BRIEFS

Making Room for Mental Health: Recommendations for Improving Mental Health Care in Low- and Middle-Income Countries

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Why Mental Health Matters for Development

Development assistance for health has increased dramatically over the last decade, but investment in mental health has been minimal. Less than 1 percent of development assistance for health goes to mental disorders although they represent at least one-fourth of the years lost to disability and about 10 percent of the global burden of disease. Spending a little on mental health could achieve a lot.

Mental disorders as a proportion of all ill health has increased by an estimated 41 percent between 1990 and 2010. This growth is largely the result of aging populations, which come with a higher number of mental and neurological disorders, including depression and anxiety. A recent article in the *Lancet Psychiatry* argues that these seemingly high figures are in fact underestimates. [1] In many places around the world, suicide goes underreported, documented instead as accidental injury.

Disabling and life-threatening mental and neurological illnesses carry a strong associated economic burden. The majority of mental health costs are not related to treatment; rather they come from indirect costs, especially the lost productivity of affected individuals and their caregivers. In high-income countries, the costs have been estimated at approximately 3 percent of gross domestic product (GDP). In middle-income countries such as South Africa the lost output has been calculated at US$4,800 per capita. Globally, the cost of mental health conditions was estimated at US$2.5 trillion

in 2010, [2] and was expected to double in the subsequent 20 years. This represents one-third of the total cost of noncommunicable diseases, on par with cardiovascular disease.

Effective mental health care exists and can save lives and livelihoods. The release of the Disease Control Priorities volume on mental and neurological disorders, [3] as well as examples of good practice from programs funded by Grand Challenges Canada and the US National Institute of Mental Health, provide a substantial body of evidence in low- and middle-income countries for feasible, culturally appropriate, and cost-effective interventions for common mental disorders. [4] Moreover, the evidence suggests that mental health interventions improve well-being and may even contribute to economic development. [5]

Peer-support groups and counseling delivered by trained lay health workers in combination with primary care–based collaborative models and pharmacotherapy
(for severe cases) have been demonstrated to reduce symptoms of depression and anxiety across vastly different cultural and economic contexts. However, counseling for common mental disorders remains a rare luxury in most countries, and antidepressants are not made available in 25 percent of primary care facilities in low-income countries.

In April 2016, the World Bank is joining the World Health Organization (WHO) to co-host an event alongside its annual spring meetings to address global mental health care as a development issue and explore financing issues. The meeting responds to a call for the scale-up of mental health care first issued in 2007 by the *Lancet* and the Movement for Global Mental Health, [6] strengthened through global consensus in the 2011 priority-setting initiative, the Grand Challenges in Global Mental Health, and reiterated in the WHO historic 2013 Mental Health Action Plan. [7] The first of four objectives in the WHO Action Plan includes improving leadership and governance for mental health, for which this meeting creates an historic opportunity.

In June 2014, we convened a group of experts and leaders in mental health care and development finance to explore innovative approaches to increasing funding and value for money in mental health care in low- and middle-income countries. This working group resulted in a policy paper, [8] which outlined concrete actions country governments and international donors can take to more effectively deliver mental health services. The following distills the group's discussion and recommendations to inform the outcomes of the World Bank / WHO high-level meeting, " Out of the Shadows: Making Mental Health a Global Development Priority." [9]

Recommendations

1. ***Invest more in mental health care to achieve coverage at scale.*** There are a number of locally tested and cost-effective interventions for mental health care, especially for common mental disorders. These range from counseling for individuals and families, peer-support, and community mobilization to supervised use of pharmacology. But given a lack of substantive funding, successful interventions remain trapped in "pilotitis," unable to break out of the pilot stage. The cost of scaling up a package of effective services for depression, alcohol disorders, epilepsy, and schizophrenia to acceptable levels of coverage is estimated at $3-$4 per capita in sub-Saharan Africa and Asia. [10] By allocating funding to integrate mental

health into existing health and social protection programs and protocols, countries stand to improve a range of outcomes—including for HIV, maternal and child health, noncommunicable diseases, and disability. In the absence of investing in these services, those suffering from mental health issues, or their families, are forced to pay out of pocket and for ineffective remedies such as vitamins, sedative herbs, and sometimes even abusive forms of containment in homes and shrines.

