World mental health report

Transforming mental health for all

3.4 Barriers to demand for care

In part, the extremely high unmet need for mental health care, even among people with severe mental health conditions, is due to a lack of demand for, or uptake of, services. This reluctance or inability to seek help can be explained by a variety of factors, from high cost, poor quality and limited accessibility, through to lack of knowledge about mental health, stigma and poor previous experiences with seeking help.

The sections that follow summarize some of the biggest barriers to demand for care worldwide.

3.4.1 Poor supply

There is a close relationship between demand and supply of mental health care. Each of the gaps described previously (gaps in information, governance, resources and services) compromise the supply of appropriate, good quality mental health care. Yet, the lack of quality mental health services available, especially at the primary and secondary levels of care, in turn suppresses demand.

In many places, formal mental health services simply do not exist. Even when they are available, they are often inaccessible. Concerns about location, cost, treatment and confidentiality can all drive up reluctance to seek help.

Locating services appropriately is key. In LMICs many mental health services are disproportionately concentrated in psychiatric hospitals in or near major cities. This means that rural populations often cannot or choose not to use them: the journey may be too expensive; the transportation systems may be too unreliable; and the time required may be too much.

Even for those living near mental health services, the cost of treatment can prove a major barrier to demand for mental health care. Two-thirds of low-income countries reporting to WHO in 2020 did not include mental health care in national health insurance schemes *(5)*. This means that people in need have to fund their care themselves, often spending significant and potentially impoverishing sums out of pocket. Research in Ethiopia, India, Nepal and Nigeria shows that spending money on mental health care significantly increases the likelihood of a household outspending its resources, which can lead to debt and poverty *(148)*. One study in Goa, India, showed that depressed women were three times more likely than other women to spend more than half their monthly household expenditure on out-of-pocket health care costs *(149)*.

Weak or low-quality care systems pose another barrier to demand. Negative past experiences with mental health services, distrust of health professionals and treatment and unwillingness to disclose mental health problems can all play a big part in preventing help-seeking. Many people, faced with the option of no care versus contacting services that may offer little help, may not be confidential, or may stigmatize or even mistreat them, choose to go untreated.

> **Two-thirds**
> of low-income countries did not include mental health in national health insurance schemes.

3.4.2 Low levels of health literacy about mental health

Low demand for mental health care can also be driven by low levels of health literacy

about mental health, including a lack of knowledge and understanding of mental health as well as prevailing beliefs and attitudes that undermine the value placed on mental health and effective mental health care.

When it comes to physical health, it is widely accepted that people need to appreciate and look after their own health, and that governments can help to inform and support people, for example by promoting physical activity, healthy diets and no tobacco and alcohol use. This approach is just as important for mental health.

A recent global survey by the Wellcome Trust found that most people around the world believe mental health is as or more important than physical health *(150)*. Yet the idea that mental health is something everyone needs to understand and nurture is not part of the common public discourse in most communities.

The reality is that most people may not have access to evidence-based information on opportunities that can promote their mental health. Meanwhile, pervasive negative attitudes continue to devalue and perpetuate discrimination against and abuse of people living with mental health conditions.

The above mentioned global survey shows that people are not sure science can help in addressing mental health issues *(150)*. In many cases, people do not recognize their own need for treatment (read Steven's experience).

Caregivers may not have access to tailored information to recognize mental health conditions in their children, especially when these manifest as stomachaches, headaches, irritability, frustration, anger, rapid mood changes and emotional outbursts, and destructive or challenging behaviour. General health care providers can also often miss these symptoms of mental health problems *(151)*.

Differences in beliefs across cultures influence help-seeking outside the formal health system, for example through traditional or complementary medicine or self-reliance *(152)*. All societies probably have terms and concepts to describe people with mental health conditions, but ideas about how or why these conditions arise vary markedly.

Similarly, the need to provide dedicated support for people with severe mental health conditions is widely acknowledged, but ideas about what that support should look like may not match prevailing evidence-based treatments. For example, in many cultural contexts, common mental health conditions such as depression and anxiety are not regarded as health conditions that can be helped through the formal health care system. Rather, these conditions are often expected to improve through social and emotional support from relatives or through religious, traditional or alternative and complementary healing methods *(153)*.

3.4.3 Stigma

One of the biggest barriers to demand for mental health care is the stigma associated with mental health conditions. All over the world, people living with mental health conditions are the subject of deep-rooted stigma and discrimination.

