Global mental health: the social, economic and political rights challenges

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Introduction

The human rights challenges to global mental health addressed in this article include the inextricable relationship between mental health, poverty and debt. It discusses the need for more health economics research on cost-effective interventions; the limited funding available to improve access to mental health services; and the need for careful strategic dialogue and action around public policy and its implementation. It also addresses the role of health professionals and national mechanisms in scaling up access to services; the need for an improved global architecture for mental health; the need to strengthen links between mental and social development; and finally a consideration of the importance of a human rights approach.

Mental health, poverty and personal debt

Mental disorders impose a significant economic burden, but information on the economic consequences of poor mental health in low- and middle-income countries is limited, and available estimates are likely to be conservative; few take account of the ways in which families mobilise and redirect resources that adversely affect them, worsening and perpetuating socio-economic inequalities. When aggregated across an economy, these household costs have an important impact on the size and productivity of the labour force and on national income. Meanwhile, a tolerably just society may be part of averting some of these costs in the first place; evidence from Uganda and Ethiopia indicates that poverty and widening income inequalities are major risks for depression.[2,3]

Mental disorders perpetuate the cycle of poverty by interfering with the individual's capacity to function in either paid or non-income roles, leading to decreased social, as well as economic, status. Thus, people with mental health problems are often the poorest of the poor, because neither they nor their family carers may be able to work. In many low-and middle-income countries, where universal access to health care and financial and social protection systems are often lacking, individuals with mental illness may spend much of their savings or borrow money to buy conventional and/or traditional medicines, and may have transportation difficulties in accessing these services.

Poor mental health in childhood and adolescence increases the risk of poverty and other adverse economic outcomes in adulthood. About 10 per cent of children and between 10 and 15 per cent of young adults globally experience mental health problems. Longitudinal studies in a number of high-income countries demonstrate that untreated mental health and behavioural problems in childhood and youth can have profound longstanding social and economic consequences in adulthood, including:

- poorer levels of educational attainment;
- increased contact with the criminal justice system;
- reduced employment levels (with lower salaries when employed); and
- personal relationship difficulties.

In short, although the effects of poor health on poverty are by no means unique to mental illness, their negative impacts are greater than for most acute and chronic illnesses. These adverse impacts increase the risk of impoverishment for households that fall below the poverty line; and for those already below the poverty line, they potentially could lead to starvation. They can also frequently lead to physical illnesses that present to under-resourced primary care services.

Social dialogue

To date, three main approaches have been used to improve mental health in low- and middle-income countries.

- First, the public mental health approach, which focuses on a combination of prevention and treatment of the main categories of mental disorder, as well as their integration into existing health services, particularly primary care.

Box 1 Cost-effectiveness

WHO's cost-effective healthcare intervention programme

The **Cho**osing **I**nterventions that are **C**ost **E**ffective (CHOICE) programme led by the World Health Organization (WHO) has assessed the cost-effectiveness of a wide range of interventions that significantly reduce the burden of disease in a range of epidemiological and geographical settings. The CHOICE initiative has, however, focused largely on healthcare interventions, whereas in high-income countries a growing body of evidence demonstrates the important role played by employment and living arrangements in improving health outcomes.

Benefits of interventions within the education system or support for microcredit and other fair lending schemes to help individuals avoid falling into unmanageable debt also need to be better understood. Hence, there is an urgent need to assess the cost-effectiveness of prevention and promotion strategies, many of which lie outside the health system and take place, for example, in school or in the workplace. The role of primary healthcare services in liaising with these non-healthcare services also needs careful consideration.

Picture: Kakoli Prodhan/Commonwealth Photographic Awards

Gender-based violence: a major social determinant of mental health

- Second, the human rights approach (in the narrow sense), which emphasises the de-institutionalisation of people with chronic mental disorders and draws on the traditions in the West, as pioneered in Trieste, Italy in the 1970s and 1980s.[4]
- Third, a developmental approach, which targets poverty reduction to expand access to health, and which assumes that mental health will improve with increased national wealth.

All three approaches are complementary and essential, but need careful implementation, monitoring and evaluation if they are to work effectively. Greater resources are needed, as well as careful strategic dialogue and action. Epidemiological transition in low- and middle-income countries means that the integration of mental health into health sector reform is crucial to the foundation of functional health systems.

Human rights abuses against people with mental disorders are also pervasive in low-income countries, albeit with a different profile from wealthier nations. Large mental institutions are much less common in sub-Saharan Africa (SSA) than they were in the West, or in the former Soviet Union where they are still widespread. While SSA countries often have only one dedicated mental hospital dating from the colonial era, and in general there is considerable under-provision rather than over-provision of inpatient facilities, human rights abuses are commonly found in community settings. Here, healers and families sometimes resort to chaining people to 'keep them safe from harm' (by wandering into dangerous areas or falling into fires), and even beating people with severe mental symptoms for want of more accessible and effective solutions.

