

OVERVIEW:

Mental health – towards economic and social inclusion

Introduction*

Is mental health part of the NCD (non-communicable diseases) agenda – or something bigger still?

The World Health Organization (WHO) recognises that the mental health of the individual is linked to their social environment in both directions, and that if mental distress and illness is not dealt with effectively, it lays burdens and missed opportunities on their families, the community and the nation. However, health systems have not adequately responded to the challenges of mental disorders; the gaps in their treatment and prevention remain unacceptably large all over the world. Globally, annual spending on mental health is less than US \$2 per person – less than 25 cents per person in low-income countries (WHO Mental Health Atlas, 2011).

Broadly within the community of nations, there have been a number of initiatives aimed at improving public health and the quality of life for all. One of these was the adoption of the Millennium Development Goals (MDGs), and in May 2008 the 193 member states of the WHO approved a six-year plan to address NCDs, which in turn influenced the UN General Assembly in 2010 to place NCDs firmly on the agenda for the Millennium Development Goals Review Summit.

Recently there have been calls to have mental health included in the internationally accepted list of NCDs. The congruence between them is already recognised by the WHO in having NCDs and mental health bracketed together under the same directorate. WHO considers that mental disorders are chronic conditions that interact and co-exist with others – such as cancer, cardiovascular diseases, HIV infection and AIDS – and as such they require integrated services. For example, there is evidence to suggest that depression predisposes people to diabetes and heart disease.

Thanks in part to successful lobbying by India, the WHO Ministerial Conference on Healthy Lifestyles and Non-Communicable Disease Control (Moscow, April 2012) included mental health within NCDs, and this in turn has led to the establishment within WHO of the NMH (non-communicable diseases and mental health) Cluster and a web-based consultation to draft a comprehensive mental health action plan for 2013–2020.

Mental health compared with other non-communicable diseases (NCDs)

In the realm of public health policy, the NCDs which have attracted a major focus have been cancers, diabetes, coronary-vascular and respiratory diseases. What these have in common, apart from the

relatively minor involvement of microbiological pathogens, is that the conditions are chronic, often life-long, debilitating, and are induced through a mixture of genetic, environmental and lifestyle factors. Mental health conditions are quite similar in these respects: the social environment may be a causative factor or a trigger, interacting in a complex way with internal factors; and the consequences can be protracted, disabling, and create large and costly consequences for the individual, their families and immediate carers, the healthcare sector and society as a whole.

Public health interventions to deal with the rising tide of NCDs are already under way in many Commonwealth countries, and include public education campaigns aimed at promoting healthier lifestyles, policies that reduce environmental risk factors, and putting systems in place for screening and catching ailments early when they are easier to treat. However, the same preventative approach is not as well developed in the case of mental health problems. Ivbijaro, in arguing for a link between mental health and the existing MDGs, has pointed to links with MDG 1 (eradicating extreme poverty) and MDGs 3 and 5 (which address gender inequalities in health).

