

A REPORT TO THE COMMONWEALTH SECRETARIAT

Mental Health: Towards economic and social inclusion



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1 Summary

Globally, there is a fast approaching mental health crisis. Mental disorders and their associated growing disease burden on families, communities and nations, are due to the complex inter-relationships between major socio-economic, environmental and biological risk factors.

As mental disorders have an impact on the social and economic development of any society, the increasing burden of mental health problems in Commonwealth countries impedes the achievement of their development goals.

Effective and affordable interventions are available to prevent, treat and rehabilitate people with mental disorders and that can result in social and economic participation. Addressing mental health issues can also have a significant impact on the progress towards several Millennium Development Goals.

As 94 per cent of the population in the Commonwealth reside in low and middle income countries, many of the global challenges identified for mental health are therefore applicable to Commonwealth countries. Despite great disparities in the availability of mental health resources across the Commonwealth, there are important similarities in mental health contexts that are useful for consideration by policymakers and mental health professionals. Cultural influence on assessing and treating mental health problems, for example, is a key consideration given the rich diversity of people in the Commonwealth.

There are examples of best practices in mental health development to be found throughout the Commonwealth. Through practice-based evidence, successful models that are documented, shared and disseminated can inspire similar initiatives in other settings and countries.

A number of key issues relevant to the post-2015 health development goals have emerged from this review of the mental health status in the Commonwealth. The evidence and knowledge accumulated regarding cost-effective interventions, rights-based approaches and multi-sector strategies have led to important broad recommendations for implementing comprehensive mental health care.

In considering the existing strengths, partnerships and future health development goals for mental health in the Commonwealth, this review presents eight recommendations to achieve targeted impacts within a feasible time frame:

- Promote the inclusion of mental health in national health programmes;
- Foster policies to reduce risk of mental disorders;
- Support the inclusion of mental health in the development agenda;
- Identify and disseminate examples of best practices;
- Facilitate exchange of technical expertise in developing community mental health systems;
- Develop a communication strategy to promote mental health;
- Build capacity in mental health surveillance and information systems;
- Promote research for the prevention, assessment and treatment of mental disorders.

2 Introduction

The Health Section of the Social Transformation Programmes Division (STPD) commissioned this Report to generate information on the current status of mental health in the Commonwealth and implications for achieving global health targets especially post 2015. The information will inform the theme and deliberations at the Commonwealth Health Ministers Meeting scheduled for May 2013 in Geneva.

Findings would highlight contemporary mental health issues, including how public health interventions on mental health can be an enabler towards strengthened social and economic development. Information is provided to stimulate discussions among Ministers on the topic, in the context of post 2015 global health agenda.

THE TERMS OF REFERENCE

- A) Develop a broad picture of the status of mental health across the Commonwealth, paying particular attention to the cross-sectoral linkages to the economic and social dimensions.
- B) Analyse the information gathered, pull out the relevant data and draft a report for review by the Commonwealth Secretariat.
- C) Incorporate comments from the Commonwealth Secretariat review into a draft working paper for the Commonwealth Advisory Committee of Health (CACH) meeting.
- D) Prepare and present the revised draft paper on the state of mental health in the Commonwealth, in the context of the global health goals and targets, at the CACH meeting.
- E) Integrate comments, inputs and feedback from CACH meeting deliberations into the draft paper.
- F) Finalise as a report for the Commonwealth Health Ministers Meeting.

METHODOLOGY AND APPROACH

In developing the report, the consultant reviewed a wide range of international and national mental health sources as well as more specific materials focussing on important emerging issues for the Commonwealth. In the preparation of the report the following key activities were undertaken:

- A. Reviews of
 - a) Published print and electronic information on mental health from pan-Commonwealth partners
 - b) The WHO Mental Health Atlas report for the 54 Commonwealth countries
 - c) The Lancet Series on Global Mental Health 2007 and 2011
 - d) World Health Organization mental health documents including the Draft WHO Comprehensive Mental Health Action Plan 2013–2020
 - e) Available print, electronic, peer reviewed and other credible publications that examine key issues for mental health globally and from specific regions
- B) Analysis of mental health best practices from the literature and provided by Asia Pacific partners working with Asia-Australia Mental Health
- C) Summary of the emerging issues for mental health in the context of global health development
- D) Formulation of key recommendations for the ways forward for countries in the Commonwealth

3 Global Context of Mental Health

3.1 Definitions

Health is defined as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO YEAR?), indicating the significance of mental health to general health. It is often stated 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 and disorders due to substance misuse (WHO, 2010). However, they are generally characterised by different symptoms including a combination of abnormal thoughts, emotions, behaviours and relationships with others.

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). 'People living with psychosocial disabilities' refers to those who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion (Drew et al, 2011).

Vulnerable groups are at greater risk of developing mental disorders. Vulnerable groups in society 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).

3.2 The Global Burden

Mental illness occurs in all communities, in men and women and across all ages. More than 450 million people worldwide suffer from mental disorders, with many more experiencing mental health problems.

A key finding of the 1990 and 2000 studies on the Global Burden of Disease was that the large unrecognised and rising burden of mental and behavioural disorders in developed and developing countries will impose new challenges on health systems.

Taken together (mental, neurological and substance-use disorders) mental health issues are a leading cause of disability globally accounting for 13 per cent of the total global burden of disease. They are the most important contributors to non-communicable diseases (NCDs), even more than heart disease, stroke and cancer. Depression alone accounts for 4.3 per cent of the global burden of disease and is among the largest single causes of disability worldwide (11 per cent of

all years lived with disability globally), particularly for women. From 1990 to 2010, mental and behavioural disorders increased from 5.4 per cent to 7.4 per cent of global Disability Adjusted Life Years (DALYs) with five different disorders causing 15 million DALYs each: major depressive disorder, anxiety disorders, schizophrenia, alcohol and drug use (Murray, Vos et al. 2013). The degree of disability of mental health disorders was rated extremely high in the global Burden of Disease Survey (Salomon et al, 2013).

People with mental disorders experience disproportionately higher rates of disability and mortality. Due to physical health problems that are often untreated (NCDs or infectious diseases) and suicides, persons with major depression and schizophrenia have a 40-60 per cent greater chance of dying prematurely than the general population.

Mental disorders (particularly depression and alcohol-use disorders) are a major risk factor for suicide. Almost one million people die from suicide annually with a 'global' mortality rate of 16 per 100,000, or one death every 40 seconds (WHO, 2012). In the last 45 years suicide rates have increased by 60 per cent worldwide. By 2020, an estimated 1.5 million people will commit suicide each year and 15-30 million will attempt suicide (Bertolote and Flieschmann, 2002). Suicide is the second most common cause of death among young people worldwide.

3.3 Determinants of mental health and mental illness

Risk factors for mental illness include poverty, inadequate education, 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. They include: 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 such as lesbian, gay, bisexual, and transgender persons; prisoners; and people exposed to conflict, natural disasters or other humanitarian emergencies (WHO, 2013).

Mental disorders increase risks for both communicable and non-communicable diseases (NCDs), and also contribute to the morbidity and mortality of NCDs, in part due to the influences in help-seeking, diagnosis, and treatment. Patients suffering from mental illness are twice as likely to smoke cigarettes (Lesser et al, 2000). Conversely, many physical conditions increase the risk for mental disorder. Depression is about twice as common in patients with diabetes mellitus (Cosgrove et al 2008) and with cancer (Massie, 2004), than the general population. The risk of heart attack in patients who are depressed is more than twice as high as in the general population. And to go further, depression increases the risk of death in patients with cardiac disease (Rugulies, 2002; Whang et al, 2010). Moreover, treating the symptoms of depression after a heart attack has been shown to lower both mortality and re-hospitalisation rates (Mazza et al, 2010), and treating symptoms of depression in cancer patients may improve survival time (Giese-Davis et al, 2011). Therefore tackling co-morbid mental illnesses is both essential and necessary when addressing epidemics of NCDs (Kolappa et al, 2013).

Health Promotion is defined as "the process of enabling people to increase control over, and to improve, their health" at the Ottawa Charter for Health Promotion in 1986. Although the WHO definitions of health and the Ottawa Charter describe mental health as an integral part of health, mental health promotion is frequently overlooked in health promotion programmes. There is growing evidence that an approach to mental health that incorporates promotion, prevention and early intervention activities can have far-reaching benefits for improving mental health (Sturgeon, 2006). As many determinants of health, and particularly mental health, lie outside the health sector, addressing promotion requires an understanding and commitment from stakeholders outside the sector and across the lifespan. These include perinatal care, schools, work and local communities. The health sector requires the knowledge, attitudes and

skills to advocate, persuade and collaborate with these other sectors to engage in activities that enhance mental health.

3.4 Social and economic impacts of mental disorders

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

Studies over the last 20 years have indicated a close association between poverty and mental ill-health (Patel, 2001) with mental disorders frequently leading individuals and families into poverty. Poor mental health can be both a cause (determinant) and a consequence of the experience of social, civil, political, economic, and environmental inequalities.

3.4.1 Poverty and inequality leading to poor mental health

Those living in poverty face stressful conditions, which place them at higher risk of developing a mental health condition. Mental health conditions are more common in areas of deprivation and are consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events (Friedli, 2009). The evidence suggests that the relationship between poverty and mental ill-health is cyclical, where poverty increases the risk of mental disorders and having mental illness increases the chance of descending into poverty (Lund, De Silva et al, 2011).

3.4.2 Poor mental health leading to unemployment, poverty and inequality

People with mental health problems often are unable to work because of their symptoms. Due to stigma and discrimination, others are denied work opportunities or lose employment, driving them deeper into poverty. The right to work, without discrimination was enshrined in Article 23 of the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948, and is now reflected in the Commonwealth theme, "Opportunity through Enterprise". In 1995, the Copenhagen Declaration and Programme of Action acknowledged that people with disability are too often forced into poverty and unemployment. Studies have repeatedly shown that even when an economy is buoyant, those with severe mental illnesses have the highest unemployment rate of any disability group (Provencher et al, 2002). Unemployment rates of up to 90 per cent are not uncommon among people with mental and psychosocial disabilities (Patel et al, 1999).

