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Mental Health for Sustainable Development

A Topic Guide for Development Professionals

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About this Topic Guide

The K4D Emerging Issues report series highlights research and emerging evidence to policymakers to help inform policies that are more resilient to the future. Knowledge for Development (K4D) staff researchers work with thematic experts and the Department for International Development (DFID) to identify where new or emerging research can inform and influence policy.

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Acronyms	
CBR	Community-Based Rehabilitation
CBT	Cognitive Behavioural Therapy
CHNRI	Child Health and Nutrition Research Initiative
CRPD	Convention on the Rights of Persons with Disabilities
DALYs	Disability-Adjusted Life Years
DFID	Department for International Development
DRF	Disability Rights Fund
DSM	Diagnostic and Statistical Manual of Mental Disorders
EPDS	Edinburgh Postnatal Depression Scale
GHQ-12	12-Item General Health Questionnaire
HADS-A	Hospital Anxiety and Depression Scale for Anxiety
HADS-D	Hospital Anxiety and Depression Scale for Depression
HIV/AIDS	Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome
IASC	Inter-Agency Standing Committee
K4D	Knowledge for Development
LMIC	Low- and Middle-Income Country
mhGAP	Mental Health Gap Action Programme
mhGAP-HIG	mhGAP Humanitarian Intervention Guide
mhGAP-IG	mhGAP Intervention Guide
MHPSS	Mental Health and Psychosocial Support
MH-SET	Mental Health and Psychosocial Support in Humanitarian Settings – Research Priority Setting
MNS	Mental, Neurological, and Substance Use
MSF	Médecins Sans Frontières
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
NTD	Neglected Tropical Disease
PHQ-9	9-Item Patient Health Questionnaire
PRIME	Programme for Improving Mental Health Care
PTSD	Post-Traumatic Stress Disorder
RCT	Randomised Controlled Trial
SDG	Sustainable Development Goal
SRQ-20	20-Item Self-Reported Questionnaire
UK	United Kingdom
UN	United Nations
USD	United States Dollars
WHO	World Health Organization
WHODAS	World Health Organization Disability Assessment Schedule
WHOQOL	World Health Organization Quality of Life Assessment
WNUSP	World Network of Users and Survivors of Psychiatry
YLDs	Years Lived with Disability
YLLs	Years of Life Lost

Executive summary

> "We are deeply concerned about the extent of suffering experienced by our brothers and sisters on our vast continent. Poverty, human rights violations and psychosocial disability go hand in hand. We know that there can be no dignity where poverty exists. No medicines or sophisticated western technology can eradicate poverty and restore dignity... We wish for a better world in which all people are treated equally, a world where human rights belong to everyone. We invite you to walk beside us. We know where we want to go."

(Pan African Network of Users and Survivors of Psychiatry, 2011, pp. 1–2)[1]

Mental health matters

Mental health affects us all. Mental health is a continuum, ranging from good mental health and wellbeing at one end, to substantial personal suffering and impairment at the other. Everyone has mental health, and mental, neurological, and substance use (MNS) conditions can affect anyone.[2]

Together, MNS conditions are the number one cause of years lived with disability (YLDs) worldwide and are responsible for at least 10% of all disability-adjusted life years (DALYs).[3] One in four people will develop a mental health condition in their lifetime, and one in six is living with a neurological condition.[4,5] The number of people living with MNS conditions is expected to increase dramatically in coming years as population sizes and life expectancies rise, especially in low- and middle-income countries (LMICs).[6]

People with MNS conditions are often in vulnerable situations. Many people around the world believe that MNS conditions are the result of personal weakness or supernatural forces, and that people with MNS conditions pose a danger to society. This can result in harmful treatment practices, exclusion from family, community, work, and civic life, inequitable access to health and social services, and ultimately social and economic deprivation, as well as injury, poor health – even death.[7–9]

It is society's negative response to MNS conditions that makes them so profoundly disabling. Yet the voices of people with psychosocial disabilities are often left out of the disability movement.[10] In many LMICs especially, people with psychosocial disabilities have little control over their own lives and few opportunities to take a stand against stigma, discrimination, and abuse.[7–9]

Better mental health and a better world

The cyclical relationship between poverty and MNS conditions is well documented. Inequalities in terms of educational attainment, income, housing, social support, and exposure to violence are important risk factors and outcomes of MNS conditions. The effects extend beyond the individual. Family members – and particularly women and girls – are often responsible for providing care, affecting their opportunities to work and go to school.[7, 8, 11–16] The World Economic Forum estimates that MNS conditions will cost the global economy 16 trillion United States Dollars (USD) in lost economic output by 2030 – USD 7 trillion of which is attributed to LMIC economies.[17]

Despite growing recognition that there is "no health or wealth without mental health", people with MNS conditions are being left behind.[18, 19] People with MNS conditions in LMICs should be targeted both as well-warranted beneficiaries of international development and as dynamic agents of change.[7–9] The World Health Organization (WHO) anticipates that improving the participation of people with MNS conditions through

South Africa: A woman with a psychosocial disability carries out her chores in a district where mental health services are being scaled up through the DFID-funded PRIME research project.
PHOTO: © UNIVERSITY OF CAPE TOWN

development assistance is likely to also improve their psychological and material wellbeing.[7] Yet there are countless examples where people with MNS conditions and psychosocial disabilities have been excluded from international development.

Development professionals have a mandate to do more for mental health. Mental health cannot be adequately addressed by health systems alone. It is a cross-cutting development issue that is relevant across the Sustainable Development Goals (SDGs), which reference both mental health and disability.[20, 21] The commitment to "leave no one behind" – a core theme of the 2030 Sustainable Development Agenda – requires that development agencies reach those who are most excluded and disadvantaged, and who face the most discrimination.[22]

A guide for development professionals

While many development professionals recognise the need to do more for mental health, they do not always know where to begin. This topic guide is intended as a primer for development professionals interested in learning more about the basics, specifically:

- What are some of the key concepts and definitions in mental health?
- Why has mental health emerged as a development priority in recent years?
- What is the current situation in LMICs?
- How does mental health intersect with other key areas of development?
- What is the current state of the evidence, and where are the gaps?

This is not a comprehensive report or a substitute for formal training in mental health. A list of additional learning opportunities and resources is provided for further study in section 7.

1 Background

KEY POINTS

> MNS conditions are caused by a complex interplay of biological, psychological, and social factors that differ across the life course and in different contexts.

> Psychosocial disabilities are a product of various barriers in society faced by people who have, or are perceived as having, MNS conditions.

> Mental health is increasingly being framed as a public health and development issue.

The inclusion of mental health in the SDGs has prompted a radical reframing of mental health as more than just a global health issue.[2] Rather, mental health is understood as a cross-cutting issue in human rights and international development more broadly. For example, the Special Rapporteur on mental health for the United Nations (UN) Human Rights Council recently urged Member States to adopt "structural interventions in society and outside the health-care sector" (p. 2) in order to "create and sustain enabling environments that incorporate a rights-based approach to mental health… [and] a life of dignity and well-being for all persons throughout their lifetimes" (p. 1).[23] This is a call to go beyond treatment, and to see improving mental health as part of a broader and more ambitious project: building a better world.

Intersectoral collaboration is crucial to make this vision a reality, and development professionals have an important role to play. However, global mental health is a relatively new field and may still seem rather foreign, particularly to those working outside the health sector. This topic guide has been created to offer development professionals an initial orientation to key concepts, evidence and issues in mental health in LMICs. It is by no means exhaustive, but aims to provide a foundation for further study.

1.1 Key concepts and definitions

Mental health and wellbeing

WHO defines mental health as a **"state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community".**[24, 25] Mental health is crucial to the overall wellbeing of individuals, societies, and countries. With the right conditions put in place, and the right barriers lifted, people can achieve good levels of wellbeing – living a satisfying and meaningful life and participating on an equal basis with others.

MNS conditions

Mental health is increasingly understood as a continuum, ranging from good wellbeing at one end, to substantial personal suffering and impairment at the other.[2] On the latter end of this continuum, a person may be diagnosed with a MNS condition. The distinction between neurological conditions (e.g. epilepsy, dementia), mental health conditions (e.g. depression, schizophrenia), and substance use conditions (e.g. alcohol and drug dependence) is increasingly being called into question as we learn more about the brain and how it works.[26] Further, in many practical ways, people living with these different conditions often make use of the same services and face similar barriers, such as social exclusion. **As a result, the field of global mental health addresses mental health conditions, neurological conditions, and substance use conditions – not mental health conditions alone.**

"Common" versus "severe" mental health conditions

The terms "common" and "severe" mental health conditions are sometimes used to distinguish between high-prevalence conditions (such as mild depression and anxiety) and less common but often more severely disabling conditions (such as moderate to severe depression, bipolar disorder, and schizophrenia).[27]

Psychosocial disabilities

The UN Convention on the Rights of Persons with Disabilities (CRPD) describes people with disabilities as "those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others".[28] According to the Independent Commission for Aid Impact, "the term psychosocial disability is used to describe **people who have or are perceived to have mental health support needs and who have experienced discrimination (including but not limited to infringements on their liberty, autonomy, and effective participation) based on their needs or presumptions about their needs"** (p. 6).[29] Because the concept of psychosocial disabilities is rooted in a social (as opposed to biomedical) approach, this term places the focus on barriers to

participation rather than on symptoms or diagnosis. This is one reason why it is frequently used as an umbrella term for many different identities, some of which are positioned in relation to services (e.g. as "users", "consumers", or "survivors" of psychiatry or mental health services generally), and others in relation to expertise or experience (e.g. "people with" or "experts by" lived experience, "people who hear voices"), while some seek to reclaim stigmatising terminology (e.g. "mad pride").[30] However, not everyone who identifies with these various terms is comfortable with the language around psychosocial disability, and many prefer to use their own (see **Table 1**).[31]

Intellectual disabilities

WHO defines intellectual disability as "a significantly reduced ability to understand new or complex information and to learn and apply new skills… [which] results in a reduced ability to cope independently… [and] depends not only on a child's health conditions or impairments but also and crucially on the extent to which environmental factors support the child's full participation and inclusion in society".[32] One of the key features of an intellectual disability that may distinguish it from some (but not necessarily all) other forms of psychosocial disability is that it typically "begins before adulthood, with a lasting effect on development".[32] **In response to early drafts of the UN CRPD General Comment 7, campaigners have emphasised that "persons with actual or perceived psychosocial disabilities are a distinct constituency that cannot be combined with persons with intellectual disabilities"** (p. 1).[30] However, intellectual disabilities are not always distinguished from psychosocial disabilities in the literature. This topic guide does not focus explicitly on intellectual disabilities; however, some of the evidence cited may come from studies that include both intellectual and psychosocial disabilities.

1.2 Causes of MNS conditions and psychosocial disabilities

There is no single cause of MNS conditions. **The popular "biopsychosocial model" suggests the causes, outcomes, and experience of MNS conditions are affected by a complex interplay of biological (e.g. genetic, biochemical), psychological (e.g. mood, personality, behaviour), and social factors (e.g. cultural, familial, medical, socioeconomic).**[33] These factors can vary substantially at different stages in the life course, in different populations, and in different contexts.

For example, the risk of developing a MNS condition is linked to: personal characteristics, such as age, gender, and poor physical health; interpersonal factors, such as experiences of violence, racism, and unsafe, overcrowded neighbourhoods; and environmental factors, such as natural disasters, climate change, and urbanisation. In particular, poverty and inequalities in income and education are strongly linked to MNS conditions and can worsen distress, illness, and disability.[7, 8, 11–14]

Risk factors for MNS conditions can have an effect even before birth and accumulate over time. Particular life stages and events – such as early childhood, adolescence and child-rearing – are periods of exposure to heightened risks. In most studies, roughly half of all mental health conditions start by the mid-teens, and three quarters by the mid-twenties.[34]

The impairments caused by MNS conditions can be long-term in nature and, in interaction with various structural, physical, and social barriers, restrict full and equal participation in society, leading to psychosocial disability. Health services play an important – but limited – role in addressing the barriers that reduce social participation and impact negatively on quality of life. As well as access to quality health care, ensuring that people with psychosocial disabilities can access social services and other resources on an equal basis to others is a pressing human rights issue.[7–9]

1.3 Emergence of global mental health

The 1990 Global Burden of Disease study represented a pivotal moment in the early history of global mental health.[35] By taking into consideration disability – not just mortality – this study helped to reframe mental health as a public health priority. This led to the 1995 publication of *World Mental Health: Problems and Priorities in Low-Income Countries* by several influential scholars at Harvard University.[36] In 2001, WHO released its first-ever World Health Report on mental health.[37] In 2007, *The Lancet* published its first series on global mental health.[38] **By 2010, global mental health was being described as a field that had "come of age", the goals of which were to increase access to mental health services, improve treatments, and reduce human rights abuses of people with MNS conditions.**[39] The field continues to gain momentum, with two further *Lancet* Commissions (2011, 2018);[2, 40] a number of key policy reports, including semi-regular WHO Mental Health Atlas reports that map resources for mental health (2001, 2005, 2011, 2014, 2017);[41–45] high-level policy "moments" such as the inaugural Global Ministerial Mental Health Summit in 2018;[46] and political commitments, for example the ratification of the Comprehensive Mental Health Action Plan 2013–2020 by WHO Member States (see **Box 3**).[47]

However, it is worth noting that the rapid growth of the global mental health field has also engendered controversy. For example, many of the most prominent

leaders of the field come from a medical background and assume a common scientific paradigm that is sometimes at odds with more diverse and nuanced social and cultural understandings of mental health and how best to support it.[48-53] There are concerns regarding the potential commercial interest of the pharmaceutical industry in propagating what some critics have called the "medicalisation of distress".[51-54] Even the Global Burden of Disease study that helped to bring mental health into the spotlight has faced growing criticism (as discussed further in **section 2: Making the case for mental health**).[50, 52, 55] These are just a few examples, and it is not possible to do justice to all of these critiques here. However, it is generally acknowledged that supporting people with lived experience – particularly in LMICs – to have more voice, choice, and control, is essential if the field of global mental health is to successfully identify, confront, and ultimately resolve these concerns.[53]

1.4 Note on terminology

Terminology surrounding mental health can be controversial and stigmatising. As described above, different terminology can be used when referring to different contexts and perspectives – most notably, health-related concepts versus those based on a broader disability perspective. For the purposes of this topic guide, the authors adopt the umbrella terms "mental health", "psychosocial disabilities", and "mental, neurological, and substance use (MNS) conditions". "People first" language (i.e. "people/persons with psychosocial disabilities", as opposed to "disabled people") is also employed. For the sake of fidelity to the original texts, more precise terminology surrounding specific conditions, for example "depression" and "anxiety", are occasionally used when citing research evidence.

In this topic guide, "conditions" generally replaces "disorders", "illnesses", and "problems", which are also commonly used in the literature but may carry more negative connotations (exceptions are sometimes made when directly quoting the original source). Critiques of these terms are often rooted in broader theoretical debates surrounding the extent to which mental health is a biological versus a social and cultural phenomenon.[49] As mentioned previously, a full treatment of these critiques is outside the scope of this topic guide. **However, there are some terms that are generally recognised as stigmatising and should not be used, regardless of the speaker's position in these debates** (see Table 1).

