

MENTAL HEALTH AS A NEGLECTED HEALTH ISSUE

GABRIEL IVBIJARO AND ELENA BERGER,
WORLD FEDERATION FOR MENTAL HEALTH

INTRODUCTION

Around the world mental illnesses attract an extraordinary amount of prejudice in society. And yet such conditions are common: one in four adults will experience mental health difficulties. Stigma and discrimination are significant barriers that deprive people of their dignity. To make dignity in mental health a reality requires that every member of society works together. Therefore the World Federation for Mental Health, together with its friends, allies and partners, has launched The World Dignity Project to create awareness and advocacy for Dignity in mental health.¹

Over the next two years we will continue our efforts to:

- Address the stigma associated with mental ill health
- Empower people to take action to promote mental health
- Spread understanding of the equal importance of mental and physical health

There has been no universally recognised symbol to represent mental health. In 2015, the World Federation for Mental Health conducted a global consultation among patients, carers and professionals and subsequently adopted a Dignity symbol, which we would like to propose as a universal symbol to promote public awareness of the above goals. The CIVICUS State of Civil Society Report 2016 is well timed, as it enables us to work together to highlight issues concerning mental health and mental illness at home, in the community and in the workplace.

Making dignity in mental health a reality requires action in the workplace. One in five people in the workplace suffer from a mental health condition, and while many employers are developing policies to support their workers, there is no shared vision for mental health in the workplace.

Our vision, therefore, is to define best practice in promoting mental health in the workplace and to create a broad coalition to promote best practice, decrease stigma and empower individuals to promote mental health and dignity for all.

The availability of treatment in high, medium and low income countries is not adequate to the need, particularly if care for substance abuse is included. In low to middle income countries treatment continues to be inadequate or barely available at all, and we need to ask ourselves why this is the case.

¹ World Dignity Project website, <http://bit.ly/1bKhL00>.

Depression and anxiety alone account for a high proportion of the global burden of disease, according to statistics on years lived with disability. Examining treatment coverage for a single mental illness, major depression, the World Health Organization (WHO) found that only 36.3 per cent of men affected by depression receive treatment in high income countries. In low and middle income countries the proportion receiving treatment is far worse, standing at only 13.0 per cent. Depression affects more women than men, but in high income countries, less than half of those affected, 43.9 per cent, receive treatment. Only 18.6 per cent of women from low and middle income countries who experience depression receive treatment. There is a very wide gap between those who need care, and those who receive it, even in countries with the best healthcare resources.²

Why are mental illnesses neglected? Partly it is the effect of stigma and prejudice. People are intolerant of different behaviours. Families can hide the problem, or are expected to care for an individual themselves without professional help. Health budgets are usually under pressure, so that funding for mental illnesses is chronically underfunded. But partly the neglect is caused by widespread public ignorance of the dimensions of the problem.

THE SIZE OF THE PROBLEM

The WHO's 2014 Global Health Estimates showed that of the years lived with disability globally in 2012, 31 per cent were due to combined mental, neurological and substance abuse illnesses. This was equal to the combined total of 31 per cent for other major non-communicable diseases, such as cardiovascular conditions, cancer, diabetes and respiratory diseases.³

In the WHO's 2012 list of the 20 leading global causes of years lost to disability, depression was at the top, accounting for 10.3 per cent of the total. Anxiety conditions accounted for a further 3.7 per cent. Schizophrenia and bipolar conditions each accounted for 1.8 per cent.⁴

These statistics are extraordinary, and few people are aware of them. They are also extraordinary considering how little is spent on mental healthcare in health budgets compared with other non-communicable diseases. The prejudice against people with mental illnesses flows over into the resources assigned to medical care. Other illnesses have priority in funding and treatment.

Most people do not realise how common mental illnesses are. They don't understand that 'mental illness' is an umbrella term covering many different conditions, ranging from less serious diagnoses to extreme disabilities. They don't know that mental illness is treatable. Affordable and effective treatment is now available for many mental health conditions and can often be provided in primary care, by a family doctor or trained health worker. In some low income countries, however, there are no doctors or clinic workers to provide services, and people with mental illnesses are put in chains or kept in miserable mental institutions.

2 'World Mental Health Surveys, 2001-2012. Introduction to the agenda, 'Out of the Shadows: Making Mental Health a Global Development Priority'', World Health Organization (WHO), World Bank-WHO Meeting, Washington, D.C., 13 to 14 April 2016.

3 Ibid.

4 'Global Health Estimates. 20 Leading Causes of Years Lost to Disability (Global)', WHO, 2014.

