# MENTAL HEALTH AND DEVELOPMENT:

## Targeting people with mental health conditions as a vulnerable group

World Health Organization

Improving mental health, Reducing poverty

Mental Health and Poverty Project

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Targeting people with mental health conditions as a vulnerable group

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*This report on mental health and development is in memory of Edwige Faydi. Her commitment to mental health, as well as her energy and positive attitude will live on through this report and will be remembered by her many colleagues and friends around the world.*

# Acknowledgements


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http://www.psychiatry.uct.ac.za/mhapp;
http://www.who.int/mental_health/policy/development/en/index.html

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# Foreword – World Health Organization

It is with great pleasure that I introduce this report on *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group.* Based on evidence drawn from a comprehensive review of scientific literature and research studies as well as United Nations, development agencies, governmental and non-governmental data sources, this report makes the case that people with mental health conditions are a vulnerable group, and as such, deserve targeted attention in development efforts.

As you will read, people with mental health conditions are among the most marginalized and vulnerable groups. They often are excluded from mainstream social and economic activities, as well as from decision-making on issues that affect them. Their human rights are violated frequently and they are not provided with educational and vocational opportunities to meet their full potential. Given their extreme vulnerability, it is paradoxical that people with mental health conditions have been largely excluded from the development agenda.

It is in the treatment of vulnerable sections of society that we see the real test of governments' duty to protect, respect and fulfil the rights of the population. Development stakeholders have important obligations in this regard. As stated within this report, development that only improves the lives of some people – while others remain as badly off or even worse off than before – is fundamentally deficient in nature. Improving the lives of the most vulnerable is in itself a core development objective.

Through targeting by development programmes, people with mental health conditions can be empowered to reach their goals and participate fully in society. In order to achieve this they must have access to opportunities and services, be liberated from stigma and discrimination and be free to exercise their fundamental human rights.

The supporting statements provided in this report by diverse development stakeholders, including services users, non governmental organizations and governments, is testament to the huge challenges that lie ahead and the growing number of development stakeholders working to draw attention to these issues. The World Health Organization is committed to doing its part to achieve this objective, and calls upon other stakeholders to take commensurate action.

**Dr Ala Alwan**
Assistant Director-General, Noncommunicable Diseases and Mental Health
World Health Organization, Geneva

# Supporting statements

## H.R.H. Princess Muna Al Hussein, Hashemite Kingdom of Jordan

I have the pleasure to comment on this invaluable report on mental health and development. The report offers countries with guidelines and concrete actions that are potentially beneficial to people with mental disorders, their carers and to communities at large.

As nations of this world, our duty is to fully realize human rights and to establish national development programmes that support the inclusion of vulnerable people. Respect for human rights will provide people with an opportunity to live up to their potential and contribute to society.

We in Jordan are committed to improving the conditions for vulnerable people, recognizing that this will enhance development outcomes. Mental health reform requires the development of programmes especially designed to empower people with mental illness to attain full citizenship and inclusion in society.

I congratulate the World Health Organization for taking leadership on this important issue and for being an important driving force for this work that will amplify the voice of disadvantaged groups and inspire nations towards action.

This report is an important source of inspiration for all development stakeholders. Our challenge is now to include mental health, not only in the public health agenda, but also in the human rights and development agenda. I am confident that by working together we can take the significant and necessary steps to realize the recommendations of the report.

## Shuaib Chalklen, UN Special Rapporteur on Disability of the Commission for Social Development

The continued marginalization of persons with disabilities – especially mental health conditions – remains a priority for the Office of UN Special Rapporteur on Disability. My predecessors both included this issue in their stated priorities as I have already done in mine.

The situation of persons with mental health conditions who are living in poverty – including in Africa and other developing countries – needs urgent attention. One of our most pressing challenges is to change attitudes towards persons with disabilities, including those with mental health conditions. We need to raise awareness of the situation that they face and commit ourselves to fighting for their dignity and rights.

## Elena Chávez, President, ALAMO (Mental health service user organization), Lima, Peru

We, ALAMO, a group of mental health service users in Peru, want to highlight the importance of this report which clearly documents the social vulnerability of persons with mental disorders and the actions that could be taken by development stakeholders *to improve their lives.*

Although we are persons who have some mental health problems we are able to develop our capacities. The prevailing social situation in which we find ourselves, in particular poverty, is the real cause of our vulnerability and the major obstacle to overcoming our vulnerability.

In my country, Peru, some people with mental health conditions who have a high economic status do not suffer exclusion. They are called "rayados" or "chiflados". They are accepted because they have access to medicines, they look fine, they have expensive houses and cars. The rest, 98 per cent of us, are excluded: we are called "locos" and considered to be dangerous persons.

This report is an important resource for the implementation of the Convention on the rights of persons with disabilities. It will support beneficial interventions in our countries to reduce our poverty, promote respect for our dignity and right to legal capacity, guarantee us the exercise of our human, economic and social rights and provide us with the same opportunities that are provided to others in the community.

## Dr Francesco Colizzi, President, Italian Association Amici di Raoul Follereau (AIFO), Italy

Persons with mental health problems are among the most marginalized and excluded groups of persons in different societies. Their increased vulnerability coupled with social stigma and discrimination, often means poverty and violation of human rights.

Our Association has chosen to work with the most marginalized and excluded groups of persons and our experience of the past twenty years in community-based programmes in different parts of the world underlines the importance of mainstreaming, that means networking with all existing institutions and services involved in development work, to ensure that persons with mental illness can have access to all the right opportunities.

As a psychiatrist working in collaboration with persons with mental illness and their organizations in Italy and as president of AIFO/Italy that works with persons with disabilities and persons with mental illness in Asia, Africa and South America, I would like to express my appreciation and support for this report that

promotes a holistic approach to mental well being and an active role for persons with mental illness and their families. When persons with mental health problems are supported and trained to take an active role, through self-help groups and associations, they become the best advocates for their right to dignity and development.

AIFO would like to affirm its commitment to using the recommendations of this report in our work for preparing and implementing mental health programmes.

## Matrika Devkota, Chairperson, Koshish, A Mental Health Self Help Organization, Nepal

We, persons with mental health problems, are lacking access to treatment. We, persons with mental health problems, are seeking medical, psychological and social support. We believe that medical and social support should go together.

We, persons with mental health problems, are facing high levels of stigma and discrimination. When tagged as having a mental health problem, we experience social deprivation – losing our jobs, losing social prestige and becoming isolated from family and society. Women are particularly affected. If you are a woman, you are more likely to be divorced as a result of having a mental health problem and less likely to receive treatment and social support. For almost all other diseases like cancer and heart problems, society recognizes the value of treatment. Unfortunately for mental health problems, there are many misconceptions which means that if someone suffers from a mental health problem, the family and society give up as the problem is considered untreatable and unmanageable. It is a great tragedy that many beloved people with mental problems are chained, locked in dark rooms, as well as imprisoned. Persons with mental health problems are excluded from social life.

We strongly support the recommendations of the report and hope to see more attention and support for our concerns.

## Professor Dr Allen Foster, President, Christoffel Blindenmission (CBM), Germany

CBM welcomes the World Health Organization report, *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group.* The report provides evidence and arguments that people with mental health conditions are a marginalized and vulnerable group often excluded from mainstream society, including health care, by prejudice, ignorance, and fear. This is particularly true for low income countries.

Many mental health conditions can be prevented or treated, but lack of health services at the community level results in unnecessary illness and disability. Persons with mental health conditions not only face problems from their illness, but also from disability resulting from the attitudes and practices of society which exclude them from participation. Stigma, loss of dignity, discrimination and the lack of basic human rights towards persons with mental health conditions remain common, and in low-income countries this is further exaggerated by poverty and reduced opportunity to earn a livelihood for themselves and their families.

CBM, as a development agency, has been working in low income countries to improve the quality of life of persons with disabilities for over 100 years. CBM is pleased to partner the World Health Organization and other stakeholders in promoting the rights of persons with mental health conditions and in improving the provision of good community health services, as part of the wider development agenda.

## Anand Grover, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

It is my honour to welcome the Report on *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group*. The report is timely reminder about the fact that despite government obligations to respect, protect and fulfil the rights of persons with mental health conditions as enshrined in international human rights treaties, including the UN Convention on the Rights of Persons with Disabilities, their rights continue to be sidelined and ignored.

The report shows that people with mental health conditions are more likely to experience substantial disability and are at considerably higher risk of dying prematurely than the general population. The reasons for this include lack of access to health, social and emergency services; discrimination against and human rights violations of persons with mental health conditions and lack of empowerment.

Therefore an important part of the response has to be to empower people with mental health conditions. Historically, civil society advocacy and activism has played a central role in ensuring that issues such as HIV/AIDS and maternal and child health have claimed their rightful place on national and international development agendas. International human rights law requires that people be entitled to participate in decision-making processes at local, national and international levels. Yet persons with mental health conditions continue to be marginalized in decision-making processes that directly affect them. This report reinforces the crucial message that governments and other development stakeholders need to take positive steps to reach out this group and actively engage them in all stages of the design, implementation and monitoring of policies, laws and services that

affect them, including development strategies, plans and programmes. This ultimately requires capacity building of and investment in persons with mental health conditions. The proven benefits are all too evident from the HIV field. Capacity building and empowerment augurs well for better governance and development for society as a whole.

This report thus fills an important lacuna and provides essential guidance on actions to be taken by all development stakeholders in order to improve the human rights situation for people with mental health conditions and direct society towards a better future for all.

## Clemens Huitink, Policy employee, International Affairs, Dutch Association for Mental Health and Addiction Care (GGZ Nederland)

We welcome this WHO report on *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group.* From our practice, we know that thus far people with mental health conditions are often overlooked when it comes to developmental aid. Mental health is not a very "sexy" issue for policy-makers and governments and thus often neglected.

This report makes the case for the inter-linkage between mental health and a range of other subjects relevant to developmental issues. It shows convincingly that developmental aid, without paying attention to the mental health needs of the population, is often counterproductive. In a similar way it is also counterproductive when people who are directly affected by mental health conditions and their families are left out of the policy-making processes.

GGZ Nederland is convinced that solidarity among countries and systems in bringing mental health policies more to a "state of the art" level will bring us forwards on the complicated road to development. The framework of this new report will guide us to continue with the work we are already doing and will guide us to step up our efforts to find more allies along this road.

## Noreen Huni, Executive Director, Regional Psychosocial Support Initiative (REPSSI) & Chairperson, Regional Interagency Task Team on Children and AIDS (RIATT), South Africa

I fully support the argument in this excellent and timely document and look forward to working with WHO in its endeavour to uphold the economic, social and civic rights of people with mental health conditions within global, regional and national development processes.

I congratulate WHO for this important work, targeted at developing policies, strategies and interventions in order to promote the inclusion of people with mental health conditions in poverty reduction and income generation programmes. This report reinforces our current action strategies and will help guide future directions.

## Akiko Ito, Chief, Secretariat for the Convention on the Rights of Persons with Disabilities/UN Focal Point on Disability, United Nations Department of Economic and Social Affairs (UN DESA)

The United Nations advocates for universal human rights and development for *all* – with or without disabilities – as fundamental goals and as essential foundations for peace, security and prosperity. The UN Convention on the Rights of Persons with Disabilities, together with other human rights and development instruments, advances this cause. The implementation of the Convention should be taken to the next level by concrete efforts by all stakeholders towards empowerment of persons with disabilities – especially whose situations have yet to be fully addressed, including those with mental health conditions.

The report *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group* addresses a great number of issues that require urgent attention for implementation of the Convention for persons with mental health conditions. As this publication demonstrates, we need to break down the barriers to participation and access which persons with mental health conditions face in their daily lives. All development efforts should be reachable to persons with mental health conditions in order for them to be both beneficiaries and agents for development - the premise for a society for all.

As the international community prepares for this September 2010 Summit to review progress in achieving the Millennium Development Goals, its message is clear: putting persons with disabilities – including those with mental health conditions – and their communities at the heart of our efforts is a proven way to advance the development agenda. We must continue to work for its implementation and its universality.

## Jorma Julin, Director General, Department for Development Policy, Ministry for Foreign Affairs, Finland

The findings of this report are highly relevant to the Finnish Authorities.

In any society, certain groups of people face a higher degree of vulnerability than others. These groups are characterized as 'vulnerable' because they are more likely to suffer negative consequences in the event of external stressors. Any adverse life

event drives vulnerable individuals or communities into poverty, or as is often the case, deeper into poverty. Vulnerable groups are particularly disempowered in these situations because they are also less likely to be formally represented or have a voice in decision-making.

Poverty reduction and development policies often fail to reach vulnerable groups unless they are specifically designed to do so. Targeted efforts are needed to reach and empower them. This is particularly true for people with mental health conditions. As described in this report, people with mental health conditions often live silently on the outskirts of their communities, or in long-term facilities plagued with no hope for the future. It is therefore not surprising that they have escaped the attention of most development programmes.

This 'failure to notice' must end. As this report convincingly relates, people with mental health conditions meet major criteria for vulnerability. Recognized or not, they live in every community and every country. By investing in people with mental health conditions, development outcomes will be further improved. However, they require targeted attention to ensure that they are being reached.

Finland has since 1990's paid attention to the issue of mental health in the international health policy. While saying that there is no health without mental health, we have emphasized that mental health must become an integrated part of public health in all its dimensions. Second, we have stressed that we need not only improve the treatment of those suffering from mental health problems, but start to invest in the promotion of mental health.

Raising the issue of poverty and mental health in the context of development work fits to both of the principles we have advocated for: it gives mental health the visibility it deserves as an essential component of health, and it addresses one of the fundamental determinants of mental – and general – health.

## Dr Soccoh Alex Kabia, Minister of Social Welfare, Gender and Children's Affairs, Sierra Leone

This report comes at an opportune time for people in Sierra Leone. The National Mental Health Policy that I initiated in 2008–2009 as Minister of Health, with the full support of our president, has just been finalized. We will now need full support and involvement of Development Agencies and partners for the successful implementation of this crucial strategy.

Mental health is indivisible from health and development. This is a universal truth. In the aftermath of conflict, and in the context of poverty that affected and continues to affect the lives of millions of Sierra Leoneans, attention to mental health is crucial. As highlighted in this report, a comprehensive approach aimed at improving healthcare but also housing, education, employment, access to justice, civil

rights and participation is needed to address the multiple needs of people with mental health conditions. Promotion of mental health and prevention of mental health conditions is also crucial and must be supported as the nation recovers from the 11 year old conflict, that destroyed not only the infrastructure but had a traumatic effect on the nation posing an increased risk of morbidity in the area of mental health. Morbidity includes among others, alcohol and drug abuse, post traumatic stress syndrome and psychosis, and bipolar disorder.

Based on the results of a comprehensive situation analysis, a National Mental Health Strategic Plan and Policy have been developed. All step in the right direction in the quest to provide an effective mental health service for the Nation.

However, key challenges will have to be met, particularly in the area of Human and Financial Resources. Development agencies and partners will thus have an important role to play by including mental health in all development programmes, and in supporting government efforts to realize the fundamental human rights of all citizens while paying particular attention to the most vulnerable.

Without doubt, mental health is needed for successful national development. It is our fervent hope that, we shall continue to count on the support of all developmental stakeholders to enable Sierra Leone to lead the way.

## Sylvester Katontoka, President, Mental Health Users Network of Zambia

The Mental Health and Development report draws attention to a long neglected health and development issue. This concern is of great importance today because evidence proves that mental health problems are both a cause and a consequence of poverty. Eliminating world poverty and human rights violations is unlikely to be achieved unless the human rights and needs of persons with mental disabilities are taken into account. An estimated 450 million people globally are suffering from mental disabilities and many are affected by widespread stigma and discrimination making them vulnerable to violence, exploitation, physical and sexual abuse, malnutrition, illnesses and even death.

In recent years, there is a growing conviction globally that unless the rights of persons with mental disabilities are mainstreamed in development sectors, people will remain caught up in a vicious cycle of poverty and mental ill health.

Targeting persons with mental disabilities within development programmes will undoubtedly reduce the levels of poverty and accelerate the pace of economic, social and human development. Global cooperation accompanied by action is needed to ensure that persons with mental disability are supported in their efforts to develop their full potential, and to lead productive and fulfilling lives. Direct

support to country policies and programmes should incorporate mental health to help reduce and respond to the needs of persons with mental disabilities.