Table 1. Guidance note: Highly stigmatising terminology on mental health

Do not use	Examples of possible alternatives*
"A schizophrenic/depressive", etc.	"A person…" • "[living/diagnosed] with schizophrenia/depression" • "who has [experienced] schizophrenia/depression"
"A sufferer/victim", "The afflicted"	"A person with lived experience", "An expert by [lived] experience"
"Demented", "Psycho"	"Experiencing [symptoms of] dementia/psychosis"
"Inmates" (in a psychiatric hospital)	"Clients", "Inpatients", "Service Users"
"Insanity", "Lunacy", "Mental sickness"	"Mental disorder", "Mental health condition", "Mental health problem", "Mental illness"
"Mental", "Crazy"	"Experiencing [symptoms of] a mental health condition/health problem/illness/disorder"
"Released" (from a psychiatric hospital)	"Discharged", "In recovery"
"The mentally disabled", "The psychosocially disabled"	"Persons/people [living] with psychosocial disabilities"
"The mentally ill", "The insane"	"Persons/people…" • "[living/diagnosed] with mental health conditions/health problems/illness/disorders" • "who have [experienced] mental health conditions/health problems/illness/disorders"
"Trauma", "Traumatised"	"Adversity", "Exposed to [situations of] adversity"

*Mental health terminology can be controversial and stigmatising, and it is still very much evolving. As described above, there are many different ways in which people self-identify, and many people may disapprove of the alternatives provided here. It is important to consult with key stakeholders, and particularly people affected, regarding their preferences when deciding which terminology to adopt in your communications on mental health.

Source: Authors' own.

2 Making the case for mental health

KEY POINTS

- Estimates of the global burden of disease indicate MNS conditions cause 10–13% of DALYs.
- MNS conditions are expected to cost the global economy USD 16.3 trillion for the period 2010–30.
- The human rights of people with psychosocial disabilities are routinely violated.

Mental health was not included in the Millennium Development Goals,[56] and there are countless examples from different countries and development sectors not only of missed opportunities to improve mental health, but also of the deliberate exclusion of people with MNS conditions and psychosocial disabilities from development efforts (see Table 2). This is starting to change, partly in response to mounting evidence of the importance of mental health to the health and wealth of nations, as well as growing awareness of mental health as a human rights issue. Key arguments commonly used to make the case for mental health as a priority for international development – public health, economic, and human rights – are described briefly below. More sector-specific arguments are outlined in section 5: Key topics in development.

2.1 Public health case

One in four people will develop a mental health condition in their lifetime, and one in six is living with a neurological condition.[4, 5] Conservative estimates suggest that up to 6.4% of the population experience a substance use condition each year.[62] It is common for MNS conditions to first onset in childhood, adolescence, or early adulthood, interrupting a critical period of personal development. The symptoms of MNS conditions can be long lasting and severely debilitating. Although not often perceived as "killer diseases", MNS conditions are also linked to excess mortality (see Box 1).

The number of people living with MNS conditions is expected to rise dramatically in coming years as life expectancies increase, particularly in LMICs with young populations.[3, 6] This is one reason why mental health is increasingly being recognised as an important public health issue in LMICs. For example, the number of people living with dementia (including Alzheimer's disease) nearly doubles every 20 years, with the biggest increases in LMICs – already home to nearly 60% of all people living with dementia.[68] Another important reason is that physical health conditions and MNS conditions are closely interrelated: the former can serve as both a risk factor and an outcome of the latter, and vice versa.[27] Meanwhile, MNS conditions have been linked to low treatment adherence for physical health conditions such as HIV/AIDS.[27]

Table 2. Evidence summary: People with MNS conditions are being left behind

Disability Worldwide	19% of WHO Member States offer no government social support to people with psychosocial disabilities; for low- and lower middle-income countries, it is nearly 30%.[44]
Gender India	Inadequate legal protection for women with MNS conditions results in violations such as unnecessary institutionalisation, and loss of child custody and property.[57]
Health Kenya	The National Hospital Insurance Fund excludes treatment of mental health conditions; costs are often borne by patients and their families.[7, 58]
Humanitarian Kosovo	During the conflict, workers from the psychiatric institution fled, leaving residents trapped inside. Behind locked doors, hunger, cold, and sickness claimed lives.[7, 59]
Social protection Uganda	People with MNS conditions were denied access to microcredit due to the belief that they would be unable to repay loans, and because lenders feared they would have no recourse in case of non-payment.[7, 60]
Education Burundi	In rural areas, families with financial restrictions will pay to educate only their eldest sons. Children with MNS conditions are usually the first to be deprived of education, as they are deemed unworthy of the investment.[7, 61]

Source: Authors' own, based on examples across countries and development sectors from Funk, Drew, and Freeman (2010)[7] and additional literature review.

BOX 1

Evidence summary: MNS conditions increase mortality

MNS conditions contribute substantially to global mortality. Suicide – which is often (but not always) linked to MNS conditions – accounts for one death every 40 seconds, and three out of four suicides take place in a LMIC.[63] Among teenage girls, it is now the leading cause of mortality globally.[63, 64] However, each group of conditions presents its own risks, which can only be partly explained by the link to suicide.

- **Mental health conditions:** The life span of people with severe mental health conditions like schizophrenia is 10–25 years shorter than that of the general population.[65]
- **Neurological conditions:** By 2030, 12.22% of all deaths worldwide will be attributable to neurological conditions.[66]
- **Substance use conditions:** Harmful use of alcohol and illicit substances are responsible for 39 deaths per 100,000 population.[67]

Source: Authors' own, based on a literature review.

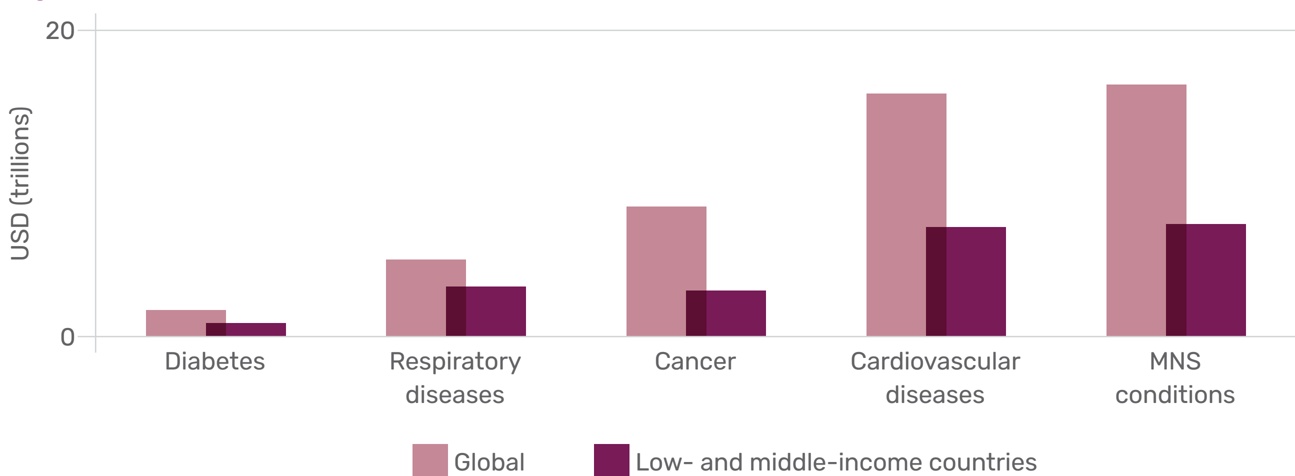
The high prevalence, early onset, and often chronic and debilitating nature of MNS conditions make them the leading cause of YLDs worldwide. Mostly as a result of differences in how mortality – or years of life lost (YLLs) – are calculated, estimates of the overall global burden of disease attributable to MNS conditions range from approximately 10% to 13% of all DALYs.[3, 69] The latter estimate puts MNS conditions on a par with cardiovascular diseases, currently the leading cause of the global disease burden. However, it is important to note that as a metric, the global burden of disease has been criticised both for methodological issues and for reinforcing a biomedical perspective of mental health[52] – for example:

> An effective tool used to elevate global mental health is the use of alarming statistics to indicate the scale and economic burden of "mental disorders". While it is uncontroversial to note that millions of people around the world are grossly underserved, the current "burden of disease" approach firmly roots the global mental health crisis within a biomedical model, too narrow to be proactive and responsive in addressing mental health issues at the national and global level. (UN Special Rapporteur (2017) on mental health, p. 5)[55]

2.2 Economic case

Economists at the World Economic Forum and Harvard University estimate that MNS conditions will cost the global economy USD 16.3 trillion (USD 7.3 trillion from LMICs) in the period 2010–30 – more than cancer, diabetes, and respiratory diseases combined (see Figure 1).[17] Much of this is due to lost economic output. Among people with disabilities, those with psychosocial disabilities have the highest rates of unemployment: 70–90%.[7, 70] Among those in work, MNS conditions can also cause substantial losses in productivity – for those with MNS conditions as well as their carers. WHO estimates

Figure 1. Evidence summary: Cost of MNS conditions, 2010–30



Source: Authors' own, based on analysis by Bloom et al. (2011),[17] comparing the global economic burden of MNS conditions to other non-communicable diseases.

12 billion working days (or 50 million years of work) are lost annually due to depression and anxiety alone.[71] Consequently, the global return on investment for depression is estimated at USD3–5 for every USD1 spent.[71]

As with the **public health case** described above, there have been critiques of the economic case. Critics have expressed concern over the implication that narrowly defined economic productivity is the main outcome of interest for investors.[52] If other outcomes are not also taken into consideration, there may be a risk that some people (e.g. those who are less likely to return to paid work) are not considered "good" investments and end up being left behind.

2.3 Human rights case

> Ground zero in global mental health is not the 15% [*sic*] global burden of disease… [nor] the cost of mental disorders… Ground zero is the routine local condition of people with mental illness (including those with dementia and autism, for example) in communities, networks, and families. It is their pain and suffering. (Kleinman, 2009, p. 603)[72]

The **public health** and **economic** cases already outlined offer compelling arguments for global action. Yet, as scholar and advocate Professor Arthur Kleinman highlights in the above quote, many working in this area are more motivated by the profound stigma, discrimination, and human rights violations experienced by people with psychosocial disabilities, particularly in LMICs (see Box 2). Further, it has been argued that advocating for the scale-up of mental health care on public health and economic grounds could lead to further human rights violations, if the status quo of mental health service provision goes unchallenged.[55] Unfortunately, as *The Lancet* Executive Editor Jocalyn Clark (2014) observes: "The human rights work in global mental health seems particularly weak compared to the treatment scale-up and research aims of the main movement".[53]

Institutionalisation and various other structural, physical, and social barriers impede equal participation in society and access to key services and support. People with psychosocial disabilities have a higher risk of experiencing violence, homelessness, and incarceration. Coercion, forced restraint, prolonged seclusion, sexual assault, and other abuses are commonplace in homes, health facilities, social care institutions, and healing centres in LMICs.[7, 8, 57, 73-76]

Those who experience abuse rarely have the opportunity to raise complaints or seek justice. Their voices are often left out of the broader disability movement, and mechanisms for monitoring and accountability of mental health systems in LMICs are generally weak.[77] Partly as a result of underrepresentation, global debate on the treatment of people with MNS conditions tends to be dominated by mental health professionals.[7-10]

Stigma and discrimination can be tackled by raising the voices of people with lived experience. Evidence from a global review of the literature suggests that social contact with people who have lived experience of MNS conditions is the most effective intervention for stigma reduction.[78] Simply raising mental health awareness does not go far enough. However, more rigorous research is needed to determine whether these findings hold true in LMICs.[79]

BOX 2

Evidence summary: Top 10 human rights violations

1. Exclusion, marginalisation, and discrimination in the community.
2. Denial or restriction of employment rights and opportunities.
3. Physical abuse/violence.
4. Inability to access effective mental health services.
5. Sexual abuse/violence.
6. Arbitrary detention.
7. Denial of opportunities for marriage/right to start a family.
8. Lack of means to enable people to live independently in the community.
9. Denial of access to general health/medical services.
10. Financial exploitation.

Source: **Drew et al. (2011)**, in which 51 people with psychosocial disabilities were consulted across 18 LMICs; listed in order of frequency of mentions by respondents.[9] Reproduced with permission from Elsevier.

3 Policy and advocacy

KEY POINTS

- There is a growing advocacy movement in LMICs.
- Not all LMICs have mental health policies and plans, and most of those that do have failed to fully implement them.
- There are a number of international policy frameworks established by UN agencies that can help to guide policy formulation in LMICs.

3.1 Advocacy in LMICs

In LMICs there are relatively few active organisations for people with psychosocial disabilities or their families and carers; they also tend to be underrepresented within the disability movement as a whole – and efforts to support capacity building are limited. However, the number of LMICs with such organisations is growing, and umbrella bodies like Transforming Communities for Inclusion – Asia Pacific (TCI Asia Pacific), the Latin American Network of Psychosocial Disabilities, and the Pan African Network of People with Psychosocial Disabilities are beginning to emerge. At present, the World Network of Users and Survivors of Psychiatry (WNUSP) has members in 30 countries. A Global Mental Health Peer Network launched in 2018 has also grown out of the Movement for Global Mental Health.

3.2 Policy in LMICs

Seventy-nine per cent of WHO Member States have a stand-alone mental health policy or plan, but most have not fully implemented it, partly due to failure to allocate adequate resources for implementation.[44] Only about half of Member States with a mental health policy or plan have estimates of the resources required to implement it, and of those, only half have allocated those resources.[44] Monitoring of policy implementation is weak in most LMICs, and policies are frequently outdated and out of step with international human rights standards. The countries with the highest proportion of children and adolescents in their population are also the most likely to be lacking a child and adolescent mental health policy in any form.[80]

According to a five-item checklist measuring observance of international human rights standards in mental health policy formulation, the biggest gaps surround the rights of people with psychosocial disabilities to: (1) make decisions about their own lives, and (2) live independently and be included in the community.[41] Observance of human rights standards in mental health policy formulation is lowest in the Southeast Asian and Eastern Mediterranean regions.[41] In these contexts, coercive practice is common, and services are rarely designed to encourage ownership over one's care and recovery.[7–9, 57, 73]

The WHO QualityRights project aims to mobilise organisations of people with psychosocial disabilities to contribute to policy reform and hold countries accountable for implementation (see Box 4). It is now being implemented nationally in more than 10 countries.

3.3 International policy

The relevance of mental health to social development, human rights, and health agendas is gaining global attention. The CRPD is reaching near universal ratification. Countries like the UK which have signed the CRPD are obligated to ensure that their overseas development and humanitarian programmes are inclusive of and accessible to people with disabilities under articles 32 (International Cooperation) and 11 (Situations of Risk and Humanitarian Emergencies).[28]

The Sustainable Development Agenda pledges to "leave no one behind" and to eradicate extreme poverty.[21] These pledges will not be met if policies and programmes fail to reach people with psychosocial disabilities (see Table 2). Disability-specific targets are included in six of the 17 SDGs, and mental health and wellbeing are explicitly targeted in SDG 3 (Health).[21, 29] Further, the Inter-agency and Expert Group on SDG Indicators calls for indicators to be disaggregated by disability.[90]

In addition to the CRPD and SDGs, a number of other key frameworks have been developed to help guide global action (see Box 3).

