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A Report by the All-Party Parliamentary Group on Global Health

New Directions for the Mental Health Workforce Globally

July 2021

All-Party Parliamentary Groups

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Glossary

APPG	All-Parliamentary Party Group on Global Health
CRPD	Convention on the Rights of Persons with Disabilities
EQUIP	Ensuring Quality in Psychological Support
FCDO	Foreign, Commonwealth and Development Office
IACD	Integrated Approach to Addressing the Challenge of Depression Among the Youth in Malawi and Tanzania
IAPT	Increasing Access to Psychological Therapies
LMICs	Low- and middle-income countries
mhGAP	Mental health gap action programme
mhLAP	Mental Health Leadership and Advocacy Program
NHS	National Health Service in the United Kingdom
SDG	Sustainable development goal
UHC	Universal Health Coverage
UN	United Nations
UPSIDES	Using Peer Support in Developing Empowering Mental Health Services
WHO	World Health Organisation

Contents

A note on terminology - mental health and the mental health workforce

Mental Health is the capacity of thought, emotion, and behaviour that enables every individual to realise their own potential in relation to their developmental stage, to cope with the normal stresses of life, to study or work productively and fruitfully, and to contribute to their community.[1]

Mental health can be viewed as a continuum or spectrum from good mental health and wellbeing on one end across to mental ill health on the other. **Mental ill health or mental health problems** refer to an individuals compromised mental health.

If these mental health problems are longer term, or impact severely on people's ability to cope with normal life, and may require clinical mental health care, these are referred to as a **mental health condition or disorder**.

Recovery is gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Importantly, recovery is defined by the person themself.[1]

More generally, there are different types of mental ill health. **Common mental health problems** refer to a group of conditions including anxiety and depression. **Severe mental health problems** refer to a group of conditions such as bipolar disorder or psychosis.

In this report, **people with lived experience or people living with mental health problems** refers to people who have experienced or are currently experiencing mental ill health. **Service users** refer to people who use mental health services of any kind.

The report recognises **the overarching importance of self-care and the role played by family, friends, carers and all sectors of society** – from employers to schools – in providing support and care, tackling the cause of ill-health, and creating health and wellbeing.

This report refers to the **mental health workforce** in two broad areas:

Specialist: Specialty mental health service staff working in inpatient mental health services, community settings or mental health and general hospitals, such as psychiatrists, psychiatric nurses, social workers, occupational therapists, psychologists and counsellors. This group increasingly includes experts by experience, peer supporters and others with specialist knowledge and skills. All these specialist staff provide mental health services as their focus.

Generalist: This includes health and social care staff who are non-specialist mental health workers such as primary health care staff, general nurses and doctors, allied health staff and community health workers. These generalists have other roles aside from contributing to mental health services.

Foreword

COVID-19 has shaken the world, causing enormous damage to the physical and mental health of millions. We need an urgent and powerful global response to this developing mental health crisis.

This report argues that the mental health workforce needs to change dramatically both in its composition and in the way mental health specialists work with the wider public and civil society in order to meet this need. It also calls for much greater investment in mental health.

The report builds on current trends and developments to set out new directions for the workforce and makes recommendations for governments, international bodies, service providers and educators. The mental health workforce is already changing. There are new roles such as peer supporters and experts by experience and new initiatives to integrate physical and mental health which enable general health workers to provide treatment and care.

It was very striking that so many of the experts interviewed for this report spoke of the need for further radical change. They also pointed us to many examples globally where innovators are developing new service models and approaches and where policy makers are introducing new concepts and guidance.

Much of this change is happening piecemeal and on a relatively small scale. We argue in this report that the time has come to build on the work of these pioneers and establish a new approach to developing the mental health workforce and bringing about radical change strategically and at scale.

This report builds on our earlier report *Mental Health for Sustainable Development* and recommends that mental health is fully integrated into all development policies. The UK Government has a significant part to play in promoting mental health and wellbeing globally as well as in the UK and we urge the government to reverse its disastrous cut in development aid.

We are greatly indebted to all the witnesses who spoke with us and to Jonathan Rolfe, Miriam Etter-Falcao and Thomas Canning of Implemental who carried out the research for the report. We are also very grateful for the participation of parliamentary colleagues – Sarah Champion MP, Baroness Sheila Hollins, Lord Bernie Ribeiro and Baroness Mary Watkins - and for the support from our Policy Officer Dr Nicole Votruba who coordinated the witness sessions and delivery of the report, and Jonathon Foster who provided additional support.

Dr Daniel Poulter MP
Chair

Lord Nigel Crisp
Co-Chair

On behalf of the All-Party Parliamentary Group on Global Health
15 July 2021

Summary

The COVID-19 pandemic is causing enormous damage to the mental health of populations globally. This is happening both directly through the trauma of loss, increased levels of fear and anxiety and the, as yet not fully known, consequences of Long COVID. It is also happening indirectly through the temporary closure of services and the disruption to education and employment. Poverty is growing again globally and many of the development gains of recent years are being lost.

COVID-19 has also highlighted the fact that what happens to people in their homes, schools, workplaces, and communities profoundly affects their mental health and wellbeing. Moreover, most of the care that people receive when they are mentally ill is provided by family, friends, neighbours, schools, employers, places of worship and voluntary organisations rather than by the formal health or care services.

The COVID-19 pandemic has demonstrated all too clearly how important these societal and environmental factors are in shaping both health and life chances and what a vital role all sectors of society can play in mental health – for good or ill.

Most of the people who contributed to this report emphasised these and similar points. However, the way that mental health services are currently organised, staffed and resourced simply do not reflect these important realities. They are the starting point of this report and the reason why radical change is needed.

The central message of this report is that the mental health workforce needs to change dramatically by combining its existing professional expertise in the provision of specialist care and treatment with a greatly strengthened role in helping people, communities, and organisations to provide care, prevent mental ill health and create health. It also needs to integrate non-professionals fully and work far more closely with general health services. The report makes five major points.

1. There is a massive and growing need for mental health services and they need to be given greater priority and increased investment.
2. There is a need to continue the development and improvement of services for people with chronic and enduring severe mental ill health as well as for those with more common and less severe illnesses.
3. The mental health workforce needs to be widened to integrate non-professionals fully and engage primary care and general health services.
4. Mental health workers need to develop new ways to work with people, communities, and organisations on care, prevention of disease, and health creation.
5. The education and training of mental health workers needs to be adapted to this new approach and to enable them to work as agents of change, leading and facilitating improvements in mental health across society.

Time and again, witnesses and stakeholders spoke of the need for radical change. The quotations shown in Box 1 begin with one from Professor Dinesh Bhugra, who has held some of the most senior positions within his profession. He makes the simple but striking statement that *mental health is too important to be left to the specialists*.

The World Health Organisation (WHO) Regional Adviser for Africa is equally direct in talking of *fighting against the psychiatrists* as are others arguing that *should also have persons with lived experience involved at inception*, that *the mental health workforce needs turning on its head*, there is *a need for a new workforce that can emerge deep in community* and stressing the importance of *addressing people's lost livelihoods and the need for inclusion and reintegration into society*.

Box 1 – The need for radical change

"Mental health is too important to be left to the specialist, it is everyone's business."

Professor Dinesh Bhugra - Former President of the Royal College of Psychiatrists, the World Psychiatric Association, and the British Medical Association.

"Almost 90% of the funding goes to the psychiatric hospitals so there is a resistance to move that funding out or even finding new funding to put into the community or primary care levels and we are fighting against the psychiatrists. I know I am one myself but I find myself fighting them."

Dr Florence Baingana – WHO African Region Advisor for Mental Health and Substance Abuse

"We need to think about a new strategy for addressing community needs, a new workforce that can emerge deep in community by community and for community."

Dr Benjamin Miller – President, Well Being Trust

"The mental health workforce needs turning on its head. We need more specialists, because populations are growing and so the needs are growing. But we need to build up some of those first level responses in everybody. Particularly in those places that people go to: schools, workplaces, community agencies, first responders."

Helen Wood – Independent Consultant

"To fully address people's needs it need to be multi-sector, it needs to consider that mental illness is impoverishing and has a multi-generational impact, and if we don't also address people's lost livelihoods and the need for inclusion and reintegration into society then we are doing a poor job of [supporting] recovery."

Dr Charlotte Hanlon – Reader in Global Mental Health and Co-director of WHO Collaborating Centre, King's College London and Addis Ababa University

"A workforce should not only comprise of mental health professionals but should also have persons with lived experience involved at inception and have a seat at the table as their experience and knowledge is invaluable to discussions pertaining global mental health"

Claudia Sartor – Deputy CEO of the Global Mental Health Peer Network

There are already many examples of people and organisations who are leading the way globally in developing different aspects of this new approach. These include, for example, MIND in the United Kingdom (UK) in working with employers on workplace mental health,[2] the development of community support systems by Sangath in India,[3] and the work of the PRIME project around the world which has demonstrated that mental health care by general health workers increases treatment coverage in ways that are safe and effective.[4]

This report argues that there is now sufficient experience and evidence available that the time has come to build on and expand the work of these pioneers across health and care systems globally.

Chapter 1 summary
The need for action and investment

Mental health has a growing profile globally and has been given greater priority in many countries in recent years. The problems are widespread; in 2019, almost one in seven people globally were living with a mental health or substance use problem.[5] The COVID-19 pandemic has increased psychological distress globally,[6] and further increased awareness of the damage done by poor mental health and wellbeing. However, there is still not parity of esteem and equality of investment with physical health anywhere in the world. The UK is one of the few countries that has adopted this as a policy and is working towards its achievement but there is still a very long way to go.

Box 2: The need for action

Mental health problems are common
Up to one in four people will have a mental health problem over their lifetime.[7]

There is little care available
Around 60% of people living with mental health problems globally do not receive care, but this can be over 90% in low-income settings.[8]

Underfunded and under prioritised
Mental health budgets around the world are only 2% of median governmental expenditure on health[9]. Just 0.3% of international development funding is specifically for mental health.[10]

Cost impacts beyond people's lives
Estimated cost to economies around the world from mental health problems is expected to be USD $16.3 trillion between 2010 to 2030.[11]

Stigma and human rights abuses are pervasive
Stigma towards people living with mental health around the world has led to under prioritisation in policy and planning and damaging impacts on people, such as neglect and human rights abuses.[12]

Action makes economic sense
Action on mental health has returns of $3-5 USD for each dollar invested.[1]

Impact of humanitarian emergencies
Emergencies have a devastating impact on communities around the world. COVID-19 has caused psychological distress in up to a third of adults.[6]

Box 2 illustrates the extent of the problem, the lack of services and resources to tackle it and the benefits that would come from greater investment and more concerted action. Action and investment make human and economic sense, reducing human suffering and creating economic benefits from having a healthier population.

These problems are reflected in the number, distribution and challenges facing the specialist mental health workforce globally:

- There is a lack of workers around the world. Only 1% of health workers provide mental health care. In 2011, there was an estimated shortage of 1.2 million mental health workers across low- and middle-income countries (LMICs).[13] No newer figures are available but it is likely that this shortage will have increased rather than decreased.

- There is an uneven and inequitable distribution of the workforce both between richer and poorer countries and within countries, between, for example, urban and rural settings and between hospitals and primary health clinics.

- Many mental health workers suffer from stigma, and poor pay and working conditions meaning that the recruitment and retention of professionals is difficult, especially in LMICs from which many emigrate to seek a better life and conditions abroad in the so-called "brain drain"..

Greater priority and investment are clearly needed and mental health should be fully part of all policies that promote universal health coverage (UHC) and health systems strengthening in LMICs. In some countries where there has been little development of mental health services this may mean starting at a very basic level to build up the necessary policy, plans and funding over several years.

High income countries such as the UK, which have a commitment to improving health globally, have a fundamental role to play in promoting and supporting the development of policies and services in lower income countries. Mental health needs to be better integrated into the UK's development agenda with support for policy, education and training and service development.[14]

The UK and other similar countries have a particular responsibility to maintain ethical recruitment policies and implement the WHO Code of Conduct. Furthermore, there needs to be a far greater focus in development policy on educating and training health workers in LMICs and there is enormous scope for extending partnerships between health workers in the UK and those abroad for mutual learning and co-development.

The UK is, however, currently reducing its support for overseas development and thereby putting some recent development gains and its own reputation as a leader in the field in jeopardy.

There is still not parity of esteem and equality of investment with physical health anywhere in the world. The UK is one of the few countries that has adopted this as a policy and is working towards its achievement but there is still a very long way to go.

Chapter 2 summary
Continuing the development of services for chronic and enduring severe mental ill health

Continuing the development of services for chronic and enduring severe mental ill health needs to take place alongside strengthening the role of the workforce in helping people, communities, and organisations to provide care, prevent mental ill health and create health.

It is essential to recognise the full range of mental health conditions and the different services they require. Many common mental health problems, such as less severe anxiety and depression, may not require medication and can be managed with informal psychosocial support and interventions such as talking therapies.

People with chronic and enduring severe mental health conditions, such as schizophrenia, drug induced psychosis and bipolar disorder, however, need access to full psychiatric assessment and treatment including antipsychotic medication. Throughout their recovery journey, people may require different levels of service at different times.

These severe problems are a small percentage of the total prevalence of mental ill health, but often have huge impacts on the most vulnerable in society and they are where human rights abuses are rampant, from chaining to coercion, institutionalisation and stigma.

This report recognises the need for continuing investment in tackling severe mental health conditions and that the mental health services in LMICs may be very underdeveloped and, in some case, non-existent. The workforce, particularly specialists, underlie the services and care responses that are needed.

It is also essential to continue the investment in the development of these more specialist services, building up better knowledge of causes and treatments, investigating the links between neuroscience and mental illness, the use of technology in diagnosis and treatment, the different genetic and environmental factors involved, and the impact of government policies, for example, on illegal and legal drugs or on food and agriculture.

Research is needed across the whole spectrum of disorders and in relation to prevention and health creation as well as to diagnosis, treatment, care and implementation. It is essential to continue to build up the body of shared knowledge that enables mental health specialists to undertake their own direct clinical work and to lead, support and inform others.

These severe problems are a small percentage of the total prevalence of mental ill health, but often have huge impacts on the most vulnerable in society and they are where human rights abuses are rampant, from chaining to coercion, institutionalisation and stigma.

Chapter 3 summary

Widening the workforce to integrate non-professionals and engage with primary care and general health services

The central message of this report is that the mental health workforce needs to change dramatically by combining its existing professional expertise in the provision of specialist care and treatment with a greatly strengthened role in helping people, communities, and organisations to provide care, prevent mental ill health and create health. It also needs to integrate non-professionals fully and work far more closely with general health services.

This report argues that the mental health workforce needs to change in three core ways:

- Integrating non-professionals workers such as experts by experience, peer workers, advocates, community workers and others fully into the system so that knowledge can be shared, planning and management of patients can be improved and more people suffering from mental health problems can be reached.

- Engaging with health workers in primary health, community care and other settings – where most people seek care - to support them in providing care, prevention and health creation. Providing this support will enable far more people to be reached with appropriate care and treatment and, very importantly, meet the needs of the many people with both physical and mental health problems who too often fall between the two systems.

- Developing the skills and ability of specialist mental health professionals to influence practice across all health and care settings, providing expertise, advocacy and leadership for change and improvement and, crucially, providing support as required in community and non-health settings.

The mental health workforce is at very different stages of development in different countries with massive differences in investment both between and within countries. It is the lowest income countries that have the greatest shortages of health workers globally and the poorest population in any country that receive the poorest mental and physical health services.

Whatever the level of investment and stage of development, countries need to take action in all these areas - integrating non-professionals, engaging with general health workers and supporting developments in the community.

These are fundamental changes that will take planning, determination, and resources over a significant period of time to bring fully into effect. The benefits, however, will be even more significant for people, society and the economy.