However, the largest human rights issue in SSA related to mental health is the lack of access to any meaningful care. In low-income countries, decentralisation of mental health care to the primary care level would enable better integration of mental health services within the health system. But as we have noted, there is limited evidence on how this can be best achieved for mental health or for other high-priority health interventions.

Given the strong role of social determinants in mental health, rehabilitative interventions must also address poverty reduction. Livelihood interventions are increasingly being linked to mental health interventions, as demonstrated by the NGO BasicNeeds UK in Uganda,[5] and to psychosocial interventions such as those offered by the Transcultural Psychosocial Organisation[6] in small pilot projects. These evaluations should provide much-needed evidence on the linkages between mental health and poverty, not just in terms of causation but also in establishing a clearer view of causal links for developing effective interventions.

Participation, accountability, non-discrimination and empowerment are hallmarks of present day 'human rights-based approaches' to development and civil society, particularly through mental health service user movements, has a key role to play. But currently in low-

income countries, there are very few international, national and local NGOs working to address mental health, and they do not have national coverage enabling them to meet national population needs. National NGOs tend just to have a presence in the capital city, and often face unfavourable environments that hinder their ability to scale up interventions.

Improved governance structures for mental health and better co-ordination between different actors at a national level, while critical, do not negate the need to shift funding so that it can help promote a more decentralised, primary care-led approach to mental health. Regions need a budget to support and supervise district level services, and to engage in intersectoral dialogue, training and service development. In turn, districts need a budget to support and supervise primary care level services and to engage in intersectoral dialogue, training and service development. The primary care level needs funds to ensure uninterrupted care delivery, and recruitment and retention of the primary healthcare workforce, as well as materials and transport to support and supervise volunteer community health workers to enhance community engagement and intersectoral dialogue at village level. Potentially, the resources required to achieve the above are relatively modest in comparison to the benefits that could be achieved.

Key to moving towards a more primary care-led mental health system is human resources. Health professionals such as general practitioners, nurses, public health doctors, psychiatrists, psychiatric nurses and psychologists can play crucial roles within countries for advocacy, leadership, service planning and development, providing support for primary care, intersectoral co-ordination and training, and inclusion of mental health in district and regional plans.

An improved global architecture for mental health

Recent global initiatives, such as the Global Health Workforce Alliance, which focus on strengthening the health workforce, including the training of psychiatrists and psychiatric nurses (and their integration into general health care), plus the training of community health workers, are providing much-needed resources for mental health training in some countries. However, there is no systematic attempt by the donor community to address health system constraints in relation to mental health.

Addressing mental health abuses in some low- and middle-income countries is essential to addressing human rights, as outlined in the recent UN Convention on the Rights of Persons with Disabilities.[7] People with serious mental illness in parts of Africa and Asia, in the absence of access to effective health interventions, may sometimes be shunned because of misconceptions about contagion, or actively punished on account of supposed spirit-possession. Serving these people and enabling them to actively participate in society is not only a question of need, but one of human dignity.

There is also an opportunity to extend international donor actions, such as DfID-supported general initiatives in relation to health systems, access to medicines (Medicines Transparency Alliance – MeTA)[8] and governance and human rights, to mental health. In this respect, the Alma Ata principles of primary health care are needed more than ever, affirming as they do equity, solidarity, social justice,

universal access to services, multisectoral action, decentralisation and community participation as the basis for strengthening health systems.[9] Training was mentioned in the World Health Report 2008 as including primary healthcare nurses, midwives, allied health professionals and family physicians working in a multidisciplinary context with community health workers. This is exactly what is needed for mental health, and there is an opportunity for a critical policy dialogue with the WHO to ensure that mental health is included in all these activities.

Mental health advocates also need to link with other sectors, health initiatives and programmes funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria, as these three diseases have a considerable burden of associated mental illness. For example, Zambia has successfully integrated mental health into Global Fund proposals for training of health staff. Tanzania, Kenya, Uganda and Malawi have integrated mental health into general health service delivery, utilising general health service budgets as set out in the national health sector strategic plans and annual operational plans. These provide good examples of systematic implementation of mental health service delivery within highly resource-constrained environments.