BOX 3

Guidance note: Key mental health policy frameworks across sectors

International human rights frameworks

United Nations Convention on the Rights of Persons with Disabilities[28]

As of August 2019, the CRPD has been ratified by 177 countries. It represents a shift from a medical and charitable model towards a rights-based approach. The CRPD entitles people with disabilities to the full spectrum of human rights without discrimination. While the whole of the CRPD is relevant to people with psychosocial disabilities, certain articles are particularly significant, such as Article 12 on legal capacity, Article 15 on freedom from torture or inhuman or degrading treatment, Article 19 on community living, and Article 25 on health.

United Nations Human Rights Council Resolution on Mental Health and Human Rights[83]

A Resolution on Mental Health and Human Rights, adopted by the UN Human Rights Council in July 2016, calls for a rights-based approach to mental health care. Following on from this resolution, a report on mental health and human rights by the UN High Commissioner for Human Rights was presented at the 39th session of the UN Human Rights Council in September 2018.[84]

Health frameworks

World Health Organization Mental Health Action Plan 2013–2020[47]

Endorsed by 194 Member States, this comprehensive action plan for mental health has been extended into 2030 and also linked to the WHO Special Initiative for Mental Health (2019–2023) in 12 priority countries. Objectives include: strengthening leadership and governance; establishing community-based mental health services and prevention and promotion programmes; and supporting research and information systems. The WHO Mental Health Atlas serves as a monitoring mechanism and measures progress against six global targets every two years. The 2017 Atlas reports that progress has been made since 2013, but that current efforts – and current investment, in particular – are insufficient to achieve the global targets.[44]

World Health Organization Mental Health Gap Action Programme[85]

The first Mental Health Gap Action Programme (mhGAP) intervention guide (mhGAP-IG) was launched in 2007 as a protocol for clinical decision-making to aid non-specialist health providers in the management of priority MNS conditions. An updated guide (mhGAP-IG 2.0) was launched in 2017 and reflects recent progress in accessible psychological and social interventions, in addition to the established medical interventions outlined in the first mhGAP-IG. The updated version is available in a wider range of formats, including for mobile devices, and strengthens efforts in many countries to not only improve knowledge of comprehensive treatment options among frontline health workers, but to facilitate effective delivery within a supportive health service infrastructure.

Humanitarian frameworks

Inter-Agency Standing Committee Guidelines[86]

Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings were released to provide conceptual and practical clarity about the role, definition, and scope of MHPSS in emergencies. New IASC Guidelines on the Inclusion of Persons with Disabilities in Humanitarian Action also cover MHPSS and are currently in production.[87] Additionally, The Sphere Handbook defines minimum standards of mental health care to be provided in humanitarian settings aligned with IASC Guidelines on MHPSS.[88] Minimum standards have also been produced for older people and people with disabilities, including people with psychosocial disabilities.[89] These documents represent a global inter-agency consensus on best practices in this field, and have been widely adopted and used.

Source: Authors' own, based on expert consultation and a literature review.[81, 82]

4 Resources

KEY POINTS

- Resources for mental health in LMICs are inadequate, and resource allocation is inequitable and inefficient.
- The proportion of national health budgets and international development assistance for health allocated to mental health are not in line with the proportion of DALYs attributed to MNS conditions.

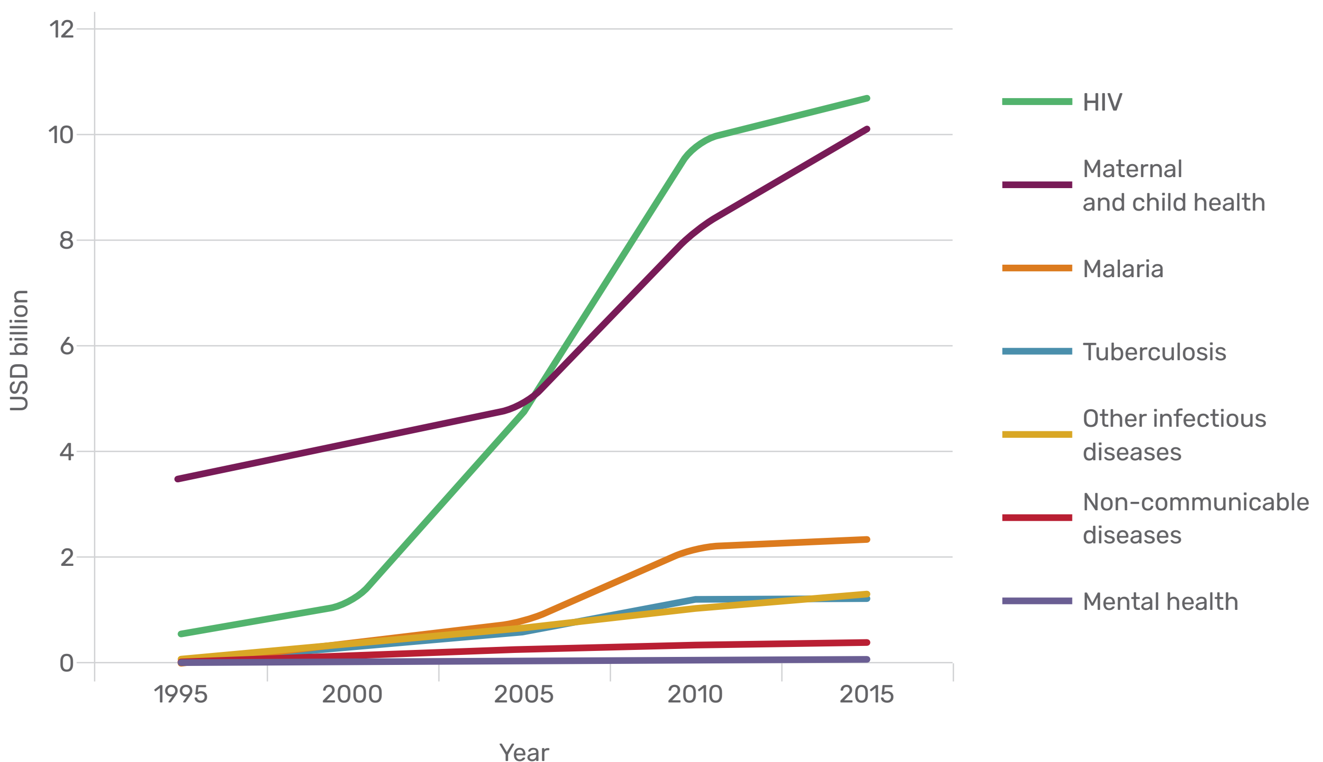
4.1 Financing

By investing just USD2 per person per annum in community-based, stepped mental health programmes, service coverage could be extended to nearly half of the population with MNS conditions in LMICs, with more than a twofold return on investment.[91] Yet government mental health expenditure is well below USD2 per capita in most LMICs. In Africa and Southeast Asia, for example, the median is only USD0.01 per capita.[44] Government mental health expenditure is also inequitably and inefficiently allocated, mostly toward running inpatient psychiatric facilities.[92] Over 80% of LMICs' mental health spending goes to these facilities.[44]

Overseas development assistance has not compensated for shortfalls in government spending. According to the most recent estimates, only 0.4% of development assistance for health (USD 132 million) is allocated specifically to mental health. This is a small fraction of what is spent on other global health priorities (e.g. HIV consumes 30%) (see Figure 2). Private philanthropy is the largest source of funding, channelled primarily through non-governmental organisations (NGOs) and foundations.[93]

Most data available on mental health financing are limited to the proportion of health spend that is allocated to mental health services. It is important to note that this is only one part of the picture; for example, there are currently no data available on the proportion of international spending on human rights allocated to mental health.

Figure 2. Evidence summary: Development assistance for health (1995–2015)



Source: Charlson et al. (2017), CC BY 4.0.[93]

4.2 Social support

For people with psychosocial disabilities in LMICs, disability payments, income support, and non-monetary assistance such as support in locating housing or employment are virtually non-existent. The WHO 2014 Mental Health Atlas indicated that only 12–14 people with psychosocial disabilities per 100,000 population received any sort of social support in LMICs, compared to 520 per 100,000 in high-income countries.[41] The 2017 Atlas reports that in approximately one quarter of all LMICs, there is no government social support at all for people with psychosocial disabilities.[44]

Mental health is frequently left out of the package of services covered by national insurance schemes in LMICs. Even in countries where treatment for physical health problems is provided by the government free of charge, households often bear some or all of the financial burden for mental health care.[8, 41] Payment for mental health services is mostly or entirely out of pocket in 17% of all WHO Member States, and in the African and Southeast Asia regions the figure is over 40%.[44]

4.3 Information

A little over a third of WHO Member States regularly compile data on mental health service activity in the public sector, representing a significant health management issue, particularly in LMICs. Twenty per cent of all LMICs have not compiled any mental health data in the past two years.[44] Frequently, the data that are reported from LMICs come exclusively from public psychiatric facilities, and fail to track mental health services in the private sector and non-specialist settings.[94]

There is also a lack of data being collected on psychosocial disabilities in international development, meaning there is limited information on the extent to which people with psychosocial disabilities are being included in development programmes.[95] If indicators on psychosocial disability, mental health, and wellbeing were regularly used, many more development activities would likely come to be recognised as effective psychosocial interventions.[7, 95] This is most evident in the humanitarian sector, where the value of psychosocial interventions is recognised and has become an integral part of emergency response.[86]

4.4 Public health

The WHO Mental Health Action Plan 2013–2020 sets a target for 80% of countries to have at least two functioning national, multisectoral promotion and prevention programmes in mental health by 2020.[47] Sixty-three per cent of WHO Member States have met this target, though the proportion of African countries that meet the target (48%) is much lower than in other regions (70–80%).[44] Over 40% of the programmes reported are mental health awareness or anti-stigma programmes, and only 10% of programmes are implemented at the district or community level.[44] While suicide mortality is a key indicator for the SDGs (see **Box 13**), only 10% of low- and lower-middle-income countries have a stand-alone government-adopted suicide prevention strategy.[44] The 2018 *Lancet* Commission on global mental health and sustainable development argues for more attention to be paid to tackling social and economic risk and protective factors for MNS conditions as part of the 2030 Sustainable Development Agenda.[2]

4.5 Mental health care

There is very little formal mental health care available in most LMICs. Where health services do provide mental health care, it is often primarily institutional and concentrated in urban areas that are difficult to access for much of the population.[41, 44, 92] Poverty, stigma, and discrimination also represent important barriers to access, and services may be abusive or of poor quality.[7-9, 57, 73-76] As a result of shortages of mental health specialists, there is often a heavy reliance on psychotropic medication in low-resource health-care settings, even for conditions that can benefit substantially from psychological interventions.[96] Yet stock-outs are commonplace in many public facilities, even though a number of psychotropic medications are included in the WHO Essential Drugs List.[97]

Much of the care that is received is informal. Families often bear personal and financial responsibility with little support. In the absence of reliable supply chains, people with MNS conditions may rely upon poorly regulated private marketplaces for medication and treatment.[98, 99] In many LMICs, traditional healing is commonly used either in lieu of or in supplement to medical care, and can sometimes involve abusive practices.[9, 100]

Conservative estimates indicate 32–78% of people with MNS conditions do not receive psychiatric care.[101] In many LMICs, the gap is especially wide (**Table 3**).[102-105] For example, each year in Nigeria only 8% of people with a severely disabling mental health condition accesses any form of care – either medical or traditional healing.[100, 104]

Table 3. Evidence summary: Access to care for mental health conditions worldwide

Condition	Africa	Americas	Eastern Mediterranean	Europe	Southeast Asia	Western Pacific
Bipolar disorder	–	60.2%	–	39.9%	–	52.6%
Major depression	67.0%	56.9%	70.2%	45.4%	–	48.1%
Schizophrenia	–	56.8%	–	17.8%	28.7%	35.9%

Note: The percentage of people with severe mental health conditions who do not receive psychiatric care, by WHO region.

Source: Adapted from **Kohn et al.'s (2004)** review of epidemiological surveys, **CC BY 3.0 IGO**.[101]

4.6 Mental health workforce

Mental health services are vastly understaffed in LMICs. Human resource shortages are in part a result of inadequate financing and competing priorities within the health sector. Contributing factors include the stigma of working in mental health, brain drain, poor working conditions, and lack of training opportunities.[106-108]

While one in ten people may have a mental health condition at any given time, there is less than one mental health worker for every 10,000 people globally. The median number of mental health workers per 100,000 population ranges from 1.6 in low-income countries to 71.7 in high-income countries.[44] The number of mental health specialists in LMICs is even lower. Tanzania, for example, has 13 psychiatrists, compared to more than 100 surgeons.[109, 110] Liberia and Sierra Leone each have only one psychiatrist currently practising.[111, 112] The situation is often most dire in the world's least developed countries and in fragile and conflict-affected states.

The level of knowledge and skills around mental health and psychosocial disability is also low among personnel in other sectors, resulting in poor access to appropriate support in social, education, and justice spheres.[113]

5 Key topics in development

KEY POINTS

- Mental health is relevant to virtually every aspect of international development.
- There are evidence-based and rights-based approaches that can improve mental health, both within and beyond the health sector, in LMICs.
- More research is generally needed to identify the "best buys" for mental health in development.

> *Let us also go beyond the medical approach […] Because that large number of people being pushed on the edge can contribute to national development, who knows? […] we are asking that we put in place some deliberate policy and programmes […] Include them in developmental programmes and see how much they can contribute [….] So we are also attaching mental health to development.*
> (Anonymous user advocate, in Kleintjes, Lund and Swartz, 2013, p. 191).[114]

As in the above quote, advocates have long recognised the need for a comprehensive approach to mental health that goes beyond the health sector and is rooted in human rights. **There is now a clear consensus that mental health is best addressed through a coordinated, multisectoral response, in which efforts at mainstreaming are coupled with mental health-specific initiatives.**[2, 7, 8, 115] For example, the UK All-Party Parliamentary Groups for Global Health and Mental Health call for development funders like the Department for International Development (DFID) to: (1) "integrate" mental health into existing work; (2) "evaluate" the mental health impact of existing work; and (3) "replicate" and scale-up work that benefits mental health.[95]

There is also significant overlap between efforts to improve mental health and a number of international development priorities involving many different sectors (see Table 4).[115] Consequently, the most recent *Lancet* Commission on global mental health and sustainable development argued for a dramatic reframing of mental health as not just a health issue, but as a cross-cutting development issue relevant to virtually all of the SDGs.[2] Improving the conditions in which people live yields benefits for mental health that cannot be achieved through treatment alone, as described further below.

This section offers a very brief overview of mental health as it relates to six key areas of international development: disability, gender, health, humanitarian, social protection, and youth. A full treatment of any one of these topics would merit a full report in itself. Although by no means comprehensive, three key subtopics are presented for each area of development, alongside a short description of evidence-based approaches commonly used in each area.