It is the lowest income countries that have the greatest shortages of health workers globally and the poorest population in any country that receive the poorest mental and physical health services.

Chapter 4 summary
Working with people, communities and organisations on care, prevention and health creation

Most common mental problems and, the evidence suggests, some severe and long-term conditions can be managed effectively with a combination of specialist input, support from general health workers and from family, friends, employers, teachers, religious and community leaders and others in a locality.

These groups from outside the health system who are not part of the workforce can also have a major role in preventing mental ill health, for example, by reducing stress in the workplace, and in creating health – by which is meant creating the conditions for people to be healthy and helping them to be so.[15]

This approach means that mental health workers will need to acquire additional competencies alongside their existing professional skills. Additional competencies would need to focus on the key themes represented in Figure 1. Some of these are related to working with other health workers but most of them such as addressing the social and environmental determinants of health, tackling stigma and helping build a health creating society are concerned with engaging with people and organisations outside health.

As leaders, enablers and agents of change, health professionals will need to play an active role in integrating mental health care across sectors and promoting healthy communities. This approach will mean focusing on local solutions informed by evidence of good practice and research both nationally and globally.

Specialist mental health workers will also need to re-double their efforts to engage with a wide range of people who are not in any sense part of the workforce – family members, friends, teachers, employers, religious and community leaders, sports coaches, artists and many more – all of whom are motivated by their own concerns and interests.

In addition, specialist mental health workers will need to work more closely with bodies responsible for the environment, housing, utilities and other services to prevent mental health problems and help create the conditions for healthy living. The pandemic has highlighted the importance of the natural and built environment with, on the one hand, green spaces having a positive impact while poor housing can have the negative impact of people becoming socially isolated and trapped.

The approach advocated in this report will mean a shift in focus to providing services in more accessible settings, where all parts of the community from schools to local employers, people with lived experience, the generalist health workforce and the specialist mental health workforce can meet, collaborate and work together. This shift will mean support being available, for example, in areas such as schools, workplaces, markets and places of worship. It will mean bringing together the private, public and not-for-profit sectors in new partnerships.

There also needs to be a new and deeper understanding of prevention – tackling the causes of disease – and of health creation or promoting the causes and drivers of health. All three activities – care, prevention and health creation – are vital for the future.

Figure 1 Key themes for workforce development

Chapter 5 summary
The education and training of mental health workers for this new approach

The mental health workforce needs to take on a greatly strengthened role as leaders, enablers and agents of change in helping people, communities, and organisations in all sectors to provide care, prevent mental illness, create health, and tackle stigma and discrimination.

The education and training of all groups of health workers will need to change to support these developments including:

- A new focus for mental health professionals on becoming leaders, influencers and agents of change is needed. Informative education provides them with the knowledge to be experts, formative education enables them to become values-based and accountable professionals, while transformative education will allow them to become leaders and agents of change.[16]

- New training pathways need to be created for innovative and existing mental health roles such as experts by experience, lay counsellors, community health workers and peer support workers.

- The pre-service education of all health and care professionals will need to include comprehensive and relevant mental health training.

- Appropriate supervision, support and professional development will need to be provided for all health workers to permit continuous development of skills and practice. Digital technology can be used effectively for the training and supervision of the workforce in more remote areas.

This radical shift in focus requires health and care professionals to be constantly supporting others and looking for better ways of bringing all the resources of the community to bear on mental health and on reducing stigma.[16] This will place even greater emphasis than now on listening, influencing and enabling skills, as well as sensitivity to the fact that what may be appropriate and work well in one culture may not in another.

It is also important that health literacy and a basic understanding of mental health and mental illness is promoted among the general population.

More generally, the management of the workforce is important with governments and employers:

- Tackling stigma attached to people working in and suffering from mental illness.

- Promoting safe and healthy workplaces with competitive salaries and opportunities to progress.

- Providing fair and equal opportunities for people who have mental health problems to be employed within the workforce.

Conclusions and recommendations

This report is based on a wide-ranging review of developments in mental health staffing and practice globally.

It demonstrates the scale of change underway around the world and the way in which pioneers in every region of the world are developing new approaches based on new and current research, experience and understanding.

Cultures, traditions, resources and experiences are different in different parts of the world but there are also similarities and, very importantly, we can all learn from each other.

The report's main conclusion is that the mental health workforce needs to change dramatically by combining its existing professional expertise in the provision of specialist care and treatment with a greatly strengthened role in helping people. It also needs to integrate non-professionals fully and work far more closely with general health services.

The report also recognises the continuing importance of scientific evidence and knowledge but requires a new mindset and a better understanding of context, culture, and experience.

Resources are needed both to provide services and to support the training and development that will be needed to implement these far-reaching changes.

The All-Party Parliamentary Group on Global Health (APPG) accordingly makes the following recommendations:

There are two overarching recommendations addressed to every sector of society:

1. **Mental health and wellbeing need to be seen as everybody's responsibility** and all sectors of society need to work together to provide care, prevent ill health and build health-creating societies as well as tackling stigma, discrimination against and exclusion of people living with mental health problems.

2. **The mental health workforce needs to take on a greatly strengthened role as leaders, enablers and agents of change** in helping people, communities, and organisations in all sectors to provide care, prevent mental illness, create health, and tackle stigma and discrimination.

All governments, policy makers and international health bodies in addition need to:

3. **Develop long term plans for investing in mental health and give it parity of esteem and equity in funding with physical health. These will involve:**

   - Integrating mental health fully into all plans for universal health coverage and health systems strengthening.
   - Enabling primary care and general health services to provide mental health care services in close collaboration with more specialist mental health care.
   - Ensuring that people with lived experience are fully, fairly and continuously engaged in the development, delivery, implementation and evaluation of new services, systems and plans.
   - Supporting research into all aspects of mental health care, prevention and health creation.

The UK Government in addition needs to:

4. **Urgently reverse the cut in development assistance restoring it to 0.7% of GNI.**

5. **Integrate mental health into the sustainable development agenda**

   - The UK, Foreign, Commonwealth and Development Office (FCDO) and Health Education England (HEE) should take a global lead by prioritising partnerships and educational exchange schemes to share learning and experience in a spirit of co-development.
   - Integrate mental health into the international development agenda and ensure the impact on mental health and wellbeing is considered and evaluated in all appropriate programmes.
   - Invest in stigma reduction programmes as a core development activity.
   - Invest funding and research into developing solutions for the underlying social challenges and inequalities and the impact this has on mental health.
   - Learn from what worked and what did not work for people in mental health care and people seeking mental

health support throughout the COVID-19 pandemic and other humanitarian crises. Take forward the positive actions from these evaluations to strengthen health and social care systems and build back better.

6. Work towards responsible recruitment

- Ensuring compliance with its Code of Practice guidance 2021, which aims to implement international recruitment in line with WHO Code of Practice.
- Developing international agreements to promote equitable and fair distribution of members of the workforce.

Service providers, health professionals and professional bodies need to:

7. Develop current and new roles

- Strengthen specialist professional roles as the key to training, teaching, and supervising other members of the mental health workforce and to focus on complex and severe mental health problems.
- Work to develop and implement, new and established workforce roles that are locally and contextually appropriate, such as peer and community health workers, delivering mental health care and community support where and how it is needed.
- Develop a team approach to mental health care with a skill mix of different specialists, generalists, peer workers and community workers to provide comprehensive and holistic care within a network of support for people with mental health problems and their family.
- For paid roles, ensure competitive salaries and work benefits in line with comparative roles for physical health. For volunteer roles working within the health profession ensure clear lines of responsibility and recognise the effort and contributions of people in these roles.
- The workforce should develop their skills still further in working together with people living with mental health problems, carers, family members and traditional support systems to reduce stigma.

8. Create healthy workplaces

- Leaders, managers and staff should work together to create healthy workspaces that are safe and nurturing.
- Value managers and use available health and social care managerial training to provide a supportive work environment and effective team leadership.
- Give space for staff to talk about their own mental health and wellbeing and include people with lived experience sharing their story.

Health Educators need to:

9. Reform pre-service education and career pathways

- Embed substantial mental health content from day one in pre-service educational health care curricula.
- Include and embed people with lived experience in reorienting educational content and sharing their experiences of care.
- Create skills and competency-based education across health and mental health specialist education and promote professionals to act as agents of change in the communities they work in.

10. Support continuous development and supervision

- Invest in continuous professional development for both specialist and non-specialist staff, allowing for career, responsibility and skill progression.
- Develop capacity for supervision and leadership support, strengthening national and international training programmes, and using available online tools such as the WHO's Ensuring Quality in Psychological Support (EQUIP) training.
- Harness digital platforms to support the delivery of training programmes and use them as a way to enable remote supervision in hard-to-reach locations, and internationally.

1. The need for action and investment

"Mental health is too important to be left to the specialist, it is everyone's business."

Professor Dinesh Bhugra – Former President of Royal College of Psychiatrists, World Psychiatric Association and British Medical Association

Key Points

The Need for Action

Mental health impacts people, families, friends, communities and societies. It involves everyone and begins before birth and continues throughout life.

People living with mental health problems face stigma and discrimination in all aspects of life.

The Mental Health Workforce

The global Mental Health Workforce has been unable to meet the need for specialist care, despite numerous policy initiatives and vigorous and innovative research.

Society

Good mental health is grounded in healthy communities and society.

The mental health workforce needs to adapt to local needs, provide better care where and when it is needed, working with society and people living with mental health problems.

There is increasing awareness of the impact of poor mental health and wellbeing on families, communities and people. In 2019, just under one in seven people were living with a mental health or substance use problem.[5] With the outbreak of the COVID-19 pandemic in 2020, psychological distress has risen across the world. Mental health has never been such a clear global priority.

Mental health problems are grouped into broad main categories [see Box 3]. They impact on all areas of people's lives and across the lifespan, with most problems having their onset in childhood and adolescence. The causes of mental health problems are complex, involving a mix of interactions between biological, psychological and social causes.[1]

The Global Burden of Disease reports that mental health and substance use disorders account for 7.4% of disability adjusted life years. Mental health and substance use problems are the leading cause of years lived with disability at 23% per year.[17] It is estimated that these figures are not comprehensive and underestimate the true level of mental health problems.[18]

Discrimination and stigma are prevalent, negatively impacting people's ability to live freely and meaningfully in society.[12] Social determinates affect people living with mental illnesses in profound ways. Gender, economic status, access to services, forced migration and trauma, to name a few, all play important roles in the establishment and ongoing lived experience of people with mental health problems.[1]

The treatment gap surpasses 60% globally but can be over 90% in low-income settings.[8] The overall care gap is much larger when considering all services needed for effective care, such as access to psychosocial and physical health care.[19] The majority of care often falls on families and communities, care which is often unseen, unpaid and unrecognised.

Mental health has been unprioritized and underfunded, with mental health budgets being around 2% of median governmental expenditure on health around the world.[9] The estimated cost to economies around the world from mental health problems are expected to be USD $16.3 trillion between 2010 to 2030,[11] equivalent to 12 billion working days lost. Despite this, action on mental health makes sense economically, with returns of between $3-5 USD for each dollar invested.[1]

Box 3 Types of Mental Health Problems

Mental health problems can be grouped into the following broad categories

- **Common mental health problems**
  Typically including anxiety, depression and related conditions
- **Severe mental health problems**
  Rarer and more severe mental health problems including bipolar disorder and psychosis
- **Substance use problems**
  Misuse of substances including alcohol and drugs
- **Developmental problems**
  Problems starting from birth, such as intellectual, sensory, and social impairments, including autistic spectrum disorders and cerebral palsy
- **Child behavioural and emotional problems**
  Behaviour and emotional problems in children, including attention deficit and hyperactivity disorders
- **Neurological problems**
  Problems which affect the neurological system, such as epilepsy and dementias

  In some settings (particularly in LMICs) neurological problems are included under mental health care

The sustainable development goals (SDGs) require cross collaborative work across society and within communities to be achieved, especially in regards to providing comprehensive health coverage. Mental health is part of and is integral to obtaining the SDGs and UHC. It should not only be integrated in health, but into all aspects of society as part of sustainable development. This includes investment in cross-sector areas such as housing, education and employment. The Lancet's Commission for Global Mental Health and Sustainable Development[1] and the APPG's work in 2014[14] provide comprehensive overviews of integrating mental health into development. For further detail on mental health policy, see Appendix 1.

The COVID-19 pandemic has highlighted the importance of accessible quality care and the vulnerability of everyone to ill mental health. Although countries have not been affected equally, there has been a shared global experience. The workforce has been at the forefront of COVID-19, where it has placed unprecedent burden on health workers with predicted substantial and long-term impact .[20]

The workforce

For decades, the challenge of inadequate capacity of the mental health workforce has been recognised with effort to scale up mental health services going hand in hand with calls to increase, train and support the workforce.[21] The 2011 WHO Mental Health Atlas estimated a shortage of 1.2 million mental health workers in all LMICs[13] with only 1% of the worlds health workforce providing mental health care.

Traditional health professional roles range from specialists such as psychiatrists, psychologists, mental health nurses to generalists such as family doctors, occupational and physical therapists. Comprehensive mental health care must refer to and support the care provided by the community, wider society and of course, family, peers and carers. It is important to recognise, however, that these last groups have their own roles, priorities and motivations that may have nothing to do with mental health and should not be seen as part of the mental health workforce. A faith organisation may provide care, for example, but its prime motivation is religious.

Mental health specialists	Generalist	Society	
		Community	Family, peers, friends and carers
Psychiatrists Psychologists Mental health nurses Licensed therapists and counsellors Mental health social workers Peer Workers (experts by experience)	Nurses Doctors Midlevel health workers Occupational therapists Pharmacists Health aids/assistants Lay and Community Health workers Social workers	Faith and traditional healers Teachers Community leaders Volunteers Other community service roles (such as first responders)	Service users Families Carers Mentors

Table 1 Example mapping of the composition of the mental health workforce including roles within wider society

A general overview of health professionals and those within wider society is presented in Table 1.

In 2017, the Mental Health Atlas showed an almost universal shortage in the mental health workforce.[9] The global median was just 9 mental health workers per 100,000 people, with a stark global variance, ranging from just under 2 in 100,000 in low-income countries to 72 per 100,000 in some high-income countries. Nurses by far make up the largest profession ranging from 30 - 50% of the workforce, whilst the global mean for psychiatrists is 1 per 100,000, with high income countries having roughly 120 times more psychiatrists than low-income countries [see Figure 2]. The majority of the existing workforce is often unevenly distributed, situated in large urban centres and in higher income countries, meaning that access to appropriate services is impossible for many.

An updated Mental Health Atlas is due in 2021 but has not yet been published. It is likely to show that the shortage in trained professionals remains substantial and critical around the world – from high resource to low resource settings.

The purpose of this report

With these challenges at the forefront, this report recognises the longstanding issues in building an effective mental health system and workforce. The report seeks to outline how the workforce can be built to transform mental health.

The central message of this report is that the mental health workforce needs to change dramatically by combining its existing professional expertise in the provision of specialist care and treatment with a greatly strengthened role in helping people, communities, and organisations to provide care, prevent mental illness and create health.

Internationally, the complex impacts of mental health mean that substantial resources are lost in developing economies, impeding growth and poverty reducing efforts. This report seeks to outline what key areas in mental health resources are best to invest in and strengthen around the world. Now is the time for governments to increase resources in overseas development for mental health, and for the UK, reverse the large cuts to the aid budget seen due to reduction from 0.7% to 0.5% of GNI.