The stigma surrounding mental illness and the neglect of people who experience them is particularly tragic because some major conditions can emerge at a comparatively young age. Such conditions slowly become visible in the teenage years, becoming full-blown in older teenagers or young adults.⁵ Early treatment can result in improvement of these conditions, helping young people and their families to cope with them. Neglect can lead to a lifetime marked by severe illness. Sometimes suicide is the outcome; like mental illness, this is another subject people don't like to talk about. The WHO reports that suicide is the second leading cause of the deaths of young people worldwide.⁶

CURRENT ADVANCES

The WHO's Department of Mental Health and Substance Abuse is playing a leading role in informing the governments of its 194 member states that mental illnesses are serious and widespread conditions. In 2008 this department introduced the Mental Health Gap Action Programme (mhGAP) to draw attention to the large gap that exists in many countries between the need for mental healthcare and the care that is available. It has also published an atlas series to show, in a different form, the absence of care, country by country. Some low income countries have only one or two psychiatrists, one or two mental health nurses, and perhaps a social worker to address an entire nation's care.

In 2013, the WHO's major annual meeting, the World Health Assembly, introduced a Comprehensive Mental Health Action Plan (2013-2020) to encourage countries to adopt targets for specific improvements in mental healthcare and the reduction of suicide rates. Governments are gradually being prodded to address inadequate mental health services, even as they grapple with care for other important illnesses. But progress remains slow, and stigma is stubborn.

THE EFFECTS OF STIGMA

One troubling reason for the treatment gap is that the perceived shame of having a mental illness discourages people from seeking care, even if care is available. People often feel it is difficult to go to a specialist health professional for help. One way to address the stigma associated with mental conditions is to provide first-line help through family doctors and general practitioners, medical professionals who treat a variety of ailments and who can provide mental healthcare as part of comprehensive care. Serious mental conditions are often associated with other non-communicable diseases, such as cardiovascular disease, cancer, respiratory diseases and diabetes, and people with mental illness often have shockingly shorter lifespans because these co-occurring conditions are neglected.⁷ Family doctors trained in mental health can provide overall treatment, referring individuals for specialist care as needed.

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5 'Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities', Mary Ellen O'Connell, Thomas Boat and Kenneth Warner, Eds., The National Academies Press, 2009, page 15.

6 'World Health Assembly. 2013. Draft Comprehensive Mental Health Action Plan, 2013-2020. A66/10 Rev.1', WHO, 16 May 2013, page 5.

7 Ibid.

THE BUDGET PROBLEM

Because so many people are affected by mental illnesses, public spending on mental healthcare will probably always be inadequate. Constant pressure is needed to make governments provide a higher share of health budgets for mental health. Civil society, including people with mental health problems, their families and professionals who work in the field, have an important role to play in advocating for reforms, better facilities and new treatment options. These efforts should be international as well as national.

Internationally, recent civil society efforts focused on getting mental health mentioned in the new United Nations Sustainable Development Goals (SDGs), which have replaced the Millennium Development Goals (MDGs) that covered the period 2000 to 2015. Organisations and individuals pressed to have mental health targets listed among the health goals, and were successful in getting a small mention inserted into the text, which compares favourably to the MDGs, in which mental health was not mentioned at all. While this will influence the international context, more practically, organisations should press their own governments to see that spending is improved.

Civil society is constrained by its own funding problems, as mental health is not a popular cause in the competitive arena of fundraising. Nevertheless, civil society has an important role to play in keeping the cause on the public agenda, and reframing it as government priorities change. A number of civil society organisations (CSOs) are able to raise funds to provide basic services in some low income countries. Examples include BasicNeeds, the Peter C Alderman Foundation and CBM.⁸

GOVERNMENT HEALTH AGENDAS

Key to addressing the neglect of mental health is advocacy at multiple levels to make sure the issue moves up on the political agenda. Advocates need to stress that government budgets do not provide adequate funding to cover the need for mental health services in the community. The World Federation for Mental Health and other CSOs advocate at the United Nations and the WHO, directly with governments when the opportunity arises, and most importantly at the grassroots level, where a better understanding is needed about how common mental illnesses are. If grassroots knowledge about these conditions remains hidden, then a satisfactory level of services will never be provided.

Civil society's objectives include pressing governments to take the broadest possible view of mental illnesses, so that support is provided by a range of departments of government, and not just in the health budget. The reality is that mental illness is not just a health matter. It should be addressed in multiple departments of government, including housing, education and justice departments. For example, in the USA, the largest government system dealing with mental illness is the prison system. Health systems should interact with other government departments to provide the medical and social care needed to enable people with complex conditions to live in the community. Most importantly, mental health is relevant to finance departments, where decisions about funding are made.

⁸ Basic Needs website, www.basicneeds.org; CBM website, www.cbm.org; Peter C Alderman Foundation website, <http://bit.ly/1qdzWll>.

In April 2016, to emphasise the neglect of adequate mental health funding, the World Bank and the WHO held a joint meeting on mental health at the time of the World Bank's Annual Meeting. The introduction to the meeting's agenda noted that mental illnesses were responsible for 23 per cent of England's total burden of disease, but received only 13 per cent of its National Health Service health expenditures. The introduction also reported that on average, low income countries give only 0.5 per cent of health budgets to mental health.