> *All over the world, people living with mental health conditions are the subject of deep-rooted stigma and discrimination.*

Society in general has stereotyped views about mental health conditions and how they affect people. People with mental health conditions are commonly assumed to be lazy, weak, unintelligent or difficult *(154)*. They are also often believed to be violent and dangerous, when in fact they are more at risk of being attacked or harming themselves than harming other people *(155)*. Women with

NARRATIVE

You can achieve anything

Steven's experience

My chronic anxiety started around 15 years ago, when I was studying for my law degree. I put a lot of pressure on myself to be a high achiever and set the bar so high it was at times unachievable. I had low self-worth.

My anxiety got so bad it was hard to get out of bed some days. It stayed with me as I trained to become a lawyer. I couldn't tell management of my mental health struggles. I felt that I would be perceived as "weak" and "not able to do my job" and I felt I'd lose the respect of my colleagues.

I didn't want to go to work anymore. I felt I was changing, becoming someone I didn't recognize or like. I tried to discuss it with my family but couldn't express how I was feeling in words. It still hurts today when I cast my mind back to this difficult period of my life.

Then I had a lightbulb moment. I reached out for support from a psychologist. It was a breath of fresh air. For the first time I felt somebody understood and didn't judge me. This lifted a huge weight off my shoulders.

The psychologist showed me how I could break things down which allowed me to cope better and not become so overwhelmed with life. I have used this advice in every aspect of my life, even today, running my own company promoting mental health awareness within business and law firms.

I still suffer with my anxiety and feelings of low self-worth. But I have learned to manage them and I am in a happy place with a good mindset. I have also been successful in what I do, which I believe is because I have lived experience and can relate to the needs of my clients.

I would like to advise anyone reading this to not let your mental health struggles define who you are. Do not feel pressured to perform or rush things: you are on your own path and you will achieve your dreams and goals in your own time.

Steven Lawlor, United Kingdom

severe mental health conditions are particularly at risk of sexual violence. Violence against people with mental health conditions can be deadly.

In many communities, mental health conditions are not considered to be health issues, but are seen as a weakness of character, a punishment for immoral behaviour or the result of illicit drug taking or supernatural forces. In all cases, the media can exacerbate misconceptions by portraying people with mental health conditions as dangerous, irresponsible or incapable of making rational decisions *(156)*.

The result is that people living with mental health conditions are often treated with fear, shame and contempt. For example, one survey in south-west Nigeria found that 97% of people believed people with mental health conditions were dangerous, 83% of people were afraid to talk to someone with a mental health condition and only 17% of people would consider marrying someone with a mental health condition *(157)*. In many cases, people with mental health conditions are also subject to human rights violations including isolation, incarceration and ill-treatment (see section 4.2 Promoting and protecting human rights).

The stigma attached to mental health conditions is universal, pervading across cultures and contexts in countries everywhere. People living with mental health conditions can experience stigma from families, neighbours, and from health professionals themselves *(158)*. In some cases, they can internalize negative messages and stereotypes and apply them to themselves in what is known as self-stigma. In many countries stigma extends to working in mental health care and can contribute to staff shortages in mental health systems *(158)*.

People will often choose to suffer mental distress without relief, rather than risk the discrimination and ostracization that comes with accessing mental health services (read Odireleng's experience). Yet with the right support, most people with severe mental health conditions can function at a very high social and economic level, maintaining excellent relationships and functioning well in employment.

NARRATIVE

Stigma stifled my recovery

Odireleng's experience

For the longest time I was afraid of speaking about my battle with mental health because of the stigma attached to it. My healing only began when I overcame the stigma and realized there is no shame in asking for help.

When I was diagnosed in 2014, I was very afraid, lonely and didn't believe that healing was possible. The single-sided story of bipolar illness that was narrated in my community focused only on the struggles it caused, rather than how to overcome them.

Even after diagnosis, I had a very difficult time and low self-esteem. But I remained hopeful and I made a pledge to myself to use the lessons I'd learned to help others. As part of my recovery I became a mental health advocate.

I am passionate about encouraging people to begin their healing by overcoming stigma and speaking up openly about their mental health condition. I strongly believe that it is possible to overcome the barrier of stigma and receive mental health care that enables you to lead a prosperous life.