To refocus the workforce, the following steps will need to be taken:

- Ensuring care is available, of high quality and conducive to their human rights for people living with mental health problems

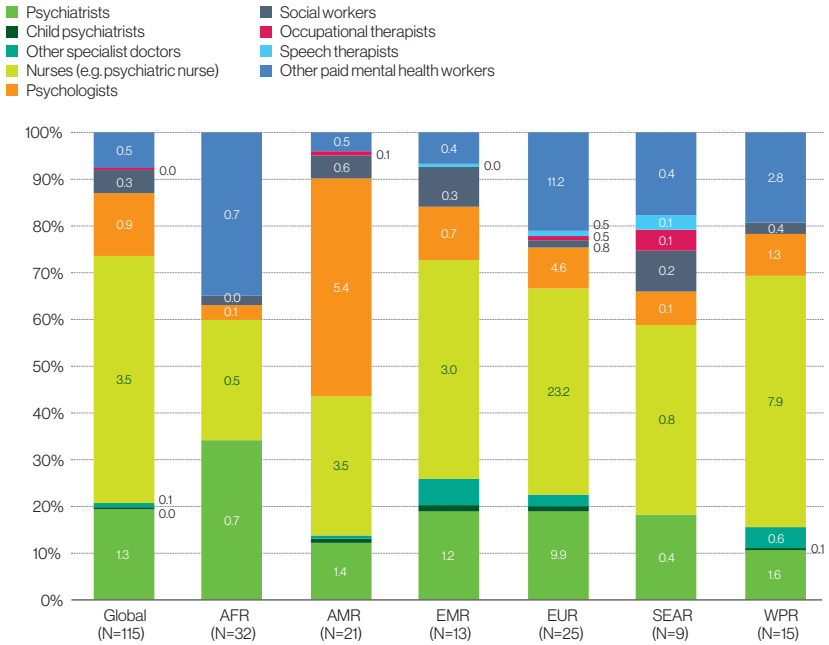

Figure 2 Estimates of mental health workforce. Breakdown per 100,000 population, reproduced from the Mental Health Atlas 2017, World Health Organisation.[9]

- Supporting community roles and services-based provision.
- Adapting and developing roles, from specialists through to community health workers and peer support workers.
- Reorienting policies and plans for effective mental health care, with society at the core.
- Addressing stigma and discrimination head on throughout society.
- Developing and adapting training, supervision and leadership programmes.

As the workforce changes in the local context to support society, there are key factors to sustain this change around the world:

- Career structures, progression and development need to be in place, with competitive and comparable salaries to other health professions.
- The mental health workforce must be a healthy one to work in, just as it works to create healthy communities.
- Local solutions, led by an informed understanding of the community, environment and culture, must be developed.
- An international environment of mutual development, research and understanding needs to be promoted.
- Governments around the world must ensure that ethical practises are implemented for the recruitment of the mental health workforce.

As part of developing this report, witnesses were invited to participate in evidence sessions, hosted by the APPG on Global Health, and stakeholders, through individual interviews and written submissions from October 2020 to March 2021. They include a wide range of professional backgrounds and expertise in the field of mental health and represent different countries and settings. Bringing stakeholders' views together with an overview of best practice, this report hopes to kickstart a global response to reorienting the mental health workforce and improving mental health and wellbeing around the world.

2. Continuing the development of services for chronic and enduring severe mental ill health

"All countries need access to medically lead multi professional mental health diagnostic and treatment services, as well as long term support from expert nurses and other mental health workers, if we are to reach the sustainable development goal of global access to comprehensive health care."

Baroness Mary Watkins, Visiting Professor Florence Nightingale Faculty of Nursing, Midwifery and Palliative Care, Kings College London

Key Points

The right to health

- People with chronic and enduring severe mental health conditions require access to appropriate, accessible care
- Care must be person-centred, recognising the autonomy and dignity of people and to be non-coercive
- Innovative rights-based approaches in care provision have arisen around the world. The workforce should be aware of these developments, and integrate and adopt these approaches within their local services

Stigma and discrimination

- Stigma and discrimination are ubiquitous throughout health services, the community and society
- Training, social contact and development of peer worker roles can help reduce stigma within the workforce
- There is evidence around the world for wider societal action on stigma and discrimination that should be part of any mental health policy plan

Improvement, research and building back better

- The research workforce has many roles to play including the improvement and localisation of mental health interventions and developing an understanding of the relationships between mental health and other factors such as the environment or policy
- Ensuring that the lessons from COVID-19 and other humanitarian crises around the world lead to service improvements, new ways of working and prioritisation by governments to improve care

Continuing the development of services

The core obligation of the right to health is to ensure "the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups."[22] People with mental health problems need, and have the right to, evidence based and rights-based approaches to their care.

Many common mental health problems, such as less severe anxiety and depression, can be managed through informal support and health interventions such as talking therapies, and may not require medication. People living with chronic and enduring severe mental health conditions need access, if they wish to utilise it, for comprehensive mental health specialist assessment and treatment including the use of appropriate antipsychotic medication. What matters is that the system provides care when and where it is needed, in a way that responds and centres to the needs of the people who use it, and to a high quality.

These services should be person-centred and grounded in maintaining the dignity, human rights and autonomy of service users. Services should shift focus from treatment to supporting people on their journey to develop meaning and purpose beyond their experience of mental illness.

Stakeholders made clear that, despite advances over the past decades, mental health services are still siloed into inpatient or hospital-based care instead of much more accessible community-based options. In South Africa, for instance, attention was drawn to much of the funding still entering institutions instead of supporting the development of community based mental health services.

In order to develop balanced care systems, policy makers can refer to multiple tools such as the WHO's 'optimal mix of services' [see Appendix 2], which outlines how services should be built in terms of need and resource allocation. Each layer of the care system should be considered in terms of the 'balanced care' model [see Appendix 3] and need to be grounded in service delivery methods such as collaborative care, stepped care and community care [see Appendix 4]. Ultimately the aim is for these services to provide a full suite of evidence-based care, integrated across sectors to meet the health and social needs of the person. Case Study 1 provides an overview of the steps Peru has taken to strengthen their mental health system over recent years.

International support and collaboration are key to success of mental health reforms. The WHO Special Initiative is supporting up to 12 countries over 5 years (2019-2023). The initiative has the aim to increase UHC through scaling up and creating affordable mental health care.[23] It will address top-level issues such as creating policies and plans, focusing on human rights and advocacy, as well as providing direct funding to augment the mental health budget.

At the core of this is a locally appropriate mental health system set up that has clear points of entry to services. The WHO has recently released guidance on how systems and services can be organised to provide effective, human rights based care, providing much more detail on concepts covered in this report.[24]

"As a rough context, of all the disabilities affecting all the people in the world, how much is attributable to mental health problems? The answer is between 23%-32%, depending on how you measure this. But is it true that governments spend this proportion of their health budgets on mental health? Absolutely not"

Professor Sir Graham Thornicroft – Professor of Community Psychiatry, Institute of Psychiatry, Psychology and Neuroscience, King's College London.

Providing care

For many people around the world, traditional mental health services have helped them recover and heal from mental ill health. For the current workforce, these services are often where expertise has been developed and traditional career pathways and training have been provided.

The powerful speciality training of psychiatrists and other specialist roles such as psychiatric nurses are and will continue to be an essential and invaluable resource around the world.

Their training in providing care to people with the most complex mental health problems offers a foundation for other care to take place. Stakeholders heavily emphasised that there is not a choice between specialists and generalists, all mental health systems need both to be effective.

Comprehensive mental health services, depending on resources and capacity, may include:

- Early intervention services for people experiencing a first episode of a severe mental health problem
- Crisis care for when there is a direct or immediate threat to a person's wellbeing
- Rehabilitation services to ensure care is provided to help people regain the skills and confidence to live in the community
- Liaison services for mental health support for people with physical health problems

In crisis care, for example, where people need immediate support, specialist care must be there to provide a response 24/7.[25] The ideal outcome is to alleviate the mental health crisis and prevent admission into inpatient care. People should be assessed and provided with initial care in the community. Then, collaboratively with their care team, they need to develop a long-term plan to help them recover and support them in the future. Crisis services can be offered by a wide range of providers, including local mental health services, voluntary or community providers, crisis phone

lines or crisis walk-in locations with places of safety, and the persons support network.

For vulnerable groups and in places where access to care may not be equitable, such as in rural areas, services should adapt to ensure that coverage is available. This can be difficult for services to do with a lack of specialists around the world. Case Study 2 highlights Rwanda's action to support mental health care in rural settings.

The use of digital services, including text lines, phone lines and video calls help bridge the gap in settings where access to care may be a challenge. Culturally appropriate care, which is also sensitive to language and family structures, should be provided when needed.

Integration of services is the key to effective care and prevention. Later in this report, integration will be highlighted as part of system wide change and the essential and needed movement of mental health care into primary care services. However, just as in crisis care, integration within the services themselves will help specialists work much better across the spectrum of help.

Young people facing increasing burden on their mental health and suicide is a leading cause of death in 15 – 29- year-olds.[26] Prevention and early intervention is key. One way in which the specialist workforce can support them is via service 'hubs'. In Australia, headspace hubs are such locations, supporting access to care and providing a one stop shop for young people to support them with their mental health, physical health and alcohol or drug use.[27]

Integration should happen with wider health services too. Non-communicable diseases, such as diabetes and heart disease, share common features with mental health and are intertwined, often related to each other and occurring as co-morbid conditions. Integrating care between specialists and physical health practitioners will enable care for the whole person, as opposed to focusing on the problem related to the practitioners speciality.[28]

The physical health of people with mental health problems is too often left behind or forgotten and contributes to the large live expectancy differences of up to 30 years for people with severe and enduring mental health problems.[29] Mental health specialists must provide physical health care, including smoking cessation or healthy activity programmes, or when expertise is lacking, work with physical health speciality practitioners.[29]

The multi-disciplinary team is at the centre of all services, including allied health professionals such as social workers, occupational therapists and pharmacists. These roles are essential in supporting ongoing care, accessing services, rehabilitation, recovery and the reintegration of people with mental health problems into society. However, stakeholders noted that these professionals are often missing in mental health teams and that there is lack of training, both in initial occupational and ongoing professional development.

The whole system approach at a local level

In the UK the Living Well System[89] is a collaborative organisation which aims to provide mental health care through a single point of access. Local stakeholders from across health systems, commissioners, service users, care givers and voluntary sector partners all came together to shift investment from secondary services into primary and community care.

The Lambeth Living Well System has shown to increase the number of people in support, including using a personal care budget to improve their own wellbeing. This has reduced waiting times, referrals to secondary care and reduced cost of care.

As a nexus of experience and expertise, specialists work as parts of teams for the most complex cases, but can also support colleagues independently. Their roles must be sufficiently regulated, with both legal and clinical mandates needed for their work. Specialist services led by psychiatrists, or other workforce roles, can leverage their expertise, technical training and knowledge of the local service environment to ensure that appropriate care is available. Around the world, this specialist input can transform services and the quality of care delivered.

Case Study 1
Improving the mental health system: Peru

Peru, an upper middle income country, recognised the heavy burden of mental ill health on their population, with 1 in 5 Peruvians affected by mental health problems each year and only 12.8% of people who need care, receiving it.[90]

To address this, Peruvian health leaders and multi-sectoral collaborators launched a series of community-focused changes to the mental health services, including:

- Reforming psychiatric hospitals, with new financing and care models and developing these hospitals as learning institutions, to increase innovation and partnership.
- Implementing a strategy for the integration of mental health into primary care.
- Developing community based mental health care centres and community treatment modalities.
- Developing supported living for vulnerable women.

Although there were challenges during this process of strengthening the Peruvian mental health system, there were key strategies, which supported these system changes:

1. Technical and robust set of actions, in line with international evidence and championed by experts.
2. Structural changes, especially in the national insurance scheme financing mental health.
3. Positive advocacy by supporters of change.
4. Cross-sectoral changes addressing other social challenges that impact on mental health.
5. Collaborative implementation and partnerships across national and local levels.

Rights based approaches to care

The 'Convention on the Rights of Persons with Disabilities (CRPD)' was adopted worldwide in 2007. The CRPD promotes, protects, and ensures the full and equal enjoyment of all human rights and fundamental freedoms by all people with disabilities, and promotes respect for their inherent dignity.[30]

It is important to acknowledge that some traditional mental health services have left many people receiving care that does not respond to their needs, and may actively coerce, dehumanise or infringe on their rights.[22]

Under rights-based approaches, service users are central to the provision and decision making of care. They are treated with dignity and autonomy, and without any coercion.[1] The workforce should be aware of how care may not work for people and build a health system that respect people's needs and rights.

Care should be grounded within the principles of recovery, which centralises the person with mental health problems in identifying what will help them to have a good quality of life, with valued social roles, irrespective of the extent of their mental ill health or disability, because they are receiving the right kind of support and care. An individual recovery journey being best defined and judged by the person with mental health problems themselves.[31]

Inclusion of people with lived experience is an instrumental part of delivering care through a human rights approach, providing expertise by their experience to what services should look like and the roles of the workforce in providing them. This will be discussed later in this report.

Open Dialogue[32] is one example of an innovative approach to providing services that breaks down hierarchal power structures between mental health specialists, service users and their families and support networks. It is centred around autonomy, dignity and generating agency for change during crisis. Approaches such as this have impacts both on how services are delivered and organised, but also on changing the way that the workforce work with people with mental health problems.

Case Study 2
Inshuti Mu Buzima: Rwanda

Inshuti Mu Buzima, a collaborative project between Partners In Health and the Rwanda Ministry of Health, sought to tackle the problem of providing effective care in rural settings with limited specialist workforce members available.[91]

Together, a general health programme called Mentoring and Enhanced Supervision at Health Centers Model was adapted and implemented for mental health in Burera district, Rwanda. The model focuses on the effective utilisation of specialist psychiatric nurses to support the delivery of mental health care through supervision and training of the generalist workforce.

There are several components:

- Training of 40 hours for general nurses in health centres for four major mental health and neurological problems; schizophrenia, bipolar disorder, major depressive disorder and epilepsy. Community health workers also had training on severe mental health problems.
- Supervision from weekly visits by government psychiatric nurses.
- Implementation of the WHO's Problem Management Plus intervention.
- Rehabilitation in the community through community outreach and income generating activities.
- Switching to an electronic mental health records system.

There are marked improvements in quality of care for people living with mental health problems in the district, with large reductions in symptoms and disability. Wider impacts for service users meant large reductions in those unable to work (51% down to 6%) and of households reporting caregivers having to leave work of their own (41% to 4%).[92]

The programme is now being expanded out to Kayona and Kirehe districts, which will cover close to 1 million people once completed.

Addressing stigma and discrimination

Stakeholders were clear that stigma is pervasive and can be found throughout the whole of society. It has led to a range of damaging impacts including the neglect of individuals and mental health services, as well as human rights abuses around the world. Its impacts are diverse:

- In daily lives, stigma has a huge impact on people living with mental health problems, affecting their quality of life, relationships, job security, and their help seeking behaviours.

- At a structural level, mental health is often side-lined in policy development, legislation and funding allocation. This can mean poorer quality or fewer number of mental health care services compared to physical health care.

- In the workforce, stigma affects the ability to recruit and retain staff, as well as influencing the attitudes and behaviours of service providers.

Whilst stigma attitudes permeate through both the wider health field and within the mental health workforce itself, they mainly manifest in two key ways:

- The first is the impact on people who use mental health services, leading to feelings of being devalued, dehumanised and dismissed by many health professionals. Reports of coercion and being left out of their own care decisions is common, with health professionals seeing "the illness ahead of the person".[33]

- The second is a reluctance or lack of awareness from health workers to provide care to people with mental health problems.[34]

For the workforce to be developed and provide effective care to those who need it, stigma must be addressed at all levels from resource prioritisation, to training, and within the attitudes and practices of the workforce itself.

There are many evidence-based methods to challenge stigma in the workforce, including transformative training, social contact, embedding person-centred care and the development of peer support roles within services and in the community.

