World mental health report

Transforming mental health for all

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5.3 Financing for mental health

Strengthening information, evidence and understanding can only go so far in facilitating mental health reform. To transform mental health services, plans and policies must be translated into action through financing that allocates resources as and where they are needed. Adequate financing provides the basis for establishing administration and governance mechanisms, developing and deploying a trained workforce and installing relevant infrastructure and technology to scale up delivery of sustainable mental health services.

Achieving adequate financing requires policy-makers and planners to devote more funds for mental health, either by getting additional resources from the state treasury or external funders, or by redistributing resources towards mental health, both within the health budget as well as across government (for example in education budgets).

Either way, budgetary restrictions and human resource constraints invariably limit what is possible. Achieving UHC requires rational and carefully considered decisions about where, how and to whom health services should be provided. In all contexts, in-depth processes to weigh up needs, resources, evidence of impact and models of intervention can help ensure that resources are allocated, and services provided, appropriately and efficiently.

Financial constraints have led to some highly innovative solutions that use minimal resources but achieve important outcomes. Such innovations, borne of necessity, may be the most favourable option in LMICs; they may also provide models that are appropriate for high-income countries. For example, both Problem Management Plus and the Friendship Bench involve brief, simplified versions of psychological interventions that were originally developed for LMIC communities but which have now been adapted for use in New York (see section 7.1.4 Scaling up care for people with common conditions) *(284, 285)*.

Mental health services generally rely entirely on health and social care budgets for resources. Resource allocation tends to follow historical convention rather than being based on ongoing evaluation of need. Budgets are usually refocused only when health care is being reformed.

There are ways that countries can increase the efficiency and equity of existing resources for mental health services, including by deinstitutionalizing mental health care and by tackling any misuse of resources. Nonetheless, no country will be able to meet the mental health needs of their populations without mobilizing additional funds and human resources and allocating increased amounts for mental health.

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Most funding for mental health should come from domestic sources, to ensure sustainability *(219)*. But there is a role for external funders, for example through direct assistance, foreign direct investment, corporate social responsibility or philanthropy *(286)*.

CASE STUDY

BOX 5.7

Peru: innovative financing for sustainable improvement

Since 2013, a process of mental health reform in Peru has been closing the care gap for people in need. The reform is focused on shifting care for mental health conditions from specialized psychiatric hospitals to community-based care. Analysis suggests that the reform has supported a gradual but significant expansion in mental health services: in 2009, 9% of people who needed care were covered; by 2018 this figure had risen to 26%.

The successful mental health reform in Peru would not have been possible without an innovative financing model to mobilize new resources and leverage existing funding streams for mental health. In 2014, the Ministry of Economy and Finance approved a ten-year results-based budget exclusively to support community-based mental health services.

By 2020, the number of community mental health centres in the county had grown ninefold (see Box 7.13 Peru: comprehensive community-based mental health care).

Mental health services were included as part of the benefits package offered under Peru's national health insurance scheme, which marked a crucial step towards achieving mental health parity in the health system. This was complemented by a revised reimbursement fee schedule to cover the costs of service provision at community mental health facilities and specialized psychiatric hospitals.

Combined, these measures helped reduce individuals' out-of-pocket payments for mental health services by a third from 2013 to 2016.

Sources: MINSA, 2019 *(287)*; APEC, 2020 *(288)*.

5.3.1 Increasing resources from domestic sources for mental health

Domestic finance for mental health services can be mobilized by advocating for funds from the state treasury; or by reallocating resources within the health budget. Either way, experience shows that when countries commit to funding mental health services themselves, transforming mental health care is possible (see Box 5.7 Peru: innovative financing for sustainable improvement).

Sourcing additional finance for mental health from the central resource pool through ministries of finance or planning is attractive in that it does not take funding from other areas of health. But any request for additional funds from the treasury also has to compete with requests from other ministries, as well as from a wide range of other organizations needing government assistance.

As countries continue to orientate and finance the move towards UHC, it is vital that mental health is incorporated into sector-wide plans for responsive and resilient health systems. The introduction of new social health insurance schemes or other health financing reforms needed for UHC provide key opportunities for mental health to be “hard wired” from inception. Beyond the health sector, mental health should be fully considered as an emerging development priority since it is linked to poverty, social inequalities, migration, and other key concerns (see section 4.3 Enabling social and economic development). In this way, mental health can be brought into development strategies that inform treasury decisions, such as medium-term budgetary frameworks.

An alternative approach is to reallocate resources within the health budget to increase the proportion that goes to mental health. Constraints related to budgetary limits and competing priorities still apply. Beyond mental health, governments have to decide how much to spend on communicable diseases, NCDs, and maternal and child health, among other health needs. Each of these areas of health may have valid and persuasive arguments for keeping their current budgets or even increasing them. Governments also have to decide how much of the health budget should be spent on primary care services, hospitals, specialized services, and prevention and promotion, all of which include mental health.

As countries continue to cope with the economic consequences of COVID-19, government budgets all over the world are under severe strain. The competition for resources is likely to be as strong as ever, while the need to rapidly scale-up mental health support for affected populations is immense (see Chapter 2, In focus: COVID-19 and mental health).

