# World mental health report

## Transforming mental health for all

## 4.2.2 The right to quality care

Everyone has a right to dignified, humane, responsive, acceptable, and decent care that respects their human rights. Yet too often people with mental health conditions are subject to some of the world's worst human rights abuses by the very health services responsible for their care.

From psychiatric hospitals all over the world there are reports of ill-treatment including physical, mental and sexual abuse, and neglect. People with mental health conditions may be arbitrarily confined in hospitals for years without reassessment of their medical status. They may be overmedicalized, given harmful or degrading treatments or routinely subjected to interventions without informed consent *(22)*. In many countries, the poor conditions and infrastructure that are associated with psychiatric hospitals are also prevalent in nursing and care homes, rehabilitation centres, orphanages and overnight-stay facilities for traditional or spiritual healing of mental health conditions.

> *Many people in mental health institutions are shackled: locked away in small, prison-like cells with no human contact.*

Many people with mental health conditions are shackled: locked away in small, prison-like cells with no human contact; or chained to their beds, unable to move for long periods of time *(184)*. Large institutions especially are renown for degrading living conditions marked by overcrowding, unsanitary environments, unnourishing or insufficient meals and pervasive tobacco smoke (read Mrs BN's experience in Chapter 3) *(22)*. Children are particularly vulnerable to the violence and neglect associated with institutional environments (see Box 4.3 Children in institutions). So too are older adults, with one out of ten staff in institutional settings across high-income countries admitting to elder physical abuse over the past year *(191)*.

Accordingly, there is a great need to transform mental health care to make it community-based (see Chapter 7 Restructuring and scaling up care for impact).

Maltreatment is not confined to institutional care. People with severe mental health conditions can find themselves hidden away by family members, chained or caged in the home, physically or sexually abused in prisons or subjected to violence in the community *(192)*. Mental health outpatient care also often violates human rights, as evidenced by treatment that is routinely forced and purely biomedical, not addressing people's needs and rights for inclusion, social care and protection, among others. And while traditional healing can be highly supportive and meaningful to people, it can also involve abusive practices *(134)*.

Those who experience abuse rarely have access to proper judicial mechanisms. In many countries, people with mental health conditions have little opportunity to raise complaints for ill-treatment or involuntary admission *(193)*. Crimes committed against people with mental health conditions also frequently go undocumented because police or prosecutors have unfounded concerns about the victims' credibility as witnesses.

Ill-treatment and abuse cause psychosocial disability, impede people's recovery and often worsen their mental health condition. Any transformation towards community-based mental health care must address human rights violations.

### Stronger rights in mental health care

Preventing ill-treatment and abuse in mental health services requires a mix of strategies designed to shift attitudes, strengthen rights

**EVIDENCE**

BOX 4.3

## Children in institutions

An estimated 5.4 million children live in institutional care around the world, many of whom have mental health conditions.

Many institutions for children are unregistered, making monitoring almost impossible. They often provide environments that are neglectful and more abusive than they are caring. Children often live far from home and spend their days in overcrowded rooms, rarely interacting with staff, family members or other children. Many of the buildings are poorly maintained and have insanitary washing facilities and poor sleeping conditions. Children are often inadequately clothed, malnourished, inappropriately medicated and physically restrained. In many institutions, violence is pervasive.

Institutionalization often harms children's mental and physical health. Children in institutions are more likely to have mental health conditions than children brought up in the community, including higher rates of aggressive behaviour, depression and anxiety, bedwetting, attention deficit hyperactivity disorder (ADHD) and oppositional defiant disorder. They are more likely to have problems with antisocial conduct, social competence and play. And they often experience attachment difficulties too.

A lack of general check-ups and immunizations also means that childhood diseases are more common among institutionalized children than in the general population; and death rates are far higher.

A transformation in mental health that shifts the care of children with psychosocial disabilities away from institutions towards community services and support will not only ensure that human rights are respected in line with the CRPD and other international frameworks but will also lead to better health and development outcomes for children in care.

Sources: Desmond et al, 2020 *(194)*; WHO, 2015 *(195)*; UNICEF, 2021 *(4)*.

and reshape care environments *(23)*. While combatting stigma is important, other tools and tactics are key to eliminate ill-treatment and uphold human rights. These include:

- rights-based laws and policies;
- development and scaling up of rights- and community-based services that are people-centred and recovery-oriented;
- monitoring and evaluation of mental health services;
- active participation of people with lived experience of mental health conditions in decision-making processes, monitoring mechanisms, design and delivery of services;
- appropriate training for mental health professionals to address stigma and discrimination and to build capacity on the rights of persons with mental health conditions; and
- reporting on rights-based policy to global conventions (see Box 4.4 WHO QualityRights).