Odireleng Kasale, Botswana

4

Benefits of change

PUBLIC HEALTH
HUMAN RIGHTS
SOCIAL AND ECONOMIC DEVELOPMENT

Chapter summary

In this chapter we make the case for investment in mental health, explaining how transforming mental health care provides a platform for advancing public health and well-being, protecting human rights and promoting social and economic development. This chapter showcases the benefits of change for individuals, families, communities and economies. And it makes clear how committing to mental health is an investment into a better life and future for all.

Key messages from this chapter are:

- Investing in mental health can greatly reduce suffering and advance public health.
- Transformation in mental health is needed to stop human rights violations that people with mental health conditions experience.
- Improving people's mental health improves educational outcomes and participation in the workforce, boosts productivity and strengthens social functioning to the benefit of all.
- Investing in mental health means investing in strategies to: ensure access to effective, quality, affordable mental health care for all; tackle stigma, discrimination and abuse; and address underlying social and economic realities that shape people's mental health.
- There is a core set of cost–effective interventions for priority mental health interventions that are feasible, affordable and appropriate.

The huge challenge posed by mental health conditions today calls for a transformation.

Rising interest in mental health over several decades has built international consensus for change and has created multiple options and opportunities for action, as described in the *Comprehensive mental health action plan 2013–2030 (3)*. Most recently, the COVID-19 pandemic put the value and vulnerability of mental health under the spotlight and exposed huge gaps in mental health systems and structures all over the world (see Chapter 2, In focus: COVID-19 and mental health). More policy-makers than ever understand the imperative for improvement and the appetite for change has never been greater.

As this chapter shows, the evidence available today makes a compelling case for change. The inextricable links between mental health and public health, human rights and socioeconomic development mean that transforming policy and practice in mental health can deliver real, substantive benefits for individuals, communities and countries everywhere. Investment into mental health is an investment into a better life and future for all.

4.1 Advancing public health

4.1.1 Reduced suffering and improved mental health and well-being

Investment and transformation in mental health is needed because good mental health is fundamental to any individual's health and well-being, including their capacity to live a fulfilling life. Conversely, experiencing a mental health condition is associated with mental suffering and, for too many people, social exclusion (read Zineb's experience).

Mental disorders affect one in eight people around the world and exact a high toll on public health (see Chapter 3 World mental health today). In 2019, they were the largest contributor to global non-fatal disease burden (measured as years lived with disability YLDs). People experiencing a mental health condition are a vastly underserved group. As such, their capacity to cope, connect, function and thrive is compromised; and they face a far greater risk of suicide and physical illness. People living with severe mental health conditions die 10–20 years earlier than the general population, most often through unrecognized and untreated physical health conditions.

Investing in mental health can greatly reduce suffering and improve the quality of life, social functioning and life expectancy of people with mental health conditions. It can both close the vast care gap that exists for mental health conditions and move significantly closer towards universal health coverage.

> *There is now more-than-adequate evidence upon which to act and invest, no matter the resource context.*

For decades, doubt has been cast on mental health interventions' effectiveness and on their collective ability to reduce public health burden, especially in LMICs. But there is now more-than-adequate evidence upon which to act and invest, no matter the resource context *(15, 159)*. For example, a modelling study focused on low-income countries showed that investing

NARRATIVE

We no longer have the capacity to bear

Zineb's experience

I am the mother of Mohammed, 27, who has had schizophrenia for ten years, and his big brother Younes, may God rest his soul, who was suffering from the same.

In 2015, Younes' condition deteriorated and he died. Mohammed was deeply affected by his brother's death and since then has also severely deteriorated. There has been constant delirium, non-acceptance of treatment and severe violence towards us. We felt forced to leave our house for him and we bought a simple apartment to shelter from his violence. We feel guilty that we left him alone, but we had to.

Mohammed has repeatedly tried to end his life and it nearly happened. His condition is getting worse day by day. We no longer have the capacity to bear.

We feel psychologically and physically destroyed. We and those like us are in dire need of assistance and facilities to save our children. We have endured the complexities of administrative procedures and expenses to no avail. There is no place in the public hospital, and the expenses of the private hospital are extremely high and we have no energy anymore.

I know Mohammed loves me so much but I live in fear of him. And now he has become depressed and lives in isolation and cannot face people.