Societal action on stigma and discrimination, as part of a wider actions on social justice, must be part of any mental health plan or policy. There is now evidence for action on stigma in the general population around the world. The pioneering work of the Time to Change campaign in England demonstrated positive change over time in knowledge, attitudes and behaviour related to stigma and discrimination.[35]

The primary mode of action is to promote 'social contact' between people who do, and who do not, have lived experience of mental health problems as key active ingredient in stigma reduction. The core approaches and principles also emphasis leadership by people with lived experience and focused grassroots strategies as essential to sustainably address stigma in communities.

"[People with lived experience] sharing their recovery stories is one of the most effective ways of breaking down stigma, but unfortunately as you can imagine, in other countries or in more rural settings, stigma actually prevents people from sharing their stories as they are afraid of what will happen to them, if they will be judged or discriminated against."

Charlene Sunkel – Founder and CEO of the Global Mental Health Peer Network

Research and implementation

Research plays avital role in developing knowledge and understanding and improving mental health services in all aspects from therapy to prevention and health creation. Two particularly important aspects in the context of this report are:

- Supporting the development and implementation of mental health care delivery within the local context, through capacity building, evaluation and localisation.

- Pursuing the understanding of the links between peoples lived environment, genetics, neuroscience and policy that enables health creating communities and new interventions.

Stakeholders from Georgia and Tunisia discussed the need for local evidence to be generated and used in practice and policy making. Without this it is challenging to implement new services, which are known to work in other settings. Localisation of mental health services will be discussed later in this report.

Local research strengthening projects are needed. They build capacity for locally led initiatives and research, allowing policymakers, health professionals and people with lived experience to understand what works best for them, within their context and resources. The African Mental Health Research Initiative (AMARI) is a successful example of this type of project, aiming to build research capacity in the local context in Ethiopia, Malawi, South Africa and Zimbabwe.[36]

The research workforce must expand its view of mental health in line with the vision of this report. Providing evidence not just for treatment and care, but also for health creation and prevention.

Understanding the underlying factors impacting on mental health is essential to preventing it early and creating good healthy communities. Unhealthy workplaces can lead to worse mental health now and in the future. Environmental factors, such as air pollution and the lack of green space access can impact on good mental health.[37] Economic recession and debt are a major factor in depression.[1] Only through research can these factors and their relationship with mental health be understood and addressed.

Developing mental health systems and services is complex and requires intensive work. Therefore, within research, it is also important to build expertise in implementation and improvement science.[38] This will allow policy makers to implement programmes and assess what elements of a mental health system are working, or are not working, and why.

Building back better

The UN estimates that 1 in 33 people were in need of humanitarian assistance in 2020, up one third from 2019.[39] Crises have a grave effect on people, triggering stress-related disorders as well as worsening existing ones; one in five people will develop a new mental health problem.[40] However, humanitarian crises, whether resulting from natural or human disasters, can help to force services to be nimble, pivot and respond to changing contexts. The aim is to maintain essential and ongoing services whilst adding other complementary services where needed.

Up to a third of adults around the world have now experienced COVID-19 related psychological distress.[6] COVID-19 disrupted services and treatment, increased stress on health workers, on individuals and families living with mental health problems, and impacted on vulnerable groups such as children, older adults, and women.[41] In light of all these challenges, the commendable actions of the mental health workforce around the world during the pandemic cannot be understated.

Stakeholders spoke of how mental health services and their workforce have been hard hit and disrupted during COVID-19. For example, staff in Qatar and the UK were shifted away from mental health services to medical services, and some mental health beds became acute physical care beds. Other stakeholders also discussed the economic strain, causing 'non-essential' services or funding to be paused or redirected, such as pausing the roll out of the mental health gap action programme (mhGAP) in Ukraine.

Adaptation of services has been key to providing care during the pandemic. Stakeholders suggested COVID-19 is pushing mental health support out into community services and away from in-patient care, as care is forced to happen at home to maintain physical distancing.

Similarly, there has been a surge in the uptake of using electronic and virtual forms of contact and therapy, particularly in middle and high income countries[42]. Remote platforms that have already been developed are now being utilised, such as tele-conferencing, self-help apps, online coaching or therapy.

Experts by experience recognised that COVID-19 had already broken-down stigma as people who have never experienced mental health problems before have been exposed to increases of stress and anxiety due to the

pandemic. As awareness and understanding increases, this opens up conversations about mental health in wider society and allows for greater prioritisation by policymakers.

The approach within humanitarian crises has been to 'build back better'.[43] With this in mind, the current COVID-19 crisis is an opportunity to stimulate building back better systems and services, particularly within mental health.[20] Just 0.3% of international development funding is specifically for mental health.[10] To changes this, high resource governments should increase contributions in line to the UN recommended contribution of 0.7% of gross national income and increase relative contributions to mental health programmes as well as integrating mental health into other relevant programmes.

The proposals in this report to strengthen the workforce and expand how it works with society and health systems, can be an integral element of developments as mental health services look to the future.

3. Widening the workforce to integrate non-professionals and engage with primary care and general health services

"The mental health workforce needs turning on its head. We need more specialists, because populations are growing and so the needs are growing. But we need to build up some of those first level responses in everybody. Particularly in those places that people go to: schools, workplaces, community agencies, first responders."

Helen Wood – Independent Consultant

Key Points

Widening the workforce

- The role of health professionals is changing and there are many new, expanding roles for the mental health workforce.
- Peer support workers, lay health workers, mid-level professionals and other professionals such as psychologists should all be part of the mental health workforce.

Integrating mental health with physical health services

- Roles are changing throughout mental health systems to meet and work with the community and society.
- Integrating mental health into primary health care and across society is a priority.
- Working as teams, across specialists, generalists and the community will underlie changes to mental health care.

Agents of change and advocacy

- The mental health workforce needs to be able to act in a transformative way, to implement global evidence locally, apply education and training to their communities and work adaptably among teams.
- As agents of change, the workforce needs to be able to advocate for mental health care that meets people's needs and is delivered when and where it is needed.

Widening the workforce

Peer workers

The inclusion of people with lived experience in the provision of good mental health care is the next key step in the development of the mental health workforce. In high resourced settings, peer support workers have already demonstrated the positive impacts of such roles on both the service user and the peer worker.[44] The benefits include reduced admissions, improved social function, empowerment, hope giving and aiding the recovery journey of the peer workers themselves.

Utilising their own lived experience of mental ill health and care, peer support workers roles are built on the premise of recovery and can provide practical support, guidance and understanding during care and onwards through recovery. The development of this role is aligned with human rights approaches and person-centred care. The role can act as part of existing mental health services alongside specialist mental health workforce members. However, they can also lead and help deliver peer-led services, including support groups.

Stakeholders from various settings spoke of the importance of working with and including people with lived experiences as a progressive and important change to mental health systems and services. In New Zealand, there are now clear career and training opportunities for peer support workers to be formally part of mental health teams. Peer workers should be viewed and accepted as part of the team and have access to structured career opportunities across mental health services, whether in hospitals or within community mental health teams.

Case Study 3
Using Peer Support in Developing Empowering Mental Health Services (UPSIDES)

UPSIDES (www.upsides.org) is an international consortium looking to scale up peer support in services for people with severe mental health problems.

Recognising the untapped resources and powerful impact of people using their own lived experience in care, UPSIDES is building evidence and capacity across the world for peer support.

Bringing together stakeholders from the UK, Germany, Israel, India, Uganda and Tanzania, the project not only seeks to build capacity and evidence but has produced learning for all around the world to implement peer support.

The programme has six key objectives, that are key steps for any capacity building:

1. Establishing an international community of practice for peer support
2. Developing a situational analysis for peer support
3. Scaling up existing models of peer support
4. Adapting and contextualising peer support to the local context
5. Evaluating the project
6. Sharing best practice with local, national and international stakeholders

Though currently undergoing a randomised controlled trial, the Peer Support Worker Training Manual and Workbook, provides the training material to build peer support capacity based on their work. This will also be part of an online training platform.

Peer workers can act as a counterbalance to traditional health professionals, helping to reduce feelings of discrimination and isolation that are common throughout service users' experience. Peer support workers can have further impacts on their teams and help can reduce stigma amongst mental health professionals.

As initiatives to include peers into the workforce grow around the world, they need to be evaluated to strengthen and develop the evidence base.[45] UPSIDES, [Case Study 3] is one project working towards this evidence from locations around the world. With this understanding, policy makers can ensure that the inclusion of people with lived experience into the workforce is not made as a token effort but can have significant positive impact on the delivery of care and its quality.

Lay and community health workers

"Patients told me they never had someone before listen to their problems or speak so politely [to them]. We learnt we did not need to solve their problems, but to help them find ways to cope, to communicate with their family at home and found their own solutions."

Pranali Kundaikar – Lay Counsellor, Sangath, India

Non-specialist lay or community workers have been a key pillar of global health for many years. There is now a rich evidence base that the mental health care they provide is effective and well accepted by communities. Whilst they take a variety of names and roles, they closely work within the community and act as a link to, or as part of, primary mental health care.

There is substantial evidence for supporting non-specialist health workers in LMICs to deliver interventions for people living with mental and substance use conditions. The evidence is clear across the world that they can improve recovery rates and reduce symptom severity.[46,47]

These roles should be integral to the mental health care and considered as core part of the global mental health workforce. As frontline lay counsellors in India highlighted, they had the time to listen and work with service users, whereas the doctors and medical officers in the primary health centres were seeing 100-200 people a day. Training of these professionals can bridge the capacity gap for primary health care staff at a lower cost.

Although lay workers will not solve the workforce shortage on its own, it has the potential to change the dynamics between mental health professionals and the community.[13] They are well placed to deliver culturally relevant care that is community centred. In Pakistan, for instance, the psychosocial intervention 'Thinking Healthy Programme' helps perinatal women with depression, supporting them as a vulnerable group at a critical time, where other services do not exist or may not be appropriate.[48]

Violence and Alcohol Treatment (VATU) trial, Zambia

The Common Elements Treatment Approach (CETA) is a model of care, based on evidence-based interventions for mental health problems specifically in resource settings that rely on non-specialist providers. It has been used around the world, but as part of the VATU trial in Zambia,[93] being deployed by lay counsellors.

The approach, which is implemented by lay counsellors, who are trained in an apprenticeship model and working in community settings, is showing reduction in intimate partner violence (IPV) and hazardous alcohol use.

Mid-level professionals

Mid-level professionals are emerging around the world, including clinical officers or nurse practitioners. Working with and in close proximity to the community, these roles offer a chance for systems to bridge the care gap as part of an effective workforce. In order for these roles to be best utilised, they need to be properly planned in the organisation of services and supervised adequately, which is often not the case.[49]

Mental health mid-level roles and clinical officers now exist in LMICs such as Sri Lanka,[50] and Kenya.[51] They are often working in more rural or remote areas and are able to provide quality care for a fraction of the cost of other health professionals, who can take longer to train.

Nursing

Nursing roles are of global significance as they make up the majority of the formally employed mental health workforce,[9] as well as accounting for approximately 59% of the overall health workforce.[52] The nursing profession should be expanded and maintain its key part in the mental health workforce, as it includes both specialist and non-specialist mental health workers and it can act as a bridging role between the two.

Evidence from high-income countries shows that nurses delivering health care compared with doctors have equal or better outcomes for a range of illnesses and, in particular, for chronic conditions.[53] This huge potential means that nurse-led services, especially in countries where there are less doctors, are pragmatic and can reduce training costs and time, and deliver care to a high standard.

In Ethiopia, for example, the health service has established a psychiatric specialisation for nurses to help with the overall shortfall of mental health specialists. Some of their responsibilities included identification and management of mental health problems, counselling, prescribing medications and providing prevention and community based education.[54]

Stakeholders reported that nurses are often the only therapeutic agents, working with families and people with mental health problems. The Triple Impact report by this APPG highlights the benefits, such as reducing gender inequality, to society when professional nurses are developed and deployed into the workforce.[55]

Psychology

Utilising existing resources can allow mental health systems to further bridge the care gap. Psychology is a popular university undergraduate degree, but often these courses do not translate directly into a workforce role that can provide care. Multiple stakeholders mentioned the unharnessed potential of using psychology, or similar graduates, to deliver mental health interventions. In particular, for low-level therapies targeted at common mental health problems.

In Qatar, for example, psychology graduates have helped to run a new COVID-19 national mental health help line to provide education and support, reducing the impact of COVID-19 on stress and anxiety in the community.

The UK's Increasing Access to Psychological Therapies (IAPT) services uses this approach as a way to offer therapy to more people at the community level. People with common mental health problems are seen by a psychological wellbeing practitioner, who train whilst working, often with a related or applicable undergraduate degree. Step-up care is available with senior therapists or clinical psychologists. This approach is effective and works in those with anxiety and depression.[56]

Allied health professionals

Allied health and social care professionals are workforce roles that can provide additional support at steps along the recovery journey. They include but are not limited to social workers, occupational therapists and pharmacists. They are what makes up the multi-disciplinary team, supporting traditional specialists such as psychiatrists.

Stakeholders noted that these professionals were often missing in teams around the world. These roles can provide essential input to facilitate accessing services, and promoting rehabilitation, recovery and the reintegration of people with mental health problems into society and the workplace.

Occupational therapists, for example, can provide the skills and the confidence for people living with mental health problems to participate in their community and develop the skills for independent living, such as managing finances or safety after having received mental health care.

Principles of mental health integration

"Almost 80 to 90% of the funding goes to the psychiatric hospitals so there is a resistance to move that funding out or even finding new funding to put into the community or primary care levels and we are fighting against the psychiatrists. I know I am one myself but I find myself fighting them."

Dr Florence Baingana – WHO African Region Advisor for Mental Health and Substance Abuse

The integration of mental health care refers to the process of embedding mental health services into wider health systems,

across all public sectors into the community. Policymakers should consider this integration in three main ways:

- Location: away from the provision of care solely in hospitals, to a mixed model of hospital and community care, with a focus on providing comprehensive care in primary health care settings.
- Services: away from siloed 'vertical' service provision, to mental health being embedded 'horizontally' and in parity with physical health care.
- Sectors: away from the confines of the health system, into community sectors, such as a schools and workplaces.

The WHO Mental Health Action Plan is a starting point for policymakers in developing their mental health systems. It comprises targets that can help guide and measure the improvement of mental health systems.[57] Mental Health should also be integrated as part of action for the SDGs and universal health coverage [see Box 4].

The integration of mental health services needs to be balanced and take into account local priorities. For stakeholders in Eastern Europe, developing primary health care models for mental health is the priority, as the majority of care is still provided at psychiatric institutions or tertiary centres. However, they acknowledged that community-based services need the back up of in-patient care for people experiencing a mental health crisis and people with complex needs, as recommended by the Balanced Care Model and the WHO optimal mix of services.

Box 4 Integrating mental health into universal health coverage; cost of scale and prioritisation

Development of Universal Health Coverage (UHC) is the key policy agenda for health services around the world. Integration of mental health into UHC is critical to its success and to developing a mental health system that can deliver effective, appropriate and timely care.

"No Health without Mental Health": The Urgent Need for Mental Health Integration in Universal Health Coverage'[94] by United for Global Mental Health outlines integration as:

- Including mental health care in all relevant aspects of health systems, such as health promotion, illness prevention, treatment and rehabilitation.
- Putting mental health care on a par with and – where relevant – accompanying physical health care.
- Ensuring mental health conditions are covered by population-wide financial protection measures.

