuring them. For example, while cash transfers to parents conditional on their child attending school have been shown to reduce behavioural problems in children, some microcredit schemes have shown a negative effect on mental health.<sup>40</sup> Tracking the impact of development programmes on mental health should be routine practice to ensure these important effects are taken into account, but this is rarely done.

There is an important opportunity to change this through the drafting of the SDGs, currently under intense discussion at a global level and expected to be finalized through the UN in 2015. In addition to advancing a global agenda of access to basic mental health services within health systems, the SDGs present a rare and important opportunity to align action around metrics that capture wellbeing in general, as well as specific mental health priorities for which cross-cultural measures are well developed, such as for depression.

Promotion and prevention starts with the early years. There is robust evidence from high income countries that giving every child the best possible start will generate the greatest societal and mental health benefits.<sup>37</sup> There is growing evidence that the same is true in low and middle income countries, with successful trials of interventions by community health workers promoting good parenting, child nutrition and maternal mental health in countries such as Jamaica and Pakistan.<sup>41</sup> There is also good evidence that school and community based interventions can promote mental wellbeing among children aged 6-16 years in developing countries.<sup>42</sup>

## **Solution 2** Expand access to community based treatment and care for people who do develop mental health problems

Despite the commonly held belief that improvements in mental health require sophisticated and expensive technologies and highly specialised staff, the reality is that most mental disorders can be treated by non-specialist staff without any medical equipment. The treatment of mental health problems has been shown to be as cost effective as other health treatments such as antiretroviral drugs for HIV/AIDS, and the returns on investments in mental health are considerable.<sup>43</sup> These treatments are also affordable: a scaled up package of care for epilepsy, depression, psychosis and harmful alcohol use in sub-Saharan Africa and South Asia is estimated to cost US\$3-4 per capita.<sup>44</sup>

In 2008 the WHO launched its flagship mhGAP programme. The aim of mhGAP is to expand access to services in low resource settings by providing evidence based guidelines for the treatment of a range of mental health problems by non-specialists in primary care in low resource settings.<sup>7</sup> mhGAP now forms the basis of many countries national efforts to scale up mental health services, supported by the WHO and amplified by specialists working directly with governments and other stakeholders on situation appraisal and policy support.<sup>34</sup>

Projects in low resource settings have used three broad strategies to successfully integrate mental health into community care. All these strategies share the common thread of locally adapting solutions to be culturally appropriate. The first overcomes the shortage of mental health specialists by task-sharing with other cadres: these can be generic primary health care workers, dedicated mental health community workers, specially trained lay people, or other health professionals equipped with mental health care skills. For example, the Kenyan Medical Training College has trained over 2000 front line nurses and clinical officers with a 5 day mental health continuing professional development course. This amounts to nearly half of Kenya's primary care public sector workforce. It has also run similar training for some private sector workers, faith based organisations and prison nurses.<sup>45</sup> The Kintampo Project is a UK Non-Governmental Organisation (NGO) which works in partnership with the Ghanaian Ministry of Health to train two new cadres of community mental health workers who provide services in all regions in Ghana.<sup>46</sup> The project has increased the trained national mental health workforce by over 90 per cent, resulting in a tripling of the number of people in Ghana receiving treatment.<sup>47</sup>

There is an established body of evidence from trials in low and middle income countries that demonstrates the effectiveness of lay health worker delivered psychological therapies.<sup>48</sup> These strategies are now being adopted by governments, such as in the new District Mental Health Programme in India which recommends a new cadre of community-based, non-specialist mental health worker.<sup>49</sup> Task-sharing is only successful if delivered through a health systems approach including on-going training and professional development, supportive supervision, clear referral pathways to specialist care, and a clear role for the non-specialist within the health system.

Health system strengthening for mental health is currently being investigated in the Emerging mental health systems in low- and middle-income countries (EMERALD) project, funded by the European Commission. EMERALD aims to identify key health system barriers to, and solutions for, the scaled-up delivery of mental health services in low- and middle-income countries, and by doing so enhance health system performance and improve mental health outcomes in a fair and efficient way.<sup>50</sup>



The second strategy involves empowering people with mental health problems to be agents of change. There is now global experience in the value of having people with mental health problems involved in developing services that meet their needs, and to be involved in delivering those services. HeartSounds in Uganda engages peer support workers who are ‘experts by experience’ to support fellow service users through engaging families and providing psycho-education (see map on page 20).<sup>51</sup> Other examples include Clubhouse International which runs 330 community centres run by service users in 33 countries, including a number of low and middle income countries.<sup>52</sup> These lean, service-user led models have been shown to work equally well in high income countries such as the USA and UK.