Civil society is trying to help as much as possible. I have begun a training programme aimed at increasing the capacity of families to cope with a family member's illness, but my situation makes me unable to focus and absorb information.

A solution must be found for people to enjoy their right to care and rehabilitation so they can be part of society. This requires concerted efforts between relevant sectors and stakeholders. It is necessary and urgent.

Zineb, Morocco

just US$ 1 per capita annually in a package of evidence-based care for priority mental health conditions could reduce YLDs by close to 5 000 per million population each year *(160)*. For a more scaled-up package of care costing US$ 2 per capita, the burden of mental health conditions is reduced by 13 000 YLDs per million population. So, for a country with 50 million inhabitants, this modest annual investment of US$ 1–2 per capita cuts 250 000 to 650 000 years-worth of disability across the population.

Promote, protect, restore

In part, public health is about promoting and protecting mental and physical health by identifying the underlying factors that influence health – the individual, social and structural

determinants – and intervening to enhance protective factors or reduce risks. This public health function includes a wide range of activities that can be targeted at individuals, groups of vulnerable people or whole populations.

Interventions where the evidence and experience of mental health benefits are particularly compelling include:

- suicide prevention strategies;
- positive parenting and preschool education and enrichment programmes;
- school-based social and emotional learning programmes; and
- mental health promotion and protection in work settings.

For more information on, and real-world examples of, evidence-based strategies for promoting and protecting mental health see Chapter 6 Promotion and prevention for change.

For people experiencing mental health conditions, promotion and prevention is not enough and access to quality interventions to improve or restore mental health is essential. A range of effective and evidence-based interventions exist, yet they are unavailable to most people around the world who could benefit from them. This massive gap between the need for and uptake of care was the primary motivation behind WHO's Mental Health Gap Action Programme (mhGAP). The programme seeks to significantly expand coverage of evidence-based interventions for a range of priority conditions, with a focus on primary health care and other non-specialized health care settings in LMICs *(161)*.

Providing essential care for everyone who needs it means not just integrating mental health care into primary health care. It also requires the development, strengthening or reorganization of mental health services to ensure a range of other community-based mental health care options are available, including acute inpatient care at general hospitals or community mental health centers or teams. And it involves supporting a comprehensive set of interventions beyond the health sector, alongside scaling down and closing long-stay psychiatric institutions while ensuring support in the community for discharged residents. For more information on what that restructure looks like in practice see Chapter 7 Restructuring and scaling up care for impact.

Working with other relevant sectors is especially important because clinical practice is just one part of the mental health care puzzle. For many people living with mental health conditions, recovery requires access to a broader programme of support that includes a range of activities specifically aimed at supporting social inclusion, including support in maintaining independence, making social connections, participating in community activities, managing complex relationships, and accessing supported housing, work or education. All these services and supports across sectors should protect and promote human rights (see section 4.2 Promoting and protecting human rights) *(23)*.

4.1.2 Improved physical health

The intimate links between mental health conditions and physical health mean that investing in mental health does not only reduce massive population suffering but can also deliver widespread physical health benefits.

Many of the factors that influence mental health also influence other health conditions such as those related to reproductive and maternal health as well as chronic physical diseases, including NCDs such as cardiovascular diseases, diabetes, cancer and respiratory diseases; communicable diseases such as HIV/AIDS, and neglected tropical diseases (NTDs) such as leprosy and cutaneous leishmaniasis.

The four greatest risk factors for NCDs – tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol – are all linked with various mental health conditions *(162)*. Childhood adversity, which is a major risk factor for later-life mental health conditions, is similarly related to a range of adult-onset NCDs, including heart disease, diabetes and asthma *(163)*.

Mental health conditions affect and are affected by chronic physical diseases (see Table 4.1). They can be precursors of one another, consequences, or the result of interactive effects. For example, people with depression or anxiety experience adverse changes in endocrine and immune functioning that increases their susceptibility to a range of chronic diseases. They are also more likely to engage in risk behaviours such as smoking and substance use. Conversely, people with chronic diseases are put under physical and psychological stress that can trigger the onset of depression or anxiety *(163)*.

Links between some chronic diseases (including both HIV/AIDS and several NTDs) and brain health have also been found, leading to neurological consequences that can result in significant illness and death *(164, 165)*.