Many with mental ill health have no means to pay for needed treatment; in other instances, money is spent on costly mental health care. The relationship between income and ill health is stronger for mental health than for general health and the extent of inequality increases with the severity of mental disorders, the greatest being for psychosis (Mangalore et al. 2007). The current global financial crisis is a powerful example of a macroeconomic factor contributing to the worsening of inequality and the spiral of poverty for mentally ill people. Studies have underlined the significance of increasing levels of demoralisation and risk of developing depression when individuals have been exposed to stressful economic situations (Madianos et al, 2011). In short, the crisis has led to cuts in funding to social and health services to support mentally ill people and their families, and is at the same time itself a contributor to higher rates of mental disorders and suicide as well as the emergence of new vulnerable groups (for example the young unemployed).

3.4.3 People with mental illness are among the most marginalised and vulnerable

Homelessness and inappropriate incarceration are far more common for people with mental disorders than the general population. On-going 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. This diminishes a person's ability

to earn an income, lift themselves out of poverty, and access treatment to integrate into their community and recover from their illness (Drew et al. 2011).

The basic human rights of people who suffer from mental illness are often denied and frequently violated – for example the loss of personal liberty such as the right to marry and found a family, or denial of civil and political rights such as the right to vote and to participate effectively and fully in public life. In many cases people with mental illness are not provided with educational and vocational opportunities to meet their full potential.

At the same time, vulnerability can increase the risk of mental health problems. Exposure to trauma and violence such as physical, emotional and sexual abuse can cause serious mental health problems, including depression, anxiety, and substance use disorders. In many societies, the socially defined role of women exposes them to greater stress factors, domestic violence and abuse, and leaves them with fewer opportunities. These factors among others lead to elevated rates of a range of mental disorders.

In a WHO multi-country study, women who had experienced physical or sexual violence or both reported higher levels of emotional distress than other women and were more likely to attempt suicide (WHO, 2005). In Australia, researchers found that two-thirds of homeless people develop substance abuse problems, and more than half develop mental health conditions after losing stable housing (Chamberlain et al, 2007).

3.4.4 Development stakeholders' response to vulnerability: A paradox

Commonwealth governments recognise that in order to achieve enhanced levels of development, the social and economic inclusion of vulnerable groups in society is crucial. Hence the need for targeted development programmes that address the most vulnerable.

Since development implies the improvement of the lives of all people in a country, excluding certain vulnerable groups means some are likely to be left behind as a country develops. The absence of opportunities to contribute to micro- (personal) and macro- (societal) economic prosperity and well-being will lead to deeper economic and social marginalization. Further, excluding vulnerable groups from participating fully in society means they are not empowered to change conditions that oppress them. Hence, to achieve greater levels of sustainable development, the social and economic inclusion of vulnerable groups in society is vital (WHO, 2010).

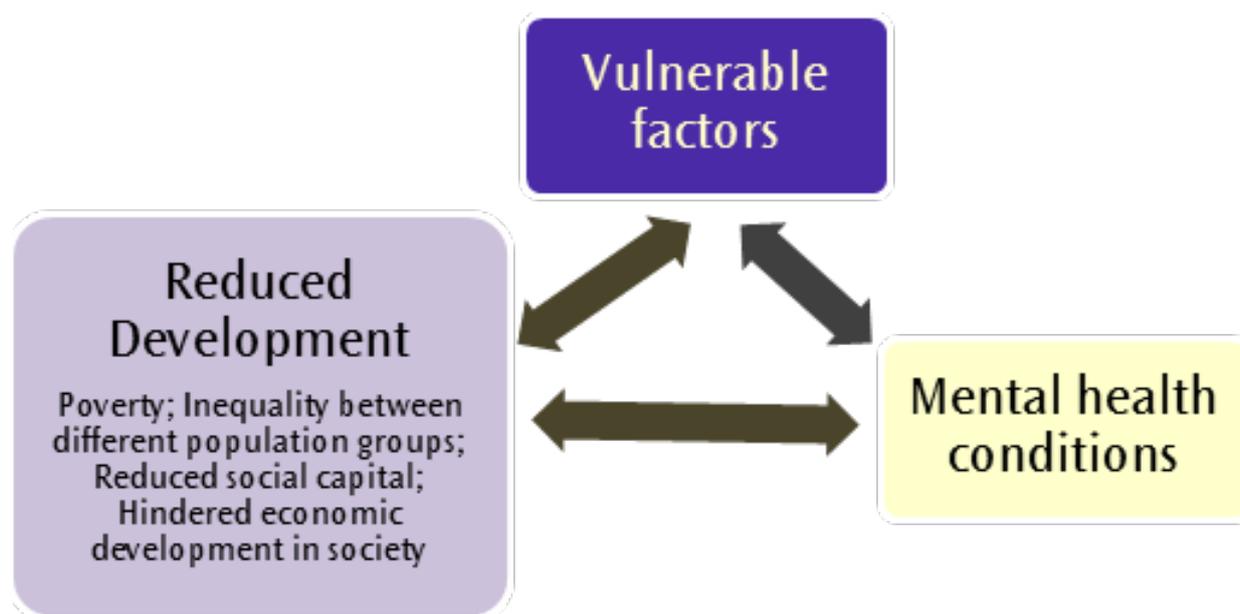
For those with mental and psycho-social disabilities, this would require addressing the associated societal and environmental challenges that makes them a vulnerable group.

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;
- Increased disability and premature death.

The cycle that can develop between vulnerable factors, mental health conditions, and reduced development is illustrated in Figure 1.

Figure 1. The cycle of vulnerable factors, mental health conditions and reduced development



Source: Adapted from WHO, 2010

Given their extreme vulnerability, it is paradoxical that people with mental health conditions have been largely excluded from the development agenda when increased evidence shows that excluding people with mental illness impedes the achievement of national and international development goals. Mental health is not often included in cross-sectoral and broader development strategies and plans.

Development stakeholders thus have an important role to play in ensuring that people with mental health conditions are recognised as a vulnerable group

3.4.5 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 in economic as well as 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 did not have any significant negative effect on economic status.

Addressing mental health problems in vulnerable groups can facilitate development outcomes, including enhanced participation in economic, social, and community activities (WHO, 2010). Supporting people with mental illness to participate in gainful employment is challenging. However, studies repeatedly show that increasing workforce participation among people with mental illness contributes not only to their recovery and improvement in their social and economic standing, but has the potential to reduce government expenditure on social assistance, and increase tax revenues and the supply of labour where needed (Philip et al, 2009).

Due to high rates of unemployment, homelessness and poverty in this group, it is necessary to build strong links between mental health services and housing, educational and other social

services, and to create employment opportunities including income-generating programmes. All development programmes should be encouraged to address the needs of people with mental health conditions as part of their development work. It is also important to focus on improving human rights protection for people with mental health conditions by building their capacity to participate fully in public affairs and developing mental health service user groups.

IMPLICATIONS

- A) People with mental illness should be recognised as a vulnerable group and consulted in all matters affecting them.
- B) At country level, mental health issues should be integrated in health policies, implementation plans and human resource development programmes.
- C) 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.

3.5 Benefits of cost-effective interventions

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

3.5.1 Mental disorders are treatable

A review of the evidence showed that interventions for the treatment and prevention of selected mental disorders in low-income and middle-income countries are effective (Table 1). Depression can be treated effectively in such countries with low-cost antidepressants or with psychological interventions such as cognitive-behaviour therapy and interpersonal therapies.

Antipsychotic drugs are cost effective for the treatment of schizophrenia and their benefits can be enhanced by psychosocial treatments, such as community-based models of care. Interventions for depression, delivered in primary care, are as cost effective as antiretroviral drugs are for HIV and AIDS.

Table 1. Effective treatment trials of mental disorders in low-income and middle-income Commonwealth countries

COUNTRY	SAMPLE	INTERVENTIONS	RESULTS
Uganda	248 villagers of both sexes with depression	Group interpersonal psychotherapy	93.5% recovered with intervention versus 45.3% in comparison group at the end of treatment
India	450 adults with common mental disorders	The antidepressant fluoxetine or individual problem-solving treatment	70% of the antidepressant group recovered at 2 months compared to 54% of placebo group; no difference between psychotherapy and placebo
Pakistan	366 lower middle class women with depression or anxiety	8 individual counselling sessions at home by minimally trained counsellors	Reduction in mean symptom scores at the end of intervention (8 weeks)
Nigeria	33 surgical patients with anxiety / depressive symptoms	Self-instructional training (SIT) or rational emotive therapy (RET)	SIT reduced anxiety and RET reduced depression in comparison to no intervention

Source: Adapted from Patel et al, 2007

3.5.2 Advancing MDG initiatives

Mental health significantly impacts on the achievement of several Millennium Development Goals, including the promotion of gender equality and empowerment of women (MDG 3), the reduction of child mortality rates (MDG 4), improving maternal and infant health (MDG 5), and combating HIV and AIDS, malaria and other diseases (MDG 6).

Improving gender equality

Women are twice as likely to develop common mental disorders compared to men (Kuehner, 2003). Lifetime prevalence rate of violence against women ranges from 16 per cent to 50 per cent and at least one in five women suffer rape or attempted rape in their lifetime (WHO, 2013). Other risk factors for common mental disorders that disproportionately affect women include gender-based discrimination, socioeconomic disadvantage, low income and income inequality, inferior social status, multiple roles (such as caring for others) and associated factors of poverty, hunger, malnutrition, overwork, and sexual abuse (WHO, 2005).