Social determinants of mental health and mental illness

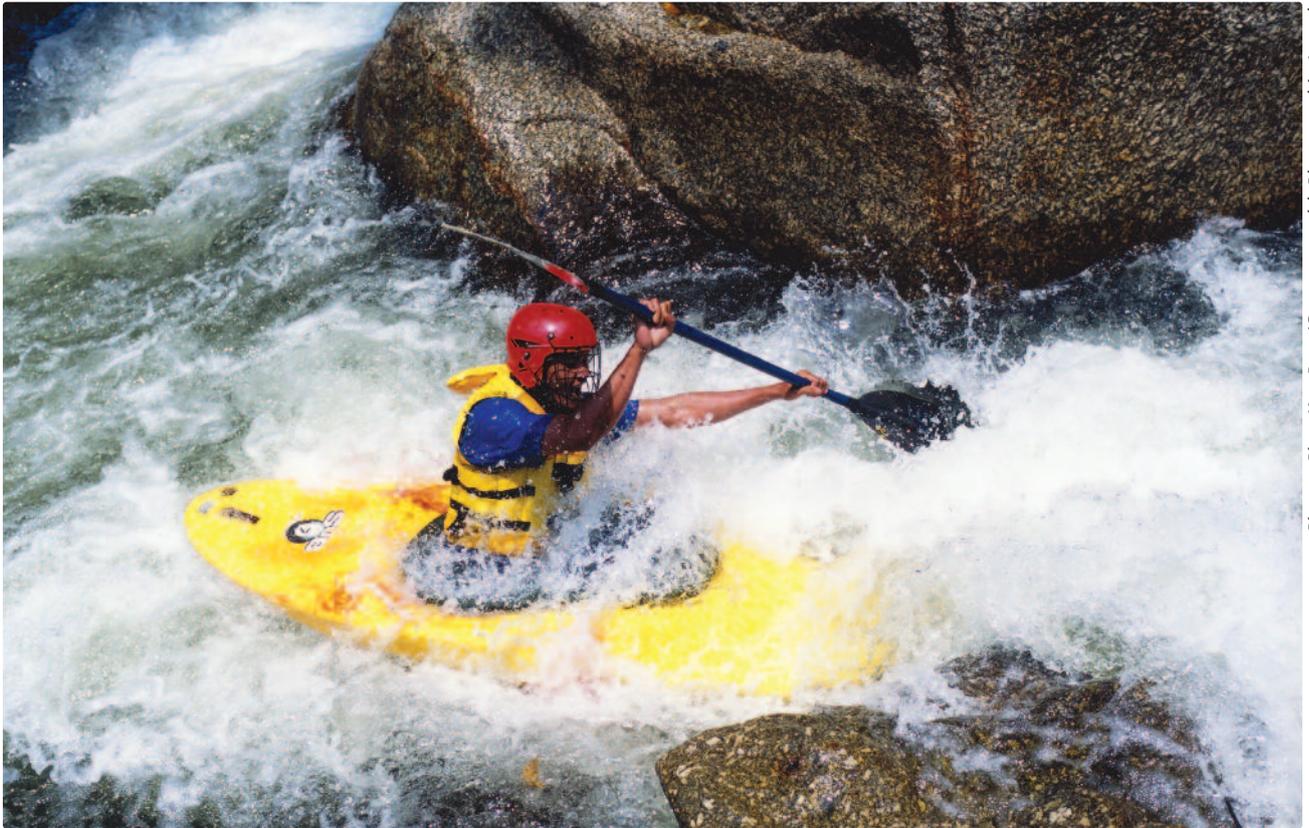
Risk factors for mental illness include poverty, inadequate early childhood education (ECE), rapid social change, social conflict, traumatic life events, stressful work conditions, gender discrimination, gender-based violence, war and post-conflict challenges, experience and threat of crime, social exclusion, unhealthy lifestyle, risks of violence and physical ill-health, human rights violations, as well as genetic predisposition.

Hence certain groups are placed at a higher risk of experiencing mental health problems, including:

- those living in poverty;
- people with chronic health conditions;
- infants and children exposed to maltreatment and neglect;
- minority groups and indigenous populations;
- people experiencing discrimination and human rights violations;
- lesbian, gay, bisexual, and transgender persons;
- prisoners; and
- people exposed to conflict, natural disasters or other humanitarian emergencies (WHO, 2013).

Studies over the last 20 years have indicated a close association between poverty and poor mental health (Patel, 2001), with mental disorders frequently leading individuals and families into

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Turbulence: are health systems ready for social change?

poverty. Poor mental health can be both a cause (determinant) and a consequence of the experience of social, civil, political, economic, and environmental inequalities.

A recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US\$ 16.3 million million (trillion) between 2011 and 2030. (World Economic Forum, 2011)

Homelessness and inappropriate incarceration are far more common for people with mental disorders than the general population. Ongoing stigma and discrimination often lead to pervasive human rights violations and exclusion from mainstream social and economic activities, as well as from decision-making on issues that affect them. (Drew et al., 2011).

People who suffer from mental illness are often not provided with educational and vocational opportunities for ‘effective enjoyment’ of the universal right to life, on an equal basis with others – and indeed enjoyment of all human rights (the UN Convention on the Rights of Persons with Disabilities specifies various domains, including home and family life, work, participation in cultural and political life, physical mobility, and so forth).

Development stakeholders’ response to vulnerability: a paradox

Most governments recognise the need for targeted development programmes that address the most vulnerable. The Commonwealth also recognises that in order to achieve enhanced

levels of development, the social and economic inclusion of vulnerable groups in society is crucial.