Linking mental health and rights-based social development

The contribution of better health goes far beyond the reduction of clinical symptoms and disability. While a renewed approach to mental health in the context of health sector reform is crucial, this needs to be complemented by a multisectoral and multi-level perspective on mental health, to ensure that factors that influence mental well being and its relationship to physical well being, empowerment at family and community levels, livelihoods, workplace productivity, human security and the development of human, social and economic capital are effectively addressed. An analysis recently explored for the UK in the Foresight project on mental capital and well-being shows the importance and benefits of a holistic approach to mental health.[10]

A societal perspective is not just an analytical point of view. It needs to be reflected in structures for planning and financing that can realise an integrative and synergistic role for mental health capacity and expertise across sectors. Appropriate financing, in line with burden, need and availability of effective interventions, should be allocated to mental health from government, multilateral and bilateral resources, including financing entities such as the Global Fund and philanthropic foundations, such as the mental health training programme for Kenya primary care staff funded by the UK-based Nuffield Trust.[11] The effectiveness of community-based approaches and the cross-sectoral benefits of investing in mental health in development need to be better documented and communicated to policy-makers.

The Paris and Accra principles of aid effectiveness commit donors to ensuring country ownership.[12] Although governments are said to be 'in the driver's seat', in most instances this is not the case, as exemplified by the neglect of mental health, which is not is a priority for donors focusing on the health Millennium Development Goals (MDGs). Mental health is all but absent in most key development plans, including Poverty Reduction Strategy Papers (PRSP) and subsequently in Poverty Reduction Strategy Credit (PRSC). Exceptions include Uganda, where despite some donor opposition, mental health was included in health policy and in three Health Sector Strategic Plans.

Human rights are an important lever by which mental health advocates have made progress in Western countries, where legal advice is accessible and affordable and where governments have resources to improve services and expand access to mental health services. However, in Western countries, the human rights and mental health movement has focused on ending the inhumane incarceration of mentally ill patients in large institutions for long periods of time: a frequent problem in rich countries but not so in low-income ones where institutionalisation is uncommon, and where the focus has been more on lack of access to adequate care. Compared with other advocacy movements, such as those for AIDS, North-South partnerships between mental health rights activists have been slower to develop as a result of such differences. Mental health legislation has an important role to play in clearly articulating human rights issues to governments and populations, especially if a person has to be admitted or treated against their will. However, mental health legislation is only effective if successfully implemented: requiring inter alia a code of practice and training for relevant sectors such as health, police, lawyers and prisons, and financial resources that low-income countries do not have. For example, Kenya still lacks a code of practice for the 1988 Mental Health Act, and the police are still operating according to the 1944 Act because their statutes and training have not been updated. Thus, the human rights approach can only have an impact if there is major funding for training staff and developing a code of practice that can be implemented.

In many SSA countries, mental health legislation is old, with most dating back to the late 1950s or early 1960s. The process of enacting new laws will require financial and human resources, which low-income countries lack. Even when new mental health legislation is enacted, implementation, as in Kenya, is likely to be slow until good practice guidelines are developed and used by the relevant sectors (health, social welfare, police and prisons), with professional training to ensure appropriate implementation. New and additional resources will be needed from both domestic and external sources. Donors have an important role to play in encouraging the adoption of good human rights practices; this has been the case with some European Commission-funded programmes.

In this regard, possible roles that donors can play include placing mental health at the heart of their policy dialogues with countries and integrating mental health with health system strengthening, health management information systems, communicable and non-communicable diseases; as well as education, social protection and criminal justice strengthening. This is especially important to sustain the successes of AIDS programmes supported by the Global Fund and the US President's Emergency Plan For AIDS Relief (PEPFAR), which are currently supporting more than six million AIDS patients to receive anti-retroviral therapy: individuals who will probably survive well into the next three decades and develop co-morbidities such as mental illness and cancer, but lack systems to manage AIDS as a long-term illness. In addition, agriculture and environmental protection may be improved if attention is paid to population mental health.

Conclusion

Our analysis shows the clear need to provide increased international financing to address growing mental illness in low- and middle-income countries, and to integrate mental health into general health policy and the essential healthcare package at all levels of the health sector, especially at primary care level, to develop a holistic and client-centred approach to health care. Integration into the non-health sectors, especially education, social welfare, employment, social, agricultural and business development, and the criminal justice system is also essential. The mental health sector needs to form partnerships, underpinned by collaborative training, research and mutual dialogue, with other health and non-health sectors to enhance the use of wider budgets and initiatives for mental health.

Given the evidence of disease burdens and suffering, perhaps the ultimate appeal on this question is non-discrimination: why should health challenges (and those who suffer them) be weighed differently according to whether they are 'mental' or 'physical'? Donors, governments and activists alike can make it clear that they regard mental health an equivalent priority to the major communicable and non-communicable diseases, stressing the inextricable links among these conditions that affect individuals. In addition, mental health can be placed at the heart of dialogue about health systems strengthening, to ensure mental health is integrated into primary care, and that any human resource strategy includes attention to psychiatric nurses, who are the mainstay of specialist mental health service delivery in the developing world.

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Endnotes

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