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

In response to severe trauma, having access to appropriate resources, sufficient autonomy to exercise control and psychosocial support can be highly protective against the development of mental problems especially depression. Effective interventions also assist those with a mental illness to recover and return to economic and social participation. In Uganda, community-based group psychotherapy was associated with significant improvements in the ability of depressed women to undertake economic activities (Bolton et al, 2003)

Child and youth health

A global report on Child and Adolescent Mental Health Resources involving 66 countries found that less than a third of countries had an individual or government entity with sole responsibility for child mental health programming, and that funding for child mental health services was rarely identifiable in national budgets (Belfer and Saxena 2006). Failure to address child and adolescent mental health impedes the achievement of basic development goals in low and middle income countries (Sachs and McArthur 2005). Particularly vulnerable groups of children include those in conflicts and natural disasters, and those used in forced labour, living on the streets, or affected by trafficking. Early intervention and prevention are opportunities to reduce the possibility of affected children carrying mental health problems in adulthood. A whole of government approach is required, involving agencies that have an important role in supporting the mental health of children and young people, particularly school education, social welfare and the criminal justice system. The WHO mhGAP Intervention Guide provides methods for the assessment and management of various disorders in childhood and adolescence, and for the management of developmental and behavioural disorders (WHO, 2008). These include the prevention and amelioration of young children's exposure to risk factors (e.g. under-nutrition, inadequate cognitive stimulation, iodine deficiency, and iron deficiency) that can contribute to cognitive deficits (Walker, Wachs et al. 2007).

Maternal and infant health

The effects of maternal perinatal mental distress on child survival and health outcomes have been increasingly studied and recognised (Harpham et al, 2005). There is a clear association between antenatal common mental disorder and low birth weight found in studies from Pakistan (Rahman et al, 2007) and India (Patel and Prince, 2006). An association between perinatal common mental disorders and infant malnutrition at 6 months is reported in several South Asian studies (Prince et al, 2007). In Barbados, a long-term study reported association between maternal mental disorder and impaired cognitive and motor development in infants at 6 months (Galler et al, 2000). In Pakistan, maternal antenatal depression was associated with failure to follow up

infant immunisation at 1 year (Rahman et al, 2004). Thus, addressing mental health of women of childbearing age will be crucial to improve maternal health and decrease child mortality.

Combating HIV/AIDS

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 HIV infection and poor mental health. In South Africa, a study showed that 44 per cent of people living with HIV also had a mental disorder, whereas the prevalence in the general population was 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 who had not been treated (Yun et al, 2005).

3.5.3 Other high impact benefits of cost effective interventions

- Studies in low- and middle-income countries **have been consistent in showing that employment schemes** in which people with mental and psychosocial disabilities undertake paid work with ongoing support and training, result in higher employment rates, improved wages, more hours of employment per month, and better mental health (Taylor et al. 2009).
- **Involving people with mental and psychosocial disabilities** in the training of mental health professionals and evaluation of mental health services leads to improvements in the quality of life and social functioning of service users. This approach also resulted in trainees having a more positive attitude towards people with mental and psychosocial disabilities (Simpson and House 2002).
- The occurrences of natural, man-made and complex disasters are increasingly common and pervasive in many countries of the Commonwealth. Within these volatile and fractured contexts there is a prevalence of mental disorders such as post-traumatic stress disorder (PTSD), depression, anxiety and other psychosocial problems (Tol et al, 2011). **Common forms of mental health and psychosocial support provided in these contexts have beneficial effects for survivors** and for strengthening community and family supports. These include the provision of mental health information, basic counseling for individuals, families and groups, facilitation of community support, provision of child-friendly spaces and strengthening traditional and community social support systems (Interagency Standing Committee, 2007).

3.6 Stigma of mental illness and lessons from other health campaigns

Widespread stigma in relation to mental disorders is a mixture of fear and prejudice that arises from myths and ignorance of mental illness. Fear prevents acceptance of new knowledge and prejudice leads to discrimination and violation of human rights. Discrimination impacts on health by limiting access to effective treatment and health-related resources such as employment, education, social connections as well as increased exposure to risk factors. The consequences of stigma are segregation, expulsion and neglect – not only for people who suffer from these disorders but also for all others who were labelled mentally ill, to all members of their families, staff working in mental hospitals and other institutions and, finally, to all treatments of mental disorder (Sartorius, 2007). Thus the ensuing shame and ignorance of available treatment often results in individuals and families hiding their mental health problems, which are not identified or treated.

There are lessons to be learnt from health campaigns to reduce the health related stigma that worsens the burden of illness and effectiveness of related interventions. For example, AIDS-related stigma is one of the biggest obstacles to prevent HIV transmission and to promote screening, treatment and care services. HIV and AIDS campaigns have been well documented as effective in raising awareness of the illness, including promotion of preventive measures and access to health services. However attempts to combat the stigma associated with HIV have had only mixed success. Findings revealed that AIDS-related stigma was still pervasive in local communities (Cloete et al, 2010).

Stigmatisation is a socially complex and ambiguous process. It does not just derive from fear, ignorance or inaccurate beliefs but it is also established and continually reinforced by official campaigns addressing HIV and AIDS. In order to address HIV and social stigmatisation, it is necessary to transform HIV and AIDS from a sexually acquired and fatal pandemic to a chronic and manageable disease by downplaying the focus on sexuality and morality (Gausset et al, 2011).

Anti-stigma campaigns involving community members must take into account the socio-cultural and economic context of stigma including family role, ethnicity, cultural norms, and religious and spiritual values (Mahdi et al, 2005; Ehiri, et al, 2005). Measures would include education, information and legislative measures to promote interaction with, and positive attitudes toward, people living with HIV and AIDS. Effective interventions should thus be based on thorough needs assessments, theory- and evidence-based intervention strategies and collaborative planning, and include attention to individual as well as the social and structural barriers of each country (Bos et al, 2008). Greater involvement of people living with HIV in the promotion of HIV awareness and health services can be quite effective.

Multifaceted response in anti-stigma campaigns is important, including a top-down approach with systemic changes together with a bottom-up approach addressing individual, social and cultural factors (Pederson, 2009). There are similar implications for efforts to de-stigmatise mental disorders where it is important to understand the indigenous concepts of mental illness, local cultural response, what people with mental disorders themselves perceive as stigmatising and where they feel discriminated against (Ng, 1997; Sartorius and Schulze, 2005). Importantly, campaigns to promote the awareness and understanding of mental health, mental disorders, and treatment availability need to be done in consultation with people with mental disorders, their families and carers (WHO, 2012).

IMPLICATIONS

- A) Investment in mental health is necessary to protect human rights as well as for socio-economic development.
- B) Community awareness campaigns need to be developed to spread awareness that most mental health disorders are treatable and preventable.
- C) Simple screening to monitor maternal mental health and well-being should be included in regular health checks for mothers and babies.
- D) Programmes aimed at reducing HIV-related risk taking and increasing adherence to HIV treatment should address mental health issues to increase effectiveness.
- E) A whole of government approach is required to support early intervention programmes and provide adequate resources to protect the mental health of children and youth in identified high-risk groups.
- F) All programmes that address mental health issues, including anti-stigma, would benefit from involving people with the lived experience of mental health problems and their families.
- G) Disaster response and recovery programmes should address mental health issues to improve recovery of individuals and communities.

4 Status of Mental Health in Commonwealth Countries

4.1 Overview of Commonwealth demographics

Commonwealth countries, with their diverse social, political, and economic backgrounds, are regarded as equal in status, and they co-operate within a framework of common values and goals including human rights, individual liberty and multilateralism. Member countries are located in six regions: Africa (19), the Americas (3), Asia (8), the Caribbean (10), Europe (3), and the Pacific (11).

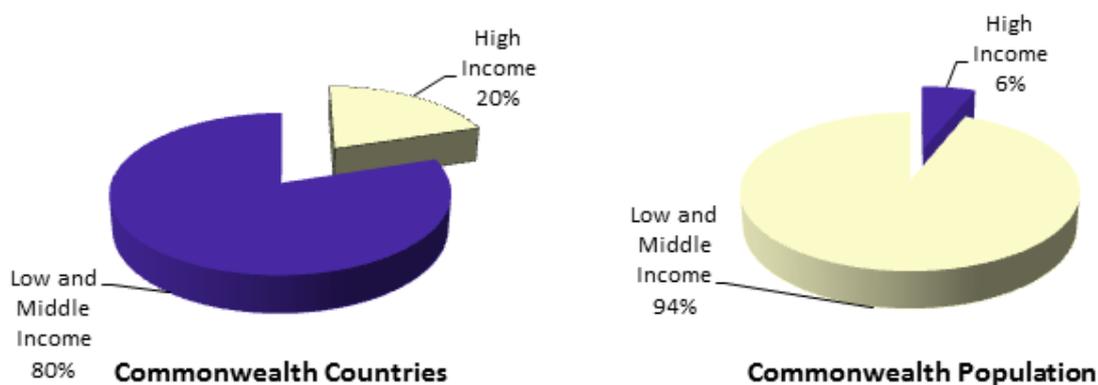
The members have a combined population of 2.2 billion people, almost a third of the world population, of which **95 per cent live in Asia and Africa combined**, and over half are aged 25 or under. The Commonwealth includes some of the world's most populous countries (India, 1.21 billion; Pakistan, 168 mil; Bangladesh, 162 mil; Nigeria, 154 mil) as well as some of the smallest (for example, Tuvalu with a population of just over 10,500, and Nauru with 10,299 inhabitants).

According to the World Bank's classification of country economies (July 2012), only 11 of the 54 Commonwealth countries (20 per cent) are high-income. They have a combined population of approximately 130.3 million, which is just 6 per cent of the total Commonwealth population.

About 80 per cent (43/54) of Commonwealth countries are classified as low and middle-income countries (LAMICs). Nine of the 10 low-income countries are in Africa. The combined population of LAMICs is over 2 billion, or 94 per cent of the total Commonwealth population.

The mental health status of Commonwealth nations overall is therefore similar to the mental health status extensively reported for LAMICs globally by WHO and related scientific sources. There are, however, important differences found in Commonwealth regions that may be unique (these are addressed in Section 4.4 below).

Figure 2. Commonwealth countries, population; low, middle and high income percentages



Source: World Bank's classification of country economies (July 2012)

4.2 Global challenges that apply to the Commonwealth

Despite neuropsychiatric disorders contributing to 13 per cent of the total global burden of disease, global health systems have not adequately addressed this challenge. As a result, the treatment gap for mental disorders is enormous. In low- and middle-income countries, 76-85 per cent of people with severe mental disorders receive no treatment; in high-income countries the figure is 35-50 per cent (WHO, 2005).