For those with mental and psychosocial disabilities, this would require addressing the associated societal and environmental challenges that makes them a vulnerable group. These include:

- stigma and discrimination;
- violence and abuse;
- restrictions in exercising civil and political rights;
- exclusion from participating fully in society;
- reduced access to health and social services;
- reduced access to emergency relief services;
- lack of educational opportunities;
- exclusion from income generation and employment opportunities; and
- increased disability and premature death.

People with mental disorders are at increased risk of contracting HIV. A study of psychiatric inpatients in India found increased HIV-related risk behaviour (Chopra et al., 1998) and a consistent association between infection with HIV and poor mental health. In South Africa, a study showed that 44 per cent of people living with HIV have a mental disorder, whereas the prevalence in the general population is only 17 per cent (Freeman et al., 2008). There is evidence that those with depression are less likely to adhere to HIV treatment (Paterson et al., 2000). Studies found that antiretroviral adherence improved for those with depression who had received

antidepressant treatment, compared with those not treated (Yun et al., 2005).

Given their vulnerability, it is paradoxical that people with mental health conditions have been largely excluded from the development agenda when evidence shows that this impedes the achievement of national and international development goals. Squandered human resources and potential is a 'deadweight loss' to society, yet mental health is not often included in cross-sectoral and broader development strategies and plans.

Box 1 Essential concepts

Health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO), indicating the significance of mental health to general health. It has been widely described that 'there is no health without mental health'.

Mental health is a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community (WHO, 2004). Mental health is also described as 'more than the absence of mental disorders or disabilities'. Mental health therefore includes the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders.

Mental disorders comprise a broad range of problems such as depression, anxiety, schizophrenia, bipolar disorder, dementia, "mental retardation" (learning disabilities) and disorders due to substance misuse (WHO, 2010). There is some debate about the constraints of conventional classifications of mental disorder or that treatments can be matched to disorders in a one to one pattern (Bentall, 2003). A high proportion of patients can have co-morbid or multiple diagnoses and mapping out the verifiable symptoms can be more helpful than limiting a single diagnostic entity.

Disability is an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (WHO, 2011).

Vulnerable groups have an elevated risk of developing mental disorders. This vulnerability is brought about by societal factors and the environment in which they live. Vulnerable groups will differ across countries, but in general they share common challenges related to their social and economic status, social supports and living conditions (WHO, 2010).

Service user (and carers') involvement/patient and public involvement (PPI) Involving people with lived experience of mental illness (as sufferers or carers) in the training of mental health professionals and evaluation of mental health services leads to more appropriate attitudes and values from healthcare professionals, new skills and better models of care (see Simpson and House 2002). And, of course, the providers and users of care overlap.

Development stakeholders thus have important roles to play in ensuring that people with mental health conditions are recognised as a vulnerable group – at the same time, it should be acknowledged that even as communicable diseases recede and incomes rise, mental disorders are something to which all are vulnerable.

The economic imperative

The scaling up of mental health services is not only a public health and human rights priority, but also an economic imperative (Lund, De Silva et al., 2011). The implementation of mental health interventions is associated with improved economic outcomes, in particular increased rates of employment. A systematic review of studies on the effect of mental health interventions showed significant improvement on economic status as well as in clinical status. Appropriate interventions resulted in significantly fewer and shorter hospital admissions, longer time in gainful employment and reduced burden on families (Xiong et al. 1994). Mental health intervention also did not have any significant negative effect on economic status.

Strong links should be developed between mental health services, housing, educational and other social services, and employment opportunities including income-generating programmes.

Increasing access to mental health care will enable people with mental disorders to return to work, reduce their healthcare costs and address conditions to support the way out of poverty (Miranda and Patel, 2005). In common with other NCDs, often simple interventions can yield significant results and socio-economic benefits.

Implications:

- people with mental illness should be recognised as a vulnerable group and consulted in all issues affecting them (as specified in the UN Convention on the Rights of Persons with Disabilities);
- at country level, mental health issues should be integrated in countries' health policies, implementation plans, and human resource development programmes; and
- development programmes and their associated policies should protect the human rights of people with mental health conditions and build their capacity to participate in public life and in their communities.

Mental disorders are treatable

A review of the evidence showed that interventions for the treatment and prevention of selected mental disorders in low-and middle-income countries (LMICs) are effective. Depression can be treated effectively in such countries with low-cost antidepressants, with psychological interventions (such as cognitive behavioural therapy and interpersonal therapies), and with 'healthy living' interventions. Appropriately administered (with due regard to lowest effective dosage, frequent review, self-reported side effects and collaborative approaches to adherence) antipsychotic drugs can be cost-effective for the treatment of acute or longer-term psychosis. Interventions for depression, delivered in primary care, are as cost-effective as antiretroviral drugs for HIV/AIDS.