## Caroline Fei-Yeng Kwok, M. Ed., Toronto, Canada, author of *Free to Fly: A Story of Manic Depression*; Chinese version, titled 個精神病患者的新生

This report about the challenges faced by the mentally ill is very well researched. As a Chinese immigrant survivor of bipolar disorder living in Toronto, Canada, I strongly agree with the recommendations made in the report which are as relevant to developed countries as they are to developing countries. I would like to highlight two specific issues. The first is that people with mental health conditions are subject to stigma and discrimination. There is an intense social stigma towards people with mental illness in many communities. It exists because of the lack of mental health education and the traditional notion that mental illness is a loss of face for the family. It is reinforced by the negative portrayal of mental illness by the media. The second issue is that individuals with mental illness lack access to health and social services. As a new immigrant to Toronto, I did not know of any social or mental health support services after my hospitalization. I was at a loss and isolated in the cold winter in Toronto. Furthermore, my mother who spoke no English did not receive any professional support as a caregiver, in spite of her daily visits to see me at the hospital. Our world today has many people suffering from mental illness and it is my sincere hope that more services and programs will address our needs and those of our families.

## Tomás López Corominas, President, HIERBABUENA, Asociación para la Salud Mental, Asturias, Spain (Mental health service user organization)

We are tens of millions, but nevertheless there is a substantial lack of knowledge about mental suffering and its consequences on the lives of all those affected. Ignorance leads to misunderstanding which in turn leads to fear, and this fear results in stigma that distorts reality and transforms our sufferings into many forms of discrimination, which multiply our problems, the likelihood of relapse and the personal, social and financial costs to our lives. If this happens in developed countries it is not difficult to imagine the extremes of suffering that can be reached in places with fewer resources, where people with mental problems are even more neglected.

We all have a responsibility for the mental health of others. In addition, all organizations have the duty to assist its most disadvantaged citizens. Greater political attention will bring the social and health resources needed to provide a sufficient

response to mental health problems. Advocacy that brings visibility to mental health issues will help combat stigma and discrimination. Both political attention and advocacy can reverse the amount of suffering that we experience.

A very sincere thanks to WHO and all its collaborators, who through this accurate diagnosis of the situation echo our simple demand for justice, and encourage us to make our voices heard and to have hope. It is time that those concerned adopt and implement the recommendations made in this important report in order to bring about much needed change.

## The Hon. Bob McMullan, MP, Parliamentary Secretary for International Development Assistance, Australian Government

Mental illness is common in all countries. Treatment and care is complex and community attitudes and stigma surrounding mental illness take time to change.

Australia is committed to reducing poverty and achieving sustainable development in developing countries, and improving responses to people with mental illness is an important building block towards achieving this.

I welcome this important WHO report: it is a timely reminder of how governments and development partners need to give mental health a higher priority. Like WHO, Australia works closely with partner governments to improve health outcomes based on robust national health plans. These plans are an indication of how governments prioritize mental health, how they will respond and what support they require from development agencies.

Australia is committed to showing leadership in international and regional cooperation to promote disability-inclusive development. Our strategy *Development for All** focuses on improving the quality of life of children, women and men with all forms of disability. It includes building the capacity of Disabled People's Organizations, and assisting partner countries – particularly those in Asia and the Pacific – to implement the Convention on the Rights of Persons with Disabilities. Unless the needs of people with disability, including those with mental illness, are met, it will not be possible to achieve the targets of the Millennium Development Goals by 2015.

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* *Development for All. Towards a disability-inclusive Australian aid program 2009–2014.* Canberra, Australian Agency for International Development (AusAID), November 2008.

## Liebling Elizabeth Marlow, member, Psychiatric Survivors' Association, Fiji

I wholeheartedly support this report on *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group.*

Without doubt, people with mental health conditions meet all the criteria for vulnerability but not enough is being done to improve their situation. As a consumer of mental health services, I can speak with some authority on this subject. The reality is this: like everyone else in the world, people with mental health conditions have the simple need to work and live a normal life in their community with friends and family. The primary role of agencies with objectives to protect the health and human rights of vulnerable and marginalized groups should be the fulfilment of this simple need.

## Professor Wilfred Mlay, Ambassador for World Vision Africa

The report *Mental Health and Development: Targeting people with mental health conditions as a vulnerable group* addresses an issue that has been long overdue and needs urgent attention. In my previous role as leader of World Vision's development, relief and advocacy work for over 10 years, with operations in 26 African countries, especially in the context of our HIV related work, I have seen first hand that mental health issues, such as depression, are significantly limiting development efforts if not addressed. As a result World Vision Africa pioneered large scale field implementation of the approach of Interpersonal Psychotherapy for Groups (IPT-G). A clinical trial study in 2002 by Columbia University and John Hopkins** showed a highly significant fall in the overall severity of depression symptoms and number of people diagnosable with depression among those who received IPT-G compared with the control group. In programmatic terms this study has also demonstrated the feasibility of this intervention with facilitators, unskilled in mental health, but trained in IPT-G, run by NGOs such as World Vision. As development agencies, we need to respond to the challenges posed by this report. We must include people with mental health conditions in our programs. This a human rights issue as well as a program quality issue. World Vision's experience with IPT-G shows that development agencies can make a significant contribution towards positive mental health outcomes at community level.

I would like to thank WHO for this excellent report. This report will help to dispel the myths and misunderstandings held by policy makers. It also provides proper direction regarding why, what and how actions need to be taken to correct the present situation.

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** Bolton, P. Bass, J. Neugebauer, R. Verdeli, H. Clougherty, KF. Wickramaratne, P. Speelman, L. Ndogoni, L. Weissman, M. 2003. Group Interpersonal Psychotherapy for Depression in Rural Uganda A Randomized Controlled Trial, *JAMA* 2003;289:3117–3124.

## Gerard Quinn, Director, Centre for Disability Law & Policy, National University of Ireland, Galway, Ireland

The Centre for Disability Law & Policy greatly welcomes this report. As director of the Centre, I led the delegation of Rehabilitation International during the Working Group sessions that drafted the United Nations Convention on the Rights of Persons with Disabilities (UN CRPD). I also had the honour of contributing to the drafting of Article 32 on International Cooperation.

Since the vast majority of persons with disabilities live in developing countries, it is obvious that little change will come about unless development aid agencies become much more inclusive in their approach. This report shows what needs to be done to make Article 32.1.(a) of the Convention on 'inclusive development' a reality. In this sense it is a very important contribution to the advancement of the UN CRPD.

I think the emphasis in the report on building capacity for persons with mental disabilities is particularly important. In many ways the best and most sustainable form of development focuses on empowering people themselves. Persons with mental disabilities need this more than others due to their relative invisibility in the political process. The CRPD itself focuses on protecting vulnerable people against violence, exploitation and abuse. It also seeks to put in place social supports to ensure participation in all aspects of life. Most importantly, the Convention seeks to restore voice and visibility to persons with disabilities themselves. The convention will not succeed if it is simply reduced to a cluster of norms with which to challenge outdated laws and practices. It will only truly succeed where the process that produces bad laws is itself transformed. There is no better way to do this than to enable people to advocate for themselves and take their rightful place in all policy and other decisions that impact on their life opportunities. This is why I especially value the prominence given in the report to capacity building.

## Nydia Rengifo, President, Foundation "I have my space", Panama

Our Foundation reaffirms the importance of this report on mental health and development, particularly, its emphasis on the vulnerability of people with mental health problems. Our Foundation, created in Panama in 2005, is a non-profit entity that has as its primary aim the support of people with chronic mental disability. In order to serve their needs, we are carrying out a programme known as the "Center of teaching and job training for persons with chronic mental disability." Consistent with the recommendations in the WHO report, our foundation works with people with mental health problems to provide education, employment and housing opportunities as well as addressing their overall health needs.

Our overarching aims are to promote the human rights of people with mental health problems and their social inclusion. To make this happen on a larger scale, the commitment of all development actors is required. Governments, donors and civil society, in particular, service-user and family associations, need to work in close partnership to provide better opportunities for development for people with mental health problems.

## Pablo Rivero Corte, Director General, Quality Agency National Health System, Spain

The evidence presented throughout this report clearly shows how development outcomes can be enhanced through targeting people with mental health conditions as a vulnerable group. Integrating mental health into primary care will improve both mental and physical health outcomes. Implementing early childhood programmes would result in measurable reductions in mental health problems, crime, and unemployment in adulthood. School-based mental health programmes would prevent the onset or worsening of mental health conditions, and help ensure that the number of children completing education is maximized. Employment programmes, in which people with mental health conditions perform paid work with ongoing support and training, would result in higher employment rates, better wages, as well as better mental health. Legal measures to protect the rights of persons with mental health conditions will put an end to violations, and promote autonomy, liberty and dignity. Importantly promoting the participation of mental health service users in decision making processes will ensure policies and services are appropriate to their needs. Collectively, implementing these interventions would enable people to lead fulfilling lives.

I welcome this report on the vulnerability of people with mental health conditions. It reinforces our current action strategies and will help guide future directions.

## Maria Isabel Rodriguez, Minister of Health and Welfare, San Salvador, El Salvador

The Ministry of Health and Welfare of the Government of El Salvador has a firm commitment to putting in place policies that aim to provide comprehensive mental health care to the population.

This is reflected in the country's 2009–2014 Ministerial Strategic Plan which includes provisions for the promotion of comprehensive mental health care, the reduction of drug and alcohol abuse and for the need to identify and address the mental health aspects related to common social problems, such as violence, in El Salvador. The recently approved National Mental Health Policy also reinforces the need for action in these areas.

The Ministry of Health and Welfare of the Government of El Salvador fully supports the WHO *Report on Mental Health and Development*. This important document is a key tool for the development of health policies around the world, that promote mental health care.

## The Hon. Clay Forau Soalaoi, MP, Minister of Health and Medical Services, Solomon Islands

As this report convincingly relates, people with mental health conditions meet major criteria for vulnerability. Recognized or not, they live in every community and every country. In the Solomon Islands, mental health conditions are a major concern. Prevalence is high, with mental health strongly influenced by the social and economic factors including unemployment and financial hardship. Cultural beliefs that mental health problems are caused by supernatural influences such as ancestral spirits or sorcery compound stigma and discourage people from seeking care early. The Solomon Islands are dispersed across 1500 km, with 82 percent of the population living in rural areas, yet services are concentrated in urban areas, resulting in a high proportion of people not being able to access the care that they need. Access to mental health services is further limited by the lack of health professionals with expertise in mental health.

The Solomon Islands has adopted a number of actions in order to address this situation and reach out to this vulnerable group, including the development of the first ever national mental health policy, the training of a wide range of health professionals so that they are better able to support people with mental health conditions, and the enlisting of other key stakeholders including community leaders such as chiefs, church pastors as well as young people to improve their understanding and response to mental health problems within the community. We strongly agree with the message of this Report, that by investing in people with mental health conditions, development outcomes can be improved for individuals, their families and their communities.

## Charlene Sunkel, Coordinator: Gauteng Consumer Advocacy Movement (GCAM); Chairperson: South African Mental Health Advocacy Movement (SAMHAM)

I am in full agreement with the contents of this report and support the statements that it is important to target people with mental health conditions as a vulnerable group.

In this statement, I am not only representing myself as a mental health care user (diagnosed with schizophrenia in 1991), but also representing the Gauteng Consumer Advocacy Movement (GCAM) – a project of Central Gauteng Mental

Health Society (CGMHS), and the South African Mental Health Advocacy Movement (SAMHAM) – a project facilitated by the South African Federation for Mental Health (SAFMH). Both movements focus on: empowering persons with mental disability to advocate for themselves; promoting the rights of persons with mental disability, and fighting the stigma and discrimination attached to having mental health conditions.

We must recognize people with mental health conditions as a vulnerable group that should be prioritized in development. In doing so we must fight the stigma and discrimination which acts as a barrier to accessing services, to obtaining equal recognition of basic human rights, and to inclusion and reintegration into society. It is also vital that advocacy movements, like GCAM and SAMHAM, nurture a strong bond with national and international movements, mental health NGOs, Government and other stakeholders, so that together we can identify and address the needs and rights of persons with mental health conditions, and ensure that we are included in all decision-making and provided opportunities to influence legislation and policies that would be most beneficial to persons with mental health conditions.

## Chris Underhill, MBE, Founder Director, BasicNeeds, United Kingdom

This report is a bold and welcome endorsement for a holistic approach to mental well-being going beyond health. It makes the case for integrating mental health within mainstream development programmes that have focuses ranging from physical health, emergencies, and human rights to housing and poverty reduction. The argument for integration of mental health into development is made from the angle of vulnerability. Indeed, it is without a doubt that the experience of mental illness is one of vulnerability, both to the person and to their family.

However, if the principles and actions of the report are heeded, then we will be in a position to move beyond the rhetoric of vulnerability, towards one of possibility. Indeed, in forty years working in the field of disability and development, I have been more struck by possibilities than by vulnerabilities or disabilities. As Founder Director of Action on Disability and Development, I had the privilege to see how effective it is when a woman in a wheelchair in Rwanda speaks out in a public forum to defend her rights, as recommended in the specific actions of this report.

As with physical disability, so too with psycho-social disability. In the ten years since I founded BasicNeeds, an NGO implementing the Model for Mental Health and Development, I have observed that getting a person back to work, be it driving a tractor, growing vegetables, or selling textiles, is one of the most powerful ways to overcome not only poverty but also stigma.

The report does well to remind us all that "integration is a process, not an event," and as such requires sustained commitment. I am reminded of my own view which is that development itself is a process and not an event. The sustainability of this work will be best ensured when we follow the advice herein and build the capacity of service users and their carers to participate fully in public life and the decisions affecting them. Self-help groups of mental health service users are springing into being across Africa and Asia as we speak. I hope that this report inspires many organizations to open their doors to this important new movement since we must stand shoulder to shoulder with their members in promoting the development process.

## Anil Vartak, Secretary, Schizophrenia Awareness Association (SAA), Pune, India

This report is an excellent addition which will help development stakeholders at macro level and micro level to understand, appreciate and incorporate issues relating to persons with mental illness in the planning and implementation of development projects. The report shows several ways for incorporating issues related to mental health in the development agenda.

The Schizophrenia Awareness Association is glad that in the last ten years even with modest financial/manpower, it has enabled several persons with disabilities to enjoy better quality of life at various levels – economic, social, cultural – and as a human being. We are glad that these efforts will be multiplied and institutionalized if development stakeholders incorporate mental health issues in their agenda. Our association is always happy to share its experiences of the last several years.

# Executive summary

This report presents compelling evidence that people with mental health conditions meet major criteria for vulnerability. The report also describes how vulnerability can lead to poor mental health, and how mental health conditions are widespread yet largely unaddressed among groups identified as vulnerable. It argues that mental health should be included in sectoral and broader development strategies and plans, and that development stakeholders have important roles to play in ensuring that people with mental health conditions are recognized as a vulnerable group and are not excluded from development opportunities. The recommended actions in this report provide a starting point to achieve these aims.

### Key messages of this report

- People with mental health conditions meet criteria for vulnerability.
- Because they are vulnerable, people with mental health conditions merit targeting by development strategies and plans.
- Different development stakeholders have important roles to play in designing and implementing policies and programmes for reaching people with mental health conditions, and in mainstreaming mental health interventions into sectoral and broader national development strategies and plans.
- 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 affairs.
- The recommended actions in this report provide a starting point to achieve these aims.

## Introduction

Despite their vulnerability, people with mental health conditions – including schizophrenia, bipolar disorder, depression, epilepsy, alcohol and drug use disorders, child and adolescent mental health problems, and intellectual impairments – have been largely overlooked as a target of development work. This is despite the high prevalence of mental health conditions, their economic impact on families and communities, and the associated stigmatization, discrimination and exclusion. The need for development efforts to target people with mental health conditions is further reinforced by the United Nations Convention on the Rights of Persons with Disabilities, which requires the mainstreaming of disability issues into strategies for sustainable development.

Two development paradigms, the need to improve aid effectiveness and the use of a human rights approach, should be taken into consideration when reviewing actions that can be taken to ensure people with mental health conditions are included in development programmes.

The emphasis on improving aid effectiveness is changing the way development stakeholders are working: towards a greater focus on country-owned sectoral and broader national development planning, and increased harmonization and alignment among stakeholders on issues such as funding mechanisms. The increased emphasis on country-owned planning has highlighted the need for effective partnerships, for inclusive decision-making processes, and for a strong civil society to voice its issues and concerns. Never before has civil society had such an opportunity to directly influence national planning processes; full advantage must be taken of this development.

The human rights-based approach to development recognizes the protection and promotion of human rights as an explicit development objective. This approach, coupled with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), places a duty on countries to ensure that the rights of people with mental health conditions are protected, and that development efforts are inclusive of and accessible to people with disabilities.

## People with mental health conditions comprise a vulnerable group

People with mental health conditions meet the major criteria for vulnerability as identified by an analysis of major development stakeholders' projects and publications. They are subjected to stigma and discrimination on a daily basis, and they experience extremely high rates of physical and sexual victimization. Frequently, people with mental health conditions encounter restrictions in the exercise of their political and civil rights, and in their ability to participate in public affairs. They also are restricted in their ability to access essential health and social care, including emergency relief services. Most people with mental health conditions face disproportionate barriers in attending school and finding employment. As a result of all these factors, people with mental health conditions are much more likely to experience disability and die prematurely, compared with the general population.