In all cases, providing accountability and redress mechanisms to record, prevent and respond to human rights abuses is important. In some countries, the office of the ombudsperson or

**TOOL**

BOX 4.4

## WHO QualityRights

QualityRights is a global initiative designed to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual and cognitive disabilities. The initiative works at the ground level to directly change attitudes and practices, as well as through policy to create sustainable change.

The initiative covers the following areas of work:

- capacity building to combat stigma and discrimination and promote human rights and recovery;
- creating community-based, person-centred and recovery-oriented services that respect and promote human rights;
- improving the quality of care and human rights conditions in mental health and related services;
- supporting civil society movements and people with lived experience to undertake advocacy and influence policy-making; and
- reforming laws and policies in line with the CRPD and other international standards.

Across all areas of work, QualityRights develops and deploys a diverse range of training materials, toolkits, technical support and practical guidance to support a human rights and recovery approach to mental health. Combined, these resources are designed to help advance mental health, eliminate stigma and promote inclusion. They aim to build knowledge and skills among mental health practitioners, service users and others, for example on how to end coercive practices such as seclusion and restraint and how to respect people's will and preferences. There is also guidance on peer support and advocacy for mental health, as well as a transformation toolkit for reshaping services to better promote human rights.

The initiative also provides QualityRights e-training on mental health, recovery and community inclusion for health workers, policy-makers, carers, community members and people with lived experience. The e-training covers how to support a person's own mental health and that of others, and how to promote human rights to help tackle stigma, discrimination, abuses and coercion experienced by people with mental health conditions. The QualityRights e-training has been launched globally, making it available to all people in all countries. In Ghana, where it has been ongoing since March 2019, more than 21 000 people had successfully completed the online QualityRights training by May 2022.

A 2019 evaluation showed important and positive shifts in attitudes towards human rights among participants completing the QualityRights e-training, including on the right to legal capacity, informed consent, ending coercive practices and community inclusion.

Sources: WHO, 2022 *(196)*; WHO, 2019 *(197)*; WHO, 2019 *(184)*; Funk et al, 2021 *(198)*.

Access the WHO QualityRights e-training at: https://www.who.int/teams/mental-health-and-substance-use/policy-law-rights/qr-e-training.

similar structure – a public official or entity appointed by, but at arm's length from, the national government or parliament – provides an important source of information, mediation and redress.

## 4.2.3 Autonomy in health decision-making

Being able to make decisions about one's life – including the right to choose one's own mental health care – is key to a person's autonomy and personhood.

The CRPD commits countries to recognizing that people with mental health conditions enjoy legal capacity on an equal basis with everyone else. And yet involuntary hospital admissions, and care against the wishes of someone experiencing a mental health condition, are routinely and widely practiced across the world, facilitated by laws and practices that give guardians of people with mental health conditions extensive substitute decision-making powers. Today, in all countries, decisions made by clinicians or other officials can legally supersede the preference of individuals with mental health conditions, which can lead to them being detained against their will and forced to have treatment.

The use of involuntary admission and treatment remains the subject of concern and debate among and between service users and professionals *(199, 200, 201, 202)*. Laws on substitute decision-making and coercive care are typically intended to safeguard the interests and well-being of affected people and people in their communities. But they do restrict people's ability to choose where to live, how to manage their finances or what medical treatment to accept. Through substitute decision-making, people experiencing mental health conditions lose their rights to informed consent, confidentiality, privacy and communication with family members. Frequently, people end up in institutions and exposed to seclusion or restraint. Involuntary admission can lead to horrific experiences (read Sandra's experience). And fear of coercion can stop people from seeking help when they experience mental health problems.

### Changing the paradigm: supported decision making

Evidence and experience suggest that there are many strategies available for reducing involuntary admission and coercive treatment in mental health care. Staff training and integrated care are both effective interventions *(203, 204)*. So too is using supported decision-making as an alternative to substitute decision-making, guardianship or other processes that exclude or go against the involvement and will of the person affected *(205)*.

Supported decision-making is about supporting people to exercise their own choices about their lives, including about their mental health care.

In supported decision-making, the person with a mental health condition chooses someone or a network of people who they trust to serve as their supporter. The person with a mental health condition is always the decision-maker; the supporter is available to discuss the issues, options or choices when necessary and communicates the will and preferences of the person if they are unable to do so themselves.