The report details that scaling up services to meet the coverage below, will require 5%-10% of the health budget for 5 main conditions, depending on income level. This will achieve an increase in treatment coverage by 2030 as presented below:

	Low income		Lower-middle income		Upper-middle income		High Income	
Change in coverage by 2030, by resource setting, as a result of increase in investment	Current	Target	Current	Target	Current	Target	Current	Target
Anxiety disorders	10%	89%	14%	55%	22%	78%	37%	85%
Depression	10%	89%	14%	55%	22%	78%	37%	85%
Psychosis	11%	90%	31%	72%	37%	93%	51%	99%
Bipolar disorder	10%	89%	14%	55%	22%	78%	37%	85%
Epilepsy	25%	100%	35%	76%	45%	100%	90%	100%
% increase in coverage by 2030	79%		41%		56%		48%	

Primary care

In terms of integration of mental health into wider health systems, the international focus is on providing effective mental health care for both common and severe mental health problems in primary care settings. Stakeholders were clear that primary care was already the location that serve mental health care around the world, but lack the capacity, training and specialist support do so effectively. Effective primary care for mental health is a fundamental aspect of achieving UHC.

Primary care mental health support is complex and requires a broad range of skills, roles and training. Primary care workers should be involved in screening, diagnosing, treating, and coordinating support in the community to ensure effective rehabilitation and reintegration, as well as providing outreach services and prevention activities. Through a wide range of services, primary care should be able to address most mental health needs.

The specific role of primary health care workers depends on the staffs' level of training and in-country regulation of the professions, such as primary care doctors compared with nurses, health officers or social workers. For instance, lady health workers in Pakistan are primary health care providers, but act in a community-based role before access to a primary health care doctor.

These roles are developing to build mental health into their provision of care, especially through programmes such as the WHO mhGAP programme.[58] Stakeholders maintained that these skills should be taught and built in general primary health care staff and supported by specialists, as opposed to capacity building programmes aimed at mental health specialists acting as the sole pathway to care for mental health problems.

What is clear is that primary care should be the focal point of strategic mental health service development, ensuring care for both complex and common mental health problems can be managed in primary care, with support of specialists and wider communities.

Team working

To meet the demands of a modern mental health workforce and to integrate care into primary care and beyond, this concept should be embedded in the idea of team working. The team as a whole should act as a collective unit with diverse competencies supporting the provision of comprehensive, biopsychosocial care.

A teams-based approach, outlined in Figure 3, is based on three pillars: specialists, generalists (in particular, primary health care teams) and the community. Together, these three pillars work together, collaborate and support one another to provide good mental health care, across the integration areas of sectors, location and services. Each part of the team is integral to the successful operation of overall service system:

- Specialists take the role of caring for the more severe cases, receiving referrals, providing training, mentoring, supervision to other mental health or lay workers. They also assist with designing and managing services.
- Mid-level mental health workers, who have diagnostic and treatment responsibilities, provide care in areas that are hard to reach or where there are no specialists.
- Generalist health workers support and manage the less complex cases through screening, diagnosing, and treatment and referrals and linking to community and specialist services. They also help in outreach services and prevention activities.
- Lay health or community workers provide screening, treatment support, and referrals, as well as low intensity psychotherapies within and as part of the community or in primary care settings.
- People with lived experiences, as peer workers, provide recovery orientated care such as coaching and reintegration in the community, using their experience to support care across the three teams.
- Other members of the community who if supported and provided with the training and capacity can help to strengthen mental health through their roles across different

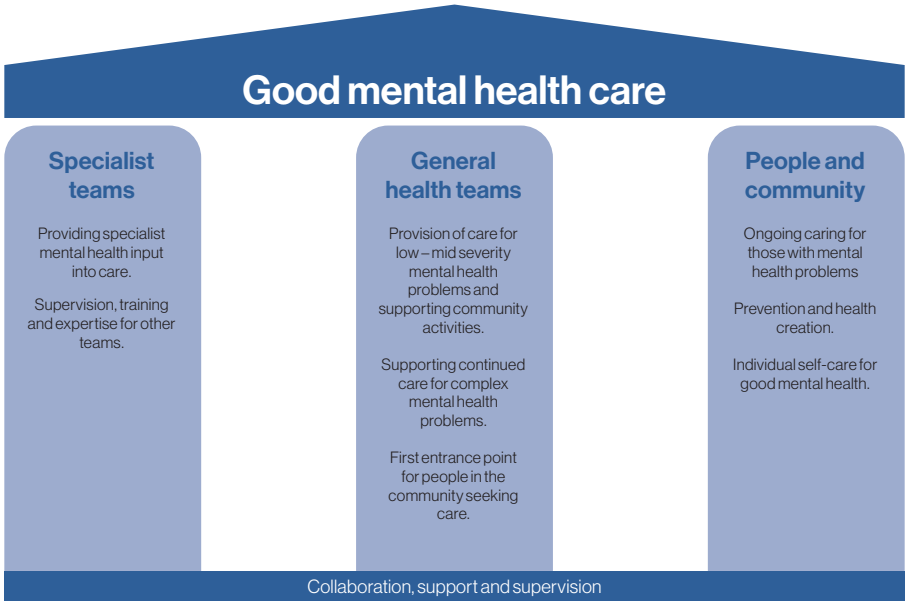

Figure 3 A teams-based approach to good mental health care.

sectors. These can include teachers providing mental health support, and traditional or faith healers helping their constituents. Support in this way is covered later in this report.

Agents of change

Health professionals have an important role to play to change the mental health system that they work in. Health education is currently focused on:

- Starting from their informative education regarding basic mental health knowledge and skills to become experts.
- Developing key values to become professionals.

Those in the health professions should aim to continue learning throughout their career, seeking to understand how to transform health systems, by applying evidence-based practice to their local context, working to develop new roles and services and supporting research and global stewardship of health systems.[16]

Health professions are agents of change in their communities and within the health sector. They should be supported to engage in and contribute to society as both responsible professionals and as citizens. This includes promoting

The Mental Health Leadership and Advocacy Programme (mhLAP)

Understanding and influencing the policy landscape in which the workforce is embed is essential for health care professionals to become agents for change.

The Mental Health Leadership and Advocacy Program (mhLAP) has built this capacity within mental health stakeholders across West Africa. Launching in 2010, it has trained 96 participants from 5 countries, developing leaders from health care workers, service users and caregivers. This programme has not only developed leaders, but in the process it also built a wide coalition of partners within each country group to effect local, country-specific change.[95]

healthy societies, providing care with dignity, as well as having a strong and functional understanding of human rights in health and mental health.[16]

Advocacy

Advocacy is needed to support and enable actions that produce positive change for society, mental health systems and people with mental health problems. It is a fundamental element to ensure the human rights of people with mental health problems are upheld to the highest level.

Advocacy is needed across all levels, from within the workforce and in the health and social care fields, to people living with mental health problems, their families, carers and communities. Advocacy can take place under three broad categories:

- Advocacy for the rights, treatment and quality of care for people with mental health problems.
- Advocacy to prioritise mental health funding, policy and integration in health systems nationally and internationally.
- Advocacy to improve mental health services and systems within the country.

Collaborations, such as the Global Mental Health Peer Network[59] and Speak your Mind campaign[59] all provide ways to advocate on national and international scales.

These collaborations not only support people with lived experience, but advocate at local, national and global levels, and influence leadership, policy, practice and research.[60]

4. Working with people, communities and organisations on care, prevention and health creation for better mental health

"We need to think about a new strategy for addressing community needs, a new workforce that can emerge deep in community by community and for community"

Dr Benjamin Miller – President, Well Being Trust

Key Points

Mental Health

- The workforce has a vital fundamental key to supporting and improving mental health, particularly in specialist services.
- They also have a fundamental role in supporting people families and organisations in dealing with mental health care, prevention and health creation.

Community

- Community-led health creation, prevention and care are key to improving mental health for all.
- Health professionals should work collaboratively with community members working to create good health and co-develop strategies to improve and protect mental health in wider society.

Local Action and Mutual Development

- Co-development and educational exchange schemes need to be promoted to share knowledge and experience across different income settings and resource contexts.
- Mental health solutions need to be developed with the community taking into account local needs and contexts.

Community and society

Stakeholders referred to the traditional view of health care 'being done' to people as 'out-dated' or 'old-fashioned', and traditional health structures were restricted to specialists and health providers only. The notion of wider 'society' is core to mental health, with mental health professionals providing support when and where it is needed.

Beyond the health system, mental health is being recognised throughout our societies, with communities taking the lead to support their own mental health on their terms.

Teachers, community workers, government officers and first responders, such as police, fire and ambulance officers, all have a role to play. Many stakeholders highlighted examples of this around the world, such as in New Zealand, where Mental Health First Aid and Mental Health 101 are being offered to people in frontline government roles.

The current specialist and generalist workforce should work with already established and existing community systems and supports. This means providing support in places such as schools, workplaces, community centres and public libraries, in coordination with local groups.

Care, wrapped around society in this way, ensures help and signposting happens at an early stage for any mental health problem, building resilience within communities to help prevent ill mental health. This will help in normalising help-seeking and reducing the stigma around mental health.

Stakeholders highlighted the need for intersectoral mental health committees (across health, education, social welfare and criminal justice etc) at national, regional and district level which will facilitate liaison and action across teams at population and individual levels.

Workplaces are a key area. The Thriving at Work report highlighted the detrimental impact of ill mental health to the

UK economy and people living with mental health problems in the workplace.[61] When workplaces are enabling and supporting good mental health, this will reduce demand on mental health services.

Workplace programmes can include training managers to provide support for employees or for mental health first aiders to be present in the business. These should also be accompanied with a whole-business policy and plan to improve the mental health and wellbeing of all employees.

Strengthening Evidence base on scHool-based intErventions for pRomoting adolescent health (SEHER)

Teachers have wide ranging responsibilities. In Bihar, India, SEHER[96] highlighted that developing and deploying new roles, such as lay counsellors, into schools enabled the programme to succeed, where teachers alone may not. Whilst this programme evaluated the impact on mental health outcomes, such as depression, it took a whole school's approach to delivery and showed improvement across a wide range of measures including good school climate.

Schools play a crucial role in supporting mental health for children and young people. Good schooling means taking a whole-school approach, providing emotional education to students and tackling negative aspects affecting their lives, such as bullying. Training teachers to understand mental health as part of their roles, will help to tackle stigma and discrimination from an early age. They can also be responsible for delivering low intensity psychotherapy for students and referring them on to health professionals when needed.

Many of these community mental health programmes, whether in schools or at the workplace, are built on a health promotion or prevention foundation. Taking this a step further is health creation, whereby local communities and leaders work to create good health for themselves and for people around them.

The City Mental Health Alliance in the UK is one example of a project advocating for such change. It is moving from workplace initiatives that help prevent mental ill health, to ones that promote and are conducive to good mental health. This might mean altering team structures to reduce long working hours or changing job roles to allow for social connection and continued learning.

Overall, the aim of building mental health skills and competencies in community roles and in wider society is to construct healthy societies, where people can find care where they need it and live and work in environments where good mental health is considered across all stages of their life.

"To fully address people's needs it needs to be multi-sectoral, it needs to consider that mental illness is impoverishing and has a multi-generational impact, and if we don't also address people's lost livelihoods and the need for inclusion and reintegration into society then we are doing a poor job of [supporting] recovery."

Dr Charlotte Hanlon – Reader in Global Mental Health and Co-director of WHO Collaborating Centre, King's College London and Addis Ababa University

The workforce of the future

As leaders, enablers and agents of change, health professionals will need to play an active role in realising the vision of this report to greatly strengthen their role in helping people, communities, and organisations to provide care, prevent mental ill health and create good health.

To achieve this principle and approach, mental health workers need to acquire additional competencies alongside their existing professional skills. Figure 1 shows the broad range of additional competencies. Some of these are related to working with other health workers but others, such as addressing the social and environmental determinants of health, tackling stigma supporting healthy communities are concerned with engaging with people and organisations outside of health. Bring new roles into the workforce can help with this process as they can leverage their experience and expertise.

To align with local communities and respond to their needs, the workforce must change the way it works, moving away from siloed health systems and working collaboratively with local communities.

Communities themselves know what is best for improving their own health, thus care should be provided in line with their vision and needs and by involving them in care planning and delivery. In this approach, the workforce is reorientated towards society and its constituent parts.

To meet the needs of society, it is also important to rethink how mental health is communicated. Health professionals often think of solutions to mental health focussing on service provision but many community-led interventions work from the assets that local community members identify and leverage themselves. For instance, community members, such as religious leaders, can help in supporting the mental health of their constituents in a way that is culturally appropriate and makes sense for them and their community, which is not necessarily the same way that health services would think about and address mental health problems.

Figure 1 Key themes for workforce development

As ill mental health and socio-economic challenges such as poverty are all tightly linked,[62] they should not be ignored by policymakers. Mental health specialists must be able to communicate these complicated relationships and how to act on them accurately to policymakers.

Policymakers need to target the underlying determinants of mental ill health and address socio-economic factors such as poverty to help reduce demands for mental health services. This helps alleviate the burden on mental health professionals particularly in under resourced workforces around the world, allowing better care to be delivered.

Inclusion of people with lived experience, carers and families

"A workforce should not only comprise of mental health professionals but should also have persons with lived experience involved at inception and have a seat at the table as their experience and knowledge is invaluable to discussions pertaining global mental health".

Claudia Sartor – Deputy CEO of the Global Mental Health Peer Network

This report emphasises the crucial role of involving and including people who have lived experience in mental health. Around the world, in every country, across society into schools, health systems and governmental policy leaders must do better to include people with lived experience in care, provision, planning and leadership.

Families living with people with mental health problems often carry a substantial portion of the caring responsibilities. This can have negative impacts on the family, reducing income and excluding them from community life. Countries around the world unjustly fail to recognise this contribution and do not support carers and families sufficiently.

Scaling up of mental health services will only work with the empowerment of people with lived experience and by offering better ways of collaboration, engagement and partnership between the health professionals and people with lived experience.

The role of people with lived experience in service design, in their own care and in communities must be embraced and integrated into society as a whole. The inclusion of carers and families in the support delivered must be recognised and valued. All stakeholders need to be actively involved in how mental health care is developed and delivered, which will improve the care provided by the workforce.

Stakeholders from the Czech Republic highlight how countries are trying to include people with lived experiences at every level, from government decision making, to service provision. They have developed a training programme for peer workers to work in clinics and hospitals and to deliver human rights advocacy at a public level. NHS England, in collaboration with the National Survivor and User Network, co-produced mental health standards in order to improve experiences of services users and to ensure that "services and interventions are accessible and appropriate for people of all backgrounds, ages and experience."[63]

Reintegration into society is a key step in recovery from mental health problems, and the promotion of the rights of people with lived experience. Social support is required for this to happen and can include the intervention and support of the workforce through roles such as occupational therapists or peer support workers. Similarly, facilitating employment opportunities for people with lived experience is a key way to enable reintegration. Contact between people with lived experience and wider society is a way to promote acceptance and tackle stigma and discrimination.

Localisation and mutual development

"What we are doing currently in our program is first to try and convince them [traditional healers] to collaborate with health professionals and we also try to provide some training, some very specific and accessible trainings in [the] local language to them. The core message is that these people [with mental health problems] are human beings and they have rights, and these people are protected by government."

Ousseini Badini, CBM Country Director, Burkina Faso

Local partnership in action

In Ethiopia, local partnerships include innovative ways to reach people. In the capital city, Addis Ababa, holy water sites where people with mental health problems often go to seek care, opened an outpatient clinic to provide mental health care. In Harar, a city in the east of the country, health services worked with religious leaders providing training around mental illnesses and substance use disorders so they can recognise and refer to health facilities.

In a holy site in Gujarat, India, the government together with the religious leaders set up a mental health clinic. The mental health staff give the medical treatment to the person though the religious leader who blesses it and the compliance with the treatment is excellent. Stigma is reduced as there is no way to know if you are praying or seeing a mental health worker and 14,000 people with mental health problems were seen in a year.

Partnerships, grounded in Goal 17 of the SDGs, are crucial to the development of an effective, accessible mental health system. These partnerships should be local and build on existing norms, working to strengthen mental health care. Stakeholders reported that the majority of help seeking will first be from community members. For example, 38% of people in Tunisia will first go to traditional healers for help.[64]

This presents potential challenges for the health system, but also an opportunity for a change in how health systems work with society. These members of the community may lack mental health knowledge and perpetuate stigma. However, just like health professionals, with training and education, the evidence shows that they can provide good care for less severe mental health problems and working with them will improve access to care.