## Other vulnerable groups have high rates of mental health conditions

Looking at the situation from a different perspective, vulnerability can lead to poor mental health. Stigma and marginalization generate poor self-esteem, low self-confidence, reduced motivation, and less hope for the future. In addition, stigma

and marginalization result in isolation, which is an important risk factor for future mental health conditions. Exposure to violence and abuse can cause serious mental health problems, including depression, anxiety, psychosomatic complaints, and substance use disorders. Similarly, mental health is impacted detrimentally when civil, cultural, economic, political and social rights are infringed, or when people are excluded from income-generating opportunities or education. Addressing mental health problems in vulnerable groups more generally can facilitate development outcomes, including improved participation in economic, social, and civic activities.

## Improving development outcomes: principles and actions

A number of principles and actions developed from best practices and consistent with the CRPD, if integrated into national development and sectoral strategies and plans, could substantially improve the lives of people with mental health conditions and thus improve development outcomes for these individuals, their families, and their communities.

As a starting point, people with mental health conditions must be recognized by development stakeholders as a vulnerable group and consulted in all issues affecting them. Targeted policies, strategies, and interventions for reaching people with mental health conditions should be developed, and mental health interventions should be mainstreamed into broader poverty reduction and development work. To make implementation a reality, adequate funds must be dedicated to mental health interventions and mainstreaming efforts, and recipients of development aid should be encouraged to address the needs of people with mental health conditions as part of their development work. At country level, people with mental health conditions should be sought and supported to participate in development opportunities in their communities.

A number of different actions can be taken at country level to improve the development outcomes of people with mental health conditions. Mental health services are cost effective and affordable, and should be provided in primary care settings and mainstreamed within general health services. At a broader level, mental health issues should be integrated in countries' health policies, implementation plans, and human resource development, as well as recognized as an important issue to consider in global and multisectoral efforts such as the International Health Partnership, the Global Health Workforce Alliance, and the Health Metrics Network. Other actions that can be taken at country level include the (re)construction of community-based mental health services (during and after emergencies), which can serve populations long beyond the immediate aftermath of an emergency situation. Strong links should be developed between mental health services, housing, and other social services, because mental health conditions often co-exist with a number of other problems such as homelessness. Access to educational

opportunities also is essential to improving the lives of people with mental health conditions. Development stakeholders have key roles in encouraging countries to enable access to educational opportunities, as well as supporting early childhood programmes that have been proven effective for vulnerable groups. Because mental health conditions are associated with high rates of unemployment, people with these conditions should be included in income generating programmes. Grants and support for small business operations have demonstrated benefits, not only for people with mental health conditions, but also for their families and communities. It is also essential for development stakeholders to focus on improving human rights protection for people with mental health conditions, thereby creating enabling environments. Finally, building the capacity of people with mental health conditions will enable them to participate fully in public affairs.

## All development stakeholders have important roles to play

Development stakeholders have important roles to play in facilitating the implementation of the principles and actions recommended in this report. Contributions by development stakeholders occur at the different levels of policy, planning, implementation, and funding of services at country level, as well as in advocacy of mental health priorities nationally and globally. One role common to all development stakeholders is promoting the implementation of the CRPD.

Civil society can play an important role in supporting people with mental health conditions to access needed resources and to integrate fully into the community, through direct service provision and advocacy. Services provided by civil society can include health care, social services, education programmes, and livelihood (income generation) projects. In addition, civil society can advocate to government and funders for the need to recognize and support people with mental health conditions.

Among all development stakeholders, governments have the most important role to play in creating enabling environments, reducing stigma and discrimination, promoting human rights, and improving the quality and quantity of services (education, health, social services and poverty alleviation). In addition, they have a duty to implement commitments such as the Accra Agenda for Action, the CRPD, and other human rights conventions. In order to improve development outcomes, different parts of government need, not only to integrate mental health in their own sector, but also to work collaboratively with other parts of government and civil society. Like civil society, government can provide support to create and strengthen mental health service user groups, and offer opportunities for these groups to express their views and participate in decision-making.

Academic and research institutions can help improve development outcomes by generating and synthesizing policy-relevant research findings, as well as by

building capacity to conduct and interpret research at local levels. Research, when properly formulated and implemented, can inform the planning and implementation of development programmes, and the allocation of scarce human and financial resources. In addition to building and managing knowledge, academic and research institutions have a key role to play in building the capacity of policymakers, planners, and service providers from different sectors.

Bilateral agencies and international funding organizations, as key development partners of governments and civil society, can advocate for a range of mental health issues: recognition of people with mental health conditions as a vulnerable group; inclusion of mental health issues into development instruments; integration of mental health interventions into primary care; mainstreaming of mental health issues into other sectors such as education and social services; identification of people with mental health conditions as important recipients of poverty alleviation interventions; and legal and regulatory reform to protect the human rights of people with mental health conditions. They also can improve development outcomes by increasing outreach to and consultation with people with mental health conditions, supporting the establishment and development of service user groups, and funding these groups to participate in public affairs and advocacy work. In addition they have a very important role to play in ensuring that financial resources in the area of mental health are provided where this has been identified as a gap.

As a result of their diversity, UN and other multilateral organizations can play many different roles in improving development outcomes. At the global level, they have an important advocacy function to place mental health higher on the agenda and ensure that adequate funding is allocated. At the country level, they can encourage member states to ratify the CRPD, and support them in its implementation. UN reform at global and national levels requires the integration of work plans and budgets among agencies (e.g. UN Development Assistance Framework), which can facilitate the prioritization of this vulnerable group. Multilaterals are also well placed to advocate for mental health to be included into national and sectoral policies and plans, and identify where and how coordination among sectors can be improved through the roles they play with regards to national planning. These include reinforcing government capacity to prepare, develop and review national development strategies, plans, budgets and aid negotiations, and participating in the coordination of sector and other broad mechanisms for country support.

Improving development outcomes for vulnerable groups is an important stated priority of development programmes. All development stakeholders have the responsibility to ensure that people with mental health conditions, as a vulnerable group, are provided with the opportunity to improve their living conditions and lead fulfiling lives within their communities.

# 1. Introduction

*People who are excluded … are not 'just like' the rest of the poor, only poorer. They are also disadvantaged by who they are or where they live, and as a result, are locked out of the benefits of development.*

*—Gareth Thomas, MP, Parliamentary Under-Secretary of State for International Development, United Kingdom*[1]

Pan American Health Organization

Vulnerable groups have been recognized by development stakeholders as important recipients of their attention and programmes. The United Kingdom's Department for International Development (DFID), for example, has stated that the vulnerable will not benefit from development unless at risk groups are identified and strategies specifically tailored to reach them.[1] Most governments similarly have recognized the need for targeted development programmes that address the most vulnerable.[2] Without targeted action, vulnerable groups are likely to be left behind as a country develops.

Groups that have been identified by development stakeholders as 'vulnerable' include, but are not limited to: people living in poverty; people living with HIV/AIDS; refugees; ethnic minorities; trafficked children and adults; commercial sex workers; and people with disabilities.[3,4,5] All vulnerable groups experience a range of adverse outcomes, including poverty, poor health, and premature death. They are not provided with opportunities to reach their full potential, and consequently their individual prosperity and well-being suffers. Death rates in vulnerable groups can be several times higher than those of the general population.

USAID/Alison Bird

**Women and children are one of many vulnerable groups targeted for development programmes, while people with mental health conditions remain overlooked.**

Despite their vulnerability, people with mental health conditions – including schizophrenia, bipolar disorder, depression, epilepsy, alcohol and drug use disorders, child and adolescent mental health conditions, and intellectual impairments – have been largely overlooked as a target of development programmes. This is despite the high prevalence of mental health conditions, their economic impact on families and communities, and the associated stigmatization, discrimination, and exclusion.

Mental health conditions affect millions of people in the world. The World Health Organization (WHO) estimates that 151 million people suffer from depression and 26 million people from schizophrenia; 125 million people are affected by alcohol use disorders. As many as 40 million people suffer from epilepsy and 24 million from Alzheimer and other dementias. Around 844 thousand people die by suicide every year.[6] In low-income countries, depression represents almost as large a problem as does malaria (3.2% versus 4.0% of the total disease burden), but the funds being invested to combat depression are only a very small fraction of those allotted to fight malaria.[7]

People with mental health conditions, particularly those with long term chronic conditions, need to be targeted by development programmes for several reasons. They often are not given the opportunities by communities and governments to reach their potential as contributors to both micro- (personal) and macro- (societal) economic prosperity and well-being. This leads to deeper economic and social marginalization. Second, people with mental health conditions habitually are excluded from participating fully in society, and they are not empowered to change that which oppresses them. Development assistance that helps improve participation is likely to lead to improved psychological and material well-being. Third, development implies the improvement of the lives of *all* people in a country or community. Development that only improves the lives of some people – while others remain as badly off or even worse off than before – is fundamentally deficient in nature. Improving the lives of the most vulnerable can be considered as the very reason for development.

> *At times, people with disabilities are not only neglected, but specifically excluded from development interventions. The Bangladesh Vulnerable Group Development Programme, which sought to provide food to the ultra-poor, targeting female-headed households, required that recipients be "mentally and physically sound" to qualify for the programme.*[8]

A number of different paradigms shape the dialogue in the development arena. Among these, two in particular should be taken into consideration when reviewing actions that can be taken to ensure people with mental health conditions are included in development programmes. The first is the consensus by all development stakeholders on the need to improve aid effectiveness (embodied in the Paris Declaration on Aid Effectiveness[9] and the Accra Agenda for Action[9]), and the second is a human rights-based approach[10] to development programming. A majority of development stakeholders are proponents of these two paradigms.

The emphasis on the need to improve aid effectiveness is changing the way development stakeholders are working. A large number have committed to the Paris Declaration on Aid Effectiveness[9], which requires them to align behind country objectives and harmonize their actions. The Accra Agenda for Action[9], which builds upon the Paris Declaration, further engages signatories to, among other things, strengthen country ownership and build more effective and inclusive partnerships.

Effective and inclusive partnerships are essential for greater impact and increased aid effectiveness. The variety and number of stakeholders within a partnership will depend on the realities within that country and its state of development, but in most countries will include some or all of the following: civil society; the country's government; research and academic institutions; bilateral agencies; global public-private partnerships; private foundations; and multilateral agencies. While this scope of stakeholders offers a wide range of valuable experience, it also

creates coordination challenges, which are addressed through the Accra Agenda for Action's commitments.

The commitments to improve aid effectiveness have led to an emphasis on national development planning, either focused on a single sector such as health or education, or on a comprehensive national development agenda. Implementation and impact of these broader plans are expected to occur country-wide and demonstrate results for all population groups. Funding also is targeting increasingly these planning and implementation efforts, through direct budgetary support, through to sectoral budget support or pooled funding.

The forums for developing, implementing and evaluating these plans are becoming more and more inclusive, as per the Accra Agenda for Action commitments, considering input from development stakeholders as well as the general public.

> *Developing countries and donors will ensure that their respective development policies and programmes are designed and implemented in ways consistent with their agreed international commitments on gender equality, human rights, disability and environmental sustainability.*
>
> *—The Accra Agenda for Action*[9]

The human rights-based approach to development recognizes the protection and promotion of human rights as an explicit development objective. It emphasizes among other things, participation, long-term planning and a multidimensional understanding of poverty. Practices include: recognizing people as key actors in their own development, rather than passive recipients of commodities and services; emphasizing participation, which is seen both as a means and a goal; undertaking analysis that includes all stakeholders; fostering locally-owned development processes; focusing on marginalized, disadvantaged and excluded groups; and designing interventions to reduce disparity.[10]

This approach, coupled with the United Nations Convention on the Rights of Persons with Disabilities (CRPD)[11, 12], places a duty on countries to ensure that the rights of people with mental health conditions are protected, and that development efforts are inclusive of and accessible to people with disabilities. The CRPD, which is referred to within this report, creates legally binding obligations on governments to respect, protect and fulfil a wide range of civil, cultural, economic, political, and social rights including the right to participation in political and public life, to education, employment, health and habilitation/rehabilitation services. It requires the mainstreaming of disability issues, including those related to mental health, into strategies for sustainable development, and promotes full inclusion and participation in community life for people with disabilities, as well as access to quality health care services as close as possible to people's communities. Importantly, the CRPD also establishes an obligation on State Parties, and on the international

community, to ensure that national and international development programmes are inclusive of and accessible to people with disabilities.

This report on mental health and development brings together data and information from diverse sources ranging from cases studies, the United Nations (UN), development agencies, governmental and nongovernmental reports through to systematic reviews of the literature to demonstrate that development outcomes would be enhanced substantially through targeting people with mental health conditions as a vulnerable group. People with mental health conditions embody all major characteristics of vulnerability, and as such should receive development assistance. In addition, mental health concerns are prominent among other recognized vulnerable groups. By addressing mental health issues, both people with mental health conditions and other vulnerable groups will benefit.

This report is divided into several sections. Section 2 provides evidence to show that people with mental health conditions meet the criteria for being a vulnerable group. Section 3 looks at the situation from a different perspective, by describing how vulnerable groups traditionally targeted by development agencies – for example, women subjected to violence – also have high rates of mental health conditions. Section 4 explores solutions and provides recommendations for specific evidence based actions that would improve the lives of people with mental health conditions thereby improving development outcomes for individuals, their communities and their country. The final part of the report, Section 5, looks at possible contributions by different development stakeholders to address mental health conditions within the context of their policies and associated programmes.

Mental health in low- and middle-income countries is the focus of this report, but the problems described are by no means confined to developing countries. The report also provides examples from all parts of the world from which solutions can be drawn. Examples from specific countries used to illustrate the different issues should not be viewed as assessments of countries' overall mental health systems, nor should they be taken to mean that any country is more or less advanced than others in protecting the rights of people with mental health conditions.

# 2. People with mental health conditions comprise a vulnerable group

*The rate of mental disorders and the need for care is highest among disadvantaged people – yet these are precisely the groups with the lowest access to appropriate services. At the same time, fear of stigma leads many to avoid seeking care. The consequences are enormous in terms of disability, human suffering and economic loss. We have a pressing obligation to scale up care and services for mental disorders, especially among the disadvantaged, while stepping up efforts to protect the human rights of those affected.*

*—UN Secretary-General Ban Ki-moon*[13]

UN Photo/Logan Abassi

## 2.1 What makes groups vulnerable?

Certain groups are more vulnerable than others. This vulnerability is brought about by societal factors and the environments in which they live.[14] Vulnerable groups share common challenges related to their social and economic status, social supports, and living conditions, including:[15]

- 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.

Over time, these factors can interact, leading to further marginalization, diminished resources, and even greater vulnerability. Vulnerability should not be confused with incapacity, nor should vulnerable groups be regarded as passive victims. Ways must be found to empower vulnerable groups to participate fully in society.[14]

## 2.2 People with mental health conditions are subject to stigma and discrimination

*States Parties shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.*

*—Article 5, United Nations Convention on the Rights of Persons with Disabilities*

Stigma surrounding mental health conditions is due mainly to widespread misconceptions about their causes and nature. Around the world, mental health conditions often are viewed as manifestations of personal weakness, or as being caused by supernatural forces. People with mental health conditions commonly are

WHO/AS. Kochar

**People with mental health conditions experience stigma and discrimination on a daily basis.**

assumed to be lazy, weak, unintelligent, difficult and incapable of making decisions. They also are thought to be violent, despite the fact that they are far more likely to be victims rather than perpetrators of violence.

The consequences are substantial. Attributions of mental health conditions to possession by evil spirits or punishment for immoral behaviour frequently lead to harmful treatment practices.[16, 17, 18, 19, 20, 21, 22, 23] Discrimination and exclusion from community life are common and can occur in housing, education, employment, as well as in social and family relationships.[24, 25, 26, 27, 28] Over time, significant social and economic deprivation occurs as a consequence.[28]

When it is believed that recovery from mental health conditions is not possible, resources are not directed towards providing people with support and care. Instead, people with mental health conditions are abandoned or placed in long-term psychiatric institutions or prisons[29, 30, 31, 32] where they very often do not receive adequate care and frequently are exposed to violations, which further exacerbate their conditions.