TABLE 4.1

Evidence on the bidirectional links between mental health conditions and physical diseases

Chronic disease	Bidirectional links to mental health
Noncommunicable diseases	• People living with heart disease are more than twice as likely to also have depression or anxiety than other people. • Diabetes is significantly linked with depression, intermittent explosive disorder, binge eating disorder and bulimia nervosa. • Depression is particularly prevalent in people with cancer. • There is a strong connection between stroke and depression in both directions. • People with common mental health conditions have an excess mortality of 8–12% through smoking, diabetes, history of myocardial infarction and hypertension.
HIV/AIDS	• Mental health conditions are more prevalent among people living with HIV/AIDS than among the general population. • Women living with HIV experience higher rates of depression, anxiety and PTSD symptoms than either men living with HIV or women who are HIV negative. • Exposure to abuse at home increases the likelihood of adolescent mental health conditions, which in turn can make it difficult for adolescents to protect themselves from HIV risk. • Treating depression can improve adherence to care and clinical outcomes for people living with HIV/AIDS.
Tuberculosis	• Depression and anxiety are more prevalent among people with tuberculosis than among the general population. • Untreated depression and psychological distress in people with tuberculosis are associated with worse clinical outcomes, poorer quality of life and greater disability. • Depression is significantly linked to non-adherence to tuberculosis treatment. • Medicines for tuberculosis can have negative impacts on mental health.
Neglected Tropical Diseases	• Cutaneous leishmaniasis, onchocerciasis and snakebite envenoming are all linked to anxiety, depression and psychological distress. • One in two people with leprosy or lymphatic filariasis experiences depression or anxiety. • In people with lymphatic filariasis, depression has been estimated to almost double the total burden of disease.

Sources: Stein et al, 2019 *(163)*, WHO and UNAIDS *(166)*; Fujiwara, 2022 *(167)*; WHO, 2020 *(168)*.

The multiple links between mental health conditions and other chronic diseases mean they often co-occur. Children with long-term physical health conditions are twice as likely to have an emotional or behavioural condition than other children; while adults with chronic diseases are two to three times more likely to develop depression than the rest of the population. People with three or more physical health conditions are seven times more likely to have depression *(169)*.

HIV/AIDS and tuberculosis (TB) are both similarly associated with various mental health conditions. People living with HIV are twice as likely to experience severe depression compared with other people *(170)*. And a recent systematic review shows that the risk of death by suicide is 100 times higher in people living with HIV than in the general population *(171)*. A study in Ethiopia similarly showed that half of people with TB had symptoms consistent with depression and that this group of people – who were much more likely to drop out of TB treatment – was half as likely to be alive at a six months follow up *(172)*.

At a global level, comorbidity of mental and physical health conditions has become the rule rather than the exception, especially in people over 60 years of age *(173)*.

Having both physical and mental health conditions delays recovery from both. Comorbidity makes the treatment of all conditions more difficult, often resulting in more complications. For example, people with chronic diseases who are depressed may find it harder to care for themselves, adhere to treatment or to reach out for health or social support when necessary. This leads to worse health outcomes, more hospitalizations and higher health care expenditures. For people living with HIV/AIDS or TB, dropping out of treatment also increases the risk of further transmission and multidrug-resistant disease *(173)*.

It is clear that individuals cannot attain full physical health without mental health. All over the world, countries cannot achieve their objectives for most priority diseases without simultaneously investing in mental health.

Integrated care is good care

When people with comorbid conditions arrive in health care, they are usually treated for one or the other of their conditions but not both. As a result, many conditions go unrecognized and untreated in their early stages, increasing the risk of disability and premature death (see section 3.1.2 Mortality). Indeed, the most common cause of death among people with severe mental health conditions is cardiovascular disease *(174)*.

> *An integrated approach to care ensures mental and physical health conditions are considered, managed and monitored simultaneously.*

An integrated approach to care ensures mental and physical health conditions are considered, managed and monitored simultaneously. Implemented well, it can improve accessibility, reduce fragmentation and duplication of infrastructure and resources and better meet people's health needs and expectations.

Integration can be implemented in many ways and at different levels of the health system *(175)*.

- **For service users**, integrated care is about having a person-centred approach that is coordinated across diseases, settings and time.
- **For health care organizations**, integrated care is about having common information systems and professional partnerships based on shared roles and responsibilities, for example through multidisciplinary teams, task sharing and links to social care and community services.
- **For ministries of health**, integrated care is about having joint policies, financing mechanisms and governance structures across physical and mental health.