Expert opinion is divided on how much of the health budget should be allocated to mental health, with various proposals about which criteria should be used to set health priorities *(289)*. Feasibility, affordability, cost–effectiveness, human rights and equity are all important considerations. There is also the need to understand broad health care financing contexts, tie budgets to nationally-agreed mental health goals and targets and use financing as a tool to introduce innovations and facilitate mental health reform *(284)*.

Whether or not countries adopt a specific target percentage of the health budget to spend on mental health, the road to UHC requires sufficient resources to make quality affordable care equally accessible for physical and mental health care. This requires all sectors, not just health, to allocate resources to mental health. For example, people with mental health conditions should have access to comprehensive support and employment programmes run by social development and labour ministries.

TOOL

BOX 5.8

Health4Life Fund on NCDs and mental health

Health4Life Fund is a UN-wide multi-partner trust fund devoted to NCDs and mental health that was established in 2021 under the auspices of the United Nations Inter Agency NCD Task Force.

It is designed to support LMICs with catalytic grants, in order to stimulate multi-stakeholder and cross-sectoral action at country level, increase domestic funding, and improve policies, legislation and regulation.

H4LF seeks to enable governments and civil society to address national priorities and achieve scale for innovative actions that strengthen the health system. This includes implementing recommended interventions for preventing and managing NCDs and mental health conditions across the life-course while enhancing a broader multisectoral response to underlying social and structural determinants.

Source: WHO, 2021 *(290)*.

5.3.2 External investors in mental health

Even if countries scale up domestic finance for mental health services, external investors still have an important role, for example, in sourcing catalytic funds (see Box 5.8 Health4Life Fund on NCDs and mental health).

External resources are particularly important in low-income countries, where budgetary pressures are often greatest. In these countries, a large and complex ecosystem of external investors exists across the public, private and third sectors, including aid agencies, development banks, corporations, small- and medium-sized enterprises, nongovernmental organization, corporations and private foundations.

External resources may also be important for middle-income countries, especially as they scale down institutional care and temporarily require a “double budget” to build up community mental health services.

In many cases, external funding can successfully catalyse positive change (see Box 5.9 Pakistan: harnessing donor funding to spark change). But although the level of external investment in mental health has risen since 2000, its contribution remains limited. Mental health attracts very little donor funding. *(291)*. Philanthropic contributions are particularly important in funding mental health improvements in LMICs, but these are still marginal compared with external investment in other areas of health *(292)*.

CASE STUDY

BOX 5.9

Pakistan: harnessing donor funding to spark change

Using a series of external grants since 2014, Interactive Research and Development in Pakistan has established and scaled up the *Pursukoon Zindagi* (Peaceful Life) programme to increase access to mental health services in low-resource communities.

The programme combines community engagement and capacity building activities to increase awareness of mental health conditions and services. Its lay counsellors also provide brief community-based psychological treatment, or referrals. From 2018, the programme started integrating its services within some primary care networks, as well as within specific disease programmes for TB, HIV, lung health and diabetes.

By December 2019, the programme reported that it had screened more than 100 000 people for anxiety and depression; and given free mental health counselling to more than 9 000 people. It now operates in 19 primary care centres, with more than 140 lay counsellors trained and deployed in communities. It plans to extend the model to three additional primary care providers with a combined network of 75 clinics in Karachi.

When the programme started, lay counsellors were grant funded; but after the programme's success the primary care facilities covered staff costs, so ensuring sustainability.

During COVID-19, the programme has also trained lay counsellors to provide mental health services through proactive calls to people tested for COVID-19; has organized support groups for frontline workers; and a crisis helpline for anyone suffering from anxiety or depression. The programme trained at least 25 health workers to provide integrated physical and mental health care remotely; and supported more than 20 000 people.

Sources: MHIN, 2021 *(293)*; Innovations in Healthcare, 2021 *(294)*.

5.4 Competencies and human resources

Alongside evidence, understanding and funding, widespread competencies in mental health are a vital component of a well-functioning mental health system. In tiered systems of care, diverse providers adopt different but complementary roles that use resources efficiently and make care more widely available. This means that competencies in mental health need to be achieved and maintained by care providers at each tier, ranging from individuals and community providers to general and specialist health care workers (see Fig. 5.4).

Mental health staff working in psychiatric hospitals may have to learn how to work in community-based settings. At the same time, primary care staff will have to develop new skills in detecting mental health conditions and providing care. A broad range of providers who are not mental health specialists, including community workers, lay volunteers, teachers, police officers and prison staff, similarly need specific skills to deliver basic mental health interventions *(295)*. Providers in all settings, including both mental health specialists and non-specialists, need to develop competencies to effectively support the social inclusion of people living with mental health conditions and ensure rights-based, person-centred, recovery-oriented care and support.

Beyond the mental health workforce, everyone in the community has a role in reducing the treatment gap by developing their individual skills and competencies in understanding and looking after their mental health, including managing their own mental health conditions where possible.

In comprehensive care systems, evidence shows that task-sharing can improve health and social outcomes for people living with mental health conditions, especially in LMICs *(296)*. Task-sharing is also cost–effective. One modelling study in KwaZulu-Natal, South Africa, concluded that task-sharing with competent non-specialists could substantially reduce the number of health care providers needed to close mental health care gaps at primary level, at minimal additional cost *(297)*.