2. ***Work with the World Bank to ensure implementation of the mental health components of the United Nation's Global Strategy for Every Woman and Every Child.***
   The global strategy acknowledges the centrality of mental health to achieving its aims. Indeed, mental health is written into the very vision of the strategy, which seeks "the highest attainable standards of health and wellbeing—physical, mental and social—at every age." [11] The strategy further notes that screening and treating depression postpartum and investing in social and mental stimulation for adolescents constitute best practice. In June 2015, the World Bank announced its support for the strategy through a new results-based global financing facility (GFF) to raise funds for countries with significant gaps in reproductive, maternal, newborn, child, and adolescent health. To move from rhetoric to practice, proven, cost-effective mental health interventions should form a component of all country plans approved by the World Bank for the release of GFF funds.

3. ***Include common mental health services in primary care as part of guaranteed packages of health benefits.*** As many countries move toward universal health coverage, countries such as Chile, Ghana, Ethiopia, and Thailand, which have incorporated mental health care into their national benefits plans, stand out as models. Thanks to its Plan AUGE (*Acceso Universal a Garantías Explicitas*), for example, Chile now delivers treatments for depression to half a million individuals through primary care, 88 percent of whom are on public insurance. Other countries can follow Chile's example. More often, however, mental health is excluded from national health guarantees, as is the case in the Philippines where treatment for suicidality is explicitly excluded. Successful health benefits plans not only outline a guaranteed package of services, but tend to carry budgetary allocations, making them more likely to be delivered. In some countries there is a need to develop new payment methods that cover integrated and team-based care, not only fee-for-service care or event-based services. If low-income countries invest early and substantially in delivering mental health services in primary care, they can get ahead of the curve of middle- and high-income countries, many of which have formed inefficient parallel channels of service delivery.

4. ***Prevent mental illness through cash transfers.*** Cash transfer programs provide payments to individuals and families with the aim of reducing poverty and its consequences. The strongest evidence for mental health gains from cash transfers comes from large-scale programs that targeted poor households with children, including programs that made payments conditional on beneficial behaviors such as school or health care attendance. For example, Mexico's *Oportunidades*, now in its 20th year, distributes over US$4 billion in direct payments annually and has been shown to decrease aggression and stress in children. And in Kenya, a cash transfer directed to households with orphans and vulnerable children reduced the odds of depressive symptoms by 24 percent among young persons who participated. For greatest mental health effect, poverty reduction interventions should be

tailored to vulnerable populations and study the impact of the mechanisms of poverty that seem to most affect mental health, namely education, food insecurity, and housing.

5. ***Improve specialist care for acute episodes of mental illness.*** Underinvesting in public hospitals puts lives at risk and creates a gap filled by private facilities that do not always comply with best practice mental health care. The escape of 40 male inpatients from a national public hospital in Nairobi, Kenya, in May 2013 serves as a powerful illustration of what can happen when there are inadequate conditions and facilities for psychiatric care in low-income countries. In middle-income countries, insalubrious and ineffective residential facilities that call themselves hospitals sometimes become warehouses for people with mental illness and serve as alternatives to social care. Appropriate short-term hospitalization in hygienic facilities that are respectful of individual rights is an essential component of a comprehensive mental health system, including for acute episodes of depression and anxiety. Integrating psychiatric beds within general hospitals is one way to mitigate against isolation and abuse that come with segregated care; though budgets for these beds should be earmarked and not integrated to ensure adequate service coverage.