5.1 Disability

The field of global mental health has been criticised for taking an overly biomedical perspective to date, with a focus on addressing the "treatment gap" (see Table 3), rather than the structural and social conditions that contribute to poor mental health and human rights abuses against people with psychosocial disabilities.[49, 51] The concept of "psychosocial disabilities", as defined by the CRPD, requires a more holistic response to the "interaction" between the "impairments" caused by MNS conditions and the "various barriers [that] may hinder their full and effective participation in society on an equal basis with others".[28] Applying principles of disability-inclusive development to mental health means taking multisectoral, multi-stakeholder approaches to tackle inequalities in access to and quality of health and social services, while protecting the broader rights of people with psychosocial disabilities: for example, the right to live independently and be included in the community (Article 19), the right to marry and have a family (Article 23), and the right to vote and participate in public affairs (Article 29).[2]

Three key issues

1. "Nothing about us without us"

A disability-inclusive perspective entails a commitment to voice, choice, and control for people with psychosocial disabilities. While involvement of people with psychosocial disabilities has been central to mental health-care reform in many high-income countries, a systematic review published in 2016 identified few examples of meaningful participation by service users in mental health systems strengthening in LMICs.[116] Less than a third of countries in the WHO Africa region have any mechanisms in place for the involvement of service users in the mental health system.[44] Thirty-six per cent of UN Member States deny all people with psychosocial disabilities the right to vote, and few organisations actively represent their interests in LMICs.[16]

Table 4. Evidence summary: Framing MNS conditions as part of the SDGs

Relevant SDG	Key risk factors	Mental health outcomes	Potential interventions
SDG 1: No Poverty **SDG 2:** Zero Hunger **SDG 8:** Decent Work and Economic Growth **SDG 9:** Industry, Innovation, and Infrastructure **SDG 10:** Reduced Inequalities	Income security, debt, assets, food security, employment, housing, income inequality, macroeconomic recessions, subjective financial strain	Depression, anxiety, substance abuse, psychosis, suicide, dementia, childhood internalising, and externalising disorders	Cash transfers or basic income grants, reductions in income inequality, improved employment
SDG 4: Quality Education	Education, social cohesion, social capital, social class	Depression, anxiety, dementia, psychosis, child and adolescent internalising disorders	Improved education, strengthened social capital
SDG 5: Gender Equality	Gender and sex	Depression, anxiety, substance abuse, psychosis, child and adolescent behavioural and developmental disorders, dementia	Reduction of gender-based violence, reduction of child maltreatment
SDG 6: Clean Water **SDG 7:** Affordable and Clean Energy **SDG 11:** Sustainable Cities and Communities **SDG 12:** Responsible Consumption and Production	Structural characteristics of neighbourhoods including infrastructure, safety, aggregate socioeconomic deprivation, built environment, leisure opportunities, urbanicity, crime, community violence, social cohesion	Depression, anxiety, substance abuse, psychosis, child and adolescent substance abuse, externalising behaviours	Improved housing, safe neighbourhoods
SDG 13: Climate Action **SDG 16:** Peace, Justice, and Strong Institutions	Natural hazards, industrial disasters, armed conflict, displacement, and disasters triggered by ecosystem hazards due to climate change or increased population	Depression, anxiety, PTSD, suicide, childhood internalising and externalising disorders	Reductions in violence, early response to environmental events, action on protecting vulnerable ecosystems

Source: Lund et al.'s (2018) systematic review.[115] Reproduced with permission from Elsevier.

Consequently, people with psychosocial disabilities are frequently missing from national plans related to CRPD compliance and reporting. The WHO QualityRights project provides practical guidance on how to address this (see Box 4).[117] Funders, policymakers, and other development actors are increasingly being encouraged to play a role in challenging exclusion, by ensuring that their engagement with representative groups of people with disabilities includes people with psychosocial disabilities.

2. Involuntary treatment

Involuntary treatment has been a major point of debate in global mental health. A General Comment on Article 12 by the CRPD Committee establishes that people with psychosocial disabilities must be guaranteed legal capacity on an equal basis with others, and therefore cannot be detained against their will, even with consent from a substitute decision maker.[118] Concerns regarding respect for the agency of people with psychosocial disabilities to make their own decisions are compounded

BOX 4

Guidance note: What is the WHO QualityRights project?

WHO's QualityRights initiative aims to improve the quality of care in mental health and social services and to promote human rights for people with psychosocial, cognitive, and intellectual disabilities. QualityRights comprises five overarching areas of work:

- Build capacity to combat stigma and discrimination and to understand and promote human rights, recovery, and independent community living.
- Improve the quality of services and human rights conditions in mental health and social care services including community-based services.
- Create community-based and recovery-oriented services that respect and promote human rights.
- Support the development of a civil society movement to conduct advocacy and influence policymaking towards a human rights-based approach in mental health.
- Reform national policies and legislation in line with best practice, the CRPD, and other international human rights standards.

WHO QualityRights tools and resources

In order to support countries in each of these areas, the QualityRights initiative has developed a number of key resources and tools to support capacity building, service transformation, civil society strengthening, and advocacy:

- **WHO QualityRights materials for training, guidance, and transformation**;
- **WHO QualityRights country implementation portal**.

Source: Based on the **QualityRights** project documentation and expert consultation.[81, 117]

by the poor conditions and abusive practices in some psychiatric facilities, the potentially deleterious side effects of many psychotropic medications, and the stigma attached to hospitalisation. Broader critiques regarding the validity of psychiatric diagnoses (e.g. "labelling theory") and treatment efficacy underlie some of these concerns as well.[49, 54]

On the other hand, some have questioned whether Article 12 could have negative ramifications for other rights protected by the CRPD. For example, is someone at high risk of self-harm who refuses intervention being deprived of their right to the highest attainable standard of health, or possibly their right to life? If guaranteed legal capacity under all circumstances, would someone with a psychosocial disability who has committed a crime no longer be given any special considerations under criminal law, potentially violating their right to justice?[119]

These are nuanced and ongoing debates that cannot be adequately addressed here. However, it is important to note that following "extensive consultations among a wide range of stakeholders" (p. 3) and critical review of the research evidence,[120] the UN Special Rapporteur on mental health (2017) has concluded that States should "take targeted, concrete measures to radically reduce medical coercion and facilitate the move towards an end to all forced psychiatric treatment and confinement" (p. 21).[23] His report has been interpreted by many as a condemnation of coercion in mental health care and a significant "win" in favour of the General Comment on Article 12. The Mental Health Action Plan 2013–2020 encourages WHO Member States to update mental health laws to be in line with international and regional human rights instruments, and involuntary treatment is one of the service development indicators that it monitors.[47]

3. Institutionalisation

Closely related to the issue of involuntary treatment is that of institutionalisation. Article 14 of the CRPD recognises the right to liberty and security, and Article 19 recognises the right to live independently and be included in the community.[28] Both require a reversal of the long-standing history of custodial, institutionalised mental health care in high-income countries as well as LMICs around the world. This is a particularly big issue in upper middle-income countries, where 29% of psychiatric inpatients have had an inpatient stay of one year or longer (12% for more than five years).[44]

The process of deinstitutionalisation, or shifting away from psychiatric institutions towards services

closer to the community, is not the same as transinstitutionalisation, in which smaller institutions are created to replace larger ones. Deinstitutionalisation requires investment in rights-based mental health-care reform, as well as safeguarding. The recent Life Esidimeni Scandal in South Africa's Gauteng Province offers a cautionary tale: over 140 people died and approximately 40 more were lost after being transferred haphazardly from specialist mental health facilities to ill-equipped hospitals, NGOs, and families, in a bid to cut public spending.[121]

Evidence-based approaches and entry-points

There has been a general lack of investment in rights-based approaches to mental health and a paucity of research from this perspective in most LMICs. There are promising "real-world" examples of disability-inclusive development interventions targeting psychosocial disabilities in LMICs (see Box 5) – though more rigorous evaluation is needed in order to identify "what works" in this area. Consultations carried out in LMICs have identified actions that can be taken to promote the human rights of people with psychosocial disabilities. However, large international inquiries with diverse samples and systematic methodologies are lacking. A 2011 *Lancet* study in which 51 people with psychosocial disabilities were consulted across 18 LMICs prioritised the following (p. 1668):[9]

1. Running public awareness and anti-stigma campaigns, and providing education about the rights of people with psychosocial disabilities, as well as about mental health in general;
2. Providing better training of mental health professionals, increased funding for mental health services, and provision of better mental health services, especially in the community;
3. Promoting the empowerment, rehabilitation, and participation of people with psychosocial disabilities in their communities;
4. Implementing effective and humane laws and policies to protect and promote the human rights of people with psychosocial disabilities;
5. Encouraging the formation of, and providing ongoing support to, organisations of people with psychosocial disabilities;
6. Monitoring and assessment of human rights of people with psychosocial disabilities, and of mental health services generally; and
7. Integrating mental health into overall health and development policies.

Although based largely on studies from high-income countries, a literature review commissioned by the UN identified a number of hospital-based and non-hospital-based measures which could play a role in reducing coercion in mental health care.[120] For hospital-based strategies, both top-down and ward-level leadership were important for changing the organisational cultures that sustain coercive practice. Crisis resolution, respite houses, and home-based support were heavily emphasised in the community-based alternatives to coercion identified by the reviewers.

In terms of evidence-based normative guidance, the Community-Based Rehabilitation (CBR) Guidelines issued by several UN agencies in 2010 includes a supplement

BOX 5

Case study: Ghana – Fighting abuse and raising awareness

The Disability Rights Fund (DRF) provides grants to organisations led by people with disabilities, including three organisations in Ghana that champion the rights of people with psychosocial disabilities. For example, MindFreedom Ghana was awarded a small grant to support the development of guidelines on the admission and treatment of people with psychosocial disabilities in prayer camps, where gross human rights violations are commonplace. These guidelines aim to regulate the admission of people to prayer camps as well as the use of inhumane practices such as shackling, restricting access to water, and administering psychotropic medications without a prescription. These guidelines were developed in collaboration with a range of stakeholders for consideration by Ghana's Mental Health Authority. While the process of developing the guidelines helped to build a relationship with the Mental Health Authority and other key stakeholders, the grant also allowed MindFreedom Ghana to raise awareness of conditions in prayer camps through radio programmes.

MindFreedom Ghana: **www.disabilityrightsfund.org/grantees/mindfreedom-ghana/**

Source: Authors' own, based on project documentation and expert consultation.[124, 125]

on mental health, though this was based largely on evidence from high-income countries.[122] More recent studies have since demonstrated the effectiveness of CBR approaches for people with severe mental health conditions in LMICs; for example, a collaborative community-based care intervention based on a CBR approach showed modest effects on symptom severity and disability score as part of a 2014 trial in India.[123]

5.2 Gender

Research suggests that there are significant gender disparities in mental health – highlighting the need to address both gendered experiences of mental health and social risk factors.[13] While substance use conditions are more prevalent in men, common mental health conditions such as depression and anxiety are approximately twice as common in women.[126] For severe mental health conditions such as schizophrenia and bipolar disorder, differences in prevalence are less pronounced. However, there are also gender differences in some neurological conditions; for example, in most world regions the prevalence of dementia is highest in women.[127, 128] Multisectoral approaches are needed to ensure that both those at risk and those living with MNS conditions are included in programme and policy interventions designed to promote gender equality.

Three key issues

1. Violence against women and girls

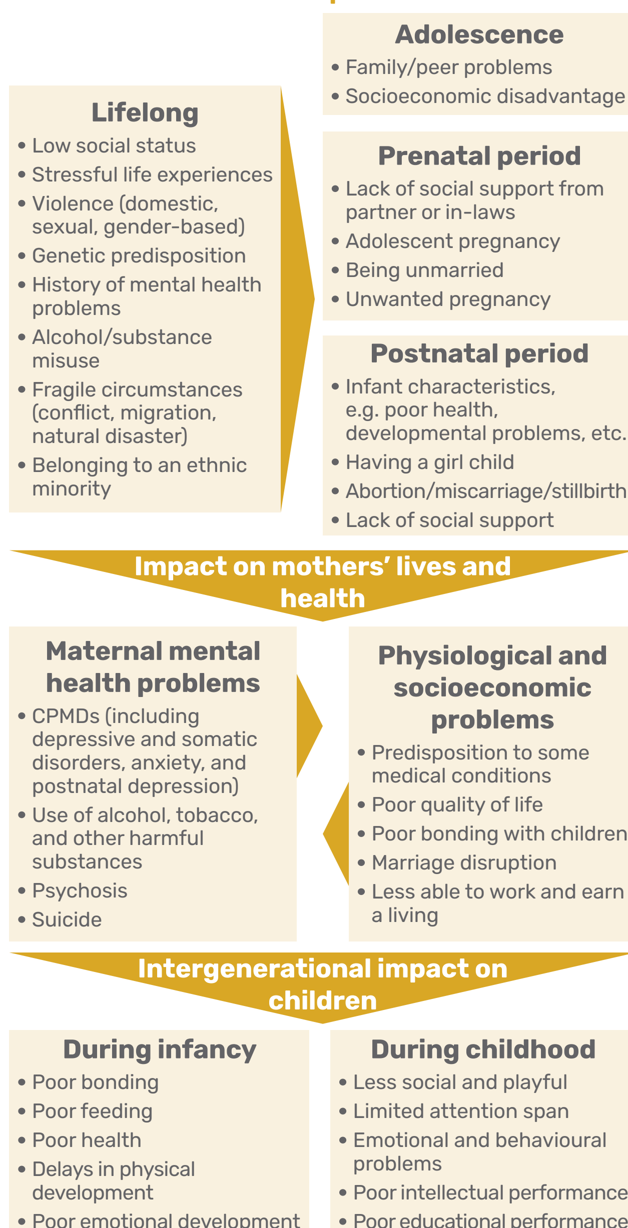
There is an intimate relationship between mental health and violence against women and girls. Not only are women and girls with MNS conditions particularly vulnerable to physical and sexual violence, but those who have experienced violence are also more likely to develop a MNS condition in the first place.[129] Women who experience intimate partner violence are twice as likely to have depression or abuse alcohol, and four and a half times more likely to either commit or attempt suicide.[130] Survivors of rape and sexual abuse have a threefold higher risk of suffering from anxiety, depression, or post-traumatic stress and a fourfold higher risk of attempting suicide.[131] Among men, harmful use of alcohol and other substances is also linked to the perpetration of violence.[129]

2. Reproductive health

Figure 3 summarises the risk factors for maternal mental health conditions that affect women across the life course.[132] Pregnant women and mothers in vulnerable situations are more likely to develop MNS conditions. Rates of common perinatal mental health conditions are highest among the most socially and economically disadvantaged women. In low- and lower-middle-income countries, about one in six pregnant women and one in five women who have recently given birth experience a common perinatal mental health condition.[133] Adverse reproductive health events, intimate partner violence and problematic gender norms related to housework, infant care, employment, and relationships with in-laws, all increase risk.[133]

Women and girls with MNS conditions have even poorer access to appropriate contraception than other women and girls in LMICs.[133] Meanwhile, they are more vulnerable to sexual abuse, exploitation and forced marriage.[129, 134, 135] Pregnancy – particularly unwanted or unintended pregnancy – can also exacerbate existing MNS conditions.[133, 136] Women and girls with MNS conditions may be subjected to forced sterilisation as a result, in violation of their human rights.[117]

Figure 3. Evidence summary: Risk factors for maternal mental health at various stages in women's lives and their impact



Source: Haegeman and Palfreyman (2019),[132] Open Government Licence v3.0.

3. Caregiving

Gender roles in terms of caregiving mean that women and girls are more likely to quit school and income-generating activities in order to care for relatives with MNS conditions.[16, 137] There is also a substantial psychological burden associated with caregiving, putting carers at higher risk of developing MNS conditions themselves.[137] Among caregivers of people with MNS conditions, women caregivers may spend more time on their caregiving duties and experience greater physical and mental strain than their male counterparts, though the evidence is inconclusive.[127] For example, an Indian study of caregivers of people with MNS conditions showed that women caregivers spent more time providing care and were less likely to be in paid employment or to belong to upper socioeconomic strata, but psychological distress was similar between men and women.[137, 138]

BOX 6

Case study: Nepal – Caring should not be a burden

In Nepal, Carers Worldwide is working with a local partner, LEADS Nepal, to provide support to 1,500 unpaid family carers of people with mental health conditions or epilepsy, by:

- Strengthening medical and counselling facilities for carers;
- Promoting mutual support groups;
- Setting up alternative care and respite arrangements;
- Providing livelihoods and opportunities to develop marketable skills; and
- Highlighting the needs of carers and advocating for changes in policy and practice.