Gender

Women are twice as likely to develop common mental disorders compared to men (Kuehner, 2003). Lifetime prevalence rates of violence against women range from 16 to 50 per cent, and at least one in five women suffer rape or attempted rape in their lifetime (WHO). Other risk factors for common mental disorders that disproportionately affect women include:

- gender-based discrimination;
- socio-economic disadvantage;
- low income and income inequality;
- inferior social status;
- multiple roles (such as caring for others);
- associated factors of poverty, hunger, malnutrition and overwork; and
- sexual abuse (WHO).

High suicides rates in women have been found to be associated with depression and social factors such marital conflict, domestic violence, and social ostracism (Niaz and Hassan, 2005). Women and children make up an estimated 80 per cent of 50 million people affected by violent conflicts, civil wars, disasters and displacement.

In response to severe trauma, access to appropriate resources, having sufficient autonomy to exercise control, and psychosocial support can be highly protective against the development of mental problems, especially depression.

Mothers and children, adolescents and young adults

The effects of maternal perinatal mental distress on child survival and health outcomes have been increasingly studied and recognised (Harpham et al., 2005). In Barbados, a long-term study reported association between maternal mental disorder and impaired cognitive and motor development in infants at six months (Galler et al., 2000). An association between perinatal common mental disorders with infant malnutrition at six months is reported in several South Asian studies (Prince et al., 2007). Thus, addressing mental health of women of childbearing age will be crucial to improve maternal health and decrease child mortality.

A global report on Child and Adolescent Mental Health Resources involving 66 countries reported that less than a third of countries had an individual or government entity with sole responsibility for child mental health programming. Furthermore, funding for child mental health services was rarely identifiable in countries' budgets (Belfer and Saxena, 2006). Special vulnerable groups include children in conflicts, forced labour, and those who live on the streets. Early intervention and prevention offer opportunities to reduce development of mental health problems in adulthood. A whole-of-government approach is required that involves school education, social welfare, criminal justice systems.

Resourcing gaps

The number of specialised and general health workers working in mental health in LMICs is grossly insufficient. Almost half the

world's population lives in countries where, on average, there is one psychiatrist to serve 200,000 or more people; other mental health professionals who can provide psychosocial interventions are even scarcer. Similarly, a much higher proportion of high-income countries than low-income countries reports having a policy, plan and legislation on mental health.

WHO-sponsored research has shown that the provision of person-centred community mental healthcare results in better outcomes, especially for those with chronic mental disorders. Generally better patient outcomes are associated with a reduction of large mental institutions, a shift from hospital to community care, the development of community treatment teams, closer links with community agencies, and the provision of mental health care as part of primary healthcare services (WHO, 2001b).

But community movements for mental health in LMICs are often not well developed. Organisations of people with mental disorders and psychosocial disabilities are present in only in 49 per cent of low-income countries compared with 83 per cent of high-income countries; for family associations, the respective figures are 39 per cent and 80 per cent. Partnerships with community mental health groups and other government organisations to improve access to health care, although essential, remain limited (Ng et al., 2013).

Globally, 63 per cent of psychiatric beds are located in mental hospitals, and 67 per cent of mental health funding is allocated to standalone mental hospitals, despite their association with poor health outcomes ('institutionalisation') and human rights violations ('warehousing', i.e. non-therapeutic containment; other forms of neglect; or outright abuse). Almost a quarter of people (23 per cent) admitted to mental hospitals remain there longer than a year after admission. Despite a growing body of recommendations to the contrary, inpatient provision for mental disorders worldwide is predominantly long-stay, resulting in scarce resources being inefficiently or underutilised when and where available.

Overall, mental health is a neglected and an under-researched area of public health globally, but most particularly in low- and middle-income countries (LMICs). A global mapping exercise was initiated by the Global Forum and WHO (2007) to provide an account of the current status of mental health research in 114 LMICs in Africa (52), Asia (32) and Latin America and the Caribbean (30). Around 57 per cent of LMICs were found to have contributed fewer than five articles to the international mental health indexed literature for a ten-year period (1993–2003), suggesting a paucity of mental health research (and researchers) in many LMICs.