> *Supported decision-making is about supporting people to exercise their own choices about their lives.*

In practice, supported decision-making can take many forms and includes support organizations and networks, advanced plans and provisions, independent advocates, peer support and personal assistance. It can be done through a legal document, for example an advance directive that specifies what actions should be taken for a person if they are no longer able

**NARRATIVE**

# Twelve hospital admissions; only one was my choice

## Sandra’s experience

Pinned down by policemen and paramedics. Gagged and handcuffed like a criminal as I was knocked unconscious by a medical cocktail. Waking up not knowing where I am, clothes off in what feels like a prison. My crime? At worst, being loud, antagonistic and manic. My life sentence? Bipolar disorder. This was the first of my eleven involuntary hospital admissions. I was literally stripped of any semblance of human rights or dignity. And it was terrifying.

I was given my diagnosis and some meds and sent home, confused and already falling into depression. Empty and emotionless I was also feeling the side effects of the medication – severe parkinsonism, akathisia and tremors.

A year on. Boom! Mania. I was out of control. My family was worried. Involuntary hospital admission number two. At least the staff treated me with care and compassion. No restraints this time. Human kindness and empathy go a long way. New meds and on I go.

Two years later I am in denial about having a mental health condition and default on my medication. Relapse. Involuntary admission number three. Back in restraints. I’m told this is the end of the line. If I don’t get it together here, I will go into placement where my family won’t be allowed to see me. Worse than prison. Eventually I’m discharged.

Four years on. My marriage is falling apart and so am I. Involuntary admission number four. Restrained and intravenously injected with what feels like boiling water through my veins. A new side effect emerges and I get stroke-like symptoms every time I have a ‘knock out’ injection.

Over the next four years I was involuntarily hospitalized seven times, including three times in a single fortnight. New meds and a new side-effect: sleep paralysis.

My twelfth and last admission was different. It was my choice. Voluntary. Acceptance that I needed help. More than help, I wanted support. My psychiatrist was stern but also patient and empathetic. She believed in my life and I felt she truly had my best interests at heart. My medication is finally on point.

I fell time and again to find my own way back up. I will continue trying and learning and, for effort alone, I will always succeed.

**Sandra Ferreira**, South Africa

to make decisions for themselves because of illness or incapacity. Or it can be less formal, for example involving personal supporters who are trusted contacts of the person involved.

In all cases, supported decision-making:

- respects the rights and wishes of the person;
- does not advance the interests of others;
- does not attempt to influence the person to make decisions they do not want to make;
- provides the level of support requested by the person; and
- is used for as short or long a time as the person requests it.

Pockets of supported decision-making can be found all over the world, including in the Americas, Europe, South-East Asia and the Western Pacific.

In the past five years Colombia, India, Peru and the Philippines have all passed legislation to remove barriers to legal capacity and recognize the role of supported decision-making in the context of mental health services *(23)*.

In South America, where a number of countries are making progress in supported decision-making, programmes often rely on informal support mechanisms provided through civil society organizations, including organizations of persons with lived experience (see Box 4.5 Supported decision-making in South America). While there is still much to be learned in how to implement supported decision-making in different treatment and resource situations, it is clear that investment and transformation in mental health must include advancing supported decision-making.

CASE STUDY

BOX 4.5

## Supported decision-making in South America

**Argentina: drawing on day-to-day life for support**
In 2017–2018, Argentina's *Persons with Disabilities: The Exercise of Their Legal Capacity and Decision-making* pilot project used participants' daily experience of psychosocial and intellectual disabilities to identify and critically analyse support systems for decision-making. Participants used person-centred planning to identify support individuals and networks (as well as limitations) in their day-to-day life.

The project evaluation stressed the need for a flexible and dynamic toolbox of support and identified the role of organizational structures for designing supported decision-making.

**Colombia: planning for life**
Colombia's *Supported Decision Making and Community Life* pilot project in 2015–2016 built a personalized support system to build capacity for decision-making, improved relationships and independent living. Participants used life-planning tools to develop a map of networks that they could draw on for support; and created a personalized booklet describing their goals, dreams, and basic preferences.

Qualitative interviews and observation of participants revealed that some individuals were empowered to make their voices heard, and that families adjusted their approach to support.

**Peru: engaging individuals, groups and whole communities**
In 2016–2018, the *Support Networks for Decision Making and Community Life* pilot project used one-to-one planning and counselling as well as group workshops, peer support, family meetings and broader stakeholder mapping and outreach to promote decision-making support networks.