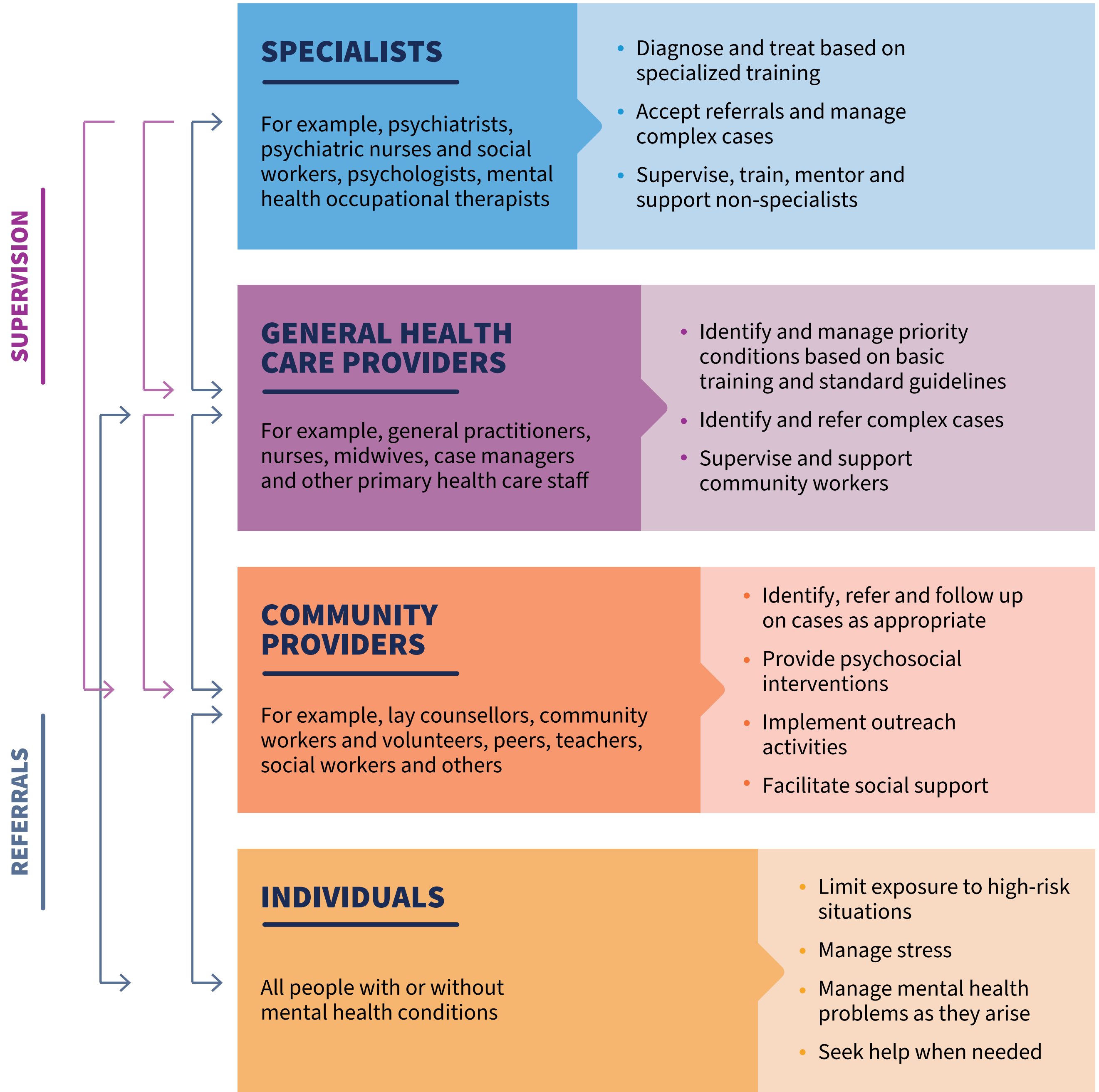
Task-sharing can improve health and social outcomes for people living with mental health conditions, especially in LMICs.

Researchers suggest that task-sharing works best when practitioners:

- belong to the same community as the people served and adapt treatment to incorporate local cultural aspects and beliefs (cultural competency);
- are supervised and have completed basic training in relevant skills to deliver the intervention, either full- or part-time;
- combine psychological and social components of care; and
- have trainers and supervisors who follow a structured supervision protocol to assure quality, as well as providing mentoring, guidance and support *(15)*.

FIG. 5.4

Tiered care allocates different but complementary tasks to workers at different levels of the health system



Source: Ryan et al, 2019 *(134)*.

5.4.1 Expanding the specialist workforce

A competent specialist workforce forms the backbone of any mental health system. As described in Chapter 3 World mental health today, the lower the income of countries, the fewer the mental health specialists. In LMICs, mental health systems – particularly services for children and adolescents – are grossly understaffed. The shortage is partly because in LMICs there are too few health specialists overall. Other contributing factors include the stigma associated with working in mental health and a lack of training opportunities *(298)*. Professional isolation, poor remuneration and job dissatisfaction, for example, all help drive high levels of emigration among psychiatrists from LMICs *(299)*.