Where mental health care is available, the quality is often poor for those receiving treatment. The WHO Mental Health Atlas (WHO, 2011) demonstrated the scarcity, inequitable distribution and inefficient use of mental health resources. For instance, the global annual spending on mental health is less than US\$2 per person in middle- and high-income countries and less than US\$0.25 per person in low-income countries.

The number of specialised and general health workers in mental health in low-income and middle-income countries 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 report having a policy, plan and legislation on mental health; only 36 per cent of people living in low-income countries are covered by mental health legislation compared with 92 per cent in high-income countries.

Research sponsored by WHO sponsored has found that the provision of person-centred community mental health care results in better outcomes, especially for those with chronic mental disorders. Generally, better patient outcomes are associated with a reduction in the number 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 health care services (WHO, 2001b).

Globally, 63 per cent of psychiatric beds are in mental hospitals, and 67 per cent of mental health funding is allocated to stand-alone mental hospitals, despite their association with poor health outcomes and human rights violations. 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 evidence to the contrary, institution-based care for mental disorders is still predominant worldwide, resulting in scarce resources being used inefficiently or under-utilised when and available.

Only 32 per cent of all countries have a majority of facilities that provide follow-up community care such as home visits to check medication, identify early signs of relapse, and assist with rehabilitation. This figure varies across income classifications: 7 per cent of low income, 29 per cent of lower-middle income, 39 per cent of upper-middle income, and 45 per cent of high income countries provide follow-up care at a majority of facilities. Similarly, only 44 per cent of countries have a majority of facilities that provide psychosocial interventions and this also varies by income: 14 per cent of low income, 34 per cent of lower-middle income, 61 per cent of upper-middle income, and 59 per cent of high income countries provide psychosocial care at a majority of facilities.

Globally, the estimated median expenditure on medicines for mental and behavioural disorders is US\$6.81 per person per year. However, the true figure is likely to be substantially lower as only 27 per cent of countries reported this data, and they were disproportionately high-income countries. Median expenditures on medicines for mental and behavioural disorders in upper-middle and high income counties is approximately 340 times greater than median expenditures in low and lower-middle income countries.

Community movements for mental health in low-income and middle-income countries 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 in high-income countries; for family associations the respective figures are 39 per cent and 80 per cent. Essential partnerships between community mental health practitioners and other government organizations to improve access to health care, remains limited (Ng et al, 2013). Disappointingly, the dependence on NGO support for the development of mental health services in some low-income countries may lead to government failure to incorporate mental health services in their national budgets (Belfer and Saxena 2006; Miller 2006).

Important barriers to appropriate care for persons with mental disorders also include:

- Low availability of basic medicines for mental disorders in primary health care;
- Lack of qualified health workers with the appropriate authority to prescribe medication;
- Lack of non-pharmacological approaches and available trained personnel to deliver these interventions.

Overall mental health is a neglected and an under-researched area of public health globally, but most particularly in low and middle-income countries. The Global Forum and WHO (2007) initiated a global mapping exercise to provide an account of the current status of mental health research in 114 LAMICs in Africa (52), Asia (32) and Latin America and the Caribbean (30). Around 57 per cent of these countries were found to have contributed fewer than five articles to the international mental health indexed literature for a 10-year period (1993–2003), suggesting a paucity of mental health research (and researchers) in many of them.

The key priorities identified for mental health research in LAMICs included 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. The priority population groups were children and adolescents, women, and persons exposed to violence/trauma.

One endeavour to address the research gap is the research programme consortium led by the University of Cape Town (MHaPP). Four Commonwealth countries (Ghana, South Africa, Uganda and Zambia) participated in the project, which aimed to provide new knowledge of comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill health in Africa. Over a 5-year period ending in 2010, the consortium conducted an analysis of country-specific mental health policies in Africa, covering planning, legislation, information systems and district primary health care interventions. This project also sought to increase research and communications capacity in participating institutions. It led to an increased input from African countries in global initiatives such as the landmark Lancet series on Global Mental Health 2007 'Call for Action' paper (Chisholm, et al, 2007), and the Movement for Global Mental Health that emerged from the Lancet series to implement the recommendations, and the WHO mhGAP programme.

4.3 Mental Health Resources across the Commonwealth

The WHO Mental Health Atlas 2011 contains the most comprehensive data to date on global mental health resources, covering 98 per cent of the world's population in 184 countries.

Information on key aspects of mental health service delivery was systematically extracted from the 2011 Atlas for each of the 54 Commonwealth countries and is presented below.

4.3.1 Mental Health Governance

Eighty per cent of the Commonwealth comprises low and middle-income countries. It is therefore not surprising that the percentage of countries with a mental health policy and plan approximate the rates found in LAMICs globally. There are 29 (54 per cent) Commonwealth countries with a specific mental health policy, 23 (43 per cent) without a mental health policy and 2 (3 per cent) countries have no available data. Thus a significant number of Commonwealth countries are lacking an adequate framework to address the mental health development needs of the country and the requirements for mental health services.

An exception is mental health legislation, which appears to be at a higher percentage in Commonwealth countries. It is important to note however, that in almost a third of these countries, the legislation was enacted prior to the 1980s and unlikely to be in line with contemporary standards.

Table 2. Mental health policies, plans, legislation; country percentages

	WORLD	LAMICS	COMMONWEALTH COUNTRIES
Mental Health Policy	61%	54%	54% (29)
Mental Health Plan	72%	66%	61% (33)
Mental Health Legislation	60%	53%	81% (44)

4.3.2 Mental Health Financing

Data for mental health financing was only available for 50 per cent of Commonwealth countries. Of those with data, 16 (59 per cent) countries (all of which are LAMICs) are allocating less funding to mental health compared to the global median percentage of health budget (2.8 per cent) allocated to mental health.

4.3.3 Integration with Primary Care

Protocols for referring patients from primary care to secondary/tertiary care are found in 37 (69 per cent) of Commonwealth countries, and from secondary/tertiary care to primary care in 30 (55 per cent). The world median figures are 76 per cent and 65 per cent respectively.

4.3.4 Mental Health Services

It appears there are insufficient mental health resources across the Commonwealth to prevent and treat disorders with many countries reporting less than expected basic level of mental health services. This is illustrated in Table 3 below.

Table 3. Commonwealth mental health services percentages

SERVICE TYPE (RATIO PER 100,000 POPULATION)	COMMONWEALTH COUNTRIES	COMMONWEALTH COUNTRIES WITH NO FACILITIES	UNKNOWN
Outpatient facilities (less than 1 per 100,000 population)	24 (44%)	2 (4%)	7 (13%)
General hospital psychiatry beds (less than 1 per 100,000 population)	20 (37%)	10 (19%)	9 (17%)
Community residential care beds (less than 1 per 100,000 population)	34 (63%)	25 (46%)	9 (17%)
Mental hospital psychiatry beds (less than 5 per 100,000 population)	24 (44%)	9 (17%)	4 (7%)
Mental hospital psychiatry beds (more than 40 per 100,000 population)	11 (20%)	-	-

A fifth of Commonwealth countries (nearly all of which are high or upper-middle income) have over 40 mental hospital beds per 100,000 population. This suggests that in many high-income countries most of the mental health spending is directed towards these institutions and not efficiently used to build patient-centred community care.

4.3.5 Mental Health Workforce

There is a marked shortage of manpower available to assess and treat disorders in the Commonwealth, with many countries reporting a less than expected adequate level of resources as shown below (Table 4).

Table 4. Professionals working in the mental health sector

PROFESSIONAL BY TYPE	COMMONWEALTH COUNTRIES	COMMONWEALTH COUNTRIES WITH NO MENTAL HEALTH PROFESSIONALS
Psychiatrists (less than 1 per 100,000 population)	33 (61%)	2 (4%)
Other medical officers (less than 1 per 100,000 population)	30 (56%)	6 (11%)
Nurses (less than 5 per 100,000 population)	23 (43%)	0 (0%)
Psychologists (less than 1 per 100,000 population)	39 (72%)	14 (26%)
Social workers (less than 1 per 100,000 population)	34 (63%)	12 (22%)
Occupational therapist (less than 1 per 100,000 population)	35 (65%)	16 (30%)

Emigration of mental health professionals from low and middle-income countries and rural-to-urban migration, seriously constrain development of human resources for mental health. Australia, New Zealand, the UK and USA employ almost 9,000 psychiatrists from Bangladesh, Egypt, India, Nigeria, Pakistan, the Philippines and Sri Lanka. Without this migration, many source countries would have two to five times the number of psychiatrists per population ratio. For instance, in 2007, 25 psychiatrists were working in Sri Lanka for a population of 20 million, whereas 142 Sri Lankan-trained psychiatrists were working in Australia, New Zealand, the UK and USA (Jenkins, Kydd et al. 2010).

Training programmes for psychiatrists are present in only 55 per cent of low-income countries, 69 per cent of lower middle-income countries, and 60 per cent of those of upper middle-income. Approaches to psychiatric education also vary widely across countries (Singh and Ng 2008).

One example of an initiative addressing the mental health workforce in lower and middle-income countries in the Commonwealth is the community mental health training programme developed for primary care in Kenya. Working with the National Council of Clinical Officers, Nursing Council of Kenya and Ministry of Health and the WHO Collaborating Centre Kings College London, Institute of Psychiatry, UK, a mental health training course was developed, evaluated and is now included in the mandatory training for primary care and community health workers. Between 2006 and 2010, 1,859 nurses, psychiatrists, health workers and supervisors attended training at six regional training centres in Kenya (Kiima and Jenkins 2010). The mental health training for community workers was based on long-term dialogue and joint actions as it was critical that the project did not develop externally funded services. Facilitating local service development using regular ministry budgets was key to sustainability (Kiima and Jenkins 2010).