Integrating mental health services into primary care is a key strategy at the level of health care organizations (see section 7.2.1 Mental health in primary care). Collaborative care models in particular have been shown to improve mental health outcomes, including in people with comorbid NCDs *(176, 177)*. A proven approach is to use service delivery platforms that already exist for chronic diseases as the basis for expanding mental health services. For example, specific platforms used to support HIV care can be used as entry points for integrating harm reduction services and care for people living with mental health conditions *(167)*.

For more information on evidence-based strategies for integrating mental and physical health care across all health care platforms, including primary care, general hospitals and disease-specific health services, see Chapter 7 Restructuring and scaling up care for impact.

4.1.3 Greater equity of access

Investment and transformation in mental health are needed because mental health and mental health care are marked by inequality. The significant influence that structural factors can have on mental health means that some groups of people in society have far poorer mental health than others. In many cases, those same people also have less access to effective and appropriate care because they are geographically distant from, or unable to pay for, services.

Particularly in lower-income settings, this means that a substantial proportion of people with mental health conditions cannot access the care they need. This can lead to worsening mental health, with adverse consequences on people's abilities to work, learn or parent. Often, people who access care have to pay for it themselves because it is excluded from essential packages of care and insurance schemes.

Direct out-of-pocket spending is an unfair way of paying for health care since poorer households end up paying a proportionately greater amount of their available income (by contrast, tax-based health insurance typically requires higher contributions from wealthier households). Cost of care is known to be a major barrier to people with mental health conditions seeking help *(178)*.

> *Private purchase is an unfair and regressive way of paying for health care.*

Out-of-pocket spending on mental health care often pushes people to adopt undesirable coping strategies – such as cutting household spending, using up life savings, selling assets or borrowing – which entrenches poverty and intergenerational disadvantage and can lead to poorer health outcomes *(10)*. Importantly it is not only the costs of treatment that puts people at financial risk, but also transport costs, loss of income for individuals and their carers, and other indirect costs.

Addressing inequalities as part of mental health reform is essential to provide the right services in the right ways and places to reach everyone and anyone. Addressing people's social needs, for example through social work-type interventions, is essential as part of, or alongside, mental health care. In addition, it is crucial to address the population-level structural determinants of mental health that create social disadvantage (see section 6.1.3 Building structural capital for mental health). Other strategies focus on scaling up access to care, including by enhancing health coverage and financial protection.

Mental health for all

Including mental health conditions and interventions in UHC basic packages of essential services is a fundamental step towards closing the care gap.

Ultimately, interventions provided under UHC should ensure that all essential mental health needs are covered. This means they need to be comprehensive, including evidence-based psychosocial and pharmacological interventions, as described in WHO's UHC compendium (see section 5.1.3 Evidence to inform policy and practice) *(179)*.

Interventions provided under UHC should ensure that all essential mental health needs are covered.

Universal public health policies that finance interventions for all can also lead to a fairer allocation of public health resources and benefit the lowest-income groups most (see Box 4.1 Chile: including mental health conditions in UHC). In this sense, enhanced health coverage is important to protect people from the potentially catastrophic cost of paying for health services out of their own pockets.

Enhanced coverage and increased financial protection are essentially two sides of the same equity coin. Improved coverage without a corresponding rise in financial protection will lead to inequitable rates of service uptake and outcomes. But improved financial protection without expanded coverage will bring little improvement at all.

CASE STUDY

BOX 4.1

Chile: including mental health conditions in UHC

In 2005, as part of a broad process of health reform, Chile introduced Acceso Universal con Garantías Explícitas (GES), a universal health coverage package of medical and psychosocial benefits.

The package, which is periodically updated, comprises a prioritized list of diagnoses and treatments for 85 health conditions, including depression, bipolar disorder, alcohol/drug dependence, schizophrenia and dementia. GES gives equal rights to both public and private sector beneficiaries. It guarantees access to quality health care through eligibility criteria, accreditation of facilities, and professional certification. It also ensures care is timely and affordable by setting upper limits on waiting times and out-of-pocket co-payments.

Overall, GES has made the Chilean health system more efficient by emphasizing health priorities. Health services have become more accessible for all, with coverage of the lowest income quintile increasing by 20%. The proportion of people with depression who die during or shortly after admission to hospital has dropped. And, by integrating mental health into all levels of the general health care, early care for first-episode schizophrenia has improved.