Health service managers must also be empowered to define, scale, and improve care, and there have been important advances in making available and applying Quality Improvement (QI) tools for this purpose. The use and spread of good ideas for how to deliver care often fail in the absence of good implementation tools and QI has been shown to be effective in filling that need in these settings for other health conditions.<sup>53</sup> The potential impact of QI methods to help accelerate adoption of mhGAP-based care in very low resourced settings is being explored through the A Billion Minds and Lives Early Adopter Network which links funded projects scaling up primary care integration of mhGAP-based care across 5 Sub-Saharan countries with the Institute for Healthcare Improvement, a global leader in the application of QI to health systems improvement.<sup>54</sup>

The third strategy harnesses developments in ‘mHealth’: using technology to improve access to care. Telemedicine is an effective way to connect people with scarce mental health specialists, to increase access to self-help treatments, and to build the capacity of the mental health workforce. Use of telemedicine is being successfully implemented in Tamil Nadu in India where a bus with a tele-psychiatry consultation room and a mobile pharmacy visits rural areas. At a cost of £7 per person, the project has treated 1500 people with severe mental disorders, 70 per cent of whom have been receiving treatment for over one year.<sup>55</sup> There are numerous low-cost, automated psychological treatments for anxiety and depressive disorders delivered via the internet such as THISWAYUP<sup>56</sup> which have a growing evidence base and have great potential for increasing access to psychological therapies particularly in middle income countries. Technology is also being used for capacity building, such as in the eData K project which uses freely available computer-based courses to train large numbers of primary health care workers to identify and treat alcohol use disorders in Kenya.<sup>57</sup>

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**“Mental health needs to become an essential part of our approach to improving primary care, strengthening health systems and achieving universal health coverage”**

Rachel Jenkins, Emeritus Professor of Epidemiology and International Mental Health, King's College London

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### **Solution 3** Advocate for the rights and representation of people with mental health problems, and for greater investment to improve access and services

Promoting mentally healthy environments and providing effective and culturally appropriate treatment and care will not happen on the scale needed to address the current crisis, without increased investment in mental health in developing countries. For this to happen, mental health needs to be more widely recognised as a human right and an economic and social priority.<sup>58</sup> There is a small but growing number of service-user led advocacy groups working in countries to advocate for improved services and campaigning for changes to discriminatory laws and practices. Examples include KOSHISH in Nepal<sup>59</sup> (see map on page 20), and the Central Gauteng Mental Health Society in South Africa.<sup>60</sup> However, such initiatives are not yet the norm in low resource settings, and their efforts must be amplified through linkages with other similar initiatives and by policy support from the highest level within the countries where they are working.

#### Is global mental health culturally imperialist?

An on-going debate exists over whether improving access to mental health interventions used in high income countries might do more harm than good. Global mental health has been likened to ‘cultural imperialism’ by some - imposing Western diagnoses and treatments onto societies with conflicting conceptions of mental health. These external influences, it is suggested, medicalise and medicate people without regard to existing support structures and local perspectives.<sup>61</sup>

Cultural appropriateness is a vital part of the effectiveness of mental health interventions, as presentation of problems, as well as what helps, can vary by context. This is a shared problem relevant to mental health everywhere – between different local boroughs in one city, as much as between different countries.

This debate therefore provides a helpful tension in the field of global mental health – challenging those working in low and middle income countries to think deeply about the cultural appropriateness of services, the involvement of communities, where local knowledge and resources work best, and where outside support is needed, and to collaborate with local expertise to research relevant protective and harmful psychosocial factors.