The specialist workforce that does exist is often unequally distributed, with most staff concentrated in cities and large institutions, and too few in rural areas. This lack and imbalance of trained personnel is a huge barrier to care and puts services out of reach for many people, especially when a large proportion of specialists work in private practice, which in many countries is not covered by health insurance.

Most specialists are clinicians at heart, motivated by providing care to those experiencing mental health conditions. But if they are to help transform mental health systems, they must also deploy diverse competencies. They must work as experts within multidisciplinary teams; as teachers strengthening the skills of students and other staff; as supervisors and mentors to general health care and community providers who are task-sharing on mental health; as researchers contributing to the evidence base on mental health; as public health specialists developing service infrastructure; and as advocates increasing awareness around key issues *(300)*.

They must also be able to work with diverse populations to assure that care is equitable for racial and ethnic minorities, LGBTIQ+ persons, migrants and refugees, and persons experiencing poverty and homelessness. The risk of not recognizing mental health conditions or misdiagnosing them is greater with these populations.

> *Specialist health professionals have multiple roles and so require diverse competencies.*

Many countries do not have training programmes for psychiatry, clinical psychology and mental health nursing. Even fewer have training programmes in child psychiatry or child mental health. In some cases, cooperation with universities in high-income countries can offer a potential solution to these challenges (see Box 5.10 The Toronto Addis Ababa Psychiatry Project (TAAPP)).

In all cases, it takes time and substantial resources to train and deploy mental health specialists. But since they are urgently needed to develop and support nationwide networks of community-based care, innovative and flexible training may be necessary. Some countries have found alternative routes by introducing new cadres of mental health professionals who can substitute for psychiatrists, clinical psychologists or psychiatric nurses, especially in rural areas where the gap in expertise is often most severe (see Box 5.11 Innovations in human resources to develop specialist expertise). These innovations in human resources have proved critical for the nationwide development of a functioning mental health system and serve as potential examples to other countries.

CASE STUDY

BOX 5.10

The Toronto Addis Ababa Psychiatry Project (TAAPP)

The TAAPP is an educational collaboration between Addis Ababa University and the University of Toronto set up to help Ethiopia's newly established psychiatry residency programme. It was designed to supplement the department of psychiatry at Addis Ababa University with external expertise, helping the department to teach, provide clinical supervision, and develop educational capacity.

Established in 2003, the TAAPP involves various faculty and staff from University of Toronto travelling to Addis Ababa to teach a jointly-set curriculum. At the same time, selected faculty from Addis Ababa University are invited to complete year-long clinical fellowships at a hospital in Toronto.

A total of 100 Ethiopian psychiatrists have been trained with the help of TAAPP, bringing the number of psychiatrists in Ethiopia up to 113. The TAAPP programme has recognized that medical faculty staff need not only clinical competencies but also educational capabilities. So the programme has focused on building teaching and training skills among Ethiopia's mental health professionals.

Since TAAPP began, eight new departments of psychiatry have opened outside Addis Ababa; and four new psychiatry residency programmes have been established across the country. Mental health services are also now being integrated into all levels of the national care system.

Sources: Wondimagegn et al, 2021 *(301)*; University of Toronto, 2021 *(302)*.

Expanding the specialist workforce also relies on attracting more people to enter mental health as a profession, retaining them once they are qualified, and ensuring they are equitably distributed across a country. Improving recruitment and retention requires, among other things, action to:

- **tackle stigma** and promote positive attitudes towards mental health as a profession, for example by marketing it as a challenging and rewarding area of the health sector;
- **support ongoing education** by providing opportunities for skills development and knowledge exchange; and
- **enable career progression** by, for example, developing a promotion strategy for staff, providing opportunities for personal growth and professional development and fostering motivation.

Improving remuneration, using flexible job descriptions, and improving social ties among staff can also help retain mental health staff. In all cases, salaries and working conditions for mental health workers should be comparable to those of other health workers.

CASE STUDY

BOX 5.11

Innovations in human resources to develop specialist expertise

Experiences from three low- and lower-middle-income countries show how innovations in human resources can expand specialist expertise, and so support the development of a functioning mental health system that extends nationwide, including hard-to-reach rural areas.

Bhutan. In 2015, Bhutan introduced a four-year undergraduate degree clinical counselling course. As a result of this initiative, more than half of the 30 district and general hospitals now have clinical counsellors on staff. Their main responsibility is identifying common conditions – such as depression, alcohol and substance use disorder, and self-harm – and managing these through psychoeducation and psychological counselling. Clinical counsellors work closely with district doctors and nurses to support any person who is on psychotropic medications and refer or follow up as necessary.

Liberia. Starting in 2010, in partnership with the Carter Center's Mental Health Program, Liberia has trained 306 primary health workers (registered nurses, physician assistants and midwives) in mental health through a six-month training programme. These include 166 specialists in general mental health care and 140 specialists in child and adolescent mental health care. with a focus on practical application. Graduates are known as Mental Health Clinicians and are licensed by the Liberian Board of Nursery and Midwifery to practice independently. While many do not work full time on mental health, most work in health care settings across the country and treat people with mental, neurological and substance use conditions.