People using GES say it has increased access to care, enabled diagnosis and treatment for the underprivileged, and guaranteed financial protection.

Consolidating community mental health services across the country has been critical for GES. Delivered through multisectoral teams, these services provide prevention, treatment and rehabilitation for people with severe mental health conditions. Most users can access psychotropic medicines free of charge. More than half also receive brief individual psychological treatment. And almost all users receive some other kind of individual, family or group psychosocial intervention.

These community mental health services are deeply connected to primary health care with robust systems for referral and counter referral. Every month, members of the community mental health team visit each primary care center in their catchment area to discuss complex cases and empower primary care teams in their clinical and community management. The result is that around 80% of people approaching GES for help with mental health conditions are treated by primary care professionals.

Sources: Aguilera et al, 2015 *(180)*; Bitran, 2013 *(181)*; Araya et al, 2018 *(182)*.

4.2 Promoting and protecting human rights

Investment and transformation in mental health is needed to help stop the widespread human rights violations that people with mental health conditions experience worldwide.

In 2008, the Convention on the Rights of Persons with Disabilities (CRPD) came into force. Comprising 50 individual Articles, this legally binding treaty marked a major milestone in efforts to promote, protect and ensure the full and equal enjoyment of all human rights for people with disabilities, including psychosocial disabilities.

Psychosocial disabilities arise when someone's long-term mental impairments interact with societal barriers such as stigma, discrimination and exclusion, and so hinder their full and effective participation in society on an equal basis with others.

Among a range of human rights, the CRPD is designed to ensure all people have the full and equal enjoyment of the right to:

- life;
- equal recognition before the law (legal capacity);
- access to justice;
- liberty and security of the person;
- freedom from exploitation, violence and abuse;
- live independently and be included in the community;
- habitation and rehabilitation;
- health, education, work and employment;
- adequate standard of living and social protection; and
- participation in political and public life.

The CRPD is invaluable in ensuring that people experiencing mental health conditions have these rights. But despite widespread ratification of the CRPD, people with mental health conditions worldwide continue to be denied human rights and protections through discriminatory attitudes, actions and laws. They are also often subjected to serious abuse, both in institutions and in the community. As long as these human rights violations are not fully addressed – including redressing physical, attitudinal, communication, social and legal barriers – there will be psychosocial disability.

4.2.1 Action against stigma and discrimination

Stigma, which is pervasive in the general population and in the health sector, is a major barrier to improved mental health services and self-care. It is present in homes, schools, workplaces, communities and even within the mental health care system itself *(183)*.

Stigma leads to social isolation and discrimination, which impacts a person's ability to earn an income, have a voice, gain access to quality care, be part of their community and recover from their mental health condition. It creates the conditions for violations of multiple human rights across multiple settings (see Fig. 4.1).

> *Stigma can lead to social isolation, discrimination and violations of human rights across multiple settings.*

In some countries, having a mental health condition provides legal grounds for divorce. In others, people with mental health conditions can lose their parental or voting rights, or may be denied a driving licence. In some countries, children with mental health conditions cannot obtain birth certificates

or other identity documents *(184)*. Around the world, people living with mental health conditions are frequently excluded from community life and denied basic rights.

They are also discriminated against in the fields of employment, education and housing. The right to work is one of the most commonly violated rights. Even when people with a mental health condition are able to get a job, they are often underpaid *(22)*.

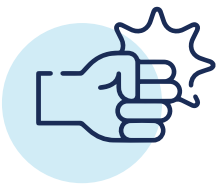
And many children and adolescents living with mental health conditions are sent to segregated schools that tend to provide lower-quality education; or they are institutionalized in facilities that provide no or highly-limited education (*22*).

In all cases, stigma and discriminatory attitudes and directives can adversely impact mental health and hinder people's recovery (read Lion's experience).

FIG. 4.1

Common human rights violations against people with mental health conditions and the settings in which they take place

COMMON HUMAN RIGHTS VIOLATIONS



- Exclusion, marginalization and discrimination
- Denial of employment opportunities
- Physical abuse and violence
- No access to effective mental health services
- Sexual abuse and violence
- Arbitrary detention
- Denial of rights to marry and have children
- No means to enable living in the community
- Denied access to general health services
- Financial exploitation

SETTINGS WHERE ABUSE CAN HAPPEN

- Shared community spaces
- Home and family settings
- Workplaces
- Mental health services and facilities
- Hospitals and health services
- Prisons and the judicial system
- Government and official services
- Schools

Source: Drew et al, 2011 *(22)*.