The challenge to well meaning, but ill-considered attempts to help is welcome, but should not lead to inaction. The examples quoted in this report show how knowledge and skills from high income contexts are drawn upon and adapted to meet local needs, considering the culture and resources of particular low income contexts through partnerships with local stakeholders including service users – and that in doing so there is equal opportunity for mutual learning. Some of these programmes have the potential to ‘turn the world upside down’ by providing important lessons on how to address the large unmet need for mental health care in the UK.



## James' story

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James resides in the Kitgum district in northern Uganda. He lost his father before he was born, and his mother suffered from guinea worm infection. He was abducted by the Lord's Resistance Army at age 14, where he was trained as a soldier and sent to Sudan. He was beaten, starved and forced to kill, and escaped many helicopter gunship attacks and bombs.

After his escape from the LRA, James was registered at a PCAF clinic where the social worker noticed that he would not talk or smile. He suffered from nightmares, loss of appetite and hopelessness about the future. The social worker noticed that he liked to draw and gave him crayons and a paper to tell his story. He produced dozens of extraordinary drawings of his experience in the bush as a soldier with the LRA.

In months of intensive treatment, James opened up and began to regain his life. He has been making artwork for PCAF ever since. He now works for a graphic design studio, has a safe place to live with his wife and child, and through an anonymous donor, has a full range of art supplies.

You can see a video of James talking about his experience, and see a gallery of his work, on the [PCAF website](#)


Photo: Cynthia MacDonald

# Improving mental health globally



All of the projects and organisations highlighted in this report and on this map are profiled on the [Mental Health Innovation Network](#) in a growing database which currently hosts more than 85 innovative examples of best practice in mental health promotion, prevention and treatment from around the world.


 The **Canadian Government** is funding the world's largest body of global mental health research projects through **Grand Challenges Canada**. They have invested over £17 million in 49 projects across the developing world since 2011, with projects including establishing family networks for child developmental disorders in **Pakistan**<sup>62</sup>, expanding and strengthening mental health services in primary care in **Haiti** following the earthquake,<sup>63</sup> and using indigenous networks for case detection, referral and follow-up in **Uganda**.<sup>64</sup>


 The **Indonesian Ministry of Health** has implemented a programme for the nation-wide elimination of the use of physical restraints to protect the human rights of people with severe mental illness. They estimate that 18,800 people in the country are currently restrained in this way. A multi-pronged approach including ensuring allocation of sufficient mental health budgets, providing community-based mental health services and intensive education campaigns has resulted in 3500 people being released from chains since 2012.<sup>65</sup>

 The UK NGO **BasicNeeds** works in 11 countries in **Africa** and **Asia** to empower people with mental health problems living in poverty through community-oriented treatment and self-help support, addressing their medical, social and economic needs. As of June 2014, BasicNeeds has reached over 120,000 people with mental illness and over 496,000 carers and family members, at a cost of approximately £20 per affected individual.<sup>66</sup>


 The **PRogramme for Improving Mental health care (PRIME)** is a partnership of researchers and Ministries of Health funded by DFID to develop, evaluate and scale up district level mental health care plans integrating mental health into primary care in **Nepal, India, Ethiopia, Uganda** and **South Africa**. Final results are due in 2017, but so far the project has informed national level policy changes in four of the five countries.<sup>67</sup>



 The **Ethiopian Ministry of Health** has made significant progress towards developing a national mental health workforce through training programmes for all cadres of health workers from psychiatrists, psychiatric nurses and community health workers to PhD level mental health researchers. To date 115 psychiatric practitioners (MSc level) and 491 psychiatric nurses have been trained, and the number of psychiatrists has increased from 12 to 40 with all but three remaining in the country.<sup>68</sup>

 The **Peter C. Alderman Foundation (PCAF)** works with governments in **Uganda, Kenya and Cambodia** to establish trauma clinics delivered through public-private partnerships in post-conflict settings using trained lay health workers and outreach services. PCAF also opened the first mental health Wellness Clinic in Liberia. More than 100,000 survivors of terrorism and mass violence have so far been treated by PCAF at a cost of £26 per patient per year, with evaluations showing significant reductions in symptoms and disability in individuals who receive treatment.<sup>69</sup>