Sri Lanka. Over the past 20 years in Sri Lanka, various training programmes have been launched for medical professionals, including a one-year diploma in psychiatry for doctors and a one-year diploma in basic mental health nursing. The government also created the position of Medical Officer of Mental Health (MOMH), which acts as a district focal point for mental health. Each MOMH receives three months of pre-service training in mental health after having completed their first medical degree. In many districts, the psychiatry diploma holders and MOMHs work under the supervision of Colombo-based psychiatrists and in effect lead and scale up mental health care in districts. Their role has been instrumental in ensuring that mental health care is available in all districts of the country (see Fig. 5.2).

Sources: Chencho Dorji, WHO, personal communication, 25 January 2022; Gwaikolo et al, 2017 *(303)*; Fernando et al, 2017 *(304)*.

5.4.2 Strengthening general health care providers' competencies

General health care providers have a major role in enabling comprehensive mental health services and scaling up mental health care, especially where mental health specialists are rare. In Chile, for example, the National Depression Detection and Treatment Programme scaled up mental health services through the primary care system *(271)*. Introduced in 2001, the programme now encompasses more than 500 primary care centres throughout the country, each of which hosts a general clinical team made up of primary care doctors, nurses and auxiliary nurses, with individual therapy and supervision by a specialist for the most severe cases.

Scaling up mental health care through general health providers means equipping them with the skills to detect mental health conditions, provide basic care, and refer people to specialized care where necessary (*305*). For individuals, receiving mental health care from competent and compassionate general health care providers can be very rewarding (read Anders' experience).

In practice, strengthening the skills of primary care doctors, clinical officers, nurses and other general health workers means training followed by ongoing supervision, mentoring and support.

Quality training of general health care providers in mental health care should be part of pre-service education. Compared with in-service training, pre-service training is more sustainable because

NARRATIVE

My GPs were my saviours

Anders' experience

Without the direct intervention of my general practitioners (GP) at critical stages of my life, my mental health problems could have been more serious. For 15 years, I have seen mental health professionals. Every appointment saw me talking to a different person, repeating my case history time and time again and receiving at best, a medicine review – so frustrating and lacking any obvious desire to give me a good quality of life.

My experience with the GP service couldn't be more different. Over time, I found two GPs who truly listened to my needs, who gave me the time I needed to explain my status and who took extraordinary steps to make sure my needs were met.

Their dedication, kindness and compassion has helped me time and again over the past few years. In late 2019, when I was severely ill with depression and thinking about suicide a lot, it was my GP, not my psychiatrist, that gave me the kind of help I needed at the time and my health started to improve. He was my saviour.

I really don't know if I would be alive today without the beautiful support of my GPs.

Anders Timms, United Kingdom

its organization is integrated in teaching curricula and is typically less costly per trainee. Trainees' motivation is often relatively high because pre-service training – unlike most in-service training – is evaluated through examinations that must be passed. Yet in many countries any mental health training provided during medical or professional schooling is brief and mostly theoretical, while clinical internships are too often limited to rotations in psychiatric hospitals that do not reflect clinical practice within general health care *(306)*.

Quality training of general health care providers in mental health care should be part of pre-service education.

Despite the strategic value of investing in mental health pre-service training, there is an urgent need to train the existing general health workforce, whether face to face, online or through a combination of both. Such training should be used to familiarize trainees with clinical assessment and management of priority mental health conditions. The training should also reduce stigma and discrimination in health care. This can be done by giving people with mental health conditions co-facilitation roles during training *(210)*. In all cases, training should include supervised practice in general health care settings.

It is important to build confidence of general health care providers in psychosocial approaches, which are a necessary part of holistic mental health care, but which are often not prominent in primary health care. Many general health care providers feel more familiar and comfortable with a purely biomedical approach in which a diagnosis is followed with medication or another biomedical intervention (for example surgery or dialysis). But psychotropic medication is not the first line of treatment for many mental health conditions.

Moreover, even when psychotropic medicines are indicated, general health care providers need to understand how to provide or arrange for psychosocial support alongside medications.