The key priorities for mental health research identified for LMICs include epidemiological studies of burden and risk factors, health systems research and social science research; the top three priority disorders were depression/anxiety, substance use disorders, and psychoses, while prioritised population groups were children and adolescents, women and persons exposed to violence/trauma.

Goal setting

As the vast majority of the population in the Commonwealth live in LMICs, the current and future needs for mental health development for LMICs globally is highly relevant for much of the Commonwealth. Five major barriers to scaling up of mental health services in LMICs have been previously identified:

1. absence of government commitment;
2. lack of government funding;
3. over-centralisation (and, we would add, *over-concentration* of services in urban centres);
4. challenges of integration of mental health care into primary care settings; and
5. scarcity of trained mental health workers (Saraceno et al., 2007).

Comparable to the global situation, health services in the Commonwealth are not provided equitably to people with mental disorders, and the quality of mental health care is highly variable, with large areas requiring improvement.

Government leadership at the highest levels in planning, structuring and financing mental health systems is essential to ensure delivery of equitable and appropriate care across any country in the Commonwealth. Establishing adequate mental health legislation is fundamental to ensuring good governance in implementing the essential national mental health plans, policies, strategies and programmes required to address the mental health development needs of the country and the scaling up of its mental health services.

Integrating mental health services into primary health care, particularly for Commonwealth LMIC settings is a highly practical and viable way of closing the mental health treatment gap. Such 'task-shifting' to primary health care and non-specialist mental health workers enables the largest number of people to access services, at an affordable cost, and in a way that minimises stigma.

The role of the family is of prime consideration in the care of people with mental illness in the Commonwealth. In many Commonwealth countries, families carry the major burden of care and are often stigmatised themselves. Support is needed to empower and strengthen the participation of persons with mental disorders, carers and family members in policy development and the design of mental health services, and public-awareness and anti-stigma campaigns.

Given the enormous deficit, and all too often fragmentation of precious resources, an urgent priority is to develop mutual co-operation across all relevant sectors. Effective partnerships for a sustainable mental healthcare system require multi-disciplinary, multi-level, multi-sector and multi-linkage approaches. Without developing sustainable partnerships and sharing the care for the mentally ill with the community, mental health specialists can only deliver limited services.

Culture matters in mental health – from development of illness, to its social meanings, diagnosis or misdiagnosis, to help-seeking behaviours and even to how it is expressed or manifested, or classified by medical professionals. When planning the delivery of the wide spectrum of mental health, it is critical that governments and local communities engage in ongoing dialogue regarding the most appropriate delivery mechanisms. Persons with mental disorders and their families, local cultural practices, traditional healers and religious leaders all need to be part of this dialogue.

Conclusion

There is a trend at a global level to recognise chronic mental illnesses as being not only similar to other Non-Communicable Diseases through having a similar mix of causative factors (internal and environmental), but also similar in the levels of disability they bring, and the economic burden this imposes on the community. However, it is still debateable what is and is not included within 'mental health' (for example, do we include substance abuse or dementia in later life?). Whatever the interplay of causes, it is clear that spending worldwide on mental health services nowhere near the level it should be to intervene in an effective and humanitarian way.

Also, the popular mind and the media attach a great deal of stigma to mental illness, and there are misunderstandings and myths in the population at large as to why people are suffering. Developing communication and media strategy can reduce community stigma of mental illness and promote the awareness of mental health and mental disorders.

An evidence-based approach to mental health requires that data should be gathered, so that policymakers can understand the prevalence and severity of mental health problems in their countries, and the burdens which this imposes on the community and the economy. But it is clear that many low- and middle-income countries, and smaller states, do not have such data to hand. It may be useful for Commonwealth countries to consider using methodology and instruments of the WHO World Mental Health survey. There are also clear advantages in sharing successful approaches and challenges for community-based and cross-sectoral interventions to prevent and treat mental disorders. Exchanging technical expertise regionally could build capacity and facilitate the implementation of culturally appropriate community-based mental health care models and systems.

There is advantage in leveraging several regional action plans and strategies for mental health and substance abuse such as aligning Commonwealth mental health action plans closely to Global Mental Health Action Plan (to be submitted to the 66th World Health Assembly). In 2012 the 65th World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It also requested the development of a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.

We hope that *Commonwealth Health Partnerships 2013* is a helpful contribution to the debate and would like to thank all the organisations and individuals who have contributed.

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