NARRATIVE

I've encountered ignorance and stigma

Lion's experience

I've used various rehabilitation services over the years. and I have encountered ignorance and stigma. Some services were just unhelpful to me. Some actively harmed my recovery journey.

I'll never forget the nurse in the psychiatric ward who chased me around when she caught me doing yoga in my room, berating me that this type of activity was not allowed. It took me ten years to start doing yoga again: it was a trigger that kept bringing me back to that difficult experience of hospitalization.

At one point I applied for financial assistance to fund a degree in social work. I was already managing the first ever peer-support programme in a psychiatric hospital in Israel. But the social worker who helped me through the application process told me it would be immoral to let me study social work. Even when I passed my tests with high grades, they tried to convince me to study education, saying that would be easier for me.

Today I lead the lived experience department at Enosh, the Israeli mental health association. We provide recovery resources to individuals and families coping with psychosocial disability. We work hard to promote person-oriented and trauma-aware services and practices that support recovery.

The difficult experiences I've been through and the ignorance I've encountered have also led me to lecture in therapeutic circles. At first I was begging to be heard, but slowly I have been invited to give more and more paid lectures. The need had probably existed for a long time. The therapists' desire to learn and improve the existing therapeutic services fill me with hope.

Lion Gai Meir, Israel
(see also my narrative on page 44)

Stopping stigma

Evidence from high- and low-income countries suggests that anti-stigma interventions can change public attitudes for the better, lessening experiences of discrimination among people living with mental health conditions *(185)*. Anti-stigma strategies tend to fall into one of three categories *(186)*.

- Education strategies use facts to address myths and misconceptions. They include literacy campaigns, public awareness campaigns and a wide range of training and learning activities.
- Contact strategies aim to shift negative attitudes in the general population through interactions with people living with mental health conditions. They may include direct social contact, simulated contact, video contact or online contact, as well as the use of peer support services in health care settings.

- Protest strategies provide formal objections to stigma and discrimination. They include public demonstrations, letter writing, petitions, product boycotts and other advocacy campaigns.

Research on the impact of these strategies suggests that, for most groups of people, social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes *(185)*. Research findings also support active engagement and empowerment of people with lived experience across all levels of the mental health care system (see In focus: Engaging and empowering people with lived experience).

Several high-income countries have successfully used large-scale public awareness campaigns and contact-based strategies to create positive changes in public attitudes to mental health (see Table 4.2).

Social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes.

There is also much promise of broad, coordinated evidence-based programmes in LMICs (see Box 4.2 Research to tackle stigma: The INDIGO Network), and large-scale government-led campaigns focusing on social contact in these contexts are needed *(185, 187)*.

Beyond direct anti-stigma campaigns, stigma can likely be reduced through work focused on improving the quality of care (see Box 4.4 WHO QualityRights).

CASE STUDY

BOX 4.2

Research to tackle stigma: The INDIGO Network

The INDIGO Network runs an evidence-based research and implementation programme to understand the mechanisms and consequences of stigma and discrimination in more than 40 countries; and to develop and test new ways to end stigma. Several LMICs participate in the network, including Bangladesh, Brazil, China, Egypt, Ethiopia, India, Jamaica, Malaysia, Nepal, Nigeria, South Africa, Tunisia, Türkiye and Venezuela.

The network coordinates multi-site projects, for example, to evaluate campaigns on improving referral rates to local health care services; or to investigate the potential of training medical students in order to improve knowledge, attitudes and behaviour towards people with mental health conditions. The INDIGO website offers scales to assess stigma and discrimination.

The INDIGO Network hosts an international research programme (the INDIGO Partnership) for developing and testing evidence-based, contextually adapted interventions to tackle stigma and discrimination. This programme involves research partners at seven collaborating institutions in China, Ethiopia, India, Nepal and Tunisia, and aims to generate findings and materials that can be applied to other LMICs.

Sources: The Indigo Network, 2021 *(189)*; Thornicroft et al, 2019 *(190)*.