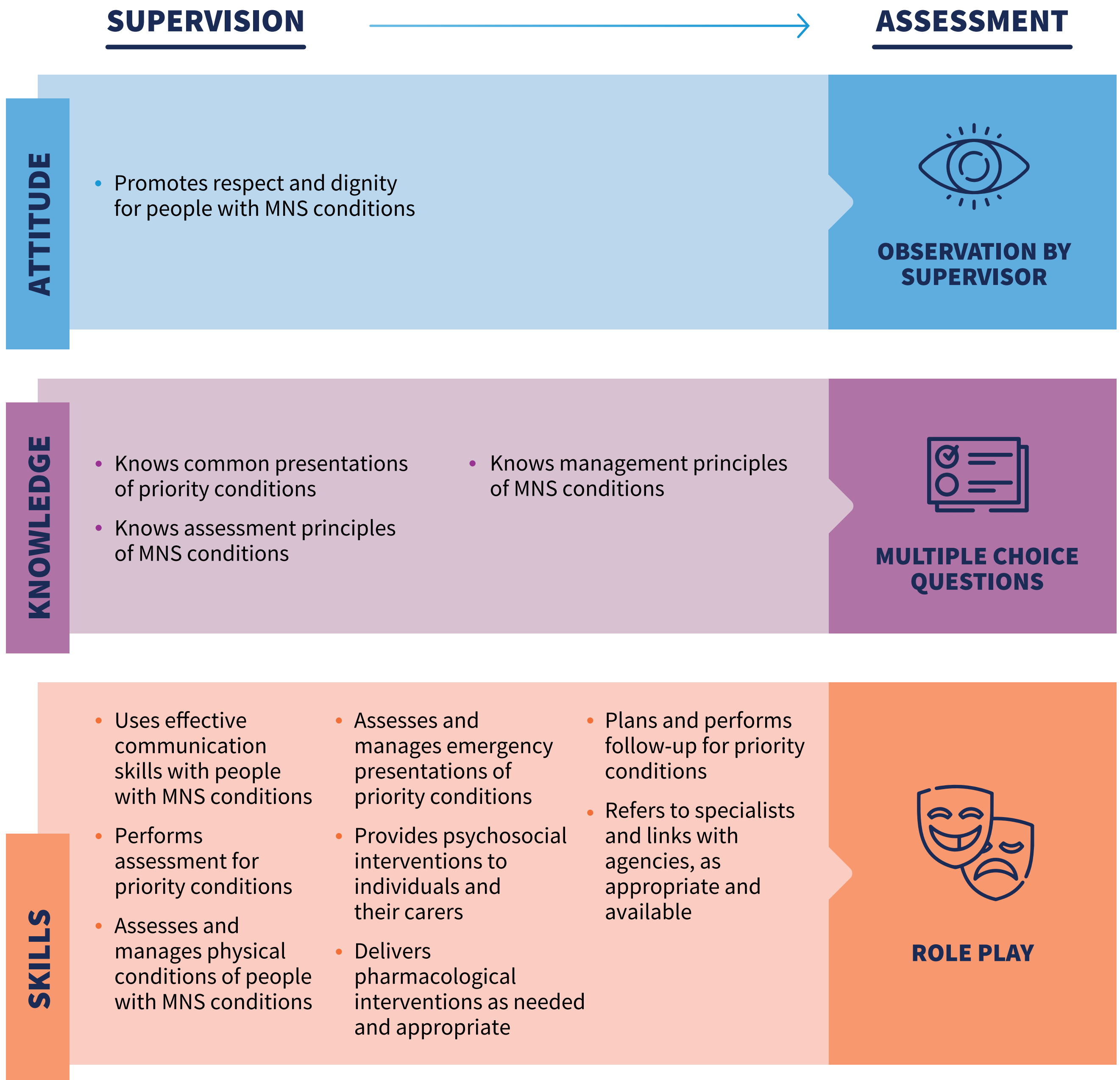
Although most primary health care providers may have too limited time to personally deliver multi-session psychological treatments for depression or anxiety, they should appreciate the relative value of such care and link, where available, to relevant providers, whether specialist or community providers skilled in psychological counselling. In addition, all primary health care providers can make time to encourage and guide people to use evidence-based self-help books or digital self-help interventions as part of depression and anxiety management (see section 7.1.4 Scaling up care for people with common conditions: self-help and In focus: Harnessing digital technologies for mental health).

To help countries implement training, supervision and support for general health care workers, WHO's mhGAP has developed a set of task-sharing training packages and implementation tools *(307)*. These are designed to teach 12 core competencies relevant to assessing, managing and following up people with depression, psychoses, epilepsy, child and adolescent mental and behavioural disorders, dementia, disorders due to substance use, and self-harming or suicidal thoughts or behaviours (see Fig. 5.5). All mhGAP training is designed to be followed up with ongoing supervision and support.

Since it was introduced in 2010, mhGAP training and supervision has been carried out in more than 100 countries, helping to improve competencies in, and access to, mental health care all over the world *(308)*. This is important as a global review of short mental health training that is based on WHO guidelines found that such training improves knowledge attitudes, skills and confidence among a wide range of general health care providers, including community health care workers, trained doctors, nurses, counsellors, paramedics and other non-medical staff *(309)*. These changes lead to improved clinical practice with better outcomes.

FIG. 5.5

Core competencies targeted by the mhGAP training of health care providers



Source: WHO, 2017 *(307)*. Note: MNS = mental health, neurological and substance use.

5.4.3 Equipping community providers with mental health care competencies

Comprehensive mental health care extends beyond health professionals to include other care providers based in the community. These potentially include people with lived experience, lay volunteers, community workers, coordinators of user groups, religious counsellors, teachers, hairdressers, lawyers, police officials, prison guards and family and friends among others.

These providers, who are not mental health specialists, are often acceptable to users because they tend to have a more direct knowledge of local attitudes, customs and languages. This makes them well placed to identify and provide timely, culturally-appropriate first-line care. They can also help access support across social, education and justice spheres. And they can provide a source of practical and emotional help with the activities of daily living in the community. Community providers also have a role in delivering preventive and promotive services and in providing crisis support to individuals and families in distress.

People with lived experience can be important first line providers of support.