> *The perception that [mental health conditions are] a personality weakness prevails not just among 'normal' people. I've heard many doctors tell patients to stop complaining and tough it out.*
>
> *—Osamu Tajima, a leading psychiatrist in Tokyo, Japan*[33]

Some country examples:

- A Lancet article reports that in Afghanistan, mental health conditions are commonly believed to be caused by Jinns, witchcraft, possession, the evil eye, or saya. In severe cases people are brought to traditional healing centres where the 'treatment' consists of chaining the individuals concerned to a wall for 40 days with minimal food and water, and no sanitation facilities.[22]
- In Oman, a study found that both the general public and medical students believe that people with mental health conditions tend to have peculiar and stereotypical appearances. Both groups also believed that people with mental health conditions should be housed in facilities that are located away from the community.[34]
- In Thailand, a study showed that people with mental health conditions sometimes are considered to be recipients of bad karma or possessed by spirits.[21] These beliefs result in stigma, marginalization, and failure to receive effective treatment and care.
- In Turkey, the perception that people with depression are dangerous was widespread among respondents of a survey. More than half of those surveyed stated that they would not marry a person with depression, and nearly half stated that they would not rent their house to a person with depression. One quarter thought that people with depression should not be free in the community.[35]

- Studies in Australia, Brazil, Canada, Croatia, England, Malaysia, Spain, and Turkey have revealed that people with mental health conditions experience and find deeply distressing ignorance, prejudice, and discrimination among both general health workers and mental health workers.[36]

## 2.3 People with mental health conditions are subject to violence and abuse

> *No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment….States Parties shall take all appropriate … measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse …*
>
> *—Articles 15 and 16, United Nations Convention on the Rights of Persons with Disabilities*

Studies from high-income countries have revealed that people with mental health conditions experience extremely high rates of physical and sexual victimization.[37, 38, 39] One study from the United States of America found that, compared with the general population, people with mental health conditions were 11 times more likely to be targets of violent crime (completed or threatened violence), and 140 times more likely to be victims of personal theft.[38] In Australia, 88% of those admitted to a psychiatric ward had experienced victimization at some point in their lives: 84% having experienced physical assault, and 57% having experienced sexual assault.[37] People with mental health conditions often are abused in prisons (See Box 1); women with mental health conditions are at particularly heightened risk for sexual victimization in prisons.[40]

Global Initiative on Psychiatry/Harrie Timmermans; Habeb Mental Health Hospital/A Ali Awale

**Both in the community and mental health facilities, people with mental health conditions are abused, restrained, and are denied vital needs and human contact.**

**Box 1 Prisons – unsuitable holding grounds for people with mental health conditions[41]**

Security staff typically view mentally ill prisoners as difficult and disruptive, and place them in barren high-security solitary confinement units. The lack of human interaction and the limited mental stimulus of twenty-four-hour-a-day life in small, sometimes windowless segregation cells, coupled with the absence of adequate mental health services, dramatically aggravate the suffering of the mentally ill. Some deteriorate so severely that they must be removed to hospitals for acute psychiatric care. But after being stabilized, they are then returned to the same segregation conditions where the cycle of decomposition begins again. The penal network is thus not only serving as a warehouse for the mentally ill, but, by relying on extremely restrictive housing for mentally ill prisoners, it is acting as an incubator for worse illness and psychiatric breakdowns.

*—Excerpted from a Human Rights Watch Document on prisoners and offenders with mental health conditions in the United States of America*

People living in mental health facilities also are exposed to violence and abuse by the very health professionals responsible for providing residents with treatment and care. Other forms of abuse also are common, including unhygienic and inhumane living conditions, and harmful and degrading treatment practices. People can be confined arbitrarily to institutions – against their will – for months or even years. Once committed, they often are restricted to cell-like seclusion rooms and/or restraints.

Some country examples:

- In Ghana, the Accra psychiatric hospital has a 'special ward' in which 300 men are locked in a set of cells designed for 50 people. These men have no access to the outside world or to treatment. One voluntary sector worker commented on this situation, stating "About one third of our residents have been chained, beaten, or whipped at shrines or churches." [42]
- A survey of 52 social care homes in Hungary in 2001 by the Mental Health Interest Forum (PÉF) in Budapest, documented that residents experience restrictions in their freedom of movement, invasion of their privacy, inadequate communication facilities, ineffective complaint and monitoring mechanisms, a lack of access to medical treatment, and the use of outdated medication. Residents sometimes are held in 'cage-beds'. These restraint devices, which consist of metal cages or plastic netting around and on top of a standard hospital bed, prevent people from standing. Some residents are kept in these beds on a more or less permanent basis, and are forced to eat, urinate, and defecate within the confines of the cage.[43]

- An investigation by the National Institute of Mental Health and Neurosciences in Bangalore, India found that in 16 of the 37 hospitals examined residents were forced to live together in overcrowded single-person cells. Many hospitals placed people in cells without water facilities, toilets, or beds, and residents were forced to urinate and defecate in them. In addition, residents received inadequate treatment and care. Less than half of hospitals had clinical psychologists and psychiatric social workers. Comprehensive medical and psychosocial treatments were almost non-existent in one third of the hospitals.[44]
- It has been reported that in some parts of Somalia, people with severe mental health conditions can be subjected to a so-called 'hyena cure'. This village practice involves dropping a person with a mental health condition into a pit with one or more hyenas that have been starved of food. It is thought that the hyenas will scare away the *djinns*, or evil spirits, that inhabit the person. Family members of the person with the mental health conditions will pay the owner of the hyena for such 'treatment'.[45, 46]
- A report by Mind, a leading mental health charity for England and Wales, indicated that 71% of survey respondents reported experiencing some form of victimization in the previous two years due to having a mental health condition. Commonly-reported forms of violence were bullying (41%), theft (34%), sexual harassment (27%), physical assault (22%) and sexual assault (10%). Around 36% of those who experienced crimes did not report them to the authorities, mainly because they feared not being believed. Sixty percent of respondents who did report a crime felt the authorities did not take the incident seriously.[39]

## 2.4 People with mental health conditions experience restrictions in the exercise of their civil and political rights

> *States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.…States Parties shall… (e)nsure that persons with disabilities can effectively and fully participate in political and public life on an equal basis with others …*
>
> *—Articles 12 and 29, United Nations Convention on the Rights of Persons with Disabilities*

People with mental health conditions routinely experience restrictions in the exercise of their civil and political rights.[47, 48] This is due mainly to the false but common assumption that people with mental health conditions lack the capacity to assume responsibilities, manage their affairs, and make decisions about their lives.

People with mental health conditions often lack access to proper judicial mechanisms. Crimes committed against them go undocumented because of unfounded concerns by police or prosecutors about their reliability or credibility as witnesses.[39]

In many countries, people cannot contest or appeal their detention in mental health facilities.[49] In addition, they do not have access to complaints mechanisms, which would enable them to stop the violence and abuse being perpetrated against them. Basic human rights such as informed consent, confidentiality, privacy, access to health-related information (including clinical records), and communication with family members are violated frequently.[48, 49]


UN PHOTO/P. SUDHAKARAN

**In many countries, people with mental health conditions are restricted from voting.**

The laws and practices of many countries confer extensive powers to guardians of people with mental health conditions. Although these measures are intended to protect the interests of affected people, in reality they often result in undue restrictions on people's ability to make decisions concerning their place of residence, their personal and financial affairs, their medical treatment, and other aspects of their daily lives.[49]

In many countries, people with mental health conditions are denied rights such as the right to vote. This contributes to their political marginalization, disenfranchisement, and invisibility in their communities.

People with mental health conditions also experience restrictions in other fundamental rights such as the right to marry and have a family, as well as the right to attend school and seek employment (see sections 2.8 and 2.9).

> *My cousin keeps pushing to be my guardian. Just because I have a mental illness and take medication, it doesn't mean it is necessary for me to have a guardian. I am worried that when my mother dies, I will be made to have a guardian, and my cousin will make me live in a social care home. Then my cousin will have our property.*[43]

Some country examples:

- An analysis of election laws in 63 democracies revealed that only four countries – Canada, Ireland, Italy, and Sweden – do not restrict in any way the right of people with mental health conditions to vote.[50]
- A report by the NGO Mental Disability Advocacy Center (MDAC) highlights that in Bulgaria, people under plenary guardianship cannot marry.[51]

- In India, several laws curtail the civil and political rights of people with mental health conditions. Under Hindu[52, 53] and Parsi[54] laws, and the Divorce Act of 1872[55], being of "unsound mind" or having a long-term mental health condition can be grounds for annulment or divorce. The Special Marriage Act of 1954 prohibits marriage for people with mental health conditions "of such a kind or to such an extent as to be unfit for marriage and the procreation of children."[56] People who are declared by a competent court to be of unsound mind may be disqualified from registering in an electoral roll.[57, 58]
- A MDAC report states that in Kyrgyzstan, the civil code restricts adults who have been deprived of their legal capacity from the right to manage property.[59]
- Under the Family Code of the Russian Federation people with mental health conditions under guardianship cannot marry[60] nor file for divorce as these decisions are made for them by their guardian.[61] Their parental rights are also terminated.[62]
- In Thailand, anyone "being of unsound mind or mental infirmity" cannot vote[63] and the civil and commercial code does not permit the marriage of an "insane person".[64]
- The Egalité Handicap Centre highlights that in Switzerland, several recent cases have been reported in which people with intellectual impairments have been denied Swiss nationality. In one case, a young woman with an intellectual impairment was refused citizenship on the basis that she was incapable of supporting herself financially, and would require support from social services. In its examination of this case, the Federal Tribunal of Switzerland found that the decision was discriminatory.[65, 66] Other similar cases are still pending.

## 2.5 People with mental health conditions are not allowed to participate fully in society

> *… persons with disabilities should have the opportunity to be actively involved in decision-making processes about policies and programmes, including those directly concerning them …*
>
> *Preamble, United Nations Convention on the Rights of Persons with Disabilities*

Participation means not only the right to vote and to stand for election, but also to effectively and fully participate in the conduct of public life. Every individual, no matter how poor or marginalized, has the right to participate in public affairs. Participation enables the creation of an active civil society that can give a voice to everyone, including vulnerable groups, and drive national reform.

In the majority of countries, people with mental health conditions fail to participate actively in policy decision-making processes. This stands in contrast to issues such as HIV/AIDS, for example, where in many countries those most directly

affected have had an important voice in policy development and allocation of resources. This failure can be explained partly by the absence of mental health service user organizations in many parts of the world, especially in low- and middle-income countries. Another significant barrier to participation is the false assumption that people with mental health conditions lack the capacity to make meaningful contributions to society.

WHO/Pierre Virot

**People with mental health conditions are excluded from participating in public affairs and civil society.**

Some country examples:

- A WHO survey revealed that fewer than 20% of countries (8 of 42 surveyed) had mental health service user organizations that provided community and individual assistance.[67]
- The UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (1991) were developed without significant involvement by people with mental health conditions. As a result, the credibility of the Principles was diminished in the eyes of many, and resulted in a call to have them revoked. In contrast, the UN Convention on the Rights of Persons with Disabilities was drafted with the active participation of disability organizations, including mental health service user representatives. The Convention has been embraced widely by the disability movement as the universal standard for the human rights of all people with disabilities, and has taken precedence over previous instruments, including the UN Principles.[68]

## 2.6 People with mental health conditions lack access to health and social services

> *States Parties shall provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities …*
>
> *—Article 25, United Nations Convention on the Rights of Persons with Disabilities*

Despite the widespread prevalence of mental health conditions, a large proportion of affected people do not receive treatment and care. In low- and middle-income

countries, 75% to 85% of people with severe mental health conditions do not have access to needed mental health treatment. In high-income countries, between 35% and 50% of people with severe mental health conditions do not receive needed treatment.[69]

People with severe mental health conditions also are less likely to receive treatment for physical health conditions.[70] For example, people with schizophrenia are 40% less likely to be hospitalized for ischaemic heart disease, compared with people without mental health conditions who suffer from the same heart problem.[71] Case reports indicate that in many low- and middle-income countries, people in psychiatric hospitals lack access to basic health care including general health examinations, dental care, vaccines, medications, and treatments for cuts and bed sores.[72, 73, 74, 75, 76]

WHO/Marko Kokic


**People with mental health conditions are unable to access essential physical and mental health care.**

Across a broad range of countries, treatment rates for mental health conditions are much lower compared to those for physical health problems.[77] Large treatment gaps are not surprising given that almost one third of countries worldwide do not have a budget for mental health services, and a further one fifth of countries spend less than 1% of their total health budget on mental health services.[78] Not only are services scarce, but many governments in low- and middle-income countries require individuals to pay for their mental health treatment, even when treatment for physical ailments is provided free of charge or covered by health insurance. This disparity disproportionately affects poorer people.[78]

Lack of access to housing and other social services also is a serious problem: numerous studies have documented a high prevalence of mental health conditions in homeless people. Problems that exist at higher rates than the general population include schizophrenia, depression, anxiety, attempted suicide, emotional problems, hopelessness, and alcohol and drug use disorders.[79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91]

> *I experienced homelessness at one stage coming out of the hospital. I had nowhere to go. I had no choice. My family at that point was struggling with their own view of my condition and there was no place in the family for me. If my family had been educated, taught how to help me, supported and helped, then my story would be very different.*
>
> *—Woman with schizophrenia, 43 years old, New Zealand [92]*

Some country examples:

- In Argentina, a report by the NGO Mental Disability Rights International (MDRI) indicated that 60% to 90% of residents in psychiatric hospitals are there only because they lack accommodation with family members or in their communities.[73]
- A European study showed that just under half (48%) of people in need of mental health care accessed services, in contrast to 92% of people with diabetes who accessed care for their physical condition.[93]
- The national hospital insurance fund in Kenya excludes treatment of mental health conditions.[78, 94]
- In Mexico, a MDRI 1999 report documented residents of a psychiatric hospital living in extremely unsanitary conditions. Many did not receive basic health care, such as treatment for cuts. Nurses, although aware of residents' injuries, did nothing to address them. Other residents had lost their teeth due to the absence of dental care.[76]
- A report on Peru by MDRI and Asociación Pro Derechos Humanos states that many residents in one psychiatric hospital were there due to lack of alternative accommodation; although well enough to go home, they had been abandoned by their families.[95]
- In the Russian Federation, treatment and care for mental health conditions are not covered by the country's compulsory medical insurance programme.[78, 96]
- A study conducted in the United States of America, involving more than 10,000 participants revealed that 15% of people diagnosed with schizophrenia, bipolar disorder or depression were homeless.[97]
- National media in Zimbabwe reported that 60 homeless people (so-called 'vagrants') were arrested in 2006. Forty were found to be "mentally unstable" by the magistrate and prosecutors and sent to prison for a mental health evaluation, in accordance with the national Mental Health Act. Twelve months later, seven of the original 40 people had died, while the others were in prison, still waiting for a mental health examination. None had been transferred to a therapeutic facility.[98]

## 2.7 People with mental health conditions lack access to emergency relief services

*States Parties shall take …all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters.*

*—Article 11, United Nations Convention on the Rights of Persons with Disabilities*

People with mental health conditions often experience worsened symptoms because of the stress of emergencies. Compounding the situation, health workers might migrate or die during emergencies, thus depriving people with mental health conditions of pre-existing health and social support services. People living in institutions, such as psychiatric hospitals, are at heightened risk of being abandoned; others can be left behind by their own families. Emergency relief services often are inadequate to address the specific needs of people with mental health conditions, or in some cases explicitly exclude people with pre-existing mental health conditions from receiving services.[99]

Some country examples:

- In 2008, a forced repatriation programme from the United Republic of Tanzania to Burundi consisted of identifying Burundian refugees, either in refugee camps or in villages, and returning them to their villages of origin via border transit camps managed by nongovernmental organizations. Families often were divided in the process; it was thought that they could be reunited in the transit camps or at the latest, in their villages of origin. Purposely or not, family members did not recognize many of their relatives with severe mental health conditions at the transit camps. Compounding the situation, some people with mental health conditions were not able to identify their villages of origin. The transit camps are now closing and the remaining people with mental health conditions are stranded with nowhere to go, because they do not know the names of their villages and their families refuse to recognize them.[100]
- Following the start of the conflict in Iraq in 2003 waves of looters descended on the Al-Rashad psychiatric hospital, burning everything that was not stolen. The hospital director reported that some residents were raped. The 1050 residents fled the hospital – for the 300 who returned, living conditions were dire. The hospital lacked sufficient drinking water; it had no water for washing or cleaning, resulting in extremely unhygienic conditions; and only very limited food was available for residents. Warehouses, offices, wards, residences, kitchens, workshops, and laundries were destroyed.[101]
- During the conflict in Kosovo, most health workers from the psychiatric institute fled the area, leaving the institute without supervision. Residents were left locked in their wards and rooms; some died from hunger, cold, and

UN Photo/Logan Abassi

**In some countries in conflict, staff abandon mental health facilities leaving patients in locked wards where they die from hunger and health complications.**

health complications. Similar scenarios occurred in some Bosnian and Croatian custodial hospitals during conflicts in the 1990s.[102]

- The Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings describe how in Sierra Leone, in the midst of conflict in 1999, a psychiatric hospital was partly damaged and most health workers fled the area. Residents wandered in the community and were used to smuggle food and run errands to the frontline.[99]
- In the United States of America, following Hurricane Katrina in 2005, a position paper by the National Council on Disability reported that people with psychiatric disabilities were discriminated against in their access to disaster relief during and after the hurricane. For example, according to some Katrina survivors with mental health conditions, the Federal Emergency Management Agency (FEMA) excluded them from its trailers because of concerns that the individuals' mental health condition made them dangerous, despite assurances from mental health professionals that the individuals were not dangerous.[103]

## 2.8 People with mental health conditions lack educational opportunities and have poorer educational outcomes

> *States Parties shall ensure that persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability.*
>
> *—Article 24, United Nations Convention on the Rights of Persons with Disabilities*

Education is well-recognized as an essential building block of human and economic development, yet most people with mental health conditions face disproportionate barriers in accessing schooling. The exclusion of children with mental health conditions is discriminatory and leads to further marginalization of this already vulnerable group. Despite this fact, in many low- and middle-income countries, people with mental health conditions or intellectual impairments are institutionalized in facilities that do not offer educational opportunities.[95, 104, 105, 106] Those who are able to attend school or university often experience ridicule, discrimination, and rejection by their peers.[107] Barriers also exist in high-income countries.