To catch the ear of politicians, advocates are now stressing the economic consequences of neglecting to invest in mental healthcare. The costs are significant. The introduction to the World Bank/WHO meeting agenda stated that depression was estimated to cost US\$800 million or more in 2010 because of lost production. Depression and anxiety cause employers to lose production because of workers' absences or poor productivity, while families lose income, and governments face higher welfare costs.

Campaigns to provide information about mental conditions will slowly provide a more realistic understanding of mental illness.

PROMOTION AND PREVENTION

To develop a more flexible government approach to the social setting of mental health, more funding should be assigned to research on promotion and prevention - the promotion of mental health and the prevention of mental conditions - and to the adoption of evidence-based interventions. Programmes such as the Nurse-Family Partnership, a home visiting intervention in the USA, have been shown to improve the wellbeing of mothers and young children.⁹ Many well-researched interventions that improve mental health outcomes can be introduced in school settings, and there are interventions appropriate for use in the workplace.¹⁰

THE PUBLIC EDUCATION EFFORT

Public education is an important way to address the knowledge gap and counter unfavourable perceptions and prejudices. Campaigns to provide information about mental conditions will slowly provide a more realistic understanding of mental illness. One example is the World Federation for Mental Health's international campaign, which sees World Mental Health Day observed each year on 10 October. This vehicle for grassroots advocacy and public education was founded by the Federation in 1992 and has wide outreach.

Each year the board of the World Federation for Mental Health selects a current mental health issue as a theme, and organises a group of experts to write short articles about it. The material is distributed electronically, and translated into several languages on our website.¹¹ The articles can be translated individually into local languages, as needed.

9 Nurse-Family Partnership website, <http://bit.ly/1umn0Lz>.

10 'Public mental health: the time is right for translation of evidence into practice', Kristian Wahlbeck, World Psychiatry, vol. 14, no. 1, February 2015, pp.36-42.

11 World Federation for Mental Health website, www.wfmh.org.

The theme and materials are used by many CSOs around the world as a basis for programmes, lectures, health fairs and other public events. Government departments, hospitals and medical schools in some places also find them useful. Programmes are widespread in some high income countries such as the UK, and also in countries with much lower levels of resources. In low and middle income countries the local approach can be imaginative: banners and signs have been placed alongside streets in Mongolia and Tanzania, and carried in parades in Nepal, Zambia and Zimbabwe. Slogans on banners have been carried by elephants and camels in India.

In 2015 the World Mental Health Day theme was ‘Dignity in Mental Health’, which addressed the many ways in which people with mental illnesses are not accorded dignity, and the many ways in which dignity could be fostered. In 2016 the theme is ‘Psychological and Mental Health First Aid’, with the aim of increasing knowledge about the Mental Health First Aid training programme that originated in Australia. This course trains members of the public to recognise the symptoms of mental illnesses or a mental health crisis, such as serious depression, psychosis and suicidal thoughts, and gives guidance on how to provide initial support until professional or other assistance can be obtained.

People who have mental conditions or who have experienced them in the past can themselves be first class advocates for better care. They know where there are inadequacies in mental health services, and can be forceful spokespeople on behalf of others who can’t or don’t want to take on this task. Moreover they exemplify the range of experience related to such conditions. Some people with mental illnesses can be severely disabled by them. But others hold jobs and take care of families. The public as a whole may not understand that these illnesses are very variable, treatment exists, improvement can be expected, and recovery is possible. People who have experienced this can be strong advocates.

Treatment is available for many conditions. We should address how best to offer care for mental and physical illness when they co-exist in a patient, as often happens. Work in Waltham Forest in London, UK, shows that when mental illness exists with long-term physical conditions in patients, costs are significantly higher than when individual chronic long-term conditions are treated alone. Lessons need to be learnt from this so that we can find the best way to address mental and physical health co-morbidity.¹²

RECOMMENDATIONS

Stigma contributes considerably to the neglect of mental illnesses. Efforts must continue to address stigma through public education about mental illnesses, and civil society has a big role to play here. People who have experienced mental illness and their families can also play a major role in advocacy. Single organisations can make a difference; coalitions of organisations can be even more effective. There are many opportunities to keep the issue in the public eye.

Advocates should campaign vigorously for improved allocations of funding for mental healthcare in government budgets, not only in the health sector but also in multiple government departments. They should adopt a ‘whole of government’ approach.

¹² ‘Collaborative care: models for treatment of patients with complex medical-psychiatric conditions’, G O Ivbijaro, Y Enum, A A Khan, S S Lam and A Gabzdyl, *Current Psychiatry Reports*, vol. 16, no. 11, article 506, November 2014.

Fundamentally, care for people with serious mental illness is a human rights issue and a matter of fairness. Alternative approaches are needed to deal with the shortage of professional staff who have specialised training and qualifications. In high income countries training to treat mental conditions should be expanded further for general practitioners and nurse practitioners. In low to middle income countries appropriate training should be provided for nurses and lay clinic workers, with referrals available for specialist care.