Carers' tremendous commitment and the critical role they play in the lives of relatives with mental health conditions are largely unrecognised in Nepal. Unsupported, they are isolated and at high risk of developing anxiety or depression as well as physical ailments, as a direct consequence of their caring responsibilities. Many carers are unable to continue their previous employment. Child carers are frequently forced to drop out of school. Carers and their families typically live in poverty as a result of loss of income and opportunities. By highlighting the existence and needs of carers across the project area with local government authorities and community organisations, over the last two years Carers Worldwide has achieved the following:

- 400 carers have been integrated into support groups;
- 200 local community heath volunteers and 64 government health workers have been trained to provide appropriate health support;
- Regular counselling services have been established in the community;
- Over 750 carers have received skills training and support to establish new sustainable livelihoods that can coexist with their caring responsibilities;
- 225 child carers have returned to school with ongoing support from school authorities;
- 44% of project households are now living above the poverty line, compared to 3% at the start of the project; and
- Two carers associations and one carers cooperative have been registered to enable carers to advocate for policy change and work with local agencies to ensure sustainability of services established by the project.

Improving the physical and mental health, promoting social inclusion, and increasing the household income of carers of mentally ill individuals in Nepal (GB-CHC-1150214-GPAFINN058): **https://devtracker.dfid.gov.uk/projects/GB-CHC-1150214-GPAFINN058/**

Source: Authors' own, based on project documentation and expert consultation.[139-141]

Nepal: Previously migrant labourers, a woman and her son who has epilepsy can now stay in their village as a result of the regular income they receive from rearing goats.
PHOTO: © CARERS WORLDWIDE

Evidence-based approaches and entry-points

There is evidence from LMIC settings that women and girls who experience violence can benefit from psychological interventions, even when delivered by non-specialists. For example, a trial of the WHO Problem Management Plus intervention among women who had experienced gender-based violence in Nairobi showed positive results in terms of several psychological outcomes, functioning, health service utilisation, and reduction in stressful life events.[142] However, there remain a number of gaps in the evidence on mental health and gender-based violence, as identified in a review conducted through the What Works to Prevent Violence Against Women and Girls Programme.[129] More research is needed to:

- Understand how mental distress, or conditions such as post-traumatic stress disorder (PTSD), may affect both the perpetration and the experience of violence;
- Develop new and evaluate existing interventions to prevent and respond to violence against women and girls with MNS conditions; and
- Test whether alcohol reduction strategies – which have shown promise in high-income countries – are effective in preventing violence against women and girls in LMICs.

Some of the most convincing evidence for the integration of mental health into general health services in LMICs comes from studies of maternal mental health.[143] A meta-analysis of 13 trials from LMICs demonstrated the effectiveness of maternal mental health interventions delivered by non-specialist health and community workers.[144] The same review identified additional benefits to children, including improved mother–infant interaction, better growth and cognitive development, fewer episodes of diarrhoea, and higher rates of immunisation.[144] A generic field-trial version of the manual used in one of these trials, Pakistan's Thinking Healthy Programme, is now available as part of the WHO Series on Low-Intensity Psychological Interventions.[145] In contrast, there is very little evidence on what works in terms of promoting the reproductive health of women with MNS conditions.

The role of caregivers in mental health is increasingly being recognised. In studies of complex interventions for the management of MNS conditions, provision is sometimes made for the material and emotional support of caregivers such as support groups and livelihoods interventions. For some conditions, such as dementia and autism, there is relatively little effective biomedical treatment available, particularly in LMICs; in these cases, the caregiver may actually be the main target of the intervention. For example, a field-test version of the WHO Caregiver Skills Training programme is being tested in rural Pakistan as an intervention to improve functioning among children with developmental disorders.[146] In Thailand, a counselling intervention for caregivers resulted in improvements in the psychological and behavioural symptoms of their family members with dementia.[147]

5.3 Health

Mental health is a significant issue in its own right, and is explicitly mentioned under SDG 3: "Ensure healthy lives and wellbeing for all at all ages";[21] however, it also impacts physical health in many important ways (see Table 5). For example, mental health can affect key risk factors for other communicable and non-communicable diseases (NCDs) such as diet, exercise, risky sexual behaviour, and the use of drugs, alcohol, and tobacco.[133, 148] The side effects of some psychotropic medications can also cause health problems such as obesity.[138, 140] Meanwhile, the distress and upset to daily life caused by poor physical health may increase the risk of developing a MNS condition or exacerbate an existing condition.[27] Consequently, there is a high level of co-morbidity between many physical health and MNS conditions.[27] Those who have both a MNS condition and a chronic physical health condition such as diabetes or HIV tend to receive a poorer quality of health care and are less likely to adhere to treatment for their physical health problems.[27, 149, 150] Their lives may be cut short as a result (see **Box 1**).

Table 5. Evidence summary: Relevance of mental health to other health priorities

Reproductive health	
Family planning	• Unwanted or unintended pregnancy is a risk factor for perinatal depression.[136] • People with MNS conditions are at higher risk of sexual exploitation and are less likely to access and use contraception.[133] • People with MNS conditions who have limited capacity to consent may be more vulnerable to coerced or forced sterilisation.[134]
Maternal health	• Many women develop depression during pregnancy or in the early days of motherhood, and some women are at greater risk of a psychotic episode.[136, 151] • Loss of pregnancy is also a risk factor for perinatal depression.[136] • The mental health of mothers affects cognitive development and a variety of other infant and child health outcomes.[144, 152] • Birth trauma and numerous prenatal infections are linked to problems with cognitive development in children.[153]
Infant and child health	
Diarrhoea and nutrition	• Mothers with depression and anxiety are more likely to have infants with untreated diarrhoea, low birthweight, and poor nutrition.[144, 152] • Micronutrient deficiencies can impede child cognitive development.[153, 154]
Immunisation and vaccination	• Common mental health conditions among mothers are linked to incomplete immunisation of young children.[144] • Some infectious diseases for which vaccinations are available, such as measles, are linked to cognitive development problems in children.[153]
Priority diseases	
Communicable diseases	• People living with HIV/AIDS are more likely to show signs of psychological distress, depression, and suicidality.[149, 155–157] • People with depression are less likely to adhere to anti-retroviral treatment, leading to poorer health outcomes.[149, 150] • Malaria, tuberculosis, meningitis, Ebola virus disease and many other infections have mental and neurological effects.[158, 159]
Non-communicable diseases	• Mental health affects risk factors for NCDs such as diet, exercise, and use of alcohol and tobacco.[148] • People with NCDs have a greater risk of developing MNS conditions, and vice versa.[148] • People suffering from depression are less likely to adhere to treatment for NCDs, leading to poorer health outcomes.[148, 160] • Some psychotropic medications affect cardiovascular and diabetes risk.[148, 161]
Neglected tropical diseases	• Some neglected tropical diseases (NTDs) directly impact the nervous system, such as cysticercosis, human African trypanosomiasis, and Chagas disease.[162] • Rates of depression and anxiety are high among people affected by NTDs, particularly severely stigmatising conditions such as lymphatic filiriasis and leprosy.[162]

Source: Based on a literature review by the authors.

BOX 7

Evidence summary: Why integrate mental health care into other health services?

- **Accessibility:** Many adults and children with MNS conditions are already presenting to general health-care services, though sometimes with physical complaints.
- **Acceptability:** Treatment in general health-care settings is often considered less stigmatising and less institutionalising than treatment in specialist facilities, and conditions are often better.
- **Affordability:** Task-sharing models offer cost-effective alternatives to specialist services.
- **Complementarity:** Many people experience chronic physical health conditions and MNS conditions concurrently, and treating MNS conditions may also improve adherence to treatment and outcomes of chronic physical health conditions.

Source: Authors' own, based on **WHO and WONCA (2008)**.[167]

Three key issues

1. Integration

Because of the close relationship between mental and physical health (see Table 5), among other reasons (see Box 7), there is a broad consensus that mental health should be integrated with general health care, particularly at the primary care and community levels.[163] Yet in many LMICs, mental health care remains heavily centralised and institutionalised, and may violate international human rights standards.[23] Where the health system is already weak, additional investment is generally needed to effectively integrate mental health care. For example, poor supply chains and the heavy workload of frontline workers have been identified as barriers to the delivery of effective mental health care in primary care facilities in several studies from sub-Saharan Africa.[164-166]

2. Recovery

Mental health services are increasingly being encouraged to adopt a recovery-based approach; for example, in the WHO Mental Health Action Plan 2013–2020.[47] The recovery approach respects that mental health is about more than symptom reduction; it is about people deciding what outcomes are important for them to live a more meaningful and satisfying life.[168] While reorganising health systems is essential, it is also important for the health sector to engage in efforts to address stigma and encourage communities to better respect the rights and dignity of people with MNS conditions. This includes involving people with MNS conditions in mental health policy, service delivery, and research.[116] Stronger intersectoral collaboration is also needed to ensure that people with MNS conditions have access to the resources and opportunities they need to support their recovery, which may include, for example, education and employment.[169] Of the WHO Member States that have a mental health policy or plan, 89% report that their policy or plan promotes a recovery approach.[44] However, failure to allocate adequate resources to implementation means that in practice, mental health care in LMICs is rarely recovery-based.

3. Traditional healing

It is important to acknowledge the role that traditional and spiritual healers (including faith-based healers) play in mental health in many LMICs. In sub-Saharan Africa, approximately half of people seeking mental health care first visit a traditional or spiritual healer.[170] However, even alternative care can be inaccessible to many. For example, the Nigerian Survey of Mental Health and Well-being found only 8% of people with severely disabling mental health conditions had received any form of biomedical treatment or alternative care over the past 12 months.[104] As in psychiatric facilities, there are also reports of abusive practices such as chaining in traditional and spiritualist healing facilities. Collaboration between the formal and informal health-care sector is needed to ensure that people with MNS conditions have access to culturally appropriate, safe, and respectful care.

Evidence-based approaches and entry-points

Much of the research conducted on global mental health to date has focused on the integration of mental health into other platforms of general health care.[171] Given the global shortage of mental health specialists, integration typically involves a task-sharing approach in which non-specialists are trained to deliver basic mental health interventions (see Box 8). A Cochrane review has shown task-sharing to be effective for mental health care in LMICs.[172] The WHO mhGAP offers normative guidance for the delivery of mental health care in non-specialist settings to help facilitate integration. mhGAP has now been evaluated in numerous LMICs,[173] including

BOX 8

Guidance note: What does stepped care look like?

An important means of integrating mental health into other services is by allocating appropriate tasks to workers at different levels of the health system, making care much more widely available and using resources more efficiently. While models vary depending on the context and condition being targeted, the following example describes a common breakdown of tasks:

Mental health specialists

- Coordinate services, advocate, and advise government on service development;
- Diagnose and treat based on specialised training in pharmacological and psychological interventions;
- Accept referrals of relatively complex cases; and
- Supervise non-specialist health professionals.

Non-specialist general health professionals

- Follow standardised guidelines for assessment and management of priority conditions for non-specialist settings (e.g. mhGAP-IG 2.0);
- Consult with specialists and refer relatively complex cases; and
- Supervise lay workers and accept referrals.

Lay workers (if available)

- Facilitate or provide basic social support and awareness-raising;
- Provide basic psychological interventions and/or psychoeducation;
- Refer cases from community to non-specialists or specialists, as appropriate; and
- Follow up on cases in the community.

Source: Authors' own, based on expert consultation and a literature review.[175]

through the DFID-funded Programme for Improving Mental Health Care (PRIME) research consortium in Ethiopia, India, Nepal, South Africa, and Uganda.[174]

To date, there has been little investment in research on recovery-based approaches to mental health care in LMICs; however, recovery-oriented interventions such as formal peer support and recovery colleges have been established in some LMICs and are being evaluated. For example, the QualityRights Gujarat programme has introduced peer support volunteers who have lived experience of MNS conditions and are responsible for organising weekly peer support groups and aiding in recovery planning at public mental health facilities in India.[176] In Uganda, the Butabika-East London NHS Foundation Trust Link has established Africa's first Recovery College on the grounds of the Butabika National Referral Hospital.[177]

A systematic review evaluating the effectiveness of traditional healing for mental health in 20 countries concluded that traditional healing may have more of an effect on common mental health conditions (such as depression and anxiety) than on severe mental health conditions (such as schizophrenia or bipolar disorder).[178] However, people experiencing acute relapses of severe mental health conditions do seem to improve in the care of traditional healers over time.[178] Several projects in LMICs have sought to improve collaboration between biomedical and traditional or spiritualist healers; for example, Wayo-Nero in Uganda where community "uncles" and "aunties" liaise between traditional healers and formal mental health-care providers,[179] and Blended Care in Haiti where spiritual leaders were trained to deliver a culturally adapted version of cognitive behavioural therapy (CBT) for depression.[180] Recently, the Lutheran World Federation and Islamic Relief have produced guidance on faith-sensitive approaches to mental health and psychosocial support (MHPSS) in humanitarian settings.[181] However, more research is needed in order to identify best practices for collaboration, both in humanitarian and non-humanitarian settings.[182]

5.4 Humanitarian

Exposure to situations of extreme adversity is a key risk factor for MNS conditions.[183, 184] New estimates show the point prevalence of mental health conditions in conflict-affected settings is 22.1%.[185] This means that at any point

in time, more than a fifth of people exposed to conflict experience a mental health condition.[185] Nearly a tenth (9.1%) have a moderate or severe condition.[185] Rates are similar for natural disasters.[186] However, many more people experience other forms of psychological distress, such as grief and acute stress, as normal responses to adversity.[183, 184] Protective factors, such as positive coping strategies and family and community support, can mitigate the distress experienced in response to a crisis, and help prevent it from turning into a longer-term mental health or substance use condition (see Figure 4). Both people with MNS conditions as well as those at risk of them can benefit from interventions to reinforce protective factors and reduce exposure to risk factors. This is why the humanitarian sector tends to focus on MHPSS, as opposed to mental health care alone.[86]

Three key issues

1. Post-traumatic stress disorder

Those who are unfamiliar with the topic of mental health in humanitarian settings often think it is mainly about treating post-traumatic stress disorder (PTSD). While PTSD appears to be one of the most prevalent mental health conditions in these settings, common mental health conditions like depression and anxiety are also highly prevalent.[185] Other MNS conditions like schizophrenia and bipolar disorder may be less common, but often cause great impairment, and present unique challenges in humanitarian settings.[184, 188]