> *There are many messages that teachers often inadvertently send to learners, that they don't belong there, they are not welcome … people who have psychiatric problems are the worst-labelled of all … they would just shun such children.*
>
> *—National policy maker, Department of Education, South Africa [108]*

Due to lack of support, mental health conditions experienced by children and adolescents can lead to school failure, including poor academic performance and higher drop-out rates.[109, 110, 111, 112, 113, 114, 115, 116, 117] Children with sub-clinical mental health conditions (mental health problems not meeting criteria for psychiatric diagnoses) also have poorer educational outcomes.[109, 116]

UN Photo/Roger Lemoyne

**Lack of support for children with mental health conditions at school leads to higher dropout rates.**

The impact of unaddressed child and adolescent mental health conditions is large-scale and long-term: prospective studies have shown that behaviour problems at age seven years are related to poorer educational attainment at age 16 years, and poorer labour market outcomes at both 22 and 33 years of age.[118] Given that approximately one in five children suffers from a mental health condition,[119, 120] up to 20% of the adult population is at risk for poor educational and employment outcomes.

> *I am here in black shadow that never leaves me. It does not let the light of joy go through, it is so cold that not a single child can come to me in order to become my friend … They laugh. I am always sad.*
>
> *—Vladmir, 14 years, Republic of Moldova* [121]

*Of the several thousand letters I received, however, the most difficult to read were the hundreds from doctors and other professionals. They recounted their own experiences with depression and manic depression, the lack of support they had received from their mentors or colleagues, and, too often, their dismissals from medical school or residency programmes. All expressed the concern that it was hard to be straightforward about mental illness when their academic degrees, medical licenses, or hospital privileges were at stake.*

*—Kay Redfield Jamison, a psychologist in the United States of America*[122]

Some country examples:

- HealthNet TPO report that in rural Burundi access to education is often restricted to the eldest boy in the family due to poverty and related financial constraints. Children with mental health conditions are usually the first to be deprived of education, as they are deemed unworthy of such investment.[100]
- In China, for the year 2000 only 0.4% of the education budget was allocated to the education of people with disabilities, according to official statistics.[123]
- Many children with intellectual impairments in south-east Europe do not have access to adequate education. Despite ongoing reforms, they continue to be placed in special 'boarding schools', thereby separated from their families. These schools suffer from low-quality education,[124, 125] due to the lack of funding, facilities, motivated teachers, and modern curricula. Some mainstream schools provide adapted curricula for children with disabilities, but they are restricted to urban areas and larger cities.[126]
- In England and Wales, United Kingdom, a survey by the National Autistic Society found that one in five children with autism and one in four children with Asperger's syndrome were excluded from school at some point. Among these children, 16% were excluded so many times that their parents lost count, and 24% were excluded permanently. The main reasons cited were lack of awareness and lack of appropriate placements in the local area.[127]

## 2.9 People with mental health conditions are denied employment and other income-generating opportunities

*States Parties recognize the right of persons with disabilities to work on an equal basis with others …*

*—Article 27, United Nations Convention on the Rights of Persons with Disabilities*

Among all sources of disability, mental health conditions are associated with the highest rates of unemployment: commonly between 70% and 90%.[128] Large

disparities in unemployment rates exist between people with mental health conditions, people with physical impairments, and the general population.

Surveys show that the vast majority of people with mental health conditions would like to be employed,[128] but stigma, discrimination, and lack of professional experience prevent them from doing so. Rates of discrimination among people with schizophrenia seeking employment are high and consistent across countries of varying income levels.[129, 130, 131] In a cross-sectional survey of 732 people with diagnosed schizophrenia across 27 countries, 70% were unemployed, and almost half experienced discrimination in finding or keeping work.[28] A number of studies have indicated the reluctance of employers to hire people with mental health conditions.[132, 133]

> *Mentally ill people […] get the thin edge of the wedge because they're not participating in tilling the fields, looking after the goats and the cows… and so this is a real dilemma,… and they're very often just locked up in a hut at the back of the village and very often neglected, because there's a lot of ignorance about mental health.*
>
> *—Statutory board member, Health Professions Council of South Africa[108]*

Global Initiative on Psychiatry

**People with mental health conditions are denied employment opportunities in comparison to the general population.**

People with mental health conditions also face barriers in accessing other sources of income. Many countries do not provide social grants to people with mental health conditions, and where available, they are usually insufficient to move people out of poverty. In other cases, people with mental health conditions are excluded from income-generating programmes. This has particular implications for the rural poor, who need support as they attempt to escape poverty through income-generating activities.

> *Most of our members are sidelined from development projects, even after undergoing treatment in the communities where they live. The result is continued poverty, and large numbers relapse as a result. It is a cost to the country because our members, who are languishing in destitute conditions, are capable of contributing to national development, but they are not being given a chance.*
>
> *—Sylvester Katontoka, President of Mental Health Users Network of Zambia*[134]

Due to lack of access to employment and other income-generating opportunities, people with mental health conditions are at heightened risk of descending into poverty. In Brazil, Chile, India and Zimbabwe, national surveys have shown that mental health conditions are twice as frequent among the lowest income groups compared with the highest.[135] Also in Brazil, children living in abject poverty have been shown to be five times more likely to have mental health conditions than middle class children.[136]

Some country examples:

- In Poland, one study found that 95% of employers would not want to employ a person with schizophrenia for any position. In a second study, 70% of respondents believed that people with mental health conditions should not be employed in positions such as childcare, medicine, or government. Data indicate that only 10% of people with mental health conditions in Poland are employed, compared with 48% of the general population.[133]
- In Uganda, a recent study revealed two important reasons why people with mental health conditions are denied access to microcredit services. The first is that they are believed to have impaired functioning, unable to meaningfully engage in productive work, and hence incapable of repaying loans. Secondly, it was believed that people with mental health conditions would not be charged before the law if they defaulted on their loans, leaving lenders without recourse in case of non-payment.[137]
- Data on employment services and outcomes in the United States of America indicate that in 2006, 73% of people with disabilities associated with mental health conditions were unemployed.[138]

UN Photo/Martine Perret

**Premature death and disability is common among people with mental health conditions.**

## 2.10 People with mental health conditions experience substantial disability and premature death

As a cumulative result of prolonged exposure to the preceding social and economic factors leading to vulnerability, people with mental health conditions are at heightened risk for premature death and disability. The substantial treatment gap – between the prevalence of mental health conditions, on one hand, and the number of people receiving treatment, and care, on the other hand – only compounds this burden.

Globally, mental health conditions account for 13% of the total burden of disease, and 31% of all years lived with disability.[6] By 2030, depression alone is likely to be the single highest contributor to burden of disease in the world – more so than heart disease, stroke, road traffic accidents, and HIV/AIDS.[139]

More than 80% of the global burden of disease due to mental health conditions can be found in low- and middle-income countries.[6] In low-income countries, depression causes almost as much burden as malaria (3.2% versus 4.0% of the total disease burden); in middle-income countries, depression is the major contributor to disease burden, accounting for twice the burden of HIV/AIDS (5.1% versus 2.6% of total disease burden).[7]

The full health impact of mental health conditions extends well beyond that which is represented by their burden of disease calculations. People with mental health conditions are more likely than others to develop significant physical

health conditions, including diabetes, heart disease, stroke and respiratory disease.[140] Mental health conditions such as depression and schizophrenia also place people at higher risk for contracting infectious diseases such as HIV, due to a range of factors including misconceptions about routes of transmission and high-risk sexual behaviour.[141, 142, 143, 144, 145, 146]

People with mental health conditions also are far more likely than the general population to die prematurely.[70, 140, 147, 148, 149, 150, 151] Systematic reviews of studies conducted in many countries have shown that people with schizophrenia and depression have an overall increased risk of premature death that is 1.6 and 1.4 times greater, respectively, than that expected from the general population.[148] Individuals with serious mental health conditions are more likely to suffer stroke and ischaemic heart disease before 55 years of age, and to survive for less than five years thereafter.[152] Studies in low- and middle-income countries have shown that mental health conditions combined with AIDS lead to increased premature death rates, compared with AIDS alone.[153] In the United States of America, a study found that women with depression and HIV were more than twice as likely to die, compared with women living with HIV without depression.[154] People living with HIV also are at heightened risk for suicide.[155, 156, 157, 158, 159, 160]

Some country examples:

- In Indonesia, a report from the Jakarta Social Agency indicated that 181 residents of the city's four 'shelters' for people with chronic mental health conditions died between October 2008 and May 22, 2009, many from diarrhoea and malnutrition. In total, 291 out of 644 people (45% of all residents) have died since 2007.[161, 162]
- A large study in the United Kingdom revealed that people with severe mental health conditions die on average 10 years younger than the general population.[70]

## 2.11 Summary

This section has provided the evidence that people with mental health conditions meet major criteria for vulnerability. They are subjected to stigma and discrimination on a daily basis, and they experience extremely high rates of physical and sexual violence. Frequently, people with mental health conditions encounter restrictions in the exercise of their political and civil rights, and in their ability to participate in public affairs. They also are restricted in their ability to access essential health and social care, including emergency relief services. Most people with mental health conditions face disproportionate barriers in attending school and finding employment. As a result of all these factors, people with mental health conditions are much more likely to experience disability and die prematurely, compared with the general population.

People with mental health conditions are unquestionably highly vulnerable, and as such, they merit targeted attention from development programmes. Before turning to what needs to be done to improve development outcomes and what the different stakeholders can do, the report next examines the high prevalence of mental health conditions among other groups that have been defined by development stakeholders as vulnerable. Many of these groups have been prioritized by development stakeholders, while people with mental health conditions have been largely overlooked.

# 3. Other vulnerable groups have high rates of mental health conditions

*Poverty is pain; it feels like a disease. It attacks a person not only materially but also morally. It eats away at one's dignity and drives one into total despair.*

*—Woman living in poverty, Republic of Moldova*[163]

UN Photo/John Isaac

The previous section showed how people with mental health conditions meet criteria for being considered as a vulnerable group. This section looks at the situation from a different perspective, by describing how vulnerable groups targeted by development stakeholders – for example, people living with HIV (see Box 2) – also have high rates of mental health conditions.[1]


Clockwise from top left: IRIN/Manoocher Deghati; UN Photo/John Isaac; WHO; IRIN/Allan Gichigi

**Studies indicate an increased prevalence of mental health conditions among vulnerable groups.**

## Box 2 HIV/AIDS and mental health conditions

Between 11% and 63% of HIV-positive people in low- and middle-income countries have depression.[164, 165] Due to the unpredictable nature of AIDS progression, people with the condition also are prone to anxiety, stress, and panic disorder.[166] Stress has been shown in several studies to impair immune function[167] and depression is linked to poor adherence to antiretroviral therapy.[168] In the United Republic of Tanzania, one study showed that 57% of HIV-positive women experienced depression at least once during the study period of 6 to 8 years, and that depression was associated with a greater likelihood of disease progression and death.[153]

How does vulnerability lead to poor mental health? Stigma and marginalization generate poor self-esteem, low self-confidence, reduced motivation, and less hope for the future. In addition, stigmatization and marginalization result in isolation, which is an important risk factor for future mental health conditions. Exposure to violence and abuse can cause serious mental health problems, including depression, anxiety, and psychosomatic complaints. This relationship has been observed for all forms of violence and abuse, including physical, sexual, and psychological abuse, and across a range of situations, from wars and conflicts through to adverse living conditions.

> *It is not the physical abuse which is the worse but the terror which follows – the emotional abuse. I am still angry and terrified.*
>
> *—A woman subjected to domestic violence, Australia*[163]

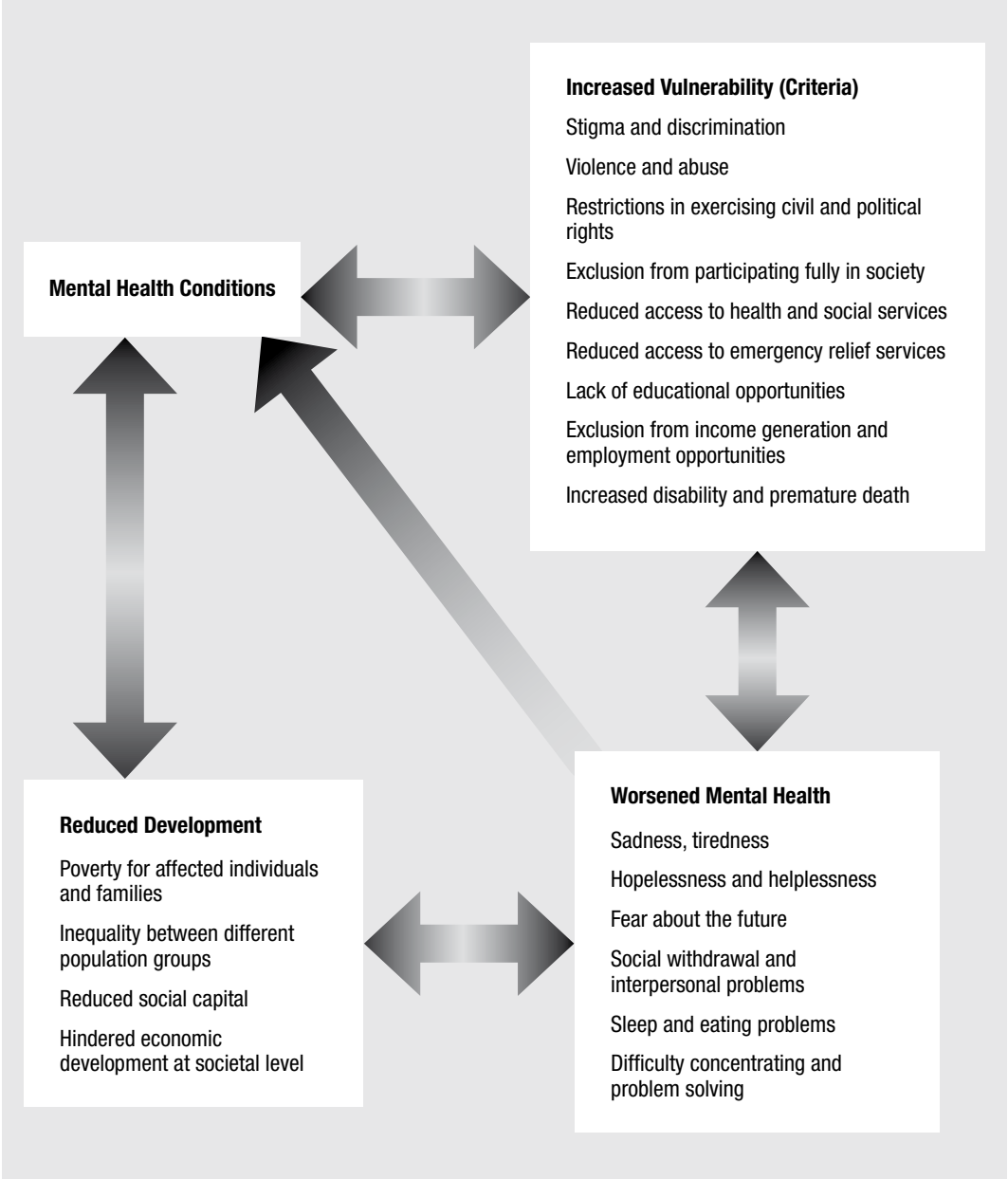
Poor mental health can be both a cause and a consequence of the experience of social, civil, political, economic, and environmental inequalities (see Box 3). Mental health conditions are more common in areas of deprivation and poor mental health is consistently associated with unemployment, less education, low income or material standard of living, in addition to poor physical health and adverse life events.[169] The cycle that can develop between vulnerable groups, mental health conditions, and adverse development outcomes is illustrated in Figure 1.

## Box 3 Poverty and mental health conditions – a vicious cycle

Poverty and mental health conditions interact in a negative cycle:

- People living in poverty not only lack financial resources to maintain basic living standards, but also have fewer educational and employment opportunities. They also are exposed to adverse living environments such as slum areas or dwellings without sanitation or water, and are less able to access good-quality health care. These stressful conditions place people at higher risk of developing a mental health condition.
- People with mental health conditions sometimes are unable to work because of their symptoms. Due to discrimination, others are denied work opportunities or lose employment, driving them deeper into poverty. Many have no means to pay for needed treatment; in other instances, money is spent on costly mental health care. If this care is ineffective or inappropriate, the result is even worse in that people have not only expended their financial resources, but also failed to get better.