 In **Nepal**, mental illness is legal grounds for divorce. As a result, women living with mental illness are commonly abandoned on the streets by their husbands. **The National Mental Health Service User Organization KOSHISH**, which is run by service users, provides emergency support for abandoned women, while fighting discriminatory laws to ensure that their rights are protected. After nearly a decade of advocacy by KOSHISH and partners, in 2014 the government committed to establish a mental health unit to address the mental health care needs of all people living with mental illness in Nepal.<sup>59</sup>

 The **Butabika East London Link** is a partnership between East London NHS Foundation Trust and Butabika Psychiatric Hospital in **Uganda**, funded by the Tropical Health Education Trust and DFID.<sup>70</sup> They have developed a number of programmes to improve mental health care in Uganda, including helping to develop child and adolescent mental health services at the hospital, training Psychiatric Clinical Officers who provide much of the mental health services in rural Uganda, and a partnership with HeartSounds Uganda training peer-support workers to provide community outreach services to people discharged from the hospital.<sup>51</sup>

## 3. The UK's current contribution to global mental health

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UK government is doing more than most to address the challenge of global mental health and British institutions are slowly beginning to recognise the importance of this field. Still, mental health remains an afterthought in most of the UK's global health and development work. Many excellent programmes exist, but they are isolated. The impact of the UK's wider international development efforts to create stable, sustainable communities on mental health goes unmeasured.

### **Department for International Development**

DFID stands out as one of the only national aid agencies to have a portfolio of work focussed on mental health.<sup>71</sup> However, these projects are limited in number and scope, comprising less than one per cent of its overall health budget.

DFID's most notable programme is the £6 million PRIME research study to develop and evaluate district level mental health care plans in five countries in Africa and Asia (see map on page 20). In addition, DFID is funding a number of projects in individual countries, such as in Ghana where £7 million has been allocated over five years to support a mix of direct service improvements (a BasicNeeds programme to establish community mental health care and a faith-based referral systems project with the Christian Health Association of Ghana) and policy development (assisting Ghana's newly established Mental Health Authority). DFID is also leading work on mental health in crisis situations, for example developing technical guidance for advisers to provide psychosocial support following humanitarian disasters.

### **NGOs and others working in international development**

Mental health is conspicuously absent from the UK's vibrant global health NGO sector, potentially limiting the impact of their development programmes through ignoring the critical missing piece of sustainable development: mental health. Few of the major health charities contacted could name any projects which aimed to improve mental health in low and middle income countries, or where mental health impacts of development programmes were being measured. This lack was largely seen as funding-driven – mental health was not something that donors would readily support over other disease areas. It is also possible that public stigma in the UK means fundraising for mental health is more challenging.

Exceptions exist in the form of a small number of UK NGOs who do include mental health as part of their wider work, including VSO, International Medical Corps and the Tropical Health Education Partnership. There is an even smaller number of relatively small but highly regarded UK NGOs who work exclusively on mental health, including BasicNeeds and Minds for Health. Minds for Health forms partnerships with existing organisations in developing countries to improve access to mental healthcare and tackle the social causes and consequences of mental health. BasicNeeds' lean, community based approach to improving the lives and livelihoods of people with mental health problems across 11 countries is featured on the map (page 20).

## Academic institutions

UK universities and research funding bodies are making some significant contributions to our understanding of global mental health. In particular, the UK hosts one of the world's leading research hubs in the field: the Centre for Global Mental Health, a collaboration between the London School of Hygiene & Tropical Medicine and King's Health Partners Academic Health Science Centre.

In terms of research funding, most of the major UK research funders can name a small number of global mental health projects they support. The Medical Research Council, the Wellcome Trust and the Economic and Social Research Council fund a variety of research projects in low and middle income countries, including the social determinants of maternal mental health, trials for mental health interventions, and studies to understand the mental health of HIV positive children. There is a promising development in the formation a new UK charity, MQ: Transforming Mental Health, though to date they have not funded any research in low and middle income countries.

Neuroscience is a major area of investment for several large UK research funding institutions. Although this work could ultimately lead to breakthroughs in mental health treatments, little of this research is aligned with the priorities of low and middle income countries, and the treatments that result are likely to be out of reach for many health systems.