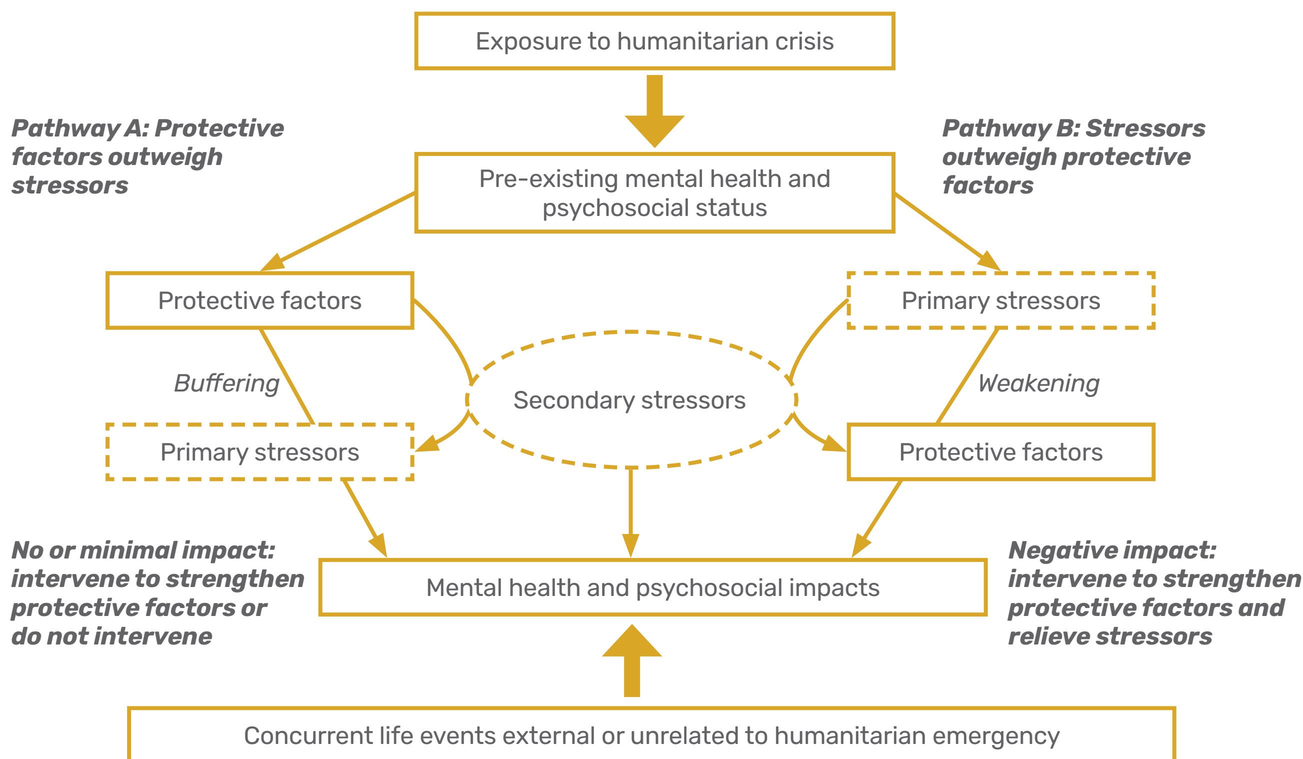
It is also worth noting that there has been substantial debate regarding the cross-cultural validity of PTSD, which was only added to the US *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1980. The concept of PTSD grew mainly out of research with US and European war veterans, and some have gone so far as to call it a "Western culture-bound disorder".[189] While this debate has not necessarily been resolved, it is becoming less relevant to humanitarian action as trends in MHPSS move more toward trans-diagnostic approaches, i.e. interventions that can be beneficial for people experiencing certain types of symptoms, regardless of their diagnosis.[190, 191]

2. People with pre-existing MNS conditions

People with pre-existing MNS conditions are particularly vulnerable in crisis situations, for several reasons.[184, 192] First, they are likely to experience more distress as a result of a crisis, exacerbating existing conditions and potentially causing new conditions to develop (see Figure 4). Second, the existing infrastructure for mental health care often breaks down in a crisis; for example, supply chains for psychotropic medications may be interrupted, mental health workers and other caregivers may flee, and psychiatric facilities may be damaged. Third, people with psychosocial disabilities are often left behind in humanitarian response. Humanitarian assistance may not be adequately tailored to their needs, and stigma and discrimination as well as the impairments caused by MNS conditions can be barriers

Uganda: Peer support workers participate in a planning workshop for Brain Gain II, a project promoting recovery-oriented care at Butabika Hospital, with funding from the Health Partnership Scheme.
PHOTO: © BUTABIKA EAST LONDON LINK

Figure 4. Evidence summary: How exposure to crisis impacts mental health



Source: Bangpan et al.'s (2017) systematic review report for the Humanitarian Evidence Programme.[187] The material is reproduced with the permission of Oxfam, Oxfam House, John Smith Drive, Cowley, Oxford OX4 2JY, UK www.oxfam.org.uk. Oxfam does not necessarily endorse any text or activities that accompany the materials.

to access. Fourth, people with psychosocial disabilities are already at higher risk of experiencing violence and abuse. Protection issues in humanitarian emergencies – for example, unsafe shelter – may disproportionately affect people with psychosocial disabilities.

3. Mental health and wellbeing of responders

The mental health and wellbeing of humanitarian aid workers is an important issue for quality assurance and staff retention. Not only are aid workers exposed to difficult living and working conditions, they are also increasingly the targets of violence: in 2008, for example, 261 humanitarian aid workers in a sample of 290,000 were attacked – mortality was higher than among UN peacekeepers.[193, 194] In addition to experiencing situations of extreme adversity first hand, aid workers can also experience secondary trauma (sometimes called "vicarious trauma"), for example by listening to others' troubling accounts.[194] A longitudinal study across 19 NGOs found higher rates of depression, anxiety, psychological distress, and burnout among humanitarian aid workers post-deployment.[195] Some of these negative effects were observable many months after their assignments were completed.[195] Another study of recently returned staff from five humanitarian aid agencies found that 30% reported significant symptoms of PTSD.[196] There is some evidence that local aid workers may be at greater risk of PTSD, depression, and secondary trauma than their international counterparts.[197]

Evidence-based approaches and entry-points

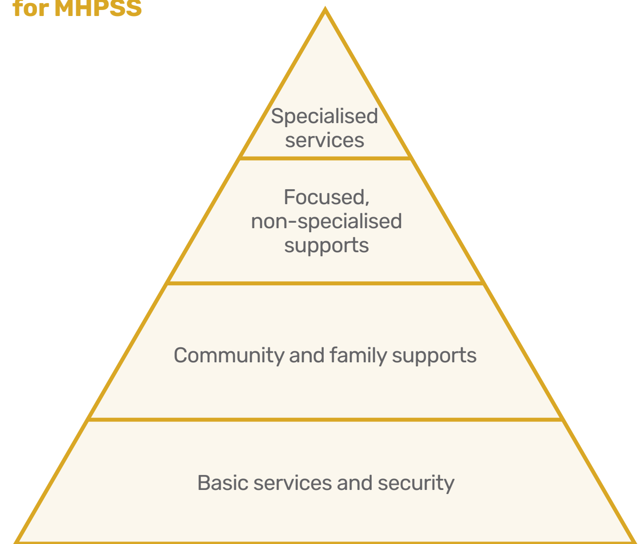
IASC Guidelines on MHPSS in Emergency Settings are the key consensus-based guidelines on best practice in MHPSS, and cover a number of topics such as assessment of needs and resources and coordination across different sectors or clusters.[86] In 2017, IASC added a Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings. The IASC depicts the organisation of MHPSS interventions as a pyramid, with specialised services at its tip, and basic services and security at its base (see Figure 5). Most of the action in MHPSS takes place toward the bottom of the pyramid, because most people experience time-limited distress and benefit most from the support of the community. Yet most of the available research evidence is on focused, non-specialist support and specialist treatment. The same is true of most evidence-based normative guidance, such as the mhGAP Humanitarian Intervention Guide (mhGAP-HIG).[183] Lack of evidence has contributed to some of the ambiguity around what constitutes "psychosocial support" and which interventions are most effective.[198]

This is certainly true in the case of PTSD, for which much of the research to date has focused on psychological treatments, such as trauma-focused CBT. Delivery by a trained non-specialist health worker or lay worker and

delivery in a group format are potentially cost-saving approaches that have been tested in LMICs. As mentioned above, trans-diagnostic approaches such as the Common Elements Treatment Approach have also proved effective in reducing PTSD symptoms.[199-201] However, there is less evidence on psychosocial interventions to promote protective factors, reduce risk factors, and ultimately reduce the incidence of PTSD in humanitarian settings.

The IASC Guidelines discuss people with pre-existing MNS conditions,[86] and guidance on disability-inclusive humanitarian response is generally relevant to psychosocial disabilities (though not always explicitly).[89] However, this is also an under-researched area. Leveraging resources and political will for mental health in the aftermath of a crisis can enable "building back better" mental health systems to cater for people's ongoing mental health-care needs (see Box 9). The WHO Building Back Better Report discusses a number of successful examples.[202]

Figure 5. Guidance note: The intervention pyramid for MHPSS



Source: Inter-Agency Standing Committee (2007).[86]

BOX 9

Case study: The Philippines – Collaborating for lasting change

On 8 November 2013, the deadliest typhoon in the history of the Philippines struck shore. The UK Department for International Development (DFID) was the biggest funder involved in the international humanitarian response and played a leading role.[141, 203] Within three weeks, the UK's humanitarian relief efforts had reached an estimated 800,000 victims, including critical psychosocial care for thousands.[204]

In the Eastern Visayas, the areas most affected by the disaster, a collaboration was formed between the Philippines Department of Health, WHO, International Medical Corps, Save the Children, and Médecins Sans Frontières (MSF) in order to better coordinate the international response to the mental health and psychosocial needs of victims in the aftermath of the typhoon. For over a year, organisations used the same mhGAP curriculum to train non-specialist health personnel in mental health.[205] At least one staff member was trained in more than 90% of the region's 159 health units (155) and 32 district and provincial hospitals (29). The programme also ensured that doctors had access to psychotropic medicines and trained 1,038 community workers in psychosocial support and care.[206]

After the typhoon struck Guiuan, for example, the Department of Health and MSF worked together to quickly erect a tented hospital, rehabilitate five regional health units, and begin offering a package of emergency mental health care including psychoeducation, group discussion sessions, and one-to-one services. Within five months, more than 130 people had accessed care in Guiuan, a municipality that had previously offered no mental health services. As part of a coordinated effort to sustain services after the emergency, the Department of Health, MSF, and WHO trained 30 staff on mental health in primary care settings using mhGAP. Stable cases were then transferred from the MSF programme to local regional health units. Among the 37 people in the programme who had been diagnosed with a severe mental health condition, approximately 68% either improved sufficiently for discharge (5) or were successfully referred to the regional health unit for further care (20).[207]

Today, four million people have access to mental health care in the areas most affected by the 2013 disaster. For those living in Guiuan and many other parts of the Eastern Visayas, it is the first time they have ever been able to access services so close to home. WHO recognises this example – partially funded by DFID – as one of the most extensive efforts to scale up mhGAP to date. The Eastern Visayas are now considered a model for other regions of the Philippines.[205]

Source: Based on expert consultation and a literature review by the authors.[82]

Debriefing, or talking about situations of extreme adversity experienced in the field, is one of the techniques that has been used for many years by international organisations to address the mental health and wellbeing of humanitarian aid workers.[194] However, some studies have indicated that forcing aid workers to engage in debriefing can actually be more harmful than helpful.[208] There are now evidence-informed alternatives available such as Psychological First Aid.[310] Other guidance has also been developed, such as the International Federation of the Red Cross "Caring for Volunteers" psychosocial support toolkit.[209]

5.5 Social protection

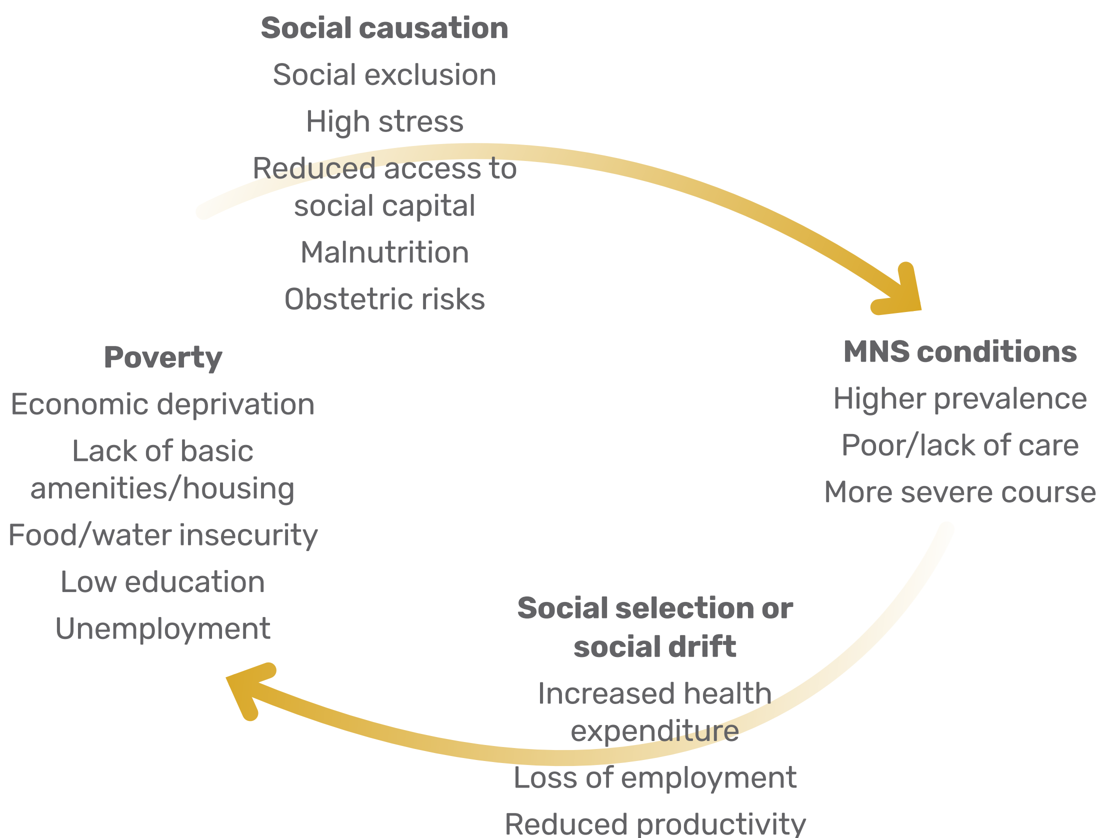
There is a cyclical relationship between poverty and mental health in LMICs (see Figure 6).[11, 210] Poverty increases the likelihood of developing MNS conditions, for example by heightening exposure to stress, malnutrition, violence, and other key risk factors.[11, 210] People with MNS conditions are also more likely to drift into and remain in poverty, for example through loss of employment and increased health expenditure.[11, 210] Yet people with MNS conditions are among those most frequently excluded from disability benefits, health insurance schemes, livelihoods programmes, and other social protection programmes.[11-14] WHO argues that people with MNS conditions should be targeted as a vulnerable group in international development, in order to break this "vicious cycle" in LMICs.[7]

Three key issues

1. Catastrophic spending

In approximately 40% of countries in Southeast Asia and sub-Saharan Africa, service users pay mostly or entirely out-of-pocket for mental health care, posing financial barriers and increasing the risk of catastrophic health expenditure and drift into poverty.[44] A recent study in a rural Ethiopian community found over 32% of households of persons with severe mental health conditions had experienced catastrophic health expenditure over the past 12 months, compared to 18% in other households.[211] As a result of financial hardship, households of persons with severe mental health conditions were also significantly more likely to reduce food consumption, cut down on medical visits, and withdraw children from school to save money – leading to the intergenerational transmission of poverty.[211] Fewer than 3% of households in the study were enrolled in a social protection scheme.[211]