Research from West Africa shows that working in collaboration with religious and traditional healers can effectively provide mental health care for people living with severe mental health problems.[65] Local partnerships are

essential to providing holistic, person centred care and supporting medication adherence.

Partnerships can extend internationally providing a sharing of knowledge, expertise and innovative ideas. These partnerships can strengthen specialist care around the world, such as psychiatric educational exchanges between Addis Ababa and Toronto universities,[66] the Scotland-Malawi mental health education project[67] and the Uganda-East London children and adolescent mental health training programme.[68]

The opportunity for knowledge sharing between resource settings works in both directions and should be embraced by service planners, though this should be sensitive to the local historical and cultural context [See Box 5]. High resource settings must learn from and adopt innovative and effective approaches developed in LMICs. One such example of this is the Zimbabwean Friendship bench innovation has found use in New York, as part of the ThriveNYC mental health programme.[69]

International collaboration in mental health must be encouraged and supported by governments around the world. The UK is well placed to facilitate this building on previous leadership, including the world's first Global Ministerial Mental Health Summit in 2018,[70] which brought together leaders from around the world and led to a declaration on achieving equality for mental health in the 21st century.

Box 5 What is global mental health?

The very understanding of ill mental health – and when to seek help for it – is different among different contexts. From black and minority ethnic groups in South-east England,[97] to help-seeking in India,[98] evidence suggests that help-seeking is grounded in societal factors outside of the mental health system.

Language and cultural understanding of mental health is essential to build into any mental health system and to ensure interventions are targeted, accessible and appropriate for the population. For instance, the Friendship bench in Zimbabwe targeted people with kufungisisa or 'thinking too much', the Shona term for describing depression or anxiety. A review of mhGAP implementation reports the difference in the cultural explanations and attitudes to mental ill health as a major challenge.[99]

This is particularly important for the context in which global mental health and its evidence based has emerged. Often built on Western paradigms of mental health problems and applied to low- or middle-income settings utilising the foundations of a care system built in a colonial context. Direct application of evidence to new and differing contexts must be sensitive to historical factors and local contextual issues. There has been effort around the world to build partnerships across historical and resource settings to address disciplines and culture.[100]

5. The education and training of mental health workers for this new approach

"The area that is most neglected [in medical education] is the area of knowledge about mental disorders, so that later on we have to compensate for it by organizing education about mental disorders for doctors in practice. That is too late. It is important to make medical doctors accept the fact that the treatment of mental disorders is a part of their practice while they are in undergraduate education and if necessary refresh their knowledge about it once they are practicing"

Professor Norman Sartorius – President of Association for the Improvement of Mental Health Programmes

Key points

Creating a healthy workforce

- Leaders, managers and staff should work together to create healthy workspaces that are safe and nurturing. Staff should feel they can be open about their own mental health and wellbeing.
- Stigma and discrimination, both within the mental health workforce, and within the wider health sector must be addressed.

Strengthening management and leadership

- Managers need to be valued and available health and social care managerial training needs to be provided to enable a supportive work environment and effective team leadership.

Changing education

- Substantial mental health content should be embedded from day one in pre-service educational health care curricula and create skills and competency-based education across health and mental health specialist education.

Supporting careers and training

- In line with national long-term plans and in coordination with policymakers, training and career pathways should be created for peer support workers and other non-specialist workers in mental health.
- Investment in continuous professional development for both specialist and non-specialist staff need to be enhanced allowing for career, responsibility and skill progression.
- Capacity for ongoing supervision and leadership support need to be develop to strengthen national and international training programmes. Digital platforms should be harnessed to support the delivery of training.

Digital change

- The role of digital technology in providing care is growing and is an important component of any mental health service.
- There is growing and compelling work especially for the use of digital resources to train the workforce.

Changing Education

Many countries have longstanding mental health specialist training programmes, particularly for specialist roles. For example, Iran has been training psychiatrists since the 1930s, Nigeria since the 1960s, Kenya and Tanzania since the 1970s and Ethiopia has been training specialist nurses since 1960s. Alone, these programmes will not provide sufficient capacity for the workforce, but can help provide a bedrock to building one.

It is now clear that mental health education should be present in training for all health professionals, providing the

confidence and technical skills to provide care where it is needed and wherever the person may be seeking help in the health system. Mainstreaming mental health into public health education and education for people working in primary health care is essential.

The underlying focus of training for primary health care staff should be on a biopsychosocial approach addressed at the tasks commonly seen at a primary health care level. As per the teams' approach, this will require input from specialists at regular intervals for support and collaboration. As an example, in mothers, perinatal depression can be coupled with physical health problems and social difficulties in raising a new-born. Primary health care must be equipped to deal with all aspects of the persons health and social wellbeing.

This notion must also be carried into wider society, ensuring sectors of community such as schools and workplaces have the means to also provide care and support for mental health up to an appropriate level.

Stakeholders emphasised that curriculum reform is imperative. Education centres should ensure curricula are readily adaptable, both to the local context and to the needs of the health system itself.

Competency based education determines which skills are required for the health system. It focuses on learners' skills and outcomes rather than on academic objectives [see Figure 4]. For example, the skills needed for professionals to work across roles in a multidisciplinary team can be developed in a way to break down traditional hierarchies. Furthermore, this competency-based approach provides an educational opportunity for overlap between professions, meaning some cadres can learn to understand each other roles and skills and work together from day one.[16]

As agents of change, educators will also need to adapt curricula to enable professionals practise and embed transformative skills into mental health care. These skills are essential to build effective mental health systems, by, for instance, applying education learning to creatively adapted available resources and to the local context. Stakeholders referred to the need for education to provide a complex-jigsaw of relevant information beyond just care competencies, encompassing policy, local health systems and law.

Stakeholders highlighted the lack of evidence-based training, which is missing in many lower to middle resource settings. They also emphasised the need for practical skills and exposure within clinical placements as an area that is particularly important for all health professionals and is fundamental to any effective training. Placements should not only take in mental health hospitals, but also in community settings.[71]

Involvement of people with lived experience in the design and delivery of mental health curricula provide a fundamental avenue for improvement of their content. This will not only support stigma reduction within the workforce, but also improve the quality of care and foster mutual understanding from day one between health professionals and people with lived experience. "Nothing for us, without us" is true for services, but equally important for education and training.

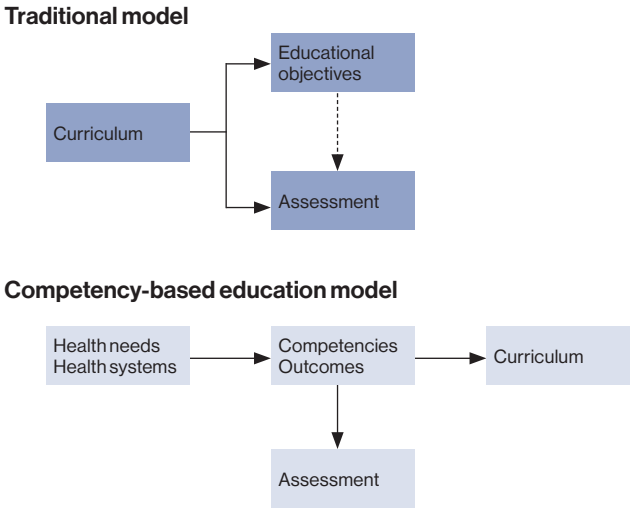

Figure 4: Competency Based Education, adapted from Education of Health Professionals for the 21st Century, The Lancet 2010.[16]

Governments and policymakers have an important role to play in the development of new educational streams. Emerging roles such as peer workers require structured

training and educational courses to ensure a quality of care can be maintained. Training for new roles does not necessarily have to orientate around higher education. Apprenticeship models have been shown to be effective ways of building capacity in all resource settings.[72]

There are many successful examples of mental health education programmes from around the world. In countries such as Georgia, Ethiopia, Tanzania and Kenya there are university level programmes, training graduates and post graduates to provide mental health care. For instance, in Georgia, a master's program uses teaching staff from multiple disciplines to train up people from different backgrounds to work in mental health, such as doctors, nurses, social workers and occupational therapists. Case study 4 highlights such programmes in Ethiopia.

The way education is delivered must also change. Digital health literacy is now a fundamental aspect of educational programmes, providing the essential skills for competent and confident use by professionals.[73] Though each role in the team will have different responsibilities, building a baseline of shared understanding regarding these tools will allow buy-in from professionals themselves, and will improve care.

Lastly, this report calls for mental health to be embedded in day one for many generalist roles. However, this must also happen in the other direction. Mental health staff are often not very well equipped or lack the confidence to care for the comorbidities of people with mental health problems. Stakeholders discussed the need for holistic education and service provision, which includes both physical and mental health care.

Incorporating digital technology

Digital technologies are being used by, and to shape, the workforce in the following areas:[74]

- Training and education of the workforce, both as part of formal learning as well as training non-specialists through providing offsite training, digital learning and mentoring.
- Supervision of non-specialist workers through access to specialists, who can give direct coaching and support, especially where this otherwise would not have been possible.
- Delivering care and screening, providing consultations, support, and follow up through online platforms.
- Supporting the individual in self-care, through online applications such as the ones with message prompts for medication adherence.
- Dissemination of education dissemination and awareness for families, carers and people living with mental health problems.
- Collection of data as regular health system practice.

Although digital technology and innovations cannot replace the workforce itself, they can help to address some of the barriers affecting mental health care such as stigma, distance to care, out of pocket expenses and shortage of staff. However, they can also create barriers especially for people who are poorer, older, and do not have technological skills or access to devices or the internet. Mental health care might be worse off if due to digitalisation of services some people are no longer able to receive services at all.

The broad remit of digital technologies across health means that the mental health workforce must be trained, equipped and literate in using digital solutions in care. Digital platforms for learning were a focus of stakeholder feedback with platforms such as EMPOWER[75] and WHO's EQUIP[76] being used to train the workforce in psychological and psychosocial interventions with a focus on high quality training and competencies.

Strengthening management and leadership

Managers, non-clinical leaders and health professionals in leadership roles are an essential part of organising the health system, planning and facilitating improvements and ensuring care is of high quality. Equally, they are an important factor in retaining the workforce and looking after its wellbeing and mental health.

Stakeholders recognised the influence that managers have on the workplace environment. Effective management means teams and health systems work well together, can organise care effectively, and ensure that it is patient-centred.

Stakeholders noted that non-clinical management can often be too removed from the clinical workplace, which means they are not effectively listening to staff and lacking the context to support health professionals and carers.

Building pathways to ensure supervision and ongoing improvement of skills comes down to management and leadership within teams providing care. Programmes implementing various mental health training packages around the world highlight the need for ongoing supervision between junior and senior workers to ensure quality and fidelity of care.

Embedding key policies and practices into care requires management to be appropriately trained. Tools such as the WHO Quality Rights Tool Kit, based on the CRPD, provides a foundation of human rights training to leaders developing mental health services and for those managing mental health services.[77] More work should be done to develop leadership training courses and building leadership skills in roles such as psychiatrists, in order to strengthen the mental health workforce around the world.[78]

Training for health professionals

Training is a fundamental mechanism to build competency within the existing workforce. It is complementary to educational systems, often focusing on specific skills for certain roles within the workforce. A key example is the WHO's mhGAP intervention guideline, which constitutes a framework to train people to recognise, treat and manage mental health problems within primary health care settings, reducing dependency on other specialist services.

Stakeholders from Ukraine, Uganda, Ethiopia, Georgia, South Africa and Tunisia all mentioned the use of this training at primary health care levels. The mhGAP intervention guideline has now been used around the world in a variety of contexts.[60] The guideline, which has been translated into different languages and has a developing evidence base from training and education to implementation.[79]

Training of health professionals should be adapted and appropriate for the local context. The Friendship bench initiative in Zimbabwe was built on the identification of people in the community who would be best suited to deliver care, and training them. The program is based on local 'grandmothers', who were trained by clinicians over a three-week period through a course that empowers them to use their own skills to improve mental health in their communities.[80]

Furthermore, training should marry the local policy aims of service planning. Across Malawi and Tanzania, "An Integrated Approach to Addressing the Challenge of Depression Among the Youth in Malawi and Tanzania" (IACD), provided training for community health teams on how to recognise and care for adolescent depression. This was a crucial linking role as the programme sought to raise awareness and refer young people from schools.[81]

Digital technologies are crucial to on-going training of health professionals. The WHO Academy has been launched as digital learning platform to scale up training for both health professional and lay workers, including the provision of mental health courses, such as mhGAP.[82] The WHO EQUIP program also provides learning tools and guidelines for people who are working and engaged in mental health care.[60]

On-going professional development

Hand-in-hand with the need for education and training programmes is the need to ensure on-going professional development opportunities. This is particularly important for new roles in the workforce, who may not have the established communities and structures that traditional workforce roles may have.

On-going professional development can include:

- Routine refresher courses through e-training or in person
- Development of new technical skills suitable for each role and team

- Career pathways into leadership and managerial roles, taking on more responsibility for systems and services

Stakeholders from the nursing profession particularly spoke about the need for ongoing professional development to gain the skills needed to be robust and resilient at work and to be able to reflect on their needs for themselves and those in their care.

The aim of this on-going professional development is to ensure a workforce that is continuingly improving and keeping up to date with developments in methods and understanding. This will help improve the care delivered by the workforce and also offer the workforce pathways and platforms to develop new ideas and innovative approaches based on their experiences as health professionals.

A healthy workforce

To create, develop and sustain a motivated, well-functioning and effective workforce, people working within it need to be properly cared for. Just as healthy communities, cities and schools are promoted, a healthy mental health workforce should be a priority.

Stakeholders across the world were clear on the huge challenges facing the day to day experience of mental health professionals. Staff burn out, poor pay and challenging working conditions mean that it is difficult to recruit, train and retain health professionals. This can lead to further impact on the mental health of staff and an ongoing cycle of unhealthy practices leading to further deterioration of these workplaces.

There are many frameworks available that tackle mental health in the workplace. Though varying in their actions and conceptual underpinnings, these frameworks offer many opportunities to intervene and create mentally healthy workplaces.[83]

A core component of healthy workforces is investing in managers and leaders with the aim to build:[84]

- Confidence in anti-stigma and discrimination approaches.
- Compassionate communication between staff, management and leadership.
- Nurturing workplaces, allowing for staff to work in an environment that empowers them to flourish.

National leadership must recognise the contributions of the mental health workforce, including adequate and fair renumeration for work, in line with those working in physical health roles. National commitment to long term service delivery plans and the development of a professional workforce is another key piece towards a healthy workforce.

"If you want to maintain a healthy workforce then you should care about them, have a staff care policy in your organisation, have staff retreats, regular staff meetings, encouragement systems [...] to show you are grateful for what they are doing, team building activities. You should really respect them and then could maintain that spirit of innovation and enthusiasm."

Dr Nino Makhashvili – Director of Global Initiative on Psychiatry, Tbilisi, Georgia

Volunteers providing support and care as part of the professional workforce are often unrecognised and taken for granted. They should not shoulder responsibilities of health professionals or provide a stop gap whilst mental health is under-prioritised. Instead, they should be fully integrated into the team alongside paid professional members of staff, ensuring those who give their time to help are recognised and appreciated fully.

Relying on the care provided by those volunteering their time outside of the health workforce has wider impacts. Women make up for the majority of the care provide, while they often continue to shoulder other responsibilities at work and in their homes, leading to a double workload. Systems relying solely on this support will only raise inequality and further disadvantage women.[85]

Many of these challenges stem from stigma and lack of prioritisation by policymakers and health systems. As discussed through this report, these challenges are starting to be broken down and addresses around the world.