4.3.5 Role of NGOs and Involvement of Users and Family Groups

No government can meet all of its nation's mental health needs. Lack of psychiatrists and mental health professionals on the one hand, and the global movement away from medical and illness-oriented models of care towards more recovery-focused and community-based care requires the acknowledgement and involvement of new bodies to help bridge the mental health treatment gap.

User groups were found to be present in 29 (53 per cent) of Commonwealth countries. No data was available for seven countries. In terms of the levels of user group participation, only 12

countries recorded having frequent participation. Family groups were present in only 19 (35 per cent) countries and only eight countries recorded frequent participation. This suggests that although family ties and support are strong in many parts of the Commonwealth such as in Asia, Africa and Pacific, there appears to be a lack of organised programming or advocacy involving and/or led by families who have members with mental health problems.

The proposed WHO model of an optimal mix of mental health services promotes the involvement of people with lived experiences in their own recovery and the greater involvement of informal care services. Implementing the WHO model requires investment by the entire global health community, including governments learning to collaborate with consumer groups and other NGOs. There are outstanding examples of NGOs across the Commonwealth countries (Thara & Patel, 2010) that have played a significant role in the last few decades supporting consumers in self-care and creating low cost replicable models of care. 'While the reach of their work cannot parallel that of government agencies, the quality of care and their efforts in reaching out to the various stakeholders, particularly those who are discriminated against such as persons with mental disorders, gives them a distinct advantage,' (WHO, 2003).

4.4 Mental health situation in selected Commonwealth Regions

4.4.1 African Region

There are 19 African Commonwealth countries with diverse populations that include the relatively small numbers living in the Seychelles (84,000) to large populations such as that of Nigeria (approximately 162.5 million in 2011).

With growing recognition that mental health is a crucial public health and development issue, mental illness has been identified as a regional priority for Africa (Fisher, Lund et al. 2007; Ndetei & Szabo, 2011).

In response, major national and regional policy drives have been launched to improve mental health services. These include the WHO Regional Strategy for Mental Health (2000-2010) that recommended integrating mental health into national health reform agendas in terms of governance, legislation and financing; promotion of mental health and provision of care to high-risk groups; prevention of substance and alcohol abuse especially among young people, and multi-sectoral collaboration and community participation (WHO, 2000). Despite these recommendations, nearly half of all African countries in the Commonwealth still do not have a national mental health policy, and 25 per cent do not yet have a mental health plan (WHO Mental Health Atlas, 2011).

The WHO Africa Regional Office noted that the practical indicators that impact on closing treatment gaps (human resources, budget allocations, accessible services) do not yet reflect the raised awareness among government and other stakeholders, and that service coverage remains typically below 80 per cent (Eaton 2012).

Resources, access and distribution of mental health services vary throughout the 19 countries. Mental health hospitals remain the main form of in-patient care, with 56 per cent of beds located in these settings in 2005 (WHO, 2011). The majority of government mental health budgets have been allocated to maintenance of psychiatric hospitals, and there are very few resources available for psychosocial and rehabilitation services (Ofori-Atta, Read et al. 2010). In many areas, population access to mental health care will be severely restricted to the individual caseload (e.g. borne by the one mental health worker in each district), without sufficient integration into community, primary care and district levels of the health system (Kiima and Jenkins 2010).

Most recently, a regional forum held in Zimbabwe in August 2012 noted that while progress has been made in some countries, many of the same gaps in service provision remain with numerous weaknesses in the response offered. Government mental health representatives from the 15 African countries attending the forum agreed to develop the next Africa Regional Strategy, with the aim of following the WHO's new Global Action Plan (Eaton 2012).

4.4.2 Caribbean Region

There are a total of 10 Commonwealth countries in the Caribbean region. A regional mental health policy and action plan was developed in early 2000 but was slow in implementation due to low capacity and funding. The Report of the Caribbean Commission on Health and Development in 2005 addressed the issue of mental health, and CARICOM Heads of Government subsequently mandated the development of a regional plan for mental health. Mental health is one of eight priority areas in the Regional Health Framework 2010-2015, which is the regional public health policy document (CARICOM, 2008).

The WHO Report on Mental Health Systems in the Caribbean Region (2011) offers a comparative study of 16 Caribbean Region countries and territories. Mental health policy and plan were present in 38 per cent of the countries. Although the average percentage of the health budget dedicated to mental health in the region is 4.3 per cent most of mental health resources are centralised. In many countries and territories, the only, or main, service is the mental hospital, which absorbs most of the available human and financial resources. A high percentage of chronic patients (60 per cent to 70 per cent in some cases) are hospitalised for many years.

There are insufficient community-based mental health services resources. Ten countries have 2 or fewer psychiatrists per 100,000 people; ten countries and territories have 1 or fewer psychologists per 100,000 people. The number of nurses working in mental health seems higher than other professions, with just 5 countries having less than 10 nurses per 100,000 people.

Unfortunately, there has been a lack of data on the mental health burden of diseases on the epidemiology of mental illness in the Caribbean. When isolated studies are done for individual populations, the prevalence rates of major mental illnesses are not very different from those reported regionally. Analysis of direct and indirect cost of the two major mental illnesses in Jamaica (depression and schizophrenia) revealed the huge amount of \$J 3.8 billion per year. The CARICOM Secretariat has conducted a study of mental health best practices in Jamaica, which needs to be expanded to other Member States.

4.4.3 Asian Region

There are eight Commonwealth countries in the Asia region including India, which is projected to be the world's most populous nation by 2025 (US Census Bureau 2012). The region is characterised by enormous diversity of peoples, cultures, ethnicities, languages, and socioeconomic development.

While most countries have mental health policies and plans, and many have mental health legislation, the standards and quality of mental health service provision vary widely between and within countries.

A common issue across many countries has been the relative lack of resources in mental health, in terms of workforce (6 of 8 countries have <1 psychiatrists per 100,000 population), facilities, availability of psychotropic drugs and research provisions. In several countries, the private sector, NGOs and international aid contribute significantly to mental health resources.

Stigma associated with psychiatric conditions and lack of community acceptance of mental illness remains a major barrier. Throughout the region, the proportion of health budget expenditure on mental health is generally low (<1 per cent). Where there is specific budget allocation available, the biggest portion of mental health funding is tied up in providing institutional care for the severely mentally ill (WHO, 2005). Facilities for community care are only available in about half the countries. Where present, community mental health services are not equally available and are often restricted to a few well-resourced areas within urban centres.

Nevertheless, large-scale community mental health care delivery that is integrated with primary care has been shown to be possible in India. The District Mental Health Programme (DMHP)

was established in 1996 and is a community-based mental health service delivery programme implemented in 123 of the 652 districts of India.

The overall goal of the DMHP is to provide sustainable basic mental health services to the community and to integrate these services with other health services, including the early detection and treatment of persons with mental disorders within the community. The programme has been integrated in the district health infrastructure. Emerging from a series of stakeholder consultations on improving the DMHP, new stakeholders such as schools, colleges, and workplaces have been included in programming. The major achievements of the programme have been the development and availability of community mental health services in the most underserved areas. Training modules and health communication materials have been prepared. Mental health training, awareness and services are provided in collaboration with various community-based partners.

4.4.4 Pacific Region

This region consists of 11 Commonwealth countries. However, as Australia and New Zealand are high-income countries (these are included in a later section), this section only refers to the nine other Pacific countries. The Commonwealth Secretariat works with member countries to strengthen their capacities and pays particular attention to the Pacific region's small island developing states due to their inherent vulnerabilities such as their size, geographical location and remoteness. An example of effective resources in this area includes the Commonwealth Fund for Technical Co-operation to support national development goals and the Commonwealth Pacific Governance Facility based in Solomon Islands.

WHO reports that although many aspects of physical health have improved in the this region, mental health has worsened over the last 50 years (WHO 2002) and that the combined index of death and disability shows the burden of mental disorders is higher than in some other parts of the world.

Less than half of the countries in this region prioritise mental health in national mental health policy or plans. Many countries are without a dedicated mental health budget and with a low percentage (<2 per cent) of the health budget spent on mental health (WHO, 2011). Others have a health structure that is associated with the WHO optimal mix of care model, but there is often insufficient training and development of the mental health workforce for consistent care and quality health outcomes.

Socio-cultural and economic transitions occurring in this region have contributed to increased personal mental stress, social exclusion and unemployment. Community-based mental health service development has sought to integrate mental health services into mainstream health. Another challenge is to balance issues of access to services, stigma and discrimination, long standing use of traditional healers who use massage, herbal potions and exorcism and more recent introductions of Western drug and therapy treatments.

All the Commonwealth countries in the region are members of the Pacific Islands Mental Health Network (PIMHnet). Established in 2005 as a means of overcoming geographical and resource constraints in the field of mental health, PIMHnet has identified priority areas of work for the region. These areas include: advocacy; human resources and training; mental health policy, planning, legislation and service development; access to psychotropic drugs; and research and information (WHO 2005).

4.4.5 High-income countries

Australia, Canada, New Zealand and the United Kingdom are high-income countries that have undergone some of the most advanced mental health systems reform in the world, consistent with international benchmarks. These countries have relatively high health budget expenditure on mental health (7-10 per cent) and have some of the highest ratio of psychiatrists, mental health

nurses and allied health professionals per population globally (for instance >10 psychiatrists and >65 nurses per 100,000 population).

These high-income Commonwealth countries share a presence of strong mental health governance, well-articulated mental health policy and plans as well as good accountability and monitoring mechanisms to support the translation of key principles of mental health care into benefits for those with mental illness (DoHA, 2010; HMG Department of Health, 2011; MHCC, 2012; MOH, 2012). These principles advocate for people with mental health problems in the following ways:

- Promoting mental health and prevention of mental illness;
- Fostering recovery, well-being, resilience and social inclusion;
- Integrating specialist services with general hospitals and primary care;
- Increasing access to the right combination of services, treatments and support systems to assist living in the community;
- Reducing disparities in risk factors and access to physical health care;
- Reducing stigma and discrimination;
- Increasing participation of consumers and carers in the planning, delivery and evaluation of mental health services.