## NHS

The NHS has also been contributing to improving global mental health through a number of partnerships with governments and providers in low and middle income countries. NHS mental health trusts operate links through the DFID-funded Health Partnerships Scheme. These partnerships largely focus on training specialist, non-specialist and lay mental health workers in order to expand access to care in the partner country. One such link, between the East London NHS Foundation Trust and the Butabika Psychiatric Hospital in Uganda (see map on page 20) has demonstrated the mutual value of these partnerships: Butabika now has many more trained mental health workers to deliver care, while the NHS staff involved have helped to experience and adapt new approaches – such as narrative therapy – that are now successfully being used with local communities in East London.

## UK's biggest contributions go unnoticed

The programmes noted above give a snapshot of the current UK activities that explicitly aim to improve mental health in developing countries. The greatest contributions to this field will not however be these dedicated projects, but the much larger global health and development work of British government, charities, companies and institutions. As section 1 outlined, economic empowerment, good physical health, security, equality and human rights can all have a hugely beneficial impact on mental health. There are a multitude of such programmes across all sectors of the UK, but the mental health impacts of these projects currently go unmeasured – despite simple, cheap and well validated tools to capture this. This means we do not know what works, or how to factor mental health benefits into resource allocation decisions. Incorporating these tools into on-going and future projects run by DFID, NGOs and UK research would be a simple change that will provide a wealth of information about the types of projects that are having positive mental health outcomes.

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“*Frankly, mental health is not an attractive subject to many funders: it's complex and there's a lack of knowledge about the extent and urgency of the problem*”

Chris Underhill, Founder  
Director, BasicNeeds

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## 4. Doing more and acting differently

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Mental health problems must be tackled to achieve sustainable development. This report recommends four key steps to achieve this. Our major health and development institutions must do more and act differently: thinking about mental health in all that they do, measuring mental health impacts of existing programmes and showing global leadership.

### Recommendation 1

The Department for International Development (DFID) to 'integrate' 'evaluate' and 'replicate' global mental health in its programmes in order to support countries to implement the WHO Action Plan

#### Integrate

DFID should conduct a 'mental health in all policies' review to assess where and how mental health could be integrated into its existing work. In particular, it should seek to come to a clear and detailed view of its role in helping countries achieve the WHO Mental Health Action Plan objectives. It should also consider cost-effective investments that aim at broader systems strengthening along the key areas emphasized here such as on-going infrastructures for training and maintaining a task-sharing and community-based workforce, capabilities for smart use of mobile health technologies, quality improvement methods, empowerment and community mobilization

#### Evaluate

As a first step, DFID should incorporate mental health impact metrics into its existing programmes that are likely to be having a significant impact on mental health (such as poverty reduction and gender equality projects). Validated measures are now widely available and would be a minimal additional burden for relevant DFID funded projects to adopt. This will allow DFID to build up a much better picture of where it is already making a difference

#### Replicate

As DFID's existing mental health initiatives mature and show successful outcomes, it should commit to scaling up and adapting these evidence-based approaches to much larger geographic areas. This should be delivered with an appropriate increase in funding for both civil society and governments

The UK has recognised the need for a comprehensive global step change in the support for mental health available in low and middle income countries. This includes scale-up of community based services, strengthened leadership and governance, more research, and systems for promotion and prevention in mental health.

Although DFID is already doing more than most development agencies on these priorities, the initiatives outlined in the previous section appear to be isolated within the Department's portfolio. This review found there to be no coherent or strategic understanding of how mental health should factor into DFID's wider health and development work.



This report is not the first to make this observation. The recent International Development Committee inquiry into disability and development noted the disproportionately low level of DFID spending on mental health, and the limited geographical coverage of this work.<sup>71</sup>

It recommended that DFID “thoroughly appraise the case” for spending more on mental health and explain its reasons if it decides against increasing funding. The Department’s response to this was insufficient, stating that its “focus is on ensuring that this is included in our work on health systems strengthening” without giving detail as to how.<sup>71</sup> The three specific actions recommended by this report would improve DFID’s understanding and strategic response to the global mental health challenge.