Case Study 4
A Master's programme in Integrated Clinical and Community Mental Health in Ethiopia

In 2010, Jimma University recognised the lack of mental health professional capacity in Ethiopia. Working with Ludwig-Maximillians-Universität in Germany and the Ministry of Health, Ethiopia, they set up a Master's programme in Integrated Clinical and Community Mental Health.[101]

This programme helps graduates who are nurses or health officers, with at least two years of work experience, to become non-physician mental health specialists, performing essential tasks in mental health services.

Jimma University is not alone in running programmes such as this, similar postgraduate programmes are also available in other universities in Ethiopia such as Gondar university and Addis Adaba University. These programmes will, over time, build the multi-disciplinary skill set needed to effectively scale up mental health services in Ethiopia.

Stakeholders commented that the mental health workforce is one that should be welcoming to people with mental health problems. Systems should facilitate people within the mental health workforce to 'come out' about their lived experiences. If the workforce could talk about their own experiences, this would be a big step in breaking down stigma and enable early help-seeking behaviour by professionals.

"It's so hard for mental health workers to come forward for help, because there is a stigma about it amongst the profession, it doesn't just stop recruitment, it affects performance and the outcomes of patients ultimately, let alone staff wellbeing."

Sue Baker – Former Global Director of Time to Change, United Kingdom

Retaining the workforce

Whilst a healthy workforce can help retain and support mental health professionals within one health system, there is the need to consider this on the global scale. Migration of workers between countries is widely acknowledged throughout health care, but is stark in mental health. Without this capacity drain, some LMICs could have five to eight times more psychiatrists per 100,000 population.[86]

Stakeholders from the UK particularly emphasised the devastating impact that LMICs face from losing their highly trained mental health specialists. Active international recruitment has detrimental effects leaving weak health systems and people without access to essential mental health services.

Systems cannot be strengthened if the very people delivering care are taken from them. The 'double whammy' of this impact is that these countries losing their staff are the ones paying for their training and education.[87] The WHO Code of Practice on international recruitment is clear that countries should not actively recruit from countries with grave shortages of trained health staff.[88] The Department of Health and Social Care in the England has released new international recruitment guidance in line with the Code of Practice, which should be fully implemented for all overseas recruitment.

Brain drain can also happen within in the country, with stakeholders highlighting well-funded international funders poorly targeting programmes, meaning existing expertise is not used to the fullest capacity. Similarly, local non-governmental organisations were also seen to attract and target specialists in country to deliver their programmes.

Beyond changing national policies towards equitable recruitment and upholding the WHO's Code of Practice, more must be done to support training internationally. Higher resourced settings must review their own education systems and ensure that they are training enough professionals to meet their own local demand, rather than seeking to recruit internationally. International opportunities must also be available to enable cross fertilisation of specialist skills and training between countries and health systems.

"One of the things we should be thinking about is doing no harm, and one of the ways we can contribute is to think seriously about how we [the UK] can be reducing the damage we do in terms of the very low numbers of professionals in other countries in mental health"

Dr Julian Eaton – Mental Health Director for CBM Global, Assistant Professor at the Centre for Global Mental Health at London School of Hygiene and Tropical Medicine

6. Conclusion

This report is based on a wide-ranging review of developments in mental health staffing and practice globally. Its conclusion and recommendations are set out in the first section; summary and recommendations.

It has demonstrated the scale of change underway around the world and the way in which pioneers in each region are developing new approaches based on new research, experience and understanding.

Cultures, traditions, resources and experiences are different in different parts of the world but there are also similarities and, very importantly, we can all learn from each other.

The report's main conclusion that the mental health workforce needs to change dramatically by combining its existing professional expertise in the provision of specialist care and treatment with a greatly strengthened role in helping people, communities, and organisations to provide care, prevent mental ill health and create health can have a profound and very positive impact if it is followed through.

It recognises the continuing importance of scientific evidence and knowledge but requires a new mindset and a better understanding of context, culture and experience.

Resources are needed both to provide services and to support the training and development that will be needed to implement these far-reaching changes.

The mental health workforce needs to change dramatically by combining its existing professional expertise in the provision of specialist care and treatment with a greatly strengthened role in helping people, communities, and organisations to provide care, prevent mental ill health and create health.

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References

1. Patel, V. *et al.* The Lancet Commission on global mental health and sustainable development. *Lancet* **392**, P1553-1598 (2018).
2. Mental Health at Work. https://www.mentalhealthatwork.org.uk/. Accessed 1st July 2021.
3. Sangath. https://www.sangath.in/. Accessed 1st July 2021.
4. PRIME Project. http://www.prime.uct.ac.za/prime-home. Accessed 1st July 2021.
5. Global Burden of Disease. *Institute for Health Metrics and Evaluation* http://ghdx.healthdata.org/gbd-results-tool. Accessed 3rd March 2021.
6. Wang, Y., Kala, M. P. & Jafar, T. H. Factors associated with psychological distress during the coronavirus disease 2019 (COVID- 19) pandemic on the predominantly general population: A systematic review and metaanalysis. *PLoS One* **15**, 1–27 (2020).
7. World Health Organization. *The WHO special initiative for mental health (2019-2023): universal health coverage for mental health.* (2019). License: CC BY-NC-SA 3.0 IGO.
8. Patel, V. et al. Reducing the treatment gap for mental disorders: A WPA survey. *World Psychiatry* **9**, 169–176 (2010).
9. World Health Organization, *Mental health atlas 2017.* Geneva, (2018). Licence: CC BY-NC-SA 3.0 IGO.
10. Liese, B. H., Gribble, R. S. F. & Wickremsinhe, M. N. International funding for mental health: A review of the last decade. *Int. Health* **11**, 361–369 (2019).
11. Bloom, D. E. et al. *The Global Economic Burden of Noncommunicable Diseases. World Economic Forum* (2011).
12. Thornicroft, G. & Sunkel, C. Announcing the Lancet Commission on stigma and discrimination in mental health. *Lancet* **396**, 1543–1544 (2020).
13. Kakuma, R. et al. Human resources for mental health care: Current situation and strategies for action. *Lancet* **378** 1654–1663 (2011).
14. Silva, M. De & Roland, J. *Mental Health for Sustainable Development. All-Party Parliamentary Group on Global Health* (2014).
15. Crisp, N. *Health is Made at Home, Hospitals are for Repairs - building a healthy and health-creating society.* Salus, Billericay, 2020
16. Frenk, J. et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* **376** 1923–1958 (2010).
17. Whiteford, H. A., Ferrari, A. J., Degenhardt, L., Feigin, V. & Vos, T. The global burden of mental, neurological and substance use disorders: An analysis from the global burden of disease study 2010. *PLoS One* **10**, 1–14 (2015).
18. Vigo, D., Thornicroft, G. & Atun, R. Estimating the true global burden of mental illness. *The Lancet Psychiatry* vol. 3 171–178 (2016).
19. Pathare, S., Brazinova, A. & Levav, I. Care gap: a comprehensive measure to quantify unmet needs in mental health. *Epidemiol. Psychiatr. Sci.* **27**, 463–467 (2018).
20. Kola, L. et al. COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. *The Lancet Psychiatry* **0366**, 1–16 (2021).
21. World Health Organization. mhGAP Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders. *WHO* (2008).
22. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN General Assembly* (2020) doi:10.1017/s0020818300024334.
23. World Health Organization. *The WHO special initiative for mental health (2019-2023): universal health coverage for mental health.* (2019). License: CC BY-NC-SA 3.0 IGO.
24. World Health Organization, *Guidance on community mental health services: promoting person-centred and rights-based approaches. Geneva* (2021). Licence: CC BY-NC-SA 3.0 IGO.
25. National Collaborating Centre for Mental Health & Positive Practice in Mental Health. All Age Crisis Care: Improving the Quality of Care in England Recommendations and positive practice. (2020).
26. World Health Organization, *Suicide in the world: Global Health Estimates.* Geneva (2019). Licence: CC BY-NC-SA 3.0 IGO.
27. Hetrick, S. E. *et al.* Integrated (one-stop shop) youth health care: best available evidence and future directions. *Med. J. Aust.* **207**, S5–S18 (2017).
28. World Health Organisation. *Integrating The Prevention, Treatment And Care Of Mental Health Conditions And Other Noncommunicable Diseases Within Health Systems.* (2019).
29. Naylor, C. et al. Bringing together mental and physical health: A new frontier for integrated care. *King's Fund Rep.* 120 (2016).
30. United Nations. *United Nations Convention on the Rights of Persons with Disabilities.* (2006).
31. Slade, M. & Longden, E. Empirical evidence about recovery and mental health. *BMC Psychiatry* **15**, 1–14 (2015).
32. Freeman, A. M., Tribe, R. H., Stott, J. C. H. & Pilling, S. Open dialogue: A review of the evidence. *Psychiatr. Serv.* **70**, 46–59 (2019).
33. Knaak, S., Mantler, E. & Szeto, A. Mental illness-related stigma in healthcare: Barriers to access and care and evidence-based solutions. *Healthc. Manag. Forum* **30**, 111–116 (2017).
34. Kakuma, R. *et al.* Human resources for mental health care: current situation and strategies for action. *Lancet* **378**, 1654–1663 (2011).
35. Henderson, C. *et al.* Public knowledge, attitudes, social distance and reported contact regarding people with mental illness 2009–2015. *Acta Psychiatr. Scand.* **134**, 23–33 (2016).
36. Langhaug, L. F. *et al.* 'we need more big trees as well as the grass roots': Going beyond research capacity building to develop sustainable careers in mental health research in African countries. *Int. J. Ment. Health Syst.* **14**, 66 (2020).

37. Houlden, V., Weich, S., de Albuquerque, J. P., Jarvis, S. & Rees, K. *The relationship between greenspace and the mental wellbeing of adults: A systematic review. PLoS ONE* vol. 13 (2018).

38. De Silva, M. J. & Ryan, G. Global mental health in 2015: 95% implementation. *The Lancet Psychiatry* **3**, 15–17 (2016).

39. United Nations Office for the Coordination of Humanitarian Affairs (OCHA). *Global Humanitarian Overview 2021. OCHA* (2020).

40. Charlson, F. et al. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet* **394**, 240–248 (2019).

41. United for Global *Mental Health. The Impact of COVID-19 on Global Mental Health: A Brief.* (2020).

42. Moreno, C. *et al.* How mental health care should change as a consequence of the COVID-19 pandemic. *The Lancet Psychiatry* **7**, 813–824 (2020).

43. World Health Organization. *Building Back Better: sustainable mental health care after emergencies.* (2013)..

44. Repper, J. & Carter, T. A review of the literature on peer support in mental health services. *J. Ment. Heal.* **20**, 392–411 (2011).

45. White, S. *et al.* The effectiveness of one-to-one peer support in mental health services: a systematic review and meta-analysis. *BMC Psychiatry* **20**, 1–20 (2020).

46. Barbui, C. *et al.* Efficacy of psychosocial interventions for mental health outcomes in low-income and middle-income countries: an umbrella review. *The Lancet Psychiatry* **7**, 162–172 (2020).

47. van Ginneken, N. *et al.* Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *Cochrane Database Syst. Rev.* (2013).

48. Rahman, A., Malik, A., Sikander, S., Roberts, C. & Creed, F. Cognitive behaviour therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomised controlled trial. *Lancet* **372**, 902–909 (2008).

49. World Health Organization and Global Health Workforce Alliance. *Mid-level health providers: A promising resource to achieve the health Millennium Development Goals.* (2010).

50. Minas, H. A mental health human resources strategy for Sri Lanka. *Sri Lanka J. Psychiatry* **6**, 1 (2015).

51. Kenya Medical Training College. Department of Clinical Medicine and Surgery. https://kmtc.ac.ke/department-of-clinical-medicine-and-surgery/. Accessed 1st July 2021.

52. World Health Organization. *State of the world's nursing 2020: investing in education, jobs and leadership.* (2020).

53. Laurant, M. *et al.* Nurses as substitutes for doctors in primary care. *Cochrane Database of Systematic Reviews* vol. 2018 (2018).

54. Araya, M., Mussie, M. & Jacobson, L. Decentralized psychiatric nursing service in Ethiopia--a model for low income countries. *Ethiop. Med. J.* **47**, 61–64 (2009).

55. All-Party Parliamentary Group on Global Health. *Triple Impact of Nursing: How developing nursing will improve health, promote gender equality and support economic growth.* (2016).

56. Wakefield, S. *et al.* Improving Access to Psychological Therapies (IAPT) in the United Kingdom: A systematic review and meta-analysis of 10-years of practice-based evidence. *Br. J. Clin. Psychol.* **60**, 1–37 (2021).

57. World Health Organization. *Mental Health Action Plan 2013-2020.* (2013).

58. Caulfield, A., Vatansever, D., Lambert, G. & Van Bortel, T. WHO guidance on mental health training: A systematic review of the progress for non-specialist health workers. *BMJ Open* **9**, 1–16 (2019).

59. Global Mental Health Peer Network. https://www.gmhpn.org/. Accessed 1st July 2021.

60. WHO EQUIP. https://www.who.int/mental_health/emergencies/equip/en/. Accessed 1st July 2021.

61. Stevenson, D. & Farmer, P. Thriving at work: The Independent Review of Mental Health and Employers. (2017).

62. Singer, M., Bulled, N., Ostrach, B. & Mendenhall, E. Syndemics and the biosocial conception of health. *Lancet (London, England)* **389**, 941–950 (2017).

63. National Health Service England. *The five year forward view for mental health.* (2016).

64. Khiari, H., Ouali, U., Zgueb, Y., Mrabet, A. & Nacef, F. Pathways to mental health care for patients with severe mental illness in Tunisia. *Pan Afr. Med. J.* **34**, 1–11 (2019).

65. Gureje, O. *et al.* Effect of collaborative care between traditional and faith healers and primary health-care workers on psychosis outcomes in Nigeria and Ghana (COSIMPO): a cluster randomised controlled trial. *Lancet* **396**, 612–622 (2020).

66. Hailemariam, M., Fekadu, A., Prince, M. & Hanlon, C. Engaging and staying engaged: A phenomenological study of barriers to equitable access to mental healthcare for people with severe mental disorders in a rural African setting. *Int. J. Equity Health* **16**, (2017).

67. Scotland-Malawi Partnership. https://www.scotland-malawipartnership.org/. Accessed 1st July 2021.

68. Rukundo, G. Z., Nalugya, J., Otim, P. & Hall, A. A Collaborative Approach to the Development of Multi-Disciplinary Teams and Services for Child and Adolescent Mental Health in Uganda. Front. *Psychiatry* **11**, 1–8 (2020).

69. Rosenberg, T. Depressed? Here's a Bench. Talk to Me. *New York Times* https://www.nytimes.com/2019/07/22/opinion/depressed-heres-a-bench-talk-to-me.html (2019).

70. Department of Health and Social Care. *2018 Global Ministerial Mental Health Summit.* (2019).

71. World Health Organization and International Council of Nurses. *Atlas: Nurses in Mental Health.* (2007).

72. Murray, L. K. *et al.* Building capacity in mental health interventions in low resource countries: An apprenticeship model for training local providers. *Int. J. Ment. Health Syst.* **5**, 1–12 (2011).

73. World Health Organization. *Global strategy on digital health 2020-2025.* Geneva, (2021). Licence: CC BY-NC-SA 3.0 IGO.

74. Raviola, G., Naslund, J. A., Smith, S. L. & Patel, V. Innovative Models in Mental Health Delivery Systems: Task Sharing Care with Non-specialist Providers to Close the Mental Health Treatment Gap. *Curr. Psychiatry Rep.* **21**, (2019).

75. EMPOWER. https://empower.care/. Accessed 1st July 2021.

76. Kohrt, B. A. *et al.* Ensuring Quality in Psychological Support (WHO EQUIP): developing a competent global workforce. *World Psychiatry* **19**, 115–116 (2020).