Despite the relative progress and advances made in such countries, the efforts are far from complete. As yet, systems of mental health care are not fully adequate and resources are not yet commensurate with mental illness being the highest contributor to disease burden (MHCA, 2005). Mental ill health represents up to 23 per cent of the total burden of ill health in the UK – the largest single cause of disability (WHO, 2008). A national survey found that one in five (20.0 per cent) Australians aged 16-85 years experienced mental disorders in the previous 12 months (Slade et al, 2009).

4.4.6 Pan-Commonwealth partners

Information from websites and communication from these regional organisations indicated that there is uneven attention paid to mental health within their respective health programmes as follows:

Oceania Health Services: <http://healthdept.vu/>

Charter is to formalise regional agreements in relation to the provision of health services to the region. This involves centralised purchasing of medical equipment and consumables, and their distribution throughout the region. Mental health does not appear in any departments, including relevant areas such as Chronic Diseases and Community Health or Public Health.

Secretariat of the Pacific Community: <http://www.spc.int/>

Works across diverse areas to assist Pacific Island peoples achieve sustainable development. Within the public health system, several programmes are set out including HIV, surveillance, TB, healthy lifestyles, and non-communicable diseases. There is no mention of funds or activities specific to mental illness. Pacific Public Health Surveillance Network connected with the Secretariat has prioritised communicable diseases and therefore has no involvement in mental health.

West African Health Organisation: <http://www.wahooas.org/>

The focus is on pooling of resources and co-operation to strategically address health problems of the sub-region through advocacy and political dialogue. Priority issues include NCDs, but not mental health.

East, Central and Southern African Health Community: <http://www.ecsa.or.tz/>

Fosters and promotes regional co-operation in health, research, capacity building, policy development, building consensus on health priorities and advocacy. Programmes include HIV, food and nutrition, family and reproductive health. There does not appear to be any mention of mental health as a regional priority or an area for ongoing work.

Southern African Development Community: <http://www.sadc.int/>

Provides a comprehensive development agenda for socio-economic development policies in the region. Regional themes include addressing NCDs such as heart disease, diabetes, and cancers. Mental health is mentioned as a health issue for which member states are encouraged to provide information and education programmes, in line with World Health Assembly guidelines.

South Asian Association for Regional Co-operation: <http://www.saarc-sec.org/SAARC-Secretariat/18/>

Its mandate is to accelerate economic growth, social progress and cultural development and promote active collaboration in the economic, social, cultural, technical and scientific fields. Health is found under Social Development (youth, gender, health and population activities). The Technical Committee on Health and Population Activities has the scope of narcotic drugs and psychotropic substances, drug rehabilitation, demand and harm reduction, mental health and physical disabilities, as well as other health areas.

Caribbean Community (CARICOM) Secretariat: <http://www.caricom.org/>

The CARICOM Secretariat, in support of Member States, contributes to the improvement of the quality of life of the people of the community and the development of an innovative and productive society. CARICOM Heads of Government asserted in their Nassau Declaration of 2001, "The Health of the Region is the Wealth of the Region", and identified HIV and AIDS, non-communicable diseases and mental health as being the health priorities in the region. At the 21st Meeting of the Council for Human and Social Development in 2011 Health Ministers agreed that mental health would be a high priority on the region's health agenda.

In summary, the regional organisations would benefit in considering mental health as a priority. Activities that can strengthen their programmes and help achieve their development goals would include strong engagement with mental health care and services in their regions.

4.5 Culture matters in the Commonwealth: The influence of culture on mental health

The Commonwealth of Nations' two billion citizens embrace all the world's major cultural groups. While having a common heritage, the Commonwealth also draws strength from the cultural diversity of its member nations.

An objective of the Commonwealth is for nations to work together to build an environment where all of its citizens are able to 'develop their potential and lead productive and creative lives in accord with their interests'.

While people all over the world suffer from mental illness, what is becoming increasingly clear is that people do not suffer in a cultural vacuum. Cultural contexts, while not the only determinants, shape our mental health and the types of services we use.

Humans are cultural beings. We learn to communicate and understand our world through sharing language, customs, behaviours, beliefs and values.

'Cultures provide their own interpretive frameworks, notions of authority and standards of truth' (Kirmayer, 2012).

There is a growing body of research that argues that mental health is not an objective, value free and universal science. Our cultural experiences and values shape our identities and our priorities. At the same time, culture shapes the way we view our own physical and mental illnesses and those of others. Culture tells us 'how to view the world, how to experience it emotionally and

how to behave in it in relation to other people, to supernatural forces or gods and to the natural environment,' (Swartz, 2002).

Culture defines the presentation of distress and interpretation of illness and interventions must require flexibility to adapt to different cultural settings (Canino and Alegria 2008).

More particularly culture 'affects the way people label illness, identify symptoms, seek help, decide whether someone is normal or abnormal, set expectations for therapists and clients, give themselves personal meaning, and understand morality and altered states of consciousness,' (Ridley et al, 1998).

There are good practices, important lessons and useful experiences of national mental health reform programmes developed in the Commonwealth's high-income country grouping, which could be shared with other countries that are at an early stage of reform. When 80-90 per cent of people from developing societies rely on traditional healers for health care, it does not make sense to exclusively explain their psychological needs and experiences with particular reference to systems imported from the West (Mkhize, 2004).

To be effective, programmes and interventions in mental health must be designed and adapted to match vastly different socio-economic contexts and cultural traditions operating within and across Commonwealth nations. In planning the delivery of the wide spectrum of mental health services from mental health promotion, prevention, treatment and rehabilitation, it is critical to consider whether diagnosis and treatment are acceptable to the person with mental disorder, their families and their communities

The following table explores the impact of culture on five mental health domains that span the way mental illness develops, how symptoms are interpreted and expressed, how help is or is not sought, to what is considered appropriate treatments.

Table 5. The impact of culture on selected mental health domains

MENTAL HEALTH DOMAIN	IMPACT OF CULTURE
1. Development of illness	<p>When traditional cultural coping structures are removed and known environments change rapidly, resilience decreases and the risk for depression and post-traumatic stress disorder increases. This can include people introduced to rapid urbanisation, which can mean changes in family structures and exposure to increased pollution. Traumatic experiences (war, genocide, violence, natural disasters) shatter coping structures and create enormous vulnerability.</p> <p>Mental health has been a cause for concern in Sri Lanka for some time. The country has one of the highest suicide rates in the world, with an average of 6,000 deaths per year (nearly 100,000 people will attempt suicide every year in Sri Lanka). In addition to the mental health problems typically reported in a stable environment, the prevalence of mental illness in the country is further compounded not only by the conflict but also by the devastating effects of the 2004 Indian Ocean tsunami. All of these factors would undeniably have caused intense stress for the people of Sri Lanka, increasing their risk of mental trauma (Nayanah Siva, 2010).</p>
2. Definition and socio-cultural meanings of illness	<p>The meaning of an illness refers to deep-seated attitudes and beliefs a culture holds about whether an illness is real or imagined, of the mind or body or both, why a person has succumbed to it and whether this person should be offered sympathy and help. For example, in some cultures a person hearing voices may mean that the person is hearing the voices of his/her ancestors and considered to be positive rather than due to a mental illness.</p> <p>Although spiritual and religious factors play a vital part in mental health among the Malays in Malaysia, in general they prefer to interpret psychological problems in physical terms in order to avoid the label of mental illness and the accompanying negative connotations. Many believe that such symptoms are indicative of the loss of 'semangat' or soul substance, which makes the person physically weak resulting in confusion. Another belief in this culture relates to 'angin' or the wind present in the stomach and in the nerves and blood vessels that causes hallucinations and delusions. A third common belief is the possession by the Jinn (Genie). It is believed that the Jinn may have possessed the ancestors of the victim and after death the ancestors may wish to stay in the bodies of their offspring (Haque, 2005)</p>
3. Expression of illness	<p>Patients in different cultures tend to selectively express or present symptoms in culturally acceptable ways. In addition there are culture bound syndromes distinctive to certain ethnic groups.</p> <p>In the Caribbean, Ataque de nervios has been identified as a specific culture bound disorder. Symptoms commonly include uncontrollable shouting, attacks of crying, trembling, heat in the chest rising into the head, and verbal and physical aggression. Some with the disorder prominently feature dissociative episodes, seizure-like or fainting episodes, and suicidal gestures, while others lack those features entirely. A key feature is a sense of being out of control, and it is usually triggered by a stressful event within the family. It is commonly thought to be a result of a chronic build up of anger over time. People may not remember what they did during the ataque, and usually return to normal following the incident (Hales, 2008).</p>

MENTAL HEALTH DOMAIN	IMPACT OF CULTURE
4. Help seeking behaviours	<p>The meanings attached to a person's illness will determine whether they or their family will seek treatment, how they cope with their symptoms, the level of support they get from their families and communities, and where they seek help, which can range from mental health specialist to faith healer and at times be a combination of both.</p> <p>Witchcraft is found in many societies across Africa, Asia, South Pacific and the Caribbean. In these societies witchcraft and spirit possession are thought to influence the behaviour of a person so as to resemble that of a mentally ill individual.</p> <p>In India, 'Babas' (Holy men) are the mediums through which spirits and jaadoo (black magic) are removed from those afflicted. A person who suffers from mental illness will be brought to the baba by family members (Stafford, 2005; Karim et al, 2004).</p>
5. Diagnoses and treatment	<p>The use of standardised 'Western' assessment instruments may not be appropriate, and norms not suitable. This can result in poor service provision decisions, especially those related to classification, diagnosis, therapy, and medications.</p> <p>Best results may be found in working in collaboration with culturally acceptable treatment providers.</p> <p>Collectivistic cultures, such as in India, place a great deal of emphasis on the family's role in a patient's care. Involuntary administration of medication by one family in India was morally sanctioned and even regarded as the family's duty towards its ill member. By contrast, in individualistic Western cultures, such involuntary administration of medication is atypical and could even be considered a violation of the patient's rights (Srinivasan and Thara, 2002).</p> <p>The emphasis on spirituality in African health services, although complicated by the attribution of symptoms to spiritual causes, and the positive and negative role of traditional healers (Eaton 2012), includes the importance of the family and community as a space for rehabilitation as opposed to the more institution-based options.</p>

5 Regional and Country Examples of Best Practices

Locally and culturally appropriate interventions and applications of best practices in community mental health service development are currently available across the Commonwealth. Examples such as those following have the potential to inspire and promote further development within and across the Commonwealth.