## Recommendation 2

NGOs and others working in international development should support staff to understand the needs and capacities of people with mental health problems, encourage the inclusion of people with mental disorders in their general development programmes, set up new mental health specific programmes, and measure the impact of their programmes on mental health

Sustainable development will not be achieved if the huge challenge of mental health is not addressed. This requires existing NGOs and others working in international development who do not currently address mental health to incorporate mental health prevention and promotion programmes into their work, and measure the mental health impacts of existing programmes to understand their effect on development. A significant barrier to achieving this is the lack of specialist expertise in mental health within the NGO sector which means that people with mental health problems are either excluded from programmes or included under the disability banner in only a cursory way. International initiatives such as the [Mental Health and Psychosocial Support network](#) and the [Mental Health Innovation Network](#) which provide expert support, information sharing and capacity building materials, along with existing mental health NGOs such as BasicNeeds, can be tapped to increase the expertise of NGO staff.

## Recommendation 3

Professional bodies and mental health providers, with the support of government, should establish and expand training and research partnerships with low and middle income countries – seeking to teach and to learn professional and implementation skills, tackling discrimination and policy reform

The UK can make a large contribution to mental health in low and middle income countries by sharing its knowledge and skills. Conversations with mental health leaders in resource-constrained settings revealed a critical shortage of training resources to develop skilled specialist, non-specialist and lay mental health workers. British assistance would be highly valued in:

- Training of existing primary care workers in mental health
- Continuing professional development of mental health staff
- Communications expertise to increase public awareness, promote self-help strategies, and tackle discrimination
- Legal and policy reforms
- Integration of mental disorders into Health Management Information Systems

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**“ It is important not to have a situation where different health issues are simply competing for the same finite resources. Building strong health systems that see the person as a whole, recognising mental and physical health is really important.”**

Jane Edmondson, Health of Human Development, Department for International Development

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Not only does the UK have strength in these areas, but crucially it also has the links to make these partnerships happen. Mental health staff in the UK are even more international in background than the general NHS workforce. Psychiatry, for example, is the third most international medical speciality in the NHS.<sup>72</sup> For three countries (all recipients of DFID funds) the UK employs more psychiatrists from that country than remain there – Nigeria (214-114), Zambia (9-2) and Malawi (1-0).<sup>73</sup> These Diaspora links offer an important untapped resource the UK could use to give back some of what we have gained.

As the previous section highlighted, the UK also benefits from mental health partnerships. The recent *Turning the World Upside Down* ([www.ttwud.org](http://www.ttwud.org)) awards shows the NHS has much to learn from low and middle income countries about improving the health and lives of people with mental disorders. The 34 projects show how innovative approaches being taken in low resource settings offer ideas and initiatives that Britain could adopt and adapt. Particular attention should be given to partnerships with parts of the world where the UK has significant Diaspora communities, since outcomes for black and ethnic minorities with mental health problems in Britain are significantly worse than for white British service users. Developing and learning from innovative solutions in communities' cultures of origin may be one way of achieving this.

#### Recommendation 4

The UK should lobby for the inclusion of the following mental health target within the Health Goal in the Sustainable Development Goals.

“The provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health and working towards universal coverage.”

The world lacks an effective architecture to support global action on mental health, partly due to the exclusion of mental health from the MDGs. The WHO has given invaluable support to many low and middle income countries in recent years, including the Mental Health Action Plan. However, this commitment is not attached to any significant levels of funding for expanded services.

A number of significant opportunities to address this gap exist in the near future. These include the World Bank and WHO high level meeting on depression in Autumn 2015, and further milestones in the development and implementation of the Sustainable Development Goals. The UK will have a key role in both of these summits, and should call internal meetings within government well in advance to come to a clear UK position on what should be done to strengthen the global architecture supporting mental health. The UK should not miss this opportunity to lead these changes, and in particular to ensure that any new initiatives are principally governed by and for low and middle income countries.

Perhaps the single most important thing in ensuring that national governments and international donors prioritise mental health for investment would be to incorporate an additional target for mental health into the Health Goal of the forthcoming Sustainable Development Goals (SDGs). This target must explicitly seek parity of esteem between physical and mental health, working towards the ultimate goal of universal coverage. To achieve this, countries will need to set themselves a transition plan to increase coverage over a realistic timeframe, including the collection of relevant local outcome indicators such as mental health diagnoses recorded in primary health care, which can be used to track progress over time.

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