**Figure 1** **The relationship between vulnerability, mental health conditions and adverse development outcomes**



Some country examples:

- 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.[170]
- In South Africa, a study showed that 44% of people living with HIV have a diagnosable mental health condition, whereas the prevalence of mental health conditions in the general population is only 17%.[171]
- Also in South Africa, researchers found that children orphaned due to AIDS have significantly higher rates of depression, posttraumatic stress disorder, and suicidal ideation than non-orphaned children.[172]
- In a WHO multi-country study women who had experienced physical or sexual violence or both by an intimate partner reported higher levels of emotional distress than other women and were more likely to attempt suicide.[173]

The implications are clear. Development strategies and plans need to reach people with mental health conditions, as well as address the mental health needs of other vulnerable groups that are already targeted. The general principles and recommended interventions in the following section provide guidance for achieving this aim.

# 4. Improving development outcomes: principles and actions

*States Parties recognize the importance of international cooperation and its promotion, in support of national efforts for the realization of the purpose and objectives of the present Convention, and will undertake appropriate and effective measures in this regard … ensuring that international cooperation, including international development programmes, is inclusive of and accessible to persons with disabilities …*

*—Article 32, Convention on the Rights of Persons with Disabilities*

**Income generation**

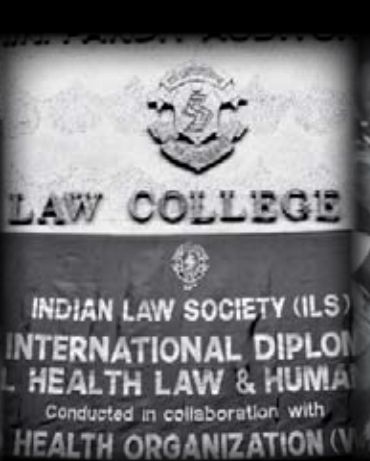
**Civil society**

**Primary care**

**Education**

**Mainstreaming**

**Housing**




**Human rights**

**Emergency care**

In many countries, mental health issues have been omitted from national development strategies and plans, even though people with mental health conditions are a vulnerable group and are often excluded from development opportunities. As more and more national development plans in low- and middle-income countries focus on vulnerable groups, people with mental health conditions (as with other vulnerable groups) should be included in the development of strategies and plans and be beneficiaries of them. Development stakeholders have a role to play in advocating for the inclusion and mainstreaming of mental health into all national development strategies and plans, and in strengthening the participation of people with mental health conditions in national planning.

This section reviews a number of general principles and specific evidence based actions that if integrated within national development and sectoral strategies and plans could substantially improve the lives of people with mental health conditions and therefore improve development outcomes.

## 4.1 General principles

Because people with mental health conditions meet criteria for vulnerability, national development and sectoral plans should be inclusive of and accessible to people with mental health conditions. Their needs, like those of other vulnerable groups, should be prioritized by development stakeholders and within development programmes.

Development stakeholders should:

- Explicitly recognize that people with mental health conditions constitute a vulnerable group;
- Consult with people with mental health conditions on all issues affecting them;
- Design and implement targeted policies, strategies, and interventions for reaching people with mental health conditions;
- Mainstream mental health interventions into broader poverty reduction and development policies, strategies, and interventions;
- Ensure that funds are dedicated to mental health interventions and mainstreaming efforts;
- Actively seek and support people with mental health conditions to participate in development programmes in their countries;
- Ensure that recipients of development funding address the needs of people with mental health conditions as part of their development work;
- Implement the specific actions highlighted in the report.

## 4.2 Specific actions

Specific programmes and actions are needed to tackle the health, social and economic factors leading to (further) vulnerability, as described in previous sections of this report. Areas for actions include the following:

1. Provide integrated mental and physical treatment and care through primary care;
2. Integrate mental health issues into broader health policies, programmes and partnerships;
3. Integrate mental health into services during and after emergencies;
4. Include mental health issues within social services development, including housing;
5. Mainstream mental health issues into education;
6. Include people with mental health conditions in income generating programmes;
7. Strengthen human rights protections for people with mental health conditions;
8. Build the capacity of people with mental health conditions to participate in public affairs.

### 4.2.1 Provide integrated mental and physical treatment and care through primary care

> *I see a doctor from the primary care centre every week. At the centre, I receive the same medications that the psychiatrist used to give me. I have been well for four years now, with no need to return to the psychiatric hospital. I like to live at home and am a happy man now, with my wife, my children, my mother and my stepfather.*
>
> *—Person living with a mental health condition, Chile*[149]

It was shown earlier in this report that a large proportion of people with mental health conditions do not receive needed treatment and care for mental and physical health problems.[69, 70] Mainly as a result of this treatment gap, people with mental health conditions are far more likely than the general population to have poor health and to die prematurely.

Mental health interventions, including psychosocial, care-management, and pharmacological strategies, have proved effective in a broad range of countries (Box 4).[174, 175, 176, 177, 178] Interventions reduce severity of symptoms[174, 175, 179] and improve daily functioning in work, social, and community life.[175]

## Box 4 Mental health interventions are cost effective [180]

The treatment of mental health conditions is as cost effective as antiretroviral treatment for HIV/AIDS, secondary prevention of hypertension, and glycaemia control for diabetes. Scaling up a full package of primary care interventions for schizophrenia, bipolar disorder, depression, and hazardous alcohol use over a 10-year period would require a total additional investment of only US$ 0.20 per capita per year in low-income countries, and US$ 0.30 per capita per year in lower middle-income countries, that is, a total financial outlay of up to $2 per person and $3–4 respectively.

As treatment of mental health conditions is affordable and cost effective all health services established as part of the national health response, should include a mental health component. Mental health interventions should be integrated systematically, starting at primary care. To be fully effective and efficient, primary care for mental health must be complemented by secondary care, and have linkages to informal community-based services and self care.[149] Interventions should focus on support, not coercion, and should be tailored to values and priorities of individuals and their families.

A recent World Health Organization and World Organization of Family Doctors report, *Integrating mental health into primary care: a global perspective*, identified ten principles for the successful integration of mental health into primary care (see Box 5).[149] By adopting the ten principles, countries can improve health workers' knowledge, skills, and confidence to provide mental health interventions; improve health and social outcomes for people with mental health conditions; and substantially increase the availability of mental health interventions across the population. A range of country experiences with integrating mental health into primary care are summarized in Box 6.


WHO/Christopher Black

**Integrating mental health into primary care services is vital.**

## Box 5 Ten principles for the successful integration of mental health into primary care [149]

1. Policy and plans need to incorporate primary care for mental health. Both mental health and general health policies and plans should emphasize mental health services at primary care level.
2. Advocacy is required to shift attitudes and behaviour. Time and effort are required to sensitize national and local political leadership, health authorities, management, and primary care workers about the importance of mental health integration.
3. Adequate training of primary care workers is required. Pre-service and/or in-service training of primary care workers on mental health issues is essential, and health workers also must practise skills and receive specialist supervision over time.
4. Primary care tasks must be limited and doable. Decisions about specific tasks must be taken after careful consideration of local circumstances.
5. Specialist mental health professionals and facilities must be available to support primary care. The integration of mental health services into primary care must be accompanied by complementary services, particularly secondary care components to which primary care workers can turn for referrals, support, and supervision.
6. Patients must have access to essential psychotropic medications in primary care. Countries should review and update legislation and regulations to allow primary care workers to prescribe and dispense psychotropic medications, particularly where mental health specialists and physicians are scarce, and they should distribute psychotropic medicines directly to primary care facilities, rather than through psychiatric hospitals.
7. Integration is a process, not an event. Integration takes time and typically involves a series of developments spanning several years.
8. A mental health service coordinator is crucial. Mental health coordinators are crucial in steering programmes around challenges and driving forward the integration process.
9. Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers, and volunteers is required. Individuals and agencies outside the public health sector can provide complementary support and help people with mental health conditions access needed resources and integrate fully into the community.
10. Financial and human resources are needed. Although primary care for mental health is cost effective, financial resources are required to employ and train primary health workers, and to purchase psychotropic medications.

## Box 6 Country experiences: providing integrated mental and physical treatment and care through primary care

- In Cape Town, South Africa, the Perinatal Mental Health Project prevents and treats psychological distress around pregnancy by partnering with public service obstetric care to provide integrated and holistic mental health support. Since 2002, more than six thousand pregnant women have been screened, and approximately one thousand have received on-site counselling and/or psychiatric care. The service presents no additional costs to the women themselves.[181, 182]
- In the Sembabule District of Uganda, people with mental health conditions receive their general health care together with their mental health care. This means that neither mental nor physical heath is neglected, and people are treated holistically. Primary health care workers identify mental health problems, treat people with uncomplicated common mental health conditions or stable chronic mental health conditions, manage emergencies, and refer those who require changes in medication or hospitalization. Specialist outreach services from hospital-level to primary health-level facilitate ongoing mentoring and training of primary health workers. In addition, village health teams, comprised of volunteers, have been formed to help identify, refer and follow-up on people with mental health conditions. Mental health treatment in primary health care, compared with the previous institutional care model, has improved access, produced better outcomes, and minimized disruption to people's lives.[149]
- The Islamic Republic of Iran has pursued full integration of mental health into primary care since the late 1980s. At village level, community health workers have clearly-defined mental health responsibilities, including active case finding and referral. General practitioners provide mental health care as part of their general health responsibilities and patients therefore receive integrated and holistic services at primary health care centres. If problems are complex, general practitioners refer patients to district or provincial health centres, which are supported by mental health specialists. An important feature of the Iranian mental health reform has been its national scale, especially in rural areas: in 2006, 82% of the rural population had access to primary mental health care.[149]

### 4.2.2 Integrate mental health issues into broader health policies, programmes, and partnerships

> *We must do more to integrate mental health awareness into all aspects of health and social policy, health-system planning, and primary and secondary general health care.*
>
> *—United Nations Secretary-General, Ban Ki-moon*[183]

Mental health issues have been omitted from broader health policy, programmes, and partnerships in many countries. Omission from the general health agenda perpetuates vertical systems of services and the development of separate mental health policies and plans to address gaps in broader policy and plans. These separate mental health policies, plans, and services often are not implemented because their basic requirements are not included in the overall health strategy.

When providing support to countries, development stakeholders have important roles in promoting mental health by highlighting issues of unmet need, vulnerability, and human rights, and advocating inclusion of these issues in national health policies and plans, and human resource development (see Box 7 for an example from Belize). They also can support the integration of mental health issues into global and multisectoral efforts, such as the International Health Partnership[184] the Global Health Workforce Alliance,[185] and the Health Metrics Network[186] as has been the case with the UN Convention on the Rights of Persons with Disabilities.

UN Photo/Paulo Filgueiras

**The rights of persons with mental health conditions are addressed by the UN Convention on the Rights of Persons with Disabilities.**

**Box 7 Belize: integrating mental health into the national health agenda [187]**

Belize's national health agenda (2007–2011) gives visibility to mental health issues and requires the government to achieve a number of key expected results in mental health policy and service development. It aims to prevent and reduce the incidence of mental health conditions, and to provide good-quality care to those in need. Services consist of primary-care based outpatient services that are complemented by inpatient/specialist care and community outreach. Specific areas for action include: development of a mental health human resource plan; training of general health workers in the management of mental health conditions; development of community-based support services, including housing; and support to the development of consumer organizations nationwide. Clear targets for each of these areas will hold the government accountable for achieving tangible results.

### 4.2.3 Integrate mental health into services during and after emergencies

*The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being. Achieving this priority requires coordinated action among all government and nongovernment humanitarian actors.*

*—Introduction to the Inter-Agency Standing Committee on Mental Health and Psychosocial Support in Emergency Settings[99]*

As described earlier in this report, disasters and other emergency situations lead to an array of mental health problems, ranging from short-term stress reactions, through to anxiety and depressive disorders and psychosis. In addition, people with pre-existing mental health conditions often experience disruptions in their treatment and care, and in some cases are abandoned by their caregivers.

Emergency primary care relief workers often are not skilled or equipped to manage and support people with mental health conditions. For example, psychotropic medicines were not included in the Interagency Emergency Health Kit until July 2009. The newly-updated version of the kit (4th edition, 2010) now includes four essential psychotropic medicines, which address the most severe and acute mental health conditions. This kit is sent to countries as part of emergency relief services, and contains essential medicines and medical devices urgently needed in the 3-month period following a disaster.[188]

Mental health interventions following emergencies often focus exclusively on (short-term) emergency relief, rather than on medium and long-term development (re)construction. This is a missed opportunity. While short-term mental health support is important, especially for vulnerable groups, development stakeholders should direct the bulk of their resources for mental health care towards (re)construction of community-based mental health services. This will help ensure enduring access to care for people with pre-existing mental health conditions, as well as those who develop chronic mental health problems as a result of the emergency. It also can serve to overcome historical shortcomings in the quality of mental health services (see Box 8), for example, by encouraging a transition from institutional to community-based care.

WHO/Marko kokic

**Post-emergency strategies should prioritize community mental health services.**

## Box 8 Post-tsunami Sri Lanka [189]

In the aftermath of the tsunami disaster of 2004, the active nurturing of numerous opportunities resulted in significant improvements in the Sri Lankan mental health system. During the months after the tsunami struck, Sri Lanka was overrun by aid agencies, each of which was offering short-term mental health and social support. With ongoing strong support from the World Health Organization, steps were taken to maintain this interest in mental health and use it to initiate a national-level policy development process. Ten months after the disaster, the Government of Sri Lanka approved a new, consensus-based national mental health policy. The new policy has guided efforts to strengthen the governance, management, and administration of mental health services, and to reconfigure the organization of mental health services so that multidisciplinary care is available locally in all districts.

### 4.2.4 Include mental health issues within social services development, including housing

*A safe environment, getting a warm meal. Somewhere to be and be supported. A social outlet.*

*—Respondent to interview on new homelessness in Australia*[190]

As discussed previously in this report, people with mental health conditions often lack stable housing. Conversely, homelessness itself can generate mental health problems. The net result is that homelessness and mental health problems often co-exist, and as such, require a holistic approach.[191]

Successful programmes for homeless people provide stable housing with supportive services, assist in developing work-related skills (including communication skills and emotional management) and finding employment, and provide supportive counselling throughout the job-search process and beyond.[192]

WHO

**A multifaceted approach to homelessness and mental health problems is required.**

The case of housing illustrates a broader point for social services development: a holistic approach is required because many clients have multiple needs (see Box 9). When establishing or strengthening social services within countries, the national development plan should establish mechanisms for strong linkages between services areas, especially between health, mental health and other social services such as housing.[193]

**Box 9 How a mental health intervention changed one youth's life** [194, 195, 196]

Youthlink is a nongovernmental organization in the United States of America that helps disadvantaged, homeless youth transition into the adult world. Many clients experienced the trauma of years of abuse in chaotic foster care systems before becoming homeless. Around 80% of Youthlink's clients have mental health conditions, some so severe that they have resulted in expulsions from shelter services, schools, and hospitals. Youthlink provides a broad range of support services in one central setting. It also connects clients with resources for health care, housing, job training, and employment.

A YouthLink client, 21 years of age, began participating in the programme three years ago. He was referred immediately to mental health services because he had a fairly new diagnosis of schizophrenia. At that time, he was not consistently taking his medication and his level of functioning was poor. With YouthLink's continued support, this young man was able to adhere to treatment. He is now living in a youth housing facility and attending university. Without Youthlink's assistance, it is unlikely he could have managed to obtain basic requirements such as clothing, food, and shelter, much less become a successful university student with a promising future.

### 4.2.5 Mainstream mental health issues into education

*Schools should initiate new efforts for promoting mental health education in the schools' health curriculum, so that children like my cousin can live a normal life.*

*—Mona, 17 years, Fiji*[121]

Development stakeholders have key roles in encouraging countries to enable children with mental health conditions – those living in communities and those living in residential facilities – to access education. Effort is required to ensure that educational opportunities are both available and accessible, and that social barriers that might prevent children with mental health conditions from attending school are mitigated (see Box 10).

**Box 10 Muthu's story** [197]

Muthu, 14 years of age, was born with multiple physical and intellectual impairments. He has difficulties walking and speaking, and as a result, he and his parents experience pervasive stigma in the remote village in India where they live. Muthu's mother, a teacher, was determined that he would receive an education despite these challenges. Muthu started his education at a special school for children with disabilities. Later, he joined an education centre with other children from the community.

Today, Muthu can walk and speak. He understands multiplication tables and can add and subtract numbers. Importantly, he also has learnt interpersonal skills that enable him to interact productively with his family and community. Muthu is not the only one who learnt from this experience: other teachers and community members now understand that all children have a right to education. Due to the success of his inclusive education, Muthu's parents are now confident that their child can face the world and become a productive member of society.