A) SOLOMON ISLANDS –TRADITIONAL NETWORKS AS PARTNERS IN MENTAL HEALTH CARE

Melanesian culture, communal, clan and family ties run strongly through the wontok system, referring to people from the same language group who are blood relatives and part of an extended family network. The bonds of kinship in the wontok system involve important obligations extending beyond the immediate family group to local and clan circles.

Recognising that the spirit of the wontok system provides an excellent basis for the care of mentally ill people in the community, a partnership was formed with families and carers to better promote the recovery of persons with mental disorders in the community and address their issues in a more holistic manner (AAMH, 2012).

B) SINGAPORE – REACHING OUT TO SCHOOLCHILDREN

Just over a decade ago, youth suicides in Singapore were among the highest in the world - 0.8 and 0.7 per 100,000 for the under 15-age group in 2000-01. The Singapore government recognised that children who are at risk can be identified early through their schools. They include delinquent youth, school dropouts, children from dysfunctional families and children with parents who are mentally ill who are potentially at a higher risk of developing some form of mental illness. The government piloted REACH, a new programme aimed at providing early intervention strategies for at-risk children. In partnership with schools, specially trained teams were developed to focus on providing community mental health services to schools and building up the capabilities of school counsellors to identify mental health disorders (behavioural and emotional) and their symptoms. The service was expanded to include other partners such as voluntary welfare agencies and other youth focused NGOs to help develop a mental health network in the community to support children at risk (AAMH, 2012).

C) UGANDA – COUNSELLING SUPPORT BY FELLOW SUFFERERS

Uganda is known for its early and effective response to HIV from as early as the mid-1980s. TASO was established in 1987 by a group of volunteers – people infected or affected by HIV/AIDS – to provide psychosocial support for and improve the quality of life of people living with HIV and AIDS (PLHA). From a small support group, TASO has since evolved into an NGO with 11 service centres and four regional offices covering most parts of Uganda. It has strong links with other NGOs and with governmental services and co-ordinating bodies. TASO provides training in counselling both to its own staff and to the staff of other organisations and has been centrally involved in initiatives to strengthen and standardise HIV counsellor training in Uganda. It has formal quality assurance programmes for all its own services, including counselling services. TASO's activities include providing scholarships for children of clients to enable them to continue with their schooling and reduce their risk of developing a mental illness themselves (Kaleeba et al, 1997).

D) INDIA –THE BANYAN: INDIVIDUALISED CARE FOR THE HOMELESS MENTALLY ILL

Approximately 40 per cent of people suffering from mental illness in India are homeless. Founded in 1993 in Chennai by two young women as a shelter and transit home for homeless mentally ill women, the Banyan is a local NGO that has changed the lives of over 5,000 people by providing the full range of services required to support recovery and reintegration into the community. Its projects offer prevention systems, provide access to care and rehabilitation, deliver community awareness, and instigate policy advocacy and research.

The Banyan's model of care combines careful and accurate medication with extensive, individualised therapy, activity, vocational training and eventual employment: a socio-medical model. The model has also been replicated by other NGOs across India and underpins the services provided in Adaikalam (the transit care facility), the Community Mental Health Project (CMHP) and the Community Living Project. Adaikalam was the first of the Banyan's projects and provided care for homeless women with mental illness. The transit-care centre facility has been home to 1,640 rescued women, most of whom have been successfully rehabilitated into their families and communities. The facility has grown since 1993, from a four-bedroom house to a comprehensive facility with space for 240 residents.

One of its initiatives, the Banyan Academy of Leadership in Mental Health (BALM) in Chennai is geared towards study and increasing stakeholder participation in the sector of mental health.

E) AFRICA - PARTNERSHIP WITH NGO FOR SERVICE DEVELOPMENT INTERVENTIONS

The international non-government organisation BasicNeeds uses a structured model for mental health and development. Similar programmes are operating in Ghana, Kenya, Tanzania and Uganda. Adopting an integrated approach to provision of care and empowerment, the programme aims to mobilise psychiatric clinicians from the public sector and health workers from the community to co-ordinate mental health clinics in community health centres. Mental health clinics have also included outreach clinics and mental health camps and were held in district hospitals, village health centres, local dispensaries, temples, and schools. The services typically include assessment, diagnosis, prescription, dispensing psychiatric medicines, counselling, review and referral. Non-health service providers play a significant role (BasicNeeds 2009). The work in these four countries has been evaluated to demonstrate the impact on mental health status, functionality and quality of life. It also demonstrates that that good quality research is possible in routine low resource settings (Lund, Kingori et al. 2009).

F) REGIONAL APPROACH: ASIA-PACIFIC – COMMUNITY MENTAL HEALTH DEVELOPMENT PROJECT

This project aims to illustrate and inspire best practices in community mental health care in the Asia-Pacific region through exchange of practical experience and local evidence. The project works through a high-level network of mental health government officials, professional and research leaders from 19 Asia-Pacific countries/regions including Australia, Fiji, India, Malaysia, Singapore and Solomon Islands. The project has generated two volumes of regional best practice principles and examples in community mental health concerning service models (Asia Australia Mental Health, 2009) and community partnership development (Asia Australia Mental Health, 2013). Innovations reflected in a number of best practice community care models for people with mental illness were analysed, shared and translated to support practical improvements in service delivery.

The multilateral exchange model could have positive implications for constructive development for the Commonwealth. The learning derived from the existing local experiences and best practice models in community mental health can inform future policy and service system development within and across different countries (Ng et al, 2009).

6 Emerging Issues and Recommendations in the Context of Future Health Developments

From the review and assessment exercise on mental health in the Commonwealth, a number of significant issues and recommendations have emerged in the context of health development beyond 2015. It must be recognised that steps to address or improve the mental health situation, although urgent, may not result in rapid changes. Comprehensive mental health reform and development of adequate mental health systems may take many years to accomplish. The key issues and recommendations are listed below. (Note: these are not in order of priority and may not include all issues that are considered critical for mental health).

- As the vast majority of the population in the Commonwealth live in low and middle-income countries, the current and future needs for mental health development for LAMICs globally is highly relevant for much of the Commonwealth. Five major barriers to the scaling up of mental health services in LAMICs have been previously identified: absence of government commitment and financial resources; centralisation of services; challenges of integration of mental health care into primary care settings; lack of public health perspectives in mental health leadership and 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 the mental health system 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.
- Mental health laws, policy and plans older than 10 years are unlikely to reflect recent developments in international human rights and evidence-based practice. Adopting and applying the framework of the 2008 UN Convention on the Rights of Persons with Disabilities (CRPD) protects and promotes the rights of all persons with disabilities, including persons with mental and intellectual impairments. States are required to take positive action to facilitate the enjoyment of basic human rights and promote their full inclusion in international development programmes. CRPD principles integrated into national development and cross-sectoral strategies and plans, could substantially improve development outcomes for individuals with mental health problems, their families, and their communities.
- Mental health systems need to be strengthened by greater resource investment in health budgets. There are significant advantages, in terms of better access and more cost-effective interventions, to allocate budget and build on existing programmes in LAMICs where mental health significantly impacts on broader health outcomes and goals. These include programmes that address infectious diseases (HIV, tuberculosis, and malaria); non-communicable diseases programmes, maternal and child programmes and domestic violence programmes. The integration of mental health into substance abuse and other health sectors is essential for

co-ordinating clinical care as well as promoting the efficient sharing of resources, technical expertise and training and education, especially in under-resourced areas.

- A shift from institution-based care to community care results in the best possible quality of life for people with mental illness and allows greater autonomy for service providers and users. It is critical to advocate for sufficient resources for the development of appropriate community mental health services. Strong health policy, governmental commitment and political will are required to move from a predominantly hospital-based to a community-based mental health care system. Service re-organisation, including redirection of existing funding to increase access to care is required to provide community mental health resources. To scale up cost-effective community mental health care models, there needs to be seamless integration between primary care and hospitals, and the development of appropriate referral systems incorporating secondary and tertiary care.
- Effective and affordable treatments are available for mental disorders. There is a need to ensure sustainable provision of psychotropic medication and improve access to psychological therapies for people with mental disorders. The WHO Mental Health Gap Action Programme (WHO, 2008; WHO, 2010), uses evidence-based technical guidance, tools and training packages to expand service provision. The programme focuses on expanding mental health services in low-resource settings and building capacity in non-specialized health-care providers. The programme asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for depression, schizophrenia, and epilepsy.
- Integrating mental health services into primary health care, particularly for Commonwealth LAMICs setting is a highly practical and viable way of closing the mental health treatment gap. In settings where there is highly disproportionate ratio of people who need mental health care to the number of qualified mental health professionals, non-specialist health professionals and community workers with brief training and appropriate supervision by mental health specialists are able to detect, treat, and monitor individuals with mental disorders and reduce caregiver burden. 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 minimizes 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 themselves often stigmatised. 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, public-awareness and anti-stigma campaigns. Organisations and support groups for persons of mental disorders, carers and families should be encouraged as well as their integration into other disability organisations.
- 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 health care system require multi-disciplinary, multi-level, multi-sector, and multi-linkage approaches. Linkages across government departments, between government and non-government sectors, between NGOs and public mental health services, and between community agencies and families will help to meet the complex needs of people experiencing mental ill health as well as their families and the community. As the mental health specialist sector can only deliver limited services, developing sustainable partnerships especially with NGO groups working in mental health is essential for sharing the care for the mentally ill in the community.
- When planning the delivery of the wide spectrum of mental health, it is critical that governments and mental health professionals take into account local cultural contexts for services and interventions and adapt mental health models of care to local contexts. This involves on-going dialogue with local communities, especially traditional community leaders

to seek advice and support regarding the most appropriate delivery mechanisms for their communities. Recovery approaches in the care of the mentally ill must address cultural sensitivities to be relevant and useful for persons with mental disorders and their families. Targeted partnerships and innovative approaches can employ local cultural practices, traditional healers and religious leaders to provide natural, accessible and practical supports for many with mental health problems.