Where More Work Is Needed

If adopted, these recommendations would make great strides toward improving mental health and well-being globally. To take them forward, however, a few key pieces of work are needed:

1. Mental health researchers have been working in consortia to choose the best available measures for capturing clinical, social, and economic outcomes. [12] Researchers must now pair with practitioners and policymakers to arrive at a consensus on how to integrate a selection of these outcomes into routine collection procedures of national health information systems. Measurable outcomes for mental health can both improve data for health planning and feed into newer results based funding mechanisms. These new funding mechanisms include the World Bank GFF for Every Woman and Every Child, and emerging development impact bonds, which are a promising new mechanism for funding large-scale interventions

2. A comprehensive mapping of where mental health is included in health benefits plans is necessary to take stock of where mental health is positioned within these instruments. Health benefits plans are one key mean of achieving universal health coverage, and health care cannot be considered universal if it excludes mental health.

3. Further and more rigorous evidence is needed on the economic outcomes of mental health interventions and, inversely, on the mental health outcomes of economic interventions. This includes further exploring the effects of poverty reduction programs on prevention of mental disorders. Truly comprehending mental health requires understanding the clinical as well as the social and economic consequences of recovery.

The Moral Argument

The tragic irony for people with mental disorders in many low-income countries today is that when they seek treatment, they are met with abuse. Agitated individuals are often tied or shackled. [13] Some are forced to fast. Bodily incisions, tattoos, and flagellation are not uncommon "cures" in some parts of the world. After a visit to prayer camps in Ghana, the United Nations Special Rapporteur on Torture concluded that some of the interventions to treat mental illness constituted torture. Equally unconscionable is the social alienation imposed on people with mental disorders who live out their lives in asylums present in many middle-income countries, segregated from the rest of the population. [14]

While the economic rationale for investing in global mental health is strong, so too is the moral argument. Let us not miss the unprecedented opportunity at the World Bank / WHO high-level meeting and what follows to take concrete actionable steps that can begin to right these wrongs, saving lives and minds.

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[2] D.E. Bloom et al., *The Global Economic Burden of Noncommunicable Diseases* (Geneva: World Economic Forum, 2011).
[3] Vikram Patel et al., *Disease Control Priorities*, Third Edition, vol. 4, *Mental, Neurological, and Substance Use Disorders* (Washington: World Bank, 2015).
[4] National Institute of Mental Health, "Grand Challenges in Global Mental Health," www.nimh.nih.gov/about/organization/gmh/grandchallenges/index.shtml.
[5] Crick Lund et al., "Poverty and Mental Disorders: Breaking the Cycle in Low-Income and Middle-Income Countries," *The Lancet*378(9801):1502–1514.
[6] The Lancet, "Global Mental Health 2007," www.thelancet.com/series/global-mental-health.
[7] WHO, *Mental Health Action Plan 2013–2020* (Geneva, 2013), www.who.int/mental_health/publications/action_plan/en/.
[8] Victoria de Menil and Amanda Glassman, "Missed Opportunities in Global Health: Identifying New Strategies to Improve Mental Health in LMICs," CGD Policy Paper 68, Center for Global Development, Washington, 2015, www.cgdev.org/publication/missed-opportunities-global-health-identifying-new-strategies-improve-mental-health.
[9] "Out of the Shadows: Making Mental Health a Global Priority," April 13–14, 2016, www.worldbank.org/en/events/2016/03/09/out-of-the-shadows-making-mental-health-a-global-priority.
[10] Dan Chisholm et al., "Cost of Scaling Up Mental Healthcare In Low- and Middle-Income Countries," *British Journal of Psychiatry*191:528–535.
[11] Ban Ki-Moon, foreword to *The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030)*, by Every Woman Every Child
(2015), 5.

[12] Mary J. De Silva et al., Evaluation of District Mental Healthcare Plans: The PRIME Consortium Methodology," *The British Journal of Psychiatry* 208:s63–s70.
[13] Sam Jones, "'Living in Hell': Mentally Ill People in Indonesia Chained and Confined," *The Guardian,* March 20, 2016, www.theguardian.com/global-development/2016/mar/21/living-in-hell-indonesia-mentally-ill-people-chained-confined-human-rights-watch-report.
[14] Juan E. Méndez, "Mission to Ghana," addendum to "Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment," March 5, 2014, available at www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session25/Documents/A-HRC-25-60-Add-1_en.doc