Once children with mental health conditions are in school, onsite mental health programmes can provide services and help them stay engaged in the education system. Schools with mental health programmes are also able to identify and support other children with mental health problems, in addition to providing ongoing services to those with severe mental health conditions.

More broadly, school-based mental health programmes provide a context where a broader population of children may be reached easily and with minimal stigma.[109] A number of mental health promotion activities, such as anti-bullying, stress-management and life skills development programs, can be delivered through school-based programmes.

The impact of school-based mental-health programmes is broad and long-term. They can prevent the onset or worsening of mental health conditions into adulthood, and help ensure that the number of people completing education is maximized. This leads to increased productivity and economic development for society as a whole.

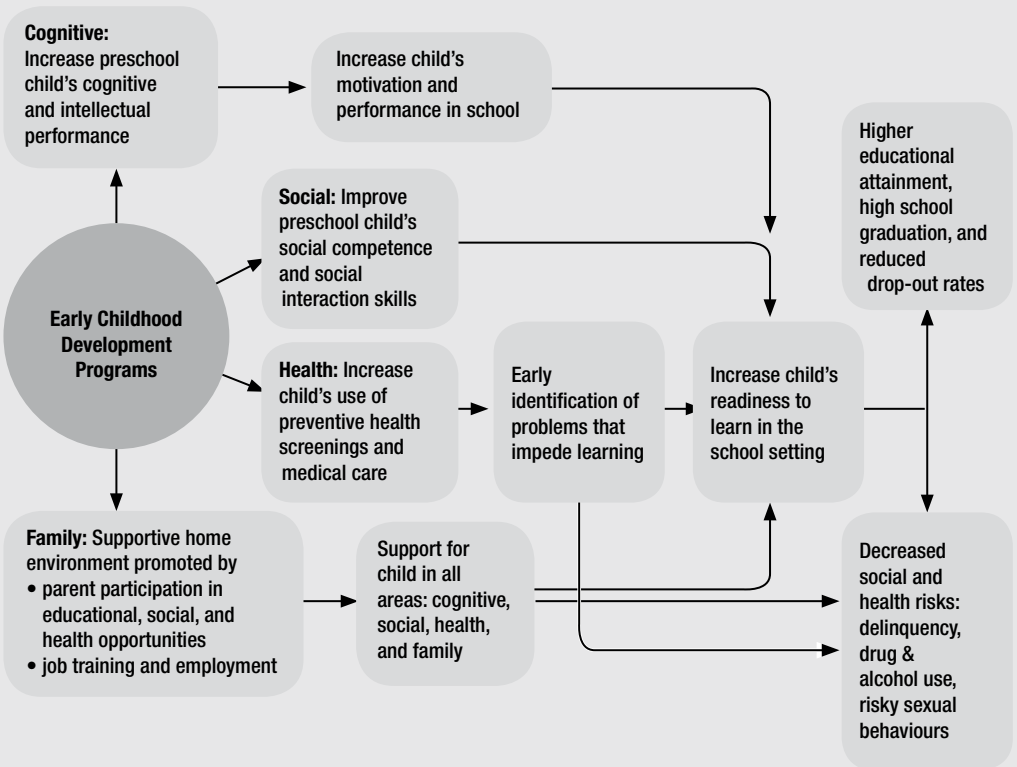
In addition to supporting school-based programmes, national development plans and education sector plans can improve education and development outcomes for vulnerable groups by supporting early childhood programmes that address the cognitive, sensory-motor (physical), and psycho-social development of children, as well as child-parent relationships.[198] These vulnerable groups may include the children of people with mental health conditions, children living in poverty, and children with developmental delays. Multiple positive effects of early childhood interventions have been documented well into adulthood, clearly indicating that it is a major investment opportunity for development. Figure 2 illustrates the ways in which early childhood development influences outcomes in adulthood.

UN Photo/x

**Children with mental health conditions need to be supported to access education.**

The benefits of early childhood programmes have been documented for up to 27 years in high-income countries[200] and for up to 17 years in low- and middle-income countries[201] (see Box 11 for additional information). Early childhood interventions have been shown to improve children's social skills, self-confidence, relationships

**Figure 2** **The suggested mechanisms through which early childhood programmes improve educational, social, and health outcomes.[199]**




**Box 11** **The High/Scope Perry Preschool Project [200, 203]**

In the United States of America, children from impoverished backgrounds attended a half-day preschool intervention and received weekly home visits. They not only experienced short-term benefits, but also long-term benefits documented up to the age of 27 years. Evidence gathered over twenty-two years indicates that the High/Scope Perry Preschool Program cut crime in half, reduced high school dropout and demand for welfare assistance, increased participants' adult earnings and property wealth, and provided taxpayers with a return of US$ 7.16 for every dollar invested in the programme.

with adults, and motivation. They also improve subsequent school enrolment rates, age of school entry, school retention, and academic performance. Importantly, early childhood interventions reduce problems in adulthood such as mental and physical health conditions, substance abuse, incarceration, and unemployment.[201, 202]

*There is robust evidence that good-quality pre-school programmes improve cognitive, verbal and social development, and result in improved educational outcomes and reductions in mental health problems, crime, and unemployment up to 27 years.*[200]

### 4.2.6 Include people with mental health conditions in income generating programmes

*I am acquiring skills here that will help me get back to a normal life. I am no longer idle. My energy has now been diverted from walking about aimlessly to doing productive work.*

*—Aminu Nasam, discussing the benefits of participating in a return-to-work project for people with mental health conditions in Ghana*[204]

As described earlier in this report, mental health conditions are associated with high rates of unemployment. This is despite the fact that people with mental health conditions are capable of working and being productive, especially when they are given appropriate mental health interventions and provided with vocational skills and social support.[107, 175, 205, 206]

*A man in a remote village in Timor-Leste was chained for 15 years by his family because they were unable to cope with his mental health condition. After only two months of treatment, he recovered sufficiently to begin to assist his family by working in the rice fields.*[207]

For this to happen, stigma and discrimination must be addressed in the community,[28, 133, 208] and people with mental health conditions also must be provided with direct support. Employment programmes, in which people with severe mental health conditions perform paid work with ongoing support and training, have been shown consistently to result in higher employment rates, better wages, more hours of employment per month, as well as better mental health. These effects have been demonstrated by numerous research studies that compared programme participants with people who did not receive this type of support.[209] In China, factory employees who develop mental health problems are provided with vocational rehabilitation in a sheltered workshop environment until they are well enough to return to their previous employment. This approach has been shown to reduce relapses.[210] In Ghana, India, Sri Lanka, Uganda, and the United Republic of Tanzania, people with mental health conditions who received treatment and support are able to engage in small-scale farming – growing crops, tending poultry, and contributing to their families' food supply.[107] Box 12 provides a description of one such project in Ghana and Sri Lanka, and Box 13 describes how one person and his family were helped as a result.

UN photo/T. Mattioli

**Employment opportunities for people with mental health conditions must be created.**

Grants for small business operations have demonstrated benefits, not only for people with mental health conditions but also for their families and communities.[107, 208, 211] Social grants are also valuable, yet lacking in many countries.[78] These provide a necessary safety net for vulnerable groups including people with mental health conditions. The inclusion of both types of grants should therefore be encouraged in development programmes. The UN Committee on Economic, Social and Cultural Rights emphasizes the importance of providing adequate income support to people with disabilities, including those with mental health conditions.[212] Studies of other vulnerable groups have shown that income transfers have a positive effect on mental health.[213, 214]

## Box 12 BasicNeeds' Horticulture Projects [215, 216, 217]

Ahmed from Ghana has experienced a remarkable recovery from a severe mental health condition several years ago. Thousands of miles away, Dayanada in Sri Lanka, who has schizophrenia, also feels he is well on the road to recovery. Both Ahmed and Dayanada work in their respective countries at horticultural farms run by BasicNeeds, which is a nongovernmental organization working in the field of mental health and development.

BasicNeeds' four horticulture projects in Ghana and Sri Lanka offer work opportunities to people who are not suited for community-based vocational interventions. Many workers have been institutionalized in psychiatric hospitals, often for many years, or are destitute and without family support. Two farms are located within the premises of psychiatric hospitals. A third is located on land that was donated by a traditional chief in the area, and the fourth is managed by a BasicNeeds partner who specialises in forming organic farmers' cooperatives.

On any day, work at these farms could include clearing land, raising beds, planting, preparing seed beds, watering, harvesting, or landscaping. Farm products include ornamental plants, mushrooms, and vegetables such as cabbage, peppers, onions, carrots, sweet peppers, and cucumber. The marketing and sales of these products are part of the project's overall functions. A portion of profits is shared among the members, and the rest is reinvested into the farm, covering expenses such as new equipment and repairs.

## Box 13 Raj's story [218]

With schizophrenia, Raj found it difficult to find and maintain employment because of recurrent bouts of illness. All that changed when he became part of a project for helping to reintegrate people back into the community. Through negotiation with the manager of the local garment factory, Raj was able to find gainful employment. In addition, he was supported by home visits that provided self-management support and counselling. At times of crisis, his social worker liaised with his employer and provided additional support. As a result of this ongoing support, Raj eventually was able to buy a small house and plot of land. His wife and daughter – as well as Raj – were thrilled to move out of the dilapidated house that they formerly inhabited.

Today, Raj helps financially support his family and produces crops on his plot of land to supplement his family's food supplies. The entire family has benefited from Raj's improved situation.

### 4.2.7 Strengthen human rights protections for people with mental health conditions

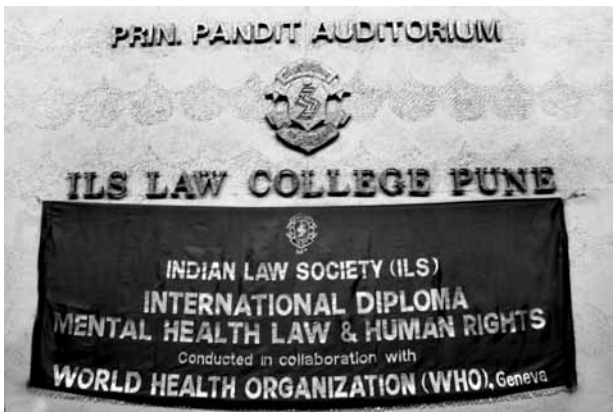
*In the early days of my diagnosis as being bipolar affective disorder – in fact hypomanic – the Medical Council of Zambia wrote to me and told me I must stop practising! Fortunately, a mention of my human rights (thank God we do have human rights) and threatening them that I would take them to the highest court in Zambia, if necessary, to prove that my illness did not make me incapable of being a dentist, was all it took for them to back off."*

*—Editorial by a paediatric dental surgeon, Zambia* [219]

The adoption of the UN Convention on the Rights of Persons with Disabilities (CRPD) in 2006 was a major step forward in improving the lives of people with mental health conditions.[220] It marks a paradigm shift away from viewing people with disabilities as objects of charity, towards viewing them as bearers of human rights with the capacity for self-determination.[11, 12] Importantly, the CRPD provides a comprehensive legal framework for ending the discrimination experienced on a daily basis by many people with mental health conditions.[220]

Development stakeholders can catalyze human rights reform through encouraging the development and implementation of policies and laws that comprehensively address mental health and human rights (see Box 14 for an example from South Africa). When well-formulated, these policies and laws can encourage the development of good-quality community-based services. They also can prevent violations and promote human rights in institutions and prisons, and ultimately empower people with mental health conditions to make choices about their lives and participate fully in the community.[47, 221]

In addition to mental health-specific policies and laws, it is essential that mental health issues are integrated into other relevant existing laws and policies related, for example, to health, social welfare, employment, education, and criminal justice [49] (see Box 15 for an example from Chile).




WHO/Indian Law Society

**Capacity needs to be built to develop policies and laws that address mental health and human rights.**

Development stakeholders also can help ensure that people with mental health conditions have

access to legal procedures that promote and protect their rights. For example, they can encourage the establishment of mechanisms within the justice system to prevent abuses in relation to involuntary admission and treatment in mental health facilities. They also can promote access to complaints mechanisms for people with mental health conditions.[49]

**Box 14 Mental health law as a catalyst for reform in South Africa [222]**

South Africa's Mental Health Care Act,[223] passed in 2002, illustrates how the language and content of the law can be changed to reflect international human rights and best practice standards. The law was developed through wide consultation, promotes an integrated approach to mental health, and has driven service reform at provincial and district levels. Two provinces have developed their own provincial mental health policies, using the new Act as a guide.[224] It codifies a number of rights for people with mental health conditions, and promotes voluntary treatment and free and informed consent. It includes oversight mechanisms such as a Mental Health Review Board, which is aimed at protecting against human rights violations.

**Box 15 UN Convention obligations addressed by reform in Chile [225]**

The Chilean Parliament has approved an important law on the Social Integration of Persons with Disability in February 2010, making it one of the first countries to reform its legislation in line with its obligations under the UN Convention on the Rights of Persons with Disabilities (CRPD).

Highlights of the new legislation include:

- Equal rights for people with mental disability
- The right for people to build and be part of a family, as well as to their sexuality and reproductive health
- Protection by the State against violence, abuse and discrimination
- The right to refuse treatment
- The right to live independently and in the community
- The right to access rehabilitation services based in the community
- The right to receive subsidies to buy a home
- The right to education taking into account special learning needs
- The right to paid employment

Governments can also be encouraged to establish independent mechanisms, such as visiting committees, to monitor conditions in mental health facilities. Such committees provide a critical function in many developed countries by ensuring that conditions are acceptable, residents are receiving appropriate care, and human rights are being respected.[49] Box 16 summarizes examples of such committees' actions in Ireland and the United Kingdom.

**Box 16 Country experiences: monitoring mental health facilities**

- The Mental Health Commission of Ireland, an independent statutory body, was established in 2002 as a result of provisions in Ireland's Mental Health Act of 2001. In 2007, the Commission established a formal inquiry into the use of seclusion and restraints in two hospitals. The inquiry led to a report that highlighted serious concerns about the quality of mental health care in these facilities.[226] It drew attention to aspects of service provision that were "totally unacceptable in a modern mental health service." [227] On the strength of these findings, the Health Service Executive (HSE) of Ireland formulated a detailed implementation plan to address the report's recommendations. The implementation plan includes the development of new community-based facilities, to be funded from the sale of hospital lands.
- In 2005, the Health Commission and the Commission for Social Inspection (CSCI) jointly investigated the Cornwall Partnership National Health Service Trust (CPT) of England, United Kingdom, following reports of human rights violations among people with intellectual impairments who were living in the Trust's residential facilities. The investigating team found evidence of "staff hitting, pushing, shoving, dragging, kicking, secluding, belittling, mocking and goading people who used the Trust's services, withholding food, giving cold showers, overzealous or premature use of restraint, poor attitude towards people who used services, poor atmosphere, roughness, care not being provided, a lack of dignity and respect, and no privacy." Their 2006 report received widespread media attention, and led to the suspension or dismissal of some staff members and the eventual closing of the hospital where many people with intellectual impairments lived. Care of residents was transferred to the Cornwall County Council's adult social care team and to charities.[228] As an outcome of the 2006 report, lawyers are in the process of gathering evidence from up to 400 former residents to launch a £2 million group action lawsuit.[229]

### 4.2.8 Build the capacity of people with mental health conditions to participate in public affairs

*"Nothing about us without us"*

*—Motto used by Disabled Peoples Organizations and other rights organizations as part of the global movement to achieve the full participation and equalization of opportunities for, by and with persons with disabilities.*

As discussed earlier in this report, civil society's response to mental health issues currently is insufficient. Most countries lack mental health service user groups. Embryonic movements, such as those described in Box 17, are starting in some low- and middle-income countries, but organizations such as these are unfortunately few and far between; they must be further encouraged, supported, and multiplied.

**Box 17 Country experiences: fostering consumer organizations for people with mental health conditions**

In Gauteng, South Africa, the Consumer Advocacy Movement advocates for the needs and rights of mental health care users. Its executive committee consists of six mental health care users. Since its creation in 2006, it has grown rapidly into an active movement of 280 members. The committee plays a vital role in raising awareness of mental health issues, and in supporting mental health care users and their families. The movement also issues a biannual consumer advocacy journal, which is written by mental health care users.[232]

In Zambia, the Mental Health Users Network of Zambia provides a forum through which users of mental health services can support each other and exchange ideas and information. The organization champions the human rights of people with mental health conditions, and works with government departments, national and international nongovernmental organizations, and the media to fulfil its objectives. Activities include: identifying needs and lobbying for rights and services for people with mental health conditions; contributing to the revision of mental health legislation; mobilizing and sensitizing communities around mental health issues; helping to mitigate the impact of HIV/AIDS on people with mental health conditions; visiting the homes of people with mental health conditions and sensitizing their family and community members; and participating on radio shows.[233]

The right to associate is important for people with mental health conditions, because membership in advocacy and peer support groups can foster skills development, empowerment, and autonomy. User-driven self-help and support networks improve the mental health of both participants and families, and result in reduced health care utilization, enhanced self-management, and improved mental health outcomes.[230]


WHO/Edwige Faydi

**Service users and carers take action: a strong civil society is a driving force for positive change.**

A strong civil society also helps create more effective, efficient, and accountable programmes and services. Organizations of people with mental health conditions, as well as others representing their interests, hold a unique perspective that can help ensure that laws, policies, and programmes address their needs and respect their human rights. As such, development stakeholders have a responsibility to ensure that representatives of people with mental health conditions are involved in the design of their own programmes and strategies. They also should encourage governments to involve mental health service user groups at national and local levels. Advocacy associations in particular give individuals a collective political voice to lobby for policy and legislative protection reform.