77. World Health Organization. *WHO quality rights tool kit: assessing and improving quality and human rights in mental health and social care facilities.* Geneva, (2012).

78. Rwafa-Madzvamutse, C., Kidia, K., Gureje, O., Mangezi, W. & Jack, H. E. Leadership and management training for African psychiatrists in the era of task-sharing. *The Lancet Psychiatry* **7**, 927–929 (2020).

79. Keynejad, R. C., Dua, T., Barbui, C. & Thornicroft, G. WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide: A systematic review of evidence from low and middleincome countries. *Evid. Based. Ment. Health* **21**, 29–33 (2018).

80. Chibanda, D. *et al.* Effect of a primary care-based psychological intervention on symptoms of common mental disorders in Zimbabwe: A randomized clinical trial. JAMA - *J. Am. Med. Assoc.* **316**, 2618–2626 (2016).

81. Kutcher, S. *et al.* Creating Evidence-Based Youth Mental Health Policy in Sub-Saharan Africa: A Description of the Integrated Approach to Addressing the Issue of Youth Depression in Malawi and Tanzania. *Front. Psychiatry* **10**, 1–8 (2019).

82. WHO Academy. https://www.who.int/about/who-academy/. Accessed 1st July 2021.

83. Petrie, K. *et al.* A framework to create more mentally healthy workplaces: A viewpoint. *Aust. N. Z. J. Psychiatry* **52**, 15–23 (2018).

84. Gayed, A. *et al.* Effectiveness of training workplace managers to understand and support the mental health needs of employees: A systematic review and meta-analysis. *Occup. Environ. Med.* **75**, 462–470 (2018).

85. Chase, L. E., Gurung, D., Shrestha, P. & Rumba, S. Gendering psychosocial care: risks and opportunities for global mental health. *The Lancet Psychiatry* vol. 0 (2021).

86. Jenkins, R. *et al.* International Migration of Doctors, and Its Impact on Availability of Psychiatrists in Low and Middle Income Countries. *PLoS One* **5**, e9049 (2010).

87. Jenkins, R. Brain Drain. *BJPsych Int.* **13**, 53–54 (2016).

88. World Health Organisation. *The WHO Global CODE of Practice on the International Recruitment of Health Personnel.* (2010).

89. Living Well System. https://www.livingwellsystems.uk/. Accessed 1st July 2021

90. World Bank Group. *HEALING MINDS, CHANGING LIVES: A movement for community-based mental health care in Perú. Delivery Innovations in a Low-Income Community, 2013-2016. World Bank Group* (2016).

91. Inshuti Mu Buzima. https://storymaps.arcgis.com/stories/61dd3f3d22184bfcb04c61ef936a8c27. Accessed 1st July 2021.

92. Smith, S. L. et al. Outcomes of a primary care mental health implementation program in rural Rwanda: A quasi-experimental implementation-effectiveness study. *PLoS One* **15**, 1–20 (2020).

93. Murray, L. K. *et al.* Effectiveness of the Common Elements Treatment Approach (CETA) in reducing intimate partner violence and hazardous alcohol use in Zambia (VATU): A randomized controlled trial. *PLoS Med.* **17**, 1–22 (2020).

94. Polyakov, M., Sale, J., Kline, S. & Saxena, S. *'No health without mental health' Why integrating mental health into Universal Health Coverage matters. United for Global Mental Health* (2020).

95. Abdulmalik, J. *et al.* The Mental Health Leadership and Advocacy Program (mhLAP): A pioneering response to the neglect of mental health in Anglophone West Africa. *Int. J. Ment. Health Syst.* **8**, (2014).

96. Shinde, S. *et al.* A multicomponent secondary school health promotion intervention and adolescent health: An extension of the SEHER cluster randomised controlled trial in Bihar, India. *PLoS Med.* **17**, 1–17 (2020).

97. Memon, A. *et al.* Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open* **6**, 1–9 (2016).

98. Roberts, T. et al. "Is there a medicine for these tensions?" Barriers to treatment-seeking for depressive symptoms in rural India: A qualitative study. *Soc. Sci. Med.* **246**, 112741 (2020).

99. Faregh, N., Lencucha, R., Ventevogel, P., Dubale, B. W. & Kirmayer, L. J. Considering culture, context and community in mhGAP implementation and training: Challenges and recommendations from the field. *Int. J. Ment. Health Syst.* **13**, 1–13 (2019).

100. Bemme, D. & Kirmayer, L. J. Global Mental Health: Interdisciplinary challenges for a field in motion. *Transcult. Psychiatry* **57**, 3–18 (2020).

101. Soboka, M. *et al.* Evaluation of a master of science in integrated clinical and community mental health (MSc ICCMH) program in Ethiopia. *GMS Ger. Med. Sci.* **16**, 1–10 (2018).

102. World Health Organisation, Mental Health Policy and Service Guidance Package. Geneva: WHO. 2003

103. Coventry, P. A. *et al.* Characteristics of Effective Collaborative Care for Treatment of Depression: A Systematic Review and Meta-Regression of 74 Randomised Controlled Trials. *PLoS One* **9**, e108114 (2014).

104. Chatterjee, S. *et al.* Effectiveness of a community-based intervention for people with schizophrenia and their caregivers in India (COPSI): a randomised controlled trial. *Lancet (London, England)* **383**, 1385–94 (2014).

105. Murray, L. K. & Jordans, M. J. D. Rethinking the service delivery system of psychological interventions in low and middle income countries. *BMC Psychiatry* **16**, 234 (2016).

Appendix 1
Foundational policy for mental health

Human rights:

The right to health is a fundamental human right and encompasses the right to a life of dignity. The Convention on the Rights of Persons with Disabilities (CRPD), adopted worldwide in 2007 and ratified in 2008 is the first comprehensive internationally signed treaty on the protection and rights of persons with disabilities.[30]

Universal health coverage and the Sustainable Development Goals:

The concept of Universal Health Coverage is a concept to deliver quality health services to all without financial burden on the individual and family, and it's a fundamental concept within the United Nations Sustainable Development Goals:

Goal 3: Ensure healthy lives and promote well-being for all at all ages

Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Means for achieving these targets related to workforce:

Target 3.c: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

In 1978 the Alma Ata declaration, health is labelled a human right, mental health and wellbeing is included in the definition of health, and primary care as the delivery model.

In 2018, the Astana Declaration committed to primary health care as the main way of achieving universal health coverage.

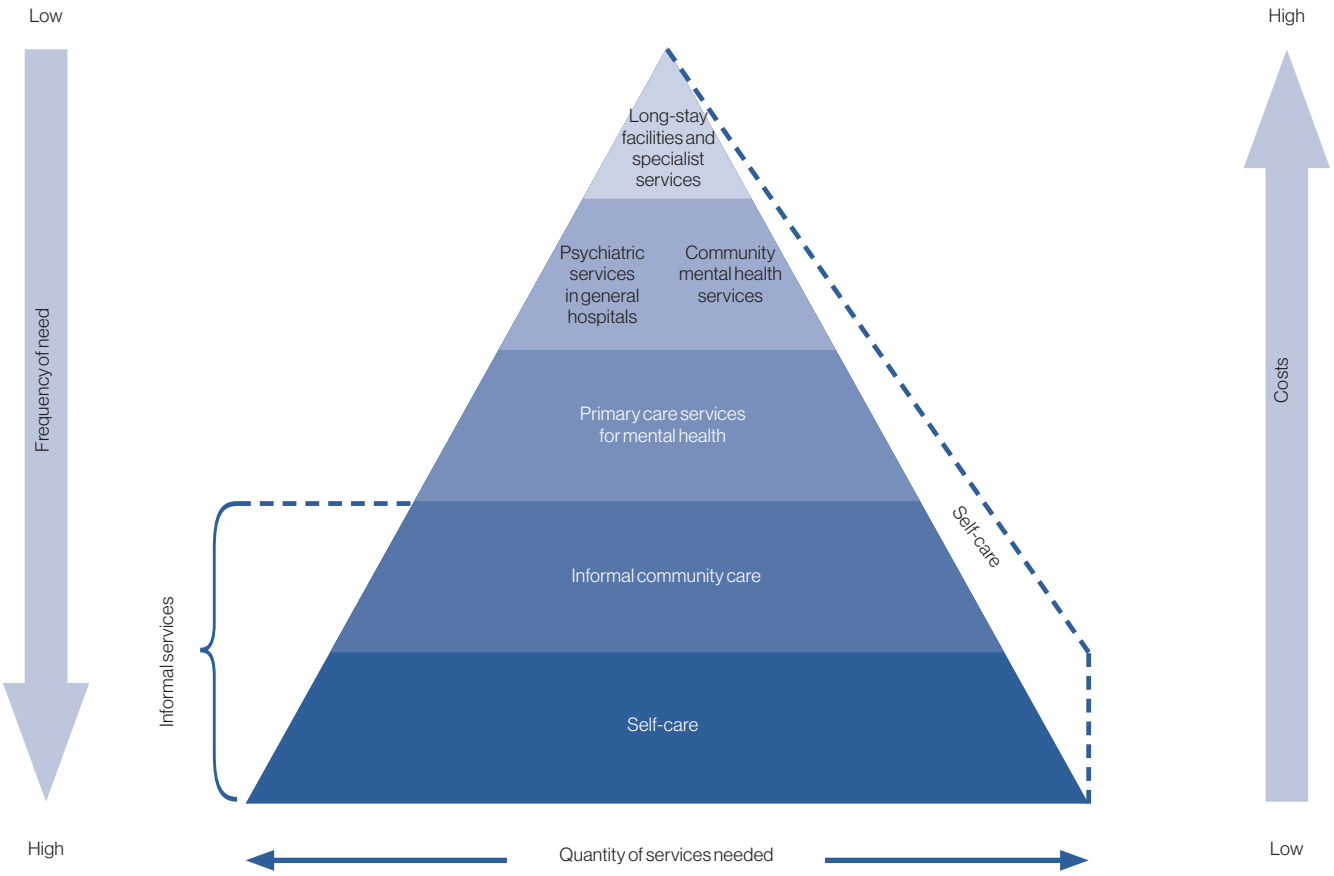
The WHO Mental Health Action Plan 2013 – 2030

The WHO's Mental Health Action Plan promotes six cross cutting principles within mental health:[57]

1. Universal health coverage
2. Human rights
3. Evidence based practice
4. Life course approach
5. Multisectoral approach
6. Empowerment of persons living with mental health and psychosocial conditions

It offers guidance and targets for WHO member states to work towards for better mental health.

Appendix 2
The WHO optimal mix of services



Adapted from Mental Health Policy and Service Guidance Package, World Health Organization (WHO), "Organization of Services for Mental health".[102]

Appendix 3
The balanced care model

Low-resource settings			
Community (provided across relevant sectors) • Basic opportunities for occupation/ employment and social inclusion • Basic community interventions to promote understanding of mental health • Interventions to reduce stigma and promote help-seeking • Range of community-level suicide prevention programmes (eg, reduce access to pesticides) • Early childhood and parenting intervention programmes • Basic school-based mental health programmes • Promotion of self-care interventions • Integration of mental health into community-based rehabilitation and community-based inclusive development programmes • Home-based care to promote treatment adherence • Activating social networks	**Primary health care (provided by general primary care workers)** • Case identification • Basic evidence-based psychosocial interventions • Basic evidence-based pharmacological interventions • Basic referral pathways to secondary care	**Secondary health care (provided in general hospitals)** • Training, support, and supervision of primary care staff • Outpatient clinics • Acute inpatient care in general hospitals • Basic referral pathways to tertiary care	**Tertiary health care (provided by mental health specialist services)** • Improve quality of care in psychiatric hospitals • Initiate move of mental health inpatient services from psychiatric hospitals to general hospitals • Initiate closure of long-stay institutions and develop alternatives in community settings Establish means of licensing all practitioners treating people with mental disorder, including non-formal care facilities Range of evidence-based psychological treatments Ensure compliance with relevant human rights conventi ans Initiate consultation-liaison services in collaboration with other medical departments and improve physical health care of people in mental health services
Medium-resource settings			
Community Services as provided in low-resource settings and: • Coordinated opportunities for occupation/employment and social inclusion • Coordinated community interventions to promote understanding of mental health • Coordinated interventions to reduce stigma and promote help-seeking • City-wide and district-wide coordination of integrated mental health-care plans • Attention to mental health in policy across all sectors • Range of independent and supported accommodation for people with long-term mental disorders • Drug and alcohol use prevention programmes • Range of services for homeless people with mental or substance use disorders • Community-based rehabilitation for people with psychosocial disabilities	**Primary health care** Services as provided in low-resource settings and: • Equitable geographical coverage of mental health care integrated in primary care • Coordinated, collaborative care across service delivery platforms • Comprehensive mental health training for general health-care staff	**Secondary health care** Services as provided in low-resource settings and: • Multidisciplinary mobile community mental health teams for people with severe mental disorders • Integration of mental health care with other secondary health care (eg, maternal and child health, HIV)	**Tertiary health care** Services as provided in low-resource settings and: • Consolidate move of mental health inpatient services from psychiatric hospitals to general hospitals • Basic range of targeted specialised services (eg, for children and young people, older adults, forensic settings) Consolidate consultation-liaison services
High-resource settings			
Community Services as provided in low-resource settings and: • Intensive opportunities for • occupation/employment and social inclusion • Intensive community interventions to promote understanding of mental health • Intensive interventions to reduce stigma and promote help-seeking • Full range of independent and supported accommodation for people with long-term mental disorders • Range of evidence-based services in community platforms (eg, in schools, colleges and workplaces) • Intensive drug and alcohol use prevention programmes • Intensive childhood and parenting intervention program mes (eg, l ife-ski l ls training) • Intensive community-level suicide prevention programmes (eg, reduce access to means of self-harm, hotlines, media training)	**Primary health care** Services as provided in low-resource settings and: • Full geographic coverage of mental health care integrated in primary care • Collaborative care model with specialists supporting primary care practitioners	**Secondary health care** Services as provided in low-resource settings and: • Full range of evidence-based psychosocial interventions delivered by trained experts • Full range of evidence-based pharmacological interventions available	**Tertiary health care** Services as provided in low-resource settings and: • Complete move of mental health inpatient services from psychiatric hospitals to general hospitals • Full range oftargeted specialist services (eg, for early intervention for psychoses, for children and young people, older adults, addictions, and forensic settings)

Adapted from *The Lancet Commission on global mental health and sustainable development,* 2018.[1]

Appendix 4
Models of care

Stepped and collaborative care

Collaborative care

Collaborative care focuses on a team approach to providing services. A study on depression details its four main elements:[103]

1. Multi-professional patient care
2. Clear management plan
3. Planned patient follow-up
4. Enhanced inter-professional communication between people caring for the individual

There is strong evidence showing that collaborative care can improve outcomes, team working and sharing of case load. One such trial was conducted in India showing that collaborative community care reduced disability and symptoms for people living with schizophrenia.[104]

This method of working can also strengthen partnerships in the local community. COSIMPO, a study looking at psychosis outcomes in Nigeria and Ghana, showed the effectiveness of collaborative care between primary health-care workers and traditional and faith healers. Care was both effective and cost effective.[65]

Stepped care

Stepped care is a way of integrating mental health services into routine health care, where at different levels, appropriate care is provided based on the persons symptoms of mental health problems.[105] A stepped care approach is seen to be resource efficient and cost effective as it aims to make treatment widely available and at the level of care needed, stepping up to more specialist care when required. It necessitates clear referral pathways and most often a collaborative approach.

The WHO's Mental Health Gap Action Programme Intervention Guide (mhGAP-IG)[79] is a guideline outlining stepped care in primary health care settings. Workers are trained to be able to diagnose and treat priority mental health conditions and refer onwards to specialists as needed.

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