Figure 6. Evidence summary: The "vicious cycle" between poverty and MNS conditions



Source: Authors' own, adapted from Lund et al.'s (2011) systematic review.[11]

2. Unemployment

Among people with disabilities, those with psychosocial disabilities have the highest rates of unemployment: 70–90%.[7, 70] In a cross-sectional survey of people diagnosed with schizophrenia carried out across 27 countries, 44% of participants reported discrimination in finding or keeping work.[212] Studies from Uganda suggest that financing institutions in LMICs may also be hesitant to extend credit to people with psychosocial disabilities so that they can establish their own income-generating activities (see Table 2).[60, 213] Yet for people with psychosocial disabilities, employment and income-generation are often important for recovery. A meta-analysis of studies from mostly high-income countries found employment of people with severe mental health conditions improves self-esteem and may also lead to reductions in psychiatric hospitalisation and improvements in symptoms, life satisfaction, and overall wellbeing.[214]

3. Homelessness

Related to the issues of catastrophic spending and unemployment is that of homelessness and mental health. As in the case of poverty more generally, MNS conditions can both precipitate homelessness and develop as a result of homelessness.[8] In studies on homelessness in LMICs, the prevalence of severe mental health conditions ranges from 8% to 47.4%.[215] For example, in a sample of people living on the street in Ethiopia, about 90% had some form of mental health or substance use condition (including 41% with psychosis) and nearly 15% had attempted suicide in the previous month.[216] Of those with psychosis, virtually all reported unmet needs (e.g. food, water, clothes, physical health and safety, etc.), underscoring their extreme vulnerability and lack of access to basic services.[216]

Evidence-based approaches and entry-points

Increasing access to health insurance and ensuring parity of mental and physical health in insurance schemes are both important for reducing catastrophic spending. Mental health system reform can also increase the availability of more cost-effective, accessible care. However, more needs to be done in terms of social protection to truly break the cycle between poverty and MNS conditions in LMICs.[11] Unfortunately, there are surprisingly few studies from LMICs on the impact of social protection on either mental health outcomes specifically or on the economic outcomes of people with MNS conditions and their families (see Box 10).[11] Two comparatively well-researched approaches include cash transfer programmes and livelihoods activities carried out via self-help groups.

Although results are mixed, there is evidence that cash transfers can improve mental health outcomes in LMICs.[11] In Mexico, for example, a randomised controlled trial (RCT) of a conditional cash transfer programme showed improvements in cognitive and behavioural functioning among children in low-income communities.[11, 217, 218] In Malawi, unconditional cash transfers have reduced symptoms of depression in youth, particularly among girls.[219] In Brazil, reduction in suicide rates has been attributed to increasing coverage of the Programa Bolsa Família conditional cash transfer programme.[220]

The mental health and development model developed by BasicNeeds, one of few international NGOs dedicated to mental health, has been applied in over a dozen LMICs.[221] In addition to mental health "camps" providing accessible treatment, self-help groups of people with

BOX 10

Evidence summary: Social protection can improve psychosocial outcomes

Examples of promising pension and economic empowerment programmes in LMICs:

- **Mexico:** A controlled study of the non-contributory social pension programme found a significant positive impact on symptoms of depression in older adults.[225]
- **Tanzania:** A pilot study found that people who were given a pension were less anxious about the future, less stressed and lonely, and had less difficulty sleeping. At the same time, they felt more confident, self-assured, and able to cope with life's challenges.[226]
- **Uganda:** A RCT of an economic empowerment programme focused on asset-accumulation for families of children orphaned by HIV/AIDS showed improvements in child self-esteem.[11, 227]

Source: Authors' own, based on a literature review.

Learning a livelihood as part of rehabilitation for young people with psychosocial disabilities in Amaudo, Nigeria.
PHOTO: AMAUDO/CBM

psychosocial disabilities and their carers provide mutual support and also undertake livelihoods activities. An evaluation in North India found this model reduced fees spent on hospital visits, hours spent caregiving and missed work days, and also improved employment, with a slight increase in family income.[222] Studies in Kenya reported increases in the proportion of participants engaged in either income-generation activities or productive work,[223] and concluded the model is cost-effective.[224] Self-help groups attached to advocacy organisations, for example in Kenya and Uganda, have also initiated group savings schemes to help pay for members' medical expenses.[114]

In terms of formal employment, more research is needed from LMICs. A systematic review of trials from the USA found that supported employment is more effective than prevocational training in helping people with severe mental health conditions to gain competitive employment.[228] In other words, people with severe mental health conditions can learn on the job with support in place, rather than undergoing lengthy training and preparation before entering into competitive employment. However, as informal employment is the status quo in many LMICs, the generalisability of these findings may be limited.

More LMIC research is also needed on interventions to support people with MNS conditions who are homeless. A recent systematic review identified papers from two religiously affiliated charities in West Africa, two NGOs in India, and one programme run from Mozambique's main psychiatric hospital.[215] However, only one was formally evaluated. In Mozambique, 52.2% of participants with schizophrenia were reintegrated with their families within three months of discharge, but there was no comparison group, and only participants in regular contact with family members were included.[215, 229]

5.6 Youth

Ensuring that young people in LMICs have the education, skills, and opportunity to combat poverty requires attention to their mental health and wellbeing.[230, 231] Onset of half of all mental health conditions is by the age of 14, and three quarters by the mid-20s.[34] Among young people aged 10–24, MNS conditions are now the leading cause of disability and among the top five biggest contributors to the global burden of disease.[231] Poor mental health in youth is a risk factor for MNS conditions in adulthood and has important consequences for future employment and productivity.[231] Yet child and adolescent mental health

receives just 0.1% of overseas development assistance for health.[232] Partly as a result of underinvestment, young people are the least likely to access mental health care, of any age group.[2] The recent *Lancet* Commission on global mental health and sustainable development resulted in the formation of a "Young Leaders" campaign to ensure that young people have a voice in addressing these issues.[233]

Three key issues

1. Acting early

Because MNS conditions commonly first onset in youth,[34] this is an important life stage for building up protective factors and addressing risk factors. Promotion interventions may target the individual (e.g. by aiming to build self-esteem) or the community (e.g. by aiming to improve social inclusion), or they may be structural, aiming to reduce barriers to wellbeing (such as inequitable access to education).[234] Similarly, interventions that aim to reduce risk factors may be universal (e.g. taxing alcohol to reduce consumption), selective (targeting at-risk individuals or groups), or indicated (targeting individuals with early warning signs).[235] Because much of the work done in development aims to improve people's lives now and in the future, it is possible that interventions seemingly unrelated to mental health in other sectors may have hidden benefits for the mental health of young people.[115]

2. Suicide

Suicide is the second leading cause of death among young people worldwide, and the leading cause of death among adolescent girls.[236, 237] Some of the highest rates of suicide come from LMICs, particularly in Eastern Europe, South Asia, and East Africa.[63]

Among adolescents in LMICs, the African region has the highest prevalence of suicidal ideation: 21.6% of adolescents report that they have thought about killing themselves over the past 12 months.[238] Although suicide is usually related to social circumstances, it is linked to depression in at least half of all cases among adolescents.[239] Bullying, alcohol use, and physical attacks are the most consistent risk factors for suicidal ideation and planning among adolescents, according to school-based surveys in LMICs.[238]

3. Education

Education is an important protective factor that reduces the likelihood of developing common mental health conditions and, in later life, dementia.[2, 115, 240] Yet children with MNS conditions are frequently excluded from the classroom, and those with severely disabling conditions may have few alternatives available to get an education.[241, 242] The World Mental Health Surveys suggest that many mental health conditions, especially bipolar disorder, disruptive behaviour, major depression, and anxiety, are linked to early termination of education.[243] In LMICs, the odds of leaving school early are one and a half times higher for adolescents with substance use conditions.[244] Neurological conditions can also negatively impact schooling; for example, in a sample of 50 schoolchildren attending epilepsy clinics in Freetown, 82% had missed school over the past month because of epilepsy, and 20% had stopped attending school permanently.[241] Consequently, those who can perhaps most benefit from an education are among the least likely to complete their schooling. The *Lancet* Commission identifies a number of different ways in which mental health can be protected under SDG 4 (Quality Education) (see Box 11).

BOX 11

Guidance note: Actions for protecting mental health under SDG 4

SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all:

- Providing early child stimulation and school readiness programmes;
- Integrating life skills in school curricula;
- Identifying and assisting children with developmental disabilities early;
- Tailoring education to the abilities and interests of children;
- Providing lifelong learning to people with mental disorders to assist recovery; and
- Providing cognitive stimulation and learning to older adults to prevent and manage dementia.

Source: Patel et al. (2018, p. 1587).[245]

Evidence-based approaches and entry-points

While youth mental health remains under-researched, the best available evidence shows that it is possible to promote good mental health and reduce risk factors among children and adolescents, in communities and in schools, in diverse LMIC contexts, in order to build a brighter future for young people.[64, 82, 245] Table 6 describes the quality of the evidence from LMICs across different types of interventions targeting children and adolescents in schools and in the community, according to a systematic review. By applying the Assessing Cost-Effectiveness in Prevention Project grading system, experts identified universal social and emotional learning programmes and parenting programmes during infancy as examples of evidence-based best practice. Other programmes with promising evidence were recommended as examples of good practice for schools and communities in LMICs.[245] To reduce the risk of suicide specifically, the *Lancet* Commission recommends "multimodal programmes" that include community- and school-based skills training, screening for young people who are at risk, education for primary care physicians and the media, and restricting access to pesticides and other lethal means.[2]

Table 6. Evidence summary: Evidence-based approaches to youth mental health in schools and communities

Community-based interventions	
Description of intervention	**Quality of LMIC evidence**
Parenting programmes for infants[246–252]	**Sufficient evidence** of effectiveness and feasibility of programmes designed to enhance mother–child interaction during infancy
Parenting programmes for preschool and school-aged children[249, 253-255]	**Promising evidence** of effectiveness for externalising disorders and risk behaviours in preschool and school-going children (2–14 years)
Gender equity/economic empowerment programmes[11, 256-263]	**Promising evidence** of the effectiveness of out-of-school gender equity/economic empowerment programmes for adolescents and young adults
Child enrichment/preschool education programmes[246, 264-267]	**Promising evidence** of the beneficial effects of child enrichment/ preschool parenting interventions
School-based interventions	
Description of intervention	**Quality of LMIC evidence**
Universal social and emotional learning programmes[64, 268-271]	**Sufficient evidence** of effectiveness of whole-school approaches to mental health promotion in schools from LMICs
School-based mental health awareness programmes[272]	**Promising evidence** for information and awareness programmes that address knowledge and attitudes about mental health, including one RCT from Pakistan performed in rural secondary schools
Supporting teachers to recognise MNS conditions[273-278]	**Promising evidence** supporting the feasibility and reliability of identifying and assessing MNS conditions among primary and secondary school students
Targeted interventions for high-risk children[279-284]	**Promising evidence**, though several RCTs targeting vulnerable children have shown effectiveness varies based on individual and contextual factors, and may be better suited for children with less severe risks and difficulties
Treatment or management of MNS conditions in schools[279, 281, 284-287]	**Inconclusive evidence** from LMICs, where results are inconsistent or equivocal, despite sufficient evidence from high-income countries

Source: Petersen et al.'s (2016) systematic review, CC BY 4.0.[245]

6 Research and evidence

KEY POINTS

- There are regional, topical, and methodological gaps in the evidence base for mental health.
- There is guidance available for choosing appropriate mental health indicators for monitoring, evaluation and research, and for disaggregating data.
- Several priority-setting exercises have been undertaken to make more efficient use of the limited resources available for mental health research in LMICs.

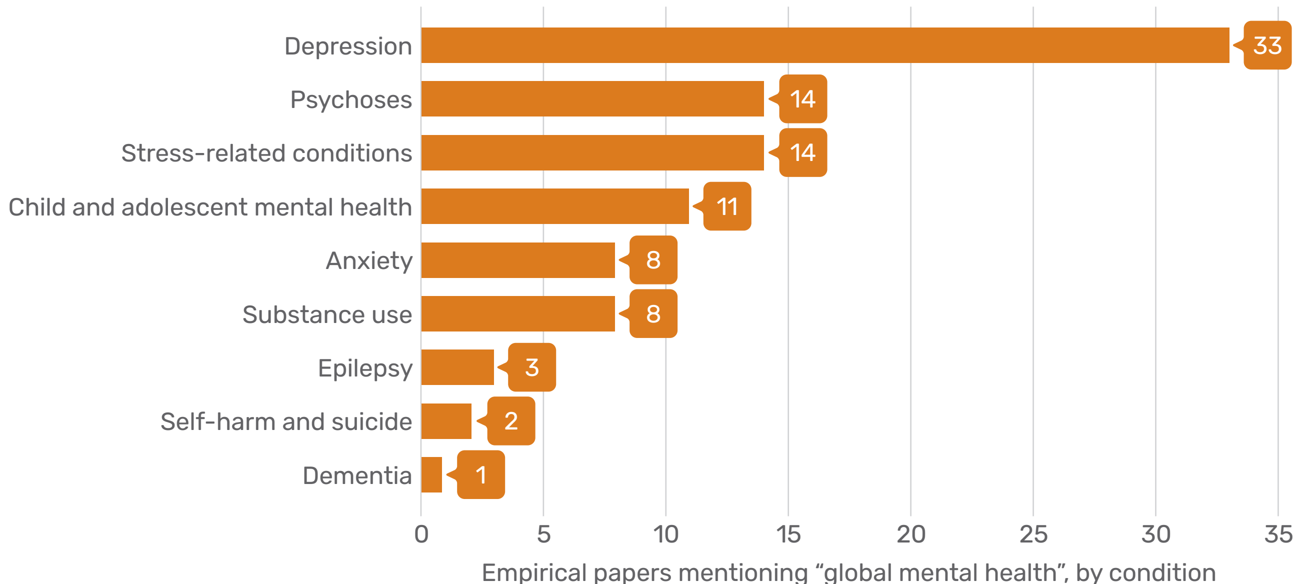
6.1 Research gaps

Less than 10% of international research funding is spent on the conditions that affect over 90% of the global population.[288] This so-called "10/90 gap" is all too evident in mental health research, which represents less than 4% of all published global health literature.[289] Ninety-four per cent of this literature comes from high-income countries.[289] For example, an analysis of submissions to the popular international mental health journal *Acta Psychiatrica Scandinavica* for the period 2002–05 found that approximately 15% of submissions came from LMICs,[290] and the acceptance rate was less than 10% – significantly lower than for submissions from high-income countries.[291]

There are also regional, topical, and methodological gaps in global mental health research. A recent systematic review of peer-reviewed articles using the term "global mental health" found that more than half of publications from sub-Saharan Africa came from just three countries: South Africa, Ethiopia, and Uganda. In South Asia, three quarters were from India or Nepal.[171] Depression was by far the most commonly studied mental health condition, appearing in more than twice as many articles (29.7%) as the runner-up, psychosis (12.6%) (see Figure 7).[171] Only 23.8% of articles reported the results of empirical studies, i.e. primary data collection and analysis. For comparison, 33.6% of articles were commentaries.[171]

Another methodological gap is the apparent lack of user-led mental health research from LMICs. Literature reviews covering the years 2004–13 and an 18-month period during 2017–18 found no examples of user-led mental health research from LMICs in peer-reviewed journals.[116, 292] It is possible that some examples were missed (particularly from the grey literature), and it is also true that participatory approaches such as Theory of Change workshops and lived experience advisory panels are popular among global mental health researchers.[293] However, it does not yet appear to be the norm to

Figure 7. Evidence summary: Gaps in "global mental health" research



Source: Misra et al.'s (2019) systematic review, CC BY-NC-ND 4.0.[171]

include people with lived experience as equal partners in or leaders of mental health research teams in LMICs.[292]

Perhaps related to the lack of user-led research is the dearth of research on mental health from a human rights perspective in most LMICs – including empirical research on important questions for the operationalisation of the CRPD, such as how to address coercion in mental health settings.[120]

6.2 Evaluation

Lack of rigorous evaluation of mental health programmes in LMICs is a major barrier to scale-up and a contributor to the "10/90 gap".[294] A systematic review of community mental health services in sub-Saharan Africa found that only a fifth of programmes were evaluated.[294, 295] Only five (20.8%) of the studies identified included any sort of comparison group and none used a randomised design.[295]

The use of comparison groups is particularly important in mental health research, as symptoms of MNS conditions often follow a relapsing and remitting pattern; for example, in adolescents 60–90% of episodes of depression may spontaneously remit over a 12-month period.[239] Without a comparison group, an evaluation of an intervention that results in a 50% reduction in depression among adolescents may conclude that the intervention has had an impact, when in reality the intervention may have produced worse outcomes than if nothing were done at all.