Development stakeholders have important roles in enabling people with mental health conditions to self-organize and advocate for their interests and needs. They can encourage governments to support the establishment of mental health services user groups, and provide financial resources for this purpose. It is crucially important, however, that these organizations maintain their autonomy and independence from government and funders. Development stakeholders also can support capacity building initiatives that help people with mental health conditions understand their rights and provide them with information and skills required to influence decision-making processes.

Building the capacity of those involved in development programming also is important. International and national development agencies, relevant government

departments, and civil society organizations, for example, should be equipped with the knowledge and skills necessary to understand mental health issues, engage with organizations representing the interests of people with mental health conditions, and create appropriate programming in this area.[231] People with mental health conditions should be involved in providing training and building this capacity.

# 5. All development stakeholders have important roles to play

Section 4 outlined what could be done to improve the lives of people with mental health conditions, based on evidence and consistent with the UN Convention on the Rights of Persons with Disabilities. This section looks at ways that development stakeholders can implement the principles and actions described above to improve development outcomes. Contributions by development stakeholders occur at the different levels of improving policy, planning, implementation, and funding of services at country level, as well as through advocacy of mental health priorities nationally and globally.

Due to their number and variety, stakeholders have been divided into distinct groups: civil society; government; academic and research institutions; bilateral organizations, global partnerships, and private foundations; and multilateral organizations. The examples listed in this section illustrate the potential role that different stakeholders could play at national and global levels. They comprise neither an exhaustive list of stakeholders nor their possible roles, and some examples, particularly in relation to bilateral and multilateral organizations, may be relevant only in low- and middle-income countries. In all contexts, potential actions described below must be adapted to realities on the ground.

## 5.1 Civil society

Civil society is made up of a number of different types of organizations, including:

- Mental health service user groups and organizations;
- National and international nongovernmental organizations (NGOs), Community Based Organizations (CBOs), and Faith Based Organizations (FBOs) working in development, mental health or human rights;
- Development and mental health networks;
- Managers, administrators and health workers of general or specialized health-care facilities both governmental and nongovernmental;
- Health-care professional associations (such as nurses or doctor's associations);
- Health-care worker training institutions (e.g. for community healthcare workers, nurses and social workers).

Civil society can play an important role in supporting people with mental health conditions to access needed resources and to integrate fully into the community, through direct service provision and advocacy. Services provided by civil society can include health care, social services, education programmes, and livelihood (income generation) projects. In addition, civil society can advocate to government and funders for the need to recognize and support people with mental health conditions as a vulnerable group.

Different civil society organizations have particular strengths on which they can capitalize. Health-care professional associations, for example, can raise awareness and build capacity to reduce stigma, tackle discrimination and promote human

rights. Organizations representing families and carers of people with mental health conditions, in addition to providing mutual support and services, can educate communities about mental health issues, denounce discrimination and human rights violations, and advocate for improved services.[234] Civil society organizations that provide direct services, for example in diverse areas such as agriculture, income generation or health, can ensure that people with mental health conditions are actively included in programme development and governance, and that their programmes are responsive to users' needs and human rights. An important part of their role is therefore to ensure that the organizations' constituents have the right attitudes, knowledge and skills to appropriately interact, involve and support people with mental health conditions.

Civil society organizations also should encourage and support the creation and strengthening of mental health service user groups, which, as noted earlier in this report, are scarce in low- and middle-income countries. User groups enable people with mental health conditions to better influence policy development in ways that meet their needs.

Since at present only a limited number of countries have a network of organizations specifically advocating for mental health, existing networks of civil society organizations working in development will need to fill the advocacy gap until more substantial mental health networks are instituted and operational. This is especially important as the few local organizations that are dedicated to mental health tend to be small and often do not have the necessary clout to be heard, to advocate for a rights based approach to development programming, or to influence policy.

At present very few international NGOs address mental health in their work, despite the significant gains that this would bring. For example, international NGOs are often the first to respond to emergencies. As described earlier in this report, emergencies often increase the vulnerability of people to develop a mental health condition as well as exacerbate symptoms for people with pre-existing mental health conditions. In response to these problems, international NGOs can ensure that mental health services are provided during and after emergencies, direct their resources towards (re)construction of community-based mental health services, and advocate to governments and funders to do the same. More generally, international NGOs can work with governments and funders to improve policy, planning, implementation, and allocation of resources for mental health at the country level, while also advocating for increased action and allocation of resources at the global level. They also are well-placed to support local organizations' efforts to build the capacity of people with mental health conditions to organize, have a voice, and participate in public affairs. Never before has there been such an opportunity for mental health service users and other civil society groups to directly influence national planning processes and full advantage must be taken of this.

## 5.2 Government

This group includes the following parts of government:

- The political branch (national, provincial and local government);
- Ministries and departments responsible for: Interior, Finance, Justice, Trade & Industry, Labour, Health, Education, Social Services, Environment (national, provincial, and local levels);
- Human rights bodies.

Among all development stakeholders, governments have the most important role to play in creating enabling environments, reducing stigma and discrimination, promoting human rights, and improving the quality and quantity of services (education, health, social services and poverty alleviation). In addition, they have a duty to implement commitments such as the Accra Agenda for Action, the UN Convention on the Rights of Persons with Disabilities, and other human rights conventions. In order to improve development outcomes, different parts of government need not only to integrate mental health in their own sector, but also to work collaboratively with other parts of government and civil society.

> *"Developing country governments will work more closely with parliaments and local authorities in preparing, implementing and monitoring national development policies and plans. They will also engage with civil society organizations (CSOs)."*
>
> *—Accra Agenda for Action*[9]

Parliament (or relevant national legislative body) has a very important role to play in creating an enabling environment, as it is politicians who are ultimately responsible for approving a national disability policy and enacting comprehensive national disability legislation with the aim of protecting the human rights of people with mental health conditions. In addition, an open and positive dialogue in the political arena on the rights of people with mental health conditions can reduce stigma and discrimination.

Most government sectors also have important roles. For example, those responsible for national development plans (usually planning or finance ministries) can ensure that people with mental health conditions are recognized as a vulnerable group and that mental health is mainstreamed. The judicial system and human rights bodies can promote the application of laws and protection of the human rights of individuals. Likewise, the health sector is key to promoting access to good-quality health and mental health services that are integrated into primary health care.

As mentioned earlier lack of health care is only one aspect of the problem – many other barriers in society affect the ability of people with mental health conditions

to pursue an education and ensure their livelihood. Coordination between different service sectors such as health, education, and social services (for housing and safety nets) therefore becomes key. In addition linkages between social services and poverty alleviation interventions for example through sustainable livelihood or income generating programmes (be they governmental or nongovernmental) help reduce the impact of mental health conditions on the individuals, families and communities.

As mentioned earlier, government has an important role in ensuring that people with mental health conditions have a voice in public policy and debate. To that end, government like civil society, can provide support to create and strengthen mental health service user groups, provide them with the opportunities to express their views and participate in decision-making as per its commitment in the Accra Agenda for Action and the Convention on the Rights of Persons with Disabilities, while allowing them to remain independent and autonomous.

## 5.3 Academic and research institutions

Academic and research institutions can help improve development outcomes by generating and synthesizing policy-relevant research findings, as well as by building capacity to conduct and interpret research at local levels. Research, when properly formulated and implemented, can inform the planning and implementation of development programmes, and the allocation of scarce human and financial resources. High-priority research topics include studying the impact and outcomes of interventions for: reducing poverty among people with mental health conditions; promoting employment and income generation; promoting access to education; and ending human rights violations in low- and middle-income countries.

In addition to building and managing knowledge, academic and research institutions have a key role to play in building the capacity of policy-makers, planners, and service providers from different sectors such as health care, education and the judicial system. National and international research and academic institutions should foster international linkages to facilitate the sharing of country experiences, knowledge, and best practices.

## 5.4 Bilateral agencies, global partnerships and private foundations

This group includes:

- Bilateral agencies, meaning governmental agencies that provide development aid (mainly funding) from a single country and that are accountable to the government and parliament of that country;

- The European Commission, which although technically is a multilateral organization, has been included here because its funding and operating procedures most closely resemble those of bilateral organizations;
- Global public-private partnerships, such as the Global Fund for AIDS, TB and Malaria;
- Private foundations, such as the Bill & Melinda Gates Foundation.

Most members of this group are proponents of or have signed up to the use of a rights based approach to development and the need for improved aid effectiveness. They are well-placed to advocate for change at country level that will lead to improved mental health and development outcomes. Most organizations in this group use a mix of support methods, including sectoral budget support, direct budget support, and direct funding of projects and interventions provided by government or nongovernmental organizations.

Funders providing direct funding of national development and/or sectoral plans are often involved in the elaboration of national development strategies and plans including poverty reduction strategies, and can therefore advocate for priorities that will impact on the planning and implementation of interventions and allocation of resources, as well as for mental health to be included within these broader development instruments. As key development partners of governments in low- and middle-income countries, they are also well placed to advocate for the recognition of people with mental health as a vulnerable group, the integration of mental health interventions into primary care, the mainstreaming of mental health issues into other sectors such as education and social services (e.g. for housing and safety nets), or the identification of people with mental health conditions as important recipients of poverty alleviation interventions (e.g. income generating activities and sustainable livelihoods programs). Members of this group can also advocate for and support legal and regulatory reform to protect the human rights of people with mental health conditions.

Funders providing support through projects and specific interventions, should also recognize that people with mental health conditions are a vulnerable group, ensure that mental health status is used as an inclusion rather than an exclusion criteria and that activities implemented to improve development outcomes are addressing the needs of people with mental health conditions.

> *"Donors will support efforts to increase the capacity of all development actors – parliaments, central and local governments, CSOs, research institutes, media and the private sector – to take an active role in dialogue on development policy and on the role of aid in contributing to countries' development objectives."*
>
> *—Accra Agenda for Action*[9]

Across a range of roles and activities, funders can improve development outcomes by increasing outreach to and consultation with people with mental health conditions, supporting the establishment and development of user groups, and funding these groups to participate in public affairs and advocacy work while allowing them to remain independent and autonomous.

Bilateral agencies, the European Commission, global partnerships, and private foundations, also can improve development outcomes by providing financial resources to mental health issues for which funding gaps have been identified.

## 5.5 Multilateral agencies

Among many others, multilateral agencies include:

- All UN agencies and programmes;
- The World Bank;
- Regional development banks such as the Asia Development Bank, the Africa Development Bank, and the Inter-American Development Bank.

Multilateral agencies vary considerably in their objectives and scope, but share in common the fact that they are established by intergovernmental agreement, They pool donations from different countries' governments and nongovernmental sources and use these pooled funds to provide technical and/or financial assistance to recipient countries. As a result of their diversity, multilateral organizations have many different roles to play.

As important development partners of governments and given their strong relationships with key policy-makers, including both civil servants and elected officials, multilateral agencies are well placed to advocate for: the repositioning of mental health issues in national agendas; the allocation of adequate resources to mental health; the ratification and implementation of the UN Convention on the Rights of Persons with Disabilities; the recognition of people with mental health conditions as a vulnerable group; and for mental health to be mainstreamed into sectoral policies and plans.

The increasing focus by funders on sectoral and direct budgetary support, the result of the emphasis on improving aid effectiveness, has led to increasing technical support being provided by multilaterals and especially the UN. At the policy level, agencies such as the World Bank, the regional development banks, and the UN Development Programme are closely involved in the development of national development plans (such as poverty reduction strategies), while agencies such as WHO and UNICEF (among others) are involved in the development of sectoral policies and plans. In these roles, multilateral agencies can reinforce government capacity to prepare, develop, review and implement national development strategies, plans, budgets and aid platforms. They can also identify where and how

coordination among sectors can be improved as well as participate in the coordination of sector and other broad mechanisms for country support.

As a result of UN reform, and the need for better coordination across multilateral agencies, it is now the norm to have integrated work plans and budgets among agencies. UN Country Teams are required to use a human rights-based approach to support country analysis, advocate for priorities and prepare their UN Development Assistance Framework.[235] This mandate provides a platform for recognizing explicitly that people with mental health conditions are a vulnerable group and ensuring that they are included in their projects and programmes. The UN Resident Coordinator at country level can take the lead to ensure this action is implemented, and integrated work plans and budgets among UN agencies can further facilitate coordination across organizations.

# Conclusion

Many people with mental health conditions, as well as their families and caregivers, experience the consequences of vulnerability on a daily basis. Stigma, abuse, and exclusion are all-too-common. Although their vulnerability is not inevitable, but rather brought about by their social environments, over time it leads to a range of adverse outcomes, including poverty, poor health, and premature death.

Because they are highly vulnerable and are barely noticed – except to be stigmatized and deprived of their rights – it is crucial that people with mental health conditions are recognized and targeted for development interventions. The case for their inclusion is compelling. People with mental health conditions meet vulnerability criteria: they experience severe stigma and discrimination; they are more likely to be subjected to abuse and violence than the general population; they encounter barriers to exercising their civil and political rights, and participating fully in society; they lack access to health and social services, and services during emergencies; they encounter restrictions to education; and they are excluded from income-generating and employment opportunities. As a cumulative result of these factors, people with mental health conditions are at heightened risk for premature death and disability. Mental health conditions also are highly prevalent among people living in poverty, prisoners, people living with HIV/AIDS, people in emergency settings, and other vulnerable groups.

Attention from development stakeholders is needed urgently so that the downward-spiral of ever-greater vulnerability and marginalization is stopped, and instead, people with mental health conditions can contribute meaningfully to their countries' development.

As a starting point, development stakeholders can consider carefully the general principles for action outlined in this report, and decide how best to incorporate them into their specific areas of work. Targeted policies, strategies, and interventions for reaching people with mental health conditions then should be developed, and mental health interventions should be mainstreamed into broader national development and poverty reduction policies, strategies, and interventions. To make implementation a reality, adequate funds must be dedicated to mental health interventions, and recipients of development aid should be encouraged to address the needs of people with mental health conditions as part of their development work. At country level, people with mental health conditions should be sought and supported to participate in development opportunities in their communities.

Specific areas for action address the social and economic factors leading to vulnerability. Mental health services should be provided in primary care settings and integrated with general health services. To that end, mental health issues should

be mainstreamed in countries' broader health policies, plans, and human resource development, as well as recognized as an important issue to consider in global and multisectoral efforts, such as the International Health Partnership,[184] the Global Health Workforce Alliance,[185] and the Health Metrics Network.[186] During and after emergencies, development stakeholders should promote the (re)construction of community-based mental health services, which can serve the population long beyond the immediate aftermath of the emergency. Development strategies and plans should also encourage strong links between health/mental health services, housing, and other social services. Access to education for people with mental health conditions, as well as early childhood programmes for vulnerable groups should be supported by development stakeholders in order to achieve better development outcomes. People with mental health conditions should be included in employment and income generating programmes to assist with poverty alleviation, improved autonomy and mental health. Throughout their different areas of work, development stakeholders can and should support human rights protections for people with mental health conditions and build their capacity to participate in public affairs.

This report provides a number of recommendations and specific areas for action that need to be integrated into policy, planning, and implementation by development stakeholders according to their role and strategic advantage. To achieve this aim development stakeholders need to recognize people with mental health conditions as a vulnerable group requiring support from development programmes.

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**PEOPLE WITH MENTAL HEALTH CONDITIONS** have been excluded from the development agenda despite being a marginalized and vulnerable group in countries all over the world. The report, *Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group* highlights the urgent need to redress this situation. It presents compelling evidence that people with mental health conditions meet major criteria for vulnerability and yet fall through the cracks of development aid and government attention. It makes the case for reaching out to this vulnerable group through the design and implementation of appropriate policies and programmes and through the inclusion of mental health interventions into broader poverty reduction and development strategies. It also describes a number of key interventions which can provide a starting point for these efforts. This report is a call to action to all development stakeholders – multilateral agencies, bilateral agencies, global partnerships, private foundations, academic and research institutions, governments and civil society – to focus their attention on mental health. By investing in people with mental health conditions, development outcomes can be improved.



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