Given the diversity in potential tasks fulfilled by community providers, training for this group can vary significantly *(310)*. Emergency field workers need to be oriented in the principles of psychological first aid *(311)*. Caregivers need to be equipped with skills to support children with mental health conditions or behavioural problems. Community health workers need to be at the very least trained in identifying people with mental health conditions and referring them, where necessary, to the relevant level of care (see section 7.1.4 Scaling up care for people with common conditions: non-specialist counselling). All providers of mental health services, including community providers, need an understanding of human rights *(184)*.

Many community providers – including emergency workers and family caregivers – may face significant stress themselves. Training for these groups should also focus on strengthening competencies in self-care (see section 5.4.4 Competencies for self-care).

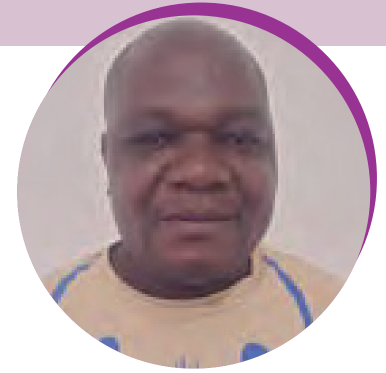
People with lived experience will also need to be prepared to support others *(312)*. Peer experts are living proof that recovery is possible; and they have a vital role in supporting other people with mental health conditions in their recovery journey (read Benjamin's experience). Peer experts in mental health also have a role within support groups for other health conditions, such as HIV, NTDs or Zika. In these cases, acknowledging and building skills in how to address emotional elements of the group members' needs is a good way of integrating mental health support.

Peer expertise, informed by the experience of mental ill-health, can be regarded as a third domain of expertise in mental health care, in addition to scientific evidence and practical knowledge and skills *(313)*. Becoming a peer expert comprises a three-step process *(313)*. It begins with the lived experience of suffering and recovering from a mental health condition. Reflection on this experience – including analysis and learning about the experience of others – turns lived experience into peer knowledge, or knowledge by experience. The third step is training in skills and attitudes to become a designated peer expert. From then on, as for all care providers, an ongoing learning process through practice is required to deepen peer experts' competencies.

All types of care providers, including community providers, can play a key role in scaling up care for depression and anxiety through psychological interventions; but their competencies should be ensured (see Box 5.12 EQUIP: Assessing and building competencies for psychological interventions). Experience shows that integrating community providers in teams with mental health professionals using a task-sharing approach can also help support people with severe conditions such as schizophrenia (see section 7.3.3 Psychosocial rehabilitation).

NARRATIVE

We can all contribute meaningfully to the world



Benjamin's experience

I became depressed as a child at the age of 14 growing up in the rural north of Liberia. The first line of treatment was traditional medicine and I was taken to a traditional healer in Guinea who reduced my anxiety by giving me traditional medicine. This helped to stabilize me to continue my secondary education and become a high school graduate.

A few years later, I relapsed. Again I was treated by faith-based healers but this time, it did not help. For many years both me and my parents struggled with my mental health. Eventually, my older brother took me to a mental health treatment facility.

I started receiving medication and it has helped me a lot. It enabled me to complete my university studies and now I work as a school teacher. I have a wife, we are blessed with three boys and I am living happily and doing great.

I am the national Secretary for the Cultivation for Users' Hope (CFUH), which is the only organization established and run by health service users in Liberia. We work in the interest of people living with mental health conditions through advocacy, capacity building, empowerment and stigma reduction.

If people with psychosocial disabilities receive the attention and services they need and are treated with respect, they too can contribute meaningfully to the world and societies at large.

Benjamin Ballah, Liberia

TOOL

BOX 5.12

EQUIP: Assessing and building competencies for psychological interventions

Research has repeatedly shown that people who are not mental health specialists can effectively provide brief psychological interventions, based on established psychotherapies, such as CBT and IPT, as long as they are trained and supervised.

But how can governments or any other stakeholder know whether these care providers deliver competent care, given that they are not licensed by professional organizations? Ensuring Quality in Psychological Support (EQUIP) is a WHO initiative to assess and build competencies for a range of interventions.

EQUIP develops and disseminates competency-based training materials and guidance and competency assessment tools. As such, EQUIP offers a mechanism to ensure and improve quality. EQUIP resources have been field tested in Ethiopia, Jordan, Kenya, Lebanon, Nepal, Peru, Uganda and Zambia and are available through an on-line platform (https://whoequip.org/en-gb). The EQUIP platform has been used for competency-driven training in psychological interventions for non-specialists, in mhGAP training for primary care workers, and in basic skills training for teachers, nurses, and community health workers.

It has been proven that use of EQUIP reduces harmful behaviour and increases competencies of trainees compared to conventional training methods.

Sources: Singla et al, 2017 *(314)*; Kohrt et al, 2020 *(315)*; Kohrt et al, 2015 *(316)*.

5.4.4 Competencies for self-care

Boosting competencies to enable a transformation in mental health care is not simply about expanding the workforce for delivering services; it is also about strengthening individuals' skills in self-care.

In WHO's optimal mix of mental health services, self-care provides a base for mental health care that, when combined with community-based mental health care, will meet the mental health needs of a population *(317)*.

Self-care is important to people. A recent survey across 113 countries found that among people with self-reported anxiety or depression, the most-endorsed methods for feeling better were improving healthy lifestyle behaviours, spending time in nature or outdoors and talking to friends or family *(150)*.