Another methodological challenge in mental health research is the selection of appropriate outcome measures (see Box 12). Many of the most commonly used outcome measures originated in high-income countries and need to be locally adapted and validated for use in LMICs. Some outcome measures are also specific to particular population sub-groups (e.g. children, women), and some require specialist training and expertise to apply. It is therefore difficult to recommend one-size-fits-all outcome measures for use internationally, although WHO has developed and tested several tools that can be applied trans-diagnostically, such as the Disability Assessment Schedule (WHODAS) and Quality of Life Assessment (WHOQOL).

As recommended by the UK All-Party Parliamentary Groups for Global Health and Mental Health, it is important to measure mental health-related outcomes not just of mental health programmes, but also of other development programmes in diverse sectors, to build a more robust evidence base.[95]

6.3 Monitoring

As described in section 4.3: Information, the monitoring of routine data on mental health and mental health service utilisation is generally poor in most LMICs. However, several core mental health indicators have been adopted by WHO for national monitoring and cross-country comparison, and are aligned with the indicators of the WHO Mental Health Action Plan 2013–2020 as well as the SDGs (see Box 13).

One of the logistical challenges in monitoring service utilisation is that of collecting and aggregating data for individuals who may come into contact with different

BOX 12

Evidence summary: How is impact on mental health outcomes evaluated?

Unfortunately, a universally valid, reliable, and cross-culturally applicable tool for measuring psychosocial wellbeing has not yet been identified. Although an imperfect solution, training non-specialists to administer a screening tool for common mental health conditions pre- and post-intervention is a common way to evaluate the impact of non-mental health interventions on mental health outcomes. The screening tool should be validated for use in the population and setting where it is being used. A systematic review comparing the performance of screening tools for common mental health conditions makes the following recommendations for situations where a validated screening tool is unavailable:

- **Common mental health conditions:** SRQ-20 (general population); GHQ-12 (patient population).
- **Depression only:** HADS-D (general population); PHQ-9 (population with high literacy); EPDS (perinatal population).
- **Anxiety only:** HADS-A (general population).

Notes: SRQ-20 – 20-Item Self-Reported Questionnaire; GHQ-12 – 12-Item General Health Questionnaire; HADS-D – Hospital Anxiety and Depression Scale for Depression; PHQ-9 – 9-Item Patient Health Questionnaire; EPDS – Edinburgh Postnatal Depression Scale; HADS-A – Hospital Anxiety and Depression Scale for Anxiety.

Source: Authors' own, based on Ali, Ryan, and De Silva's (2016) systematic review of validated screening tools for common mental health conditions in LMICs.[296]

BOX 13

Guidance note: Core Health Indicators for mental health

- **Proportion of persons with a severe mental health condition who are using services** (psychosis, bipolar affective disorder, moderate–severe depression);
- **Number of suicide deaths per year per 100,000 population**; and
- **Total alcohol per capita consumption.**

Source: **WHO (2015)**.[297]

levels of the health system, including both public and private services.[94] This is one reason why the core indicator on service coverage for severe mental health conditions is not included in the SDGs. However, researchers are investigating different approaches for strengthening mental health monitoring in LMICs. The six-country Emerald Project, for example, is conducting implementation research to test a number of key indicators proposed by experts from mostly LMICs (Box 14).[298]

While both the Emerald indicators and the Core Health Indicators include service utilisation for people with severe mental health conditions, this has also been critiqued. One of the key arguments is that without due attention to human rights and quality of care, this indicator could actually serve to measure the expansion of coercive, abusive, or otherwise negative practices, rather than improvements to the mental health system.[299]

6.4 Data disaggregation

Data disaggregation is needed in order to better understand to what extent people with psychosocial disabilities are being included in and benefiting from international development. Disaggregating data by diagnosis is not very practical in LMIC settings, where there are few specialists trained to make diagnoses, and it may also be considered stigmatising. Instead, development organisations like DFID recommend using the Washington Group Questions on Disability.[300, 301]

The Washington Group Short Set has six questions which add one minute and 15 seconds to data collection.[302] By asking questions across different domains of functioning, they identify the majority of people with limitations that are likely to restrict their active participation in society. The Short Set does not contain a specific question focused on mental health, though questions on self-care, concentration, and communication will detect some – but not all – psychosocial disabilities. Unfortunately, it is not yet possible to distinguish those with psychosocial disabilities from those with other disabilities in survey results using the Short Set.

The Extended Set of Questions can provide more detailed information on impairments related to MNS conditions.[303] There are ongoing debates about adding a question to the Short Set focused more explicitly on psychosocial disability. In the meantime, major funders such as DFID advocate for use of the Enhanced Short Set, comprising

BOX 14

Evidence summary: Top five mental health indicators for primary care in LMICs

1. Number of people diagnosed with severe mental health conditions (all health system);
2. Number of days in last one month that psychotropic drugs were out of stock;
3. Proportion of national health budget allocated to mental health services;
4. Number of trained mental health workers at inpatient and outpatient service;
5. Number of people with severe mental health conditions who receive mental health treatment.

Note: Ranked by feasibility, relevance, and significance.

Source: **Jordans et al. (2016)**.[298]

the Short Set alongside four questions on anxiety and depression from the Extended Set, in order to improve detection of psychosocial disabilities.

DFID and Leonard Cheshire have launched a Global Disability Data Portal to capture and visualise disability-disaggregated data on the SDGs, with a particular focus on education, stigma and discrimination, technology and innovation, and economic empowerment.[304]

6.5 Research priorities

In light of the substantial gaps and limited resources for mental health research in LMICs, several consensus-building exercises have been undertaken to identify research priorities in global mental health, as described further below. It is worth noting that there has been some debate as to whether these exercises adequately address the role of culture in mental health.[305] Given the gaps in research on mental health and human rights in LMICs,[9, 23] it is also notable that this does not appear to have been prioritised in any of these exercises to date.

Early attempts at priority-setting

In 2007, the *Lancet* Global Mental Health Group applied the Combined Matrix Approach, originally used by the Child Health and Nutrition Research Initiative (CHNRI),[306] to identify research priorities for the field.[307] A technical working group consisting of 39 experts (approximately three quarters psychiatrists and half from high-income countries) produced a list of 55 research questions. A smaller group of 24 experts then scored the questions according to CHNRI criteria. After scoring, a wider reference group of 43 stakeholder representatives were consulted to adjust the final score for each research question. The top five research priorities identified include:

- Implement health policy and systems research to determine the most effective inter-sectoral (social, economic, and population-based) strategies to reduce alcohol consumption in high-risk groups (particularly men), thus reducing the burden of alcohol abuse;
- Investigate what training, support, and supervision will enable existing maternal and child health workers to recognise and provide basic treatment for common maternal, child, and adolescent mental disorders;
- Study the effectiveness, and cost-effectiveness of school-based interventions, including children with intellectual disabilities;
- Conduct Health Service and Population Research to integrate management of child and adolescent mental disorders with other child and adolescent physical disease management, including nutrition; and
- Conduct research into the effectiveness of early detection and simple brief treatment methods that are culturally appropriate, are implemented by non-specialist health workers in the course of routine primary care, and can be scaled up.

"Grand Challenges in Global Mental Health"

Recognising the need for a more ambitious and wide-reaching priority-setting exercise, the US National Institute for Mental Health led the "Grand Challenges" Delphi study published in Nature in 2011.[308] Participants included researchers, advocates, programme implementers, and clinicians from over 60 countries. They were first asked to list specific barriers that "if removed, would help to solve an important health problem [in mental health]" and that could lead to interventions that "would have a high likelihood of feasibility for scaling up and impact" (p. 28). The items in the resulting list were then ranked by participants, according to several criteria. The five top-ranked challenges for global mental health research include:

- Integrate screening and core packages of services into routine primary health care;
- Reduce the cost and improve the supply of effective medications;
- Provide effective and affordable community-based care and rehabilitation;
- Improve children's access to evidence-based care by trained health providers in low- and middle-income countries; and
- Strengthen the mental health component in the training of all health-care personnel.

Priorities in humanitarian settings

Much like the "Grand Challenges" exercise, the Mental Health and Psychosocial Support in Humanitarian Settings – Research Priority Setting (MH-SET) was also published in 2011.[309] MH-SET sought to overcome some of the limitations of the original *Lancet* exercise by engaging a larger and more diverse group of participants, though still using the CHNRI methods. Some 136 people, two-thirds from LMICs, were responsible for generating research questions. Focus groups were also carried out in three crisis-affected countries on different continents (Peru, Nepal, Uganda) to identify additional research questions. A total of 773 research questions were narrowed down to 74 by independent analysts using CHNRI criteria. The top five questions identified for humanitarian settings include:

- What are the stressors faced by populations in humanitarian settings?
- What are appropriate methods to assess mental health and psychosocial needs of populations in humanitarian settings?

- How do affected populations themselves describe and perceive mental health and psychosocial problems in humanitarian settings?
- What are appropriate indicators to use when monitoring and evaluating the results of mental health and psychosocial support in humanitarian settings?
- How can we best adapt existing mental health and psychosocial interventions to different sociocultural settings?

Priorities for sustainable development

The 2018 *Lancet* Commission on global mental health and sustainable development provided a list of examples of research priorities for global mental health aligned to the SDG framework (see Table 7).[2] The list is not exhaustive and does not appear to be the result of any specific consensus-building exercise, but does offer some insight into current and future directions for research on mental health and development as envisioned by the Commissioners.

Table 7. Evidence summary: Examples of research priorities for mental health and the SDGs

Goal	Research priorities
Goal A: **Identify root causes, risk, and protective factors**	• Understand how genetic, neurodevelopmental, and social risk and protective factors interact across the life course influencing mental health and mental disorders. • Understand the influence of gender on mental health and mental disorders across the life course. • Discover biomarkers for mental health and mental disorders.
Goal B: **Advance prevention and implementation of early interventions**	• Understand early stages in the development of mental disorders. • Identify novel interventions for prevention and early interventions targeting key determinants across the life course. • Identify sensitive and specific tools for early detection and to improve diagnosis.
Goal C: **Improve treatments and expand access to care**	• Identify more effective pharmacological, psychosocial, and social treatment interventions, including those that are trans-diagnostic. • Develop improved decision-making algorithms for diagnosis and for person-centred care (precision medicine). • Design, evaluate, and compare delivery mechanisms for care, ensuring equity and quality. • Elaborate and test approaches for supported decision-making for mental health care for people with severe mental disorders.
Goal D: **Raise awareness of the global burden**	• Develop, evaluate, and disseminate effective methods for communicating the burden of mental disorders. • Develop, evaluate, and disseminate effective methods to increase the demand for mental health care.
Goal E: **Build human resource capacity**	• Identify skills needed by non-specialist care providers to deliver mental health care, and feasible and scalable ways to train, support, and supervise them. • Develop and evaluate innovations for synergising and integrating services delivered by human and digital methods.
Goal F: **Transform health system and policy responses**	• Identify the most feasible and effective ways to integrate mental health within universal health coverage in a variety of health systems. • Implement a comprehensive monitoring system to assess the determinants of mental health and the inputs and outputs of mental health services. • Evaluate the feasibility and impact of innovative financing mechanisms for mental health care (e.g. social impact bonds and insurance schemes).

Source: Patel et al. (2018).[2] Reproduced with permission from Elsevier.

7 Where to learn more

Global mental health is a rapidly expanding field, with new learning opportunities and resources appearing all the time. Although the following list is not comprehensive, it gives some initial suggestions for how development professionals can further their learning in this area.

7.1 Knowledge management platforms

A good place to start is with one of the online knowledge management platforms focusing on mental health in LMICs. The two largest are:

- **mhpss.net** The Mental Health and Psychosocial Support Network online community of practice for people interested in MHPSS in situations of adversity; and
- **mhinnovation.net** The Mental Health Innovation Network (MHIN) online platform for stakeholders in global mental health.

7.2 Global campaigns

Several global campaigns are also actively involved in organising face-to-face and online events, and regularly produce useful material on mental health in international development. The **World Federation for Mental Health** leads the annual World Mental Health Day, with a different theme each year. The **Movement for Global Mental Health** grew out of the first *Lancet* Commission report on global mental health, and while its website is currently being renovated, it remains an important resource for the field. More recently, **United for Global Mental Health** has been coordinating mental health communications and advocacy across a number of different low-, middle- and high-income countries, and recently launched the #speakyourmind campaign.

7.3 Short courses

There are now a number of face-to-face short courses on global mental health held annually, including in LMICs:

- Egypt: WHO **Eastern Mediterranean Mental Health Leadership Course**
- India: **Sangath Leadership in Mental Health Course**
- Nigeria: **Mental Health Leadership and Advocacy Programme (mhLAP)**
- Portugal: **Lisbon Learning Programme on Mental Health Policy and Services**
- United Kingdom: **Centre for Global Mental Health Summer School**

7.4 Online courses

Following early efforts to develop a free online **Global Mental Health Supercourse**, several academic institutions and policy organisations have opted to develop higher-quality distance learning courses, though these typically come with fees attached, and some have a face-to-face component:

- Centre for Mental Health Law and Policy, India: **International Diploma in Mental Health, Human Rights and Law**
- Johns Hopkins Bloomberg School of Public Health, USA: **Summer Institute Online Course** on MHPSS in International Humanitarian Settings
- London School of Hygiene and Tropical Medicine, UK: **Global Mental Health Distance Learning Module**, **Global Health and Disability Massive Open Online Course**
- Queen Mary University London, UK: **Post-Graduate Certificate, Diploma, and Master's Programmes** in Cultural and Global Perspectives in Mental Health Care
- University of Glasgow, UK: **Post-Graduate Certificate**, **Diploma** and **Master's** Programmes in Global Mental Health
- World Health Organization, Switzerland: **QualityRights E-Training**

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