- Emigration of mental health professionals from countries of origin constrains the development of mental health services within LAMICs. Appropriate systems must be developed to foster the training and development of mental health professionals in these countries. Mental health needs to be incorporated into undergraduate and postgraduate academic programmes as well as in professional development training programmes for non-specialists. All mental health training needs to be evidence-based, person-centered, culturally sensitive and consistent with global human rights approaches.
- Development stakeholders should recognise people with mental illness as a vulnerable and marginalized group. Further, addressing mental health problems in all vulnerable groups can facilitate development outcomes, including economic, social, and community contribution. Inclusion of mental health into development policies, agenda and interventions (such as poverty reduction, livelihood, vocational and educational programmes) can significantly facilitate the attainment of development goals.
- As many parts of the Commonwealth are highly prone to disasters and emergencies, mental health and psychosocial input into disaster management systems is critical, especially at the community level. To cope with the psychosocial impact of devastating disasters, effective disaster preparation and response can only be achieved if a comprehensive community mental health system can be established or rebuilt that is grounded in multi-sectoral partnerships in the community.
- There is need to align Commonwealth mental health action plans closely to other global action plans, including the WHO Global Mental Health Action Plan (currently in the process of finalisation). In 2012 the Sixty-fifth 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. The final draft of the comprehensive mental health action plan 2013–2020 (See Appendix 1) has been prepared, and will be submitted to the Sixty-sixth World Health Assembly for its consideration. There is advantage in leveraging several regional action plans and strategies for mental health and substance abuse. The WHO Quality Rights Project (WHO, 2012) provides information and guidance on human rights standards that aim to improve quality and human rights conditions in mental health facilities and social care homes, and promote a civil society movement for mental health.
- Building research capacity and evidence-based practice is fundamental to advancing mental health interventions and improving treatment effectiveness. Strong partnerships need to be built between well-resourced research institutions and researchers and practitioners in low-income and middle-income countries. This approach should also build local research capacity to ensure high scientific standards and participation by all stakeholders, including people using mental health services (Eaton et al. 2011).

7 Recommended Key Steps for the Way Forward

Given the comprehensive coverage and extensive representation of the global action plan, the Commonwealth mental health initiatives need to build on the plans and recommendations of the WHO Comprehensive Mental Health Action Plan 2013–2020 (see draft: Appendix 1). These should also complement other global action plans and regional plans and strategies for mental health and substance abuse (WHO 2010; Commonwealth regional secretariats and offices) that have been developed.

There are wide opportunities and scope for the Commonwealth to make significant inroads into improving the lives of the people with mental ill health, their families, and their communities within reasonable timeframes. The following recommendations are intended to assist the Commonwealth to encourage and advocate for sustainable investment in mental health in member nations through leveraging, wherever possible, existing resources, partnerships and frameworks:

- 1) The Commonwealth promotes the inclusion of mental health strategies into national health programmes and plans. Strategies need to address the prevention of mental illness, treatment and recovery of persons with mental disorders at the local, national and international levels. Strategies should also focus on partnerships particularly with NGOs as well as with the private, academic, community and non-health public sectors.
- 2) The Commonwealth fosters policies to reduce the risk of mental disorders and enhance community-based initiatives across sectors, to discourage discrimination, gender-based violence, stressful work conditions and stigma; and to promote healthy lifestyles, social inclusion and human rights protection of people with mental disorders.
- 3) The Commonwealth works with countries to support the inclusion of mental health in development agendas, initiatives and aid programmes at the national and international levels. This will require targeted educational programmes focusing on the linkages between mental health, poverty and sustainable development, paying attention to various impacts such as economic crises, education, climate change, population ageing, migration and urbanisation.
- 4) The Commonwealth convenes regional consultative meetings and workshops to identify successful approaches and challenges for community-based and cross-sectoral interventions to prevent and treat mental disorders. Sharing culturally appropriate models and disseminating examples of best practices between countries in tackling the rising burden of mental disorders and associated risk factors can inspire similar initiatives and act as a catalyst for regional response throughout the Commonwealth.
- 5) The Commonwealth partners with relevant organisations to strengthen national mental health policies and reforms by exchanging experiences and mobilising north-south and south-south technical expertise to build capacity and facilitate the implementation of culturally appropriate community-based mental health care models and systems.
- 6) The Commonwealth elevates the importance of mental health through a communication and media strategy to reduce community stigma of mental illness and promote the awareness and understanding of mental health, mental disorders, treatment availability, and human rights of people with mental disorders in consultation with people with mental disorders, their families and carers.
- 7) The Commonwealth assists member countries to build capacity in establish mental health surveillance and information systems building on existing WHO surveillance data such as the WHO Mental Health Atlas and the WHO AIMS country reports.

- 8) The Commonwealth promotes research for the prevention, assessment and treatment of mental disorders by supporting the recommendations of the WHO and Global Forum for Health Research (2007), and encouraging the research community to prioritise and fund research agendas included in 'Grand Challenges in Global Mental Health'. (See Appendix 2)

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9 Appendices

APPENDIX 1: EXTRACTS OF THE DRAFT 'WHO GLOBAL COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020'

Vision: A world in which mental health is valued and promoted, mental disorders are prevented and in which persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society free from stigmatization and discrimination.

Goal: To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

Core principle: There is no health without mental health

Cross-cutting principles and approaches

1) Universal access and coverage

Regardless of age, sex, social position, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

2) Human rights

Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments

3) Evidence-based practice

Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

4) Life-course approach

Policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

5) Multi-sectoral approach

A comprehensive and co-ordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, criminal justice, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

6) Empowerment of persons with mental disorders and psychosocial disabilities

Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

PROPOSED ACTIONS FOR MEMBER STATES

- 1) Policy and law: Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.
- 2) Resource planning: Plan according to measured or systematically estimated need and

allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions.

- 3) **Stakeholder collaboration:** Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.
- 4) **Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations:** Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services.
- 5) **Service reorganization and expanded coverage:** Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, day care and primary care, support of people with mental disorders living with their families, and supported housing.
- 6) **Integrated and responsive care:** Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including access to basic human rights such as employment, housing, educational opportunities and community activities) through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.
- 7) **Mental health in humanitarian emergencies (including conflicts and other disasters):** Work with national emergency committees in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services for persons with (pre-existing as well as emergency-induced) mental disorders or psychosocial problems, including those for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.
- 8) **Human resource development:** Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services, for children and adolescents inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders and offer appropriate treatment and support as well as to refer people, as appropriate, to other levels of care.
- 9) **Address disparities:** Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.
- 10) **Mental health promotion and prevention:** Lead and coordinate a multi-sectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.
- 11) **Suicide prevention:** Develop comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.
- 12) **Information systems:** Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and

age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory.

- 13) Evidence and research: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.

Objectives and targets of the WHO Comprehensive Mental Health Action Plan 2013–2020

OBJECTIVES	TARGETS
1. To strengthen effective leadership and governance for mental health	<p>Target 1.1: 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).</p> <p>Target 1.2: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).</p>
2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	Target 2: The treatment and service gap for mental disorders will be reduced by 20% (by the year 2020).
3. To implement strategies for promotion and prevention in mental health	<p>Target 3.1: 80% of countries will have at least two functioning national, multi-sectoral promotion and prevention programmes in mental health (by the year 2020).</p> <p>Target 3.2: The rate of suicide in countries will be reduced by 20% (by the year 2020).</p>
4. To strengthen information systems, evidence and research for mental health	Target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).

APPENDIX 2: RESEARCH CAPACITY FOR MENTAL HEALTH IN LOW- AND MIDDLE-INCOME COUNTRIES – GLOBAL FORUM FOR HEALTH RESEARCH AND WHO (SHARAN ET AL, 2007)

The findings of the report emphasize the need for:

- 1) Governments and other institutions considering mental health crucial to the overall health of their populations and an important bearing on national development
- 2) Integrating mental health research within health research systems to enhance synergies and avoid inefficiencies, gaps and duplications
- 3) Establishing a leading body to identify and monitor gaps in national and regional mental health research, formulate priorities, advocate for funds, assess research capacity, establish networks, disseminate information and provide technical and financial support
- 4) Formulating and implementing mental health research priorities through a transparent, participatory and scientific process.
- 5) Increasing national funding for mental health research, bringing it into line, as far as possible, with the country's burden of mental disorders. In addition, leading research donors must include a specific mental health component in their budgetary allocations
- 6) Investing in mental health research capacity strengthening, particularly through research trainings and incentives for mental health professionals
- 7) Developing research networks and public-private partnerships. In particular, more LAMICs researchers and other stakeholders should be connected to established research networks
- 8) Mainstreaming cross-cutting issues, such as socioeconomic status and gender, in all strategies and research designs, as key variables
- 9) Connecting with information networks in health research to ensure the sharing and utilization of mental health information by researchers, policy-makers, and the general population

GRAND CHALLENGES IN GLOBAL MENTAL HEALTH

The 'Grand Challenges in Global Mental Health' (Collins et al, 2011) identifies the priorities for research in next 10 years to make impact on mental health. It was based on the feedback using the Delphi method with input from over 400 mental health experts from over 60 countries. It consists of several broad themes: use a life-course approach to study; system wide approach to change; biopsychosocial evidence-based interventions; and understands environmental influences. It features the full research gamut from identifying causes, prevention and early intervention, improving treatments, mental health promotion, building human resource capacity, and integrating mental health into health systems.

The top challenges are:

- 1) Integrate screening and treatment packages into primary care
- 2) Reduce cost and improve supply of medications
- 3) Provide effective and affordable community-based care services
- 4) Improve evidence-based interventions for children by health professionals in LAMICs
- 5) Strengthen mental health component in the training of health workers.

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