For self-care, all people should, as far as possible, know how to *(318)*:

- limit exposure to 'high risk' situations that may adversely impact mental health;
- manage stress;
- discuss and manage mental health problems as they arise; and
- seek help when it's needed.

For people living with mental health conditions, self-care also requires skills and confidence to manage one's own mental health conditions

NARRATIVE

I play an active role in my recovery

Tamira's experience

My experience with our health care system highlighted the importance of a holistic approach to well-being that incorporates physical, mental and emotional health: and how difficult it is to be well in the absence of health in any of these categories.

My drive for holistic well-being was fuelled in part by the words 'apprehension' and 'detention' on my Form 1 (the form that a physician submits to authorize involuntary admission to a psychiatric facility for up to 72 hours). This language made me feel incredibly inferior and showed me how little our mental health care system attempts to disguise the atrocities of what passes for 'care'. It set me on a search for recovery outside the formal system.

My search for answers to support my mental health included researching eastern, naturopathic and functional medicine. I also looked to exercise, religion, spirituality, meditation and mindfulness and forms of positive psychology. I found being outdoors and in nature was a great support tool.

I also looked inside myself, reflecting on my life, my values and my purpose. And I explored communities, online via blogs and social media, which I then used as a tool to find my voice and share my experiences.

I'm not prepared to say I have 'recovered'. And I recognize that some avenues of my search have been more fruitful than others. But what I've learned is that for myself and my mental health nothing is more valuable than the belief that I have the power within me to change myself. Consent is still not considered necessary in our mental health care system; but now I have the power not to give the system consent to make me feel inferior.

Tamira Loewen, Canada

outside of formal services (read Tamira's experience). That might be achieved by oneself, or with the help of family and friends (see section 7.1.1 Putting people first: recovery-oriented care). The development of self-care skills can start early. For example, from early childhood we learn from our parents how to deal with difficult emotions. Within schools, life skills training can teach emotional and social competencies such as emotional regulation, problem-solving, inter-personal skills and stress management (see section 6.3.2 Protecting and promoting child and adolescent health: school-based programmes).

For adults, self-care competencies are usually supported through self-help materials and interventions that draw on evidence-based psychological treatment principles (see section 7.1.4 Scaling up care for people with common conditions: self-help). Such materials can be provided in multiple formats, including one-to-one and group self-help interventions, facilitated or not. They can also be delivered through multiple media, including self-help books, audio-visual materials, and online or app-based interventions (see Box 5.13 Living with the times: a toolkit for older adults). In all cases, resources designed

CASE STUDY

BOX 5.13

Living with the times: a toolkit for older adults

Living with the Times is a psychosocial support toolkit designed to address the information and coping needs of older adults during the COVID-19 pandemic. As a high-risk group for severe disease and death from COVID-19, older adults have had to be especially cautious to avoid contracting it. Many have faced long periods of isolation and uncertainty.

The toolkit comprises a series of posters that address common concerns of older adults during the pandemic, such as how to stay healthy, how to lift one's mood, how to stay connected, how to seek help and how to cope with grief and loss.

Each poster combines illustrations and short texts for print or online use. Key messages require minimal reading skills, are culturally diverse and aim to engage older adults in conversations and activities. An accompanying manual shows carers how to use the posters in guided conversations to facilitate engagement.

The posters were tested with older adults from different countries and backgrounds. They have been widely translated and adapted in accessible formats for people with special needs. They have, for example, been used in Greece, Nigeria, Republic of Korea and Syria, where they have had a high degree of user acceptance.

Source: IASC, 2021 *(319)*.

to build self-care skills should be available in languages and literacy levels that enable as many people to understand them as possible.

The use of self-help materials can be integrated in clinical care (see section 7.1.4 Scaling up care for people with common conditions: self-help). For example, facilitators can guide people to use self-help materials. This is called guided self-help, and it has been repeatedly shown to be as effective as conventional face-to-face specialist interventions for depression and anxiety *(320)*. Guided self-help tools can be used to support people through the process of setting up a recovery plan for themselves *(321)*. They can also be rapidly deployed at scale, making them particularly promising for mental health transformation.

Recovery colleges

Recovery colleges involve supporting people living with mental health conditions through adult education rather than treatment. Their curricula may vary, from understanding different mental health issues and treatment options to exploring what recovery means and how family and friends can help support it (see section 7.1.1 Putting people first: recovery-oriented care). They often include courses focused on strengthening competencies for self-care and developing life skills and confidence to either rebuild life outside services or get the most out of services.

Guided self-help for depression and anxiety has been found to have comparable effects to face-to-face treatments.

A key feature of recovery colleges is that people with lived experience co-produce all aspects of the college, from curriculum development to course delivery and quality assessment. Studies show that recovery colleges can play an important role in decreasing the use of mental health services, suggesting that students develop improved agency and ability to manage their own mental health *(322)*. These colleges can also benefit staff with key outcomes including experiencing and valuing co-production, changed perceptions of service users and increased passion and job motivation *(323)*. At the societal level, recovery colleges provide opportunities to engage more people in learning alongside people with mental health conditions and tackle stigma through social contact.