Participants reported feeling empowered through greater knowledge.

Source: Vásquez et al, 2021 *(206)*.

# Engaging and empowering people with lived experience

Valuing the insight of people with lived experience of mental health conditions, and giving them voice, choice and influence in multiple aspects of the mental health care system, is a vital step towards transforming mental health worldwide.

People with lived experience may have survived human rights abuses by mental health services, and as such they have much insight into how mental health services can fail people. They can be powerful advocates for people-centred, recovery-oriented, human rights-based mental health care and for policy and legislation that protects their rights.

Empowerment gives people with lived experience better understanding and control over their lives *(207)*. It requires governments, employers, educational institutions, nongovernmental organizations and members of the public to remove barriers that may hinder full and effective participation in society for people with lived experience of mental health conditions.

Over recent decades there has been a progressive shift towards service users and their carers having greater involvement at different levels within the mental health system.

- **Personal level:** involvement in one's own health care planning, assessment and management, for example through shared decision-making, advanced planning, supported self-management and person-centred recovery approaches to care.
- **Community level:** involvement in local service planning, delivery, monitoring and evaluation, advocacy, public awareness campaigns (especially to reduce stigma), and training for mental health staff and others.
- **Strategic level:** participation in shaping mental health policy, plans and laws, service monitoring and research.

Participatory approaches are key to implementing UHC *(208)*. Yet they are still infrequently applied to mental health care in many countries. The growth in participatory processes for people with lived experience has mainly taken place in high-income countries *(209)*. Only a third of middle-income countries – and just 16% of low-income ones – have a formal mechanism in place for involving service user associations in the mental health system *(5)*.

There are varying degrees of participation, from being consulted to joint decision-making; and from being involved in service-delivery to user-led services. Whatever the level of involvement, it is important that participation is not tokenistic; and that the views of people with lived experience are fully considered and valued in policy and practice. This requires time. In all cases, provisions should be made to ensure individuals are adequately supported throughout the participatory process.

## Positive partnerships for care

Empowering people to have control over their life and mental health care instils personal dignity, value and respect. It can increase self-esteem and confidence. It also gives people a level of choice and autonomy they may not have received otherwise.

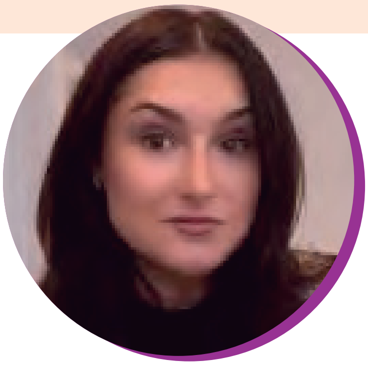
At the same time, meaningful engagement of people with lived experience builds service providers' understanding of what it's like to have a mental health condition; it can help challenge assumptions and increase the level of trust between them and service users.

The potential result is better therapeutic relationships and more equal, collaborative and effective partnerships of care. Individuals and health care providers can work together to map out the options for care and select those that are most appropriate and acceptable to the individual (see section 7.1.1 Putting people first).

All this contributes positively towards a person's recovery and quality of life (read Alexandra's experience).

**NARRATIVE**

## Autonomy was the key to my recovery



### Alexandra's experience

Receiving autonomy over my mental health care was the greatest contributor to my recovery. I was diagnosed with a mental illness when I was seven. Throughout my childhood and adolescence, I had no say in my own recovery: my own ideas of what would work well for me were often dismissed. This lack of autonomy eroded my already-low self-esteem and worsened my mental illness.

I remember walking into my current therapist's office at the age of nineteen. I was a shell of an individual. Years of being forced into specific care pathways and bubble-wrapped by caring adults had shattered my confidence. I barely believed I was capable of making basic decisions, let alone helping myself. But this therapist was different: she saw me as a person rather than my mental illness. She asked me about interests, wanted to know my work style, and was eager to work together to construct a pathway to mental well-being.

We started small, but with her guidance, I gradually gained the confidence to make complex decisions about my health and well-being. Her willingness to collaborate with me, create care plans that suited me as an individual, while still giving me the space to make autonomous decisions, helped me build the confidence to thrive not only mentally, but in all other areas of my life. To this day, I attribute my recovery to her collaborative nature.

**Alexandra M Schuster**, United Kingdom

## Social contact for better care

Social contact strategies that engage people with lived experience are the evidence-based way of reducing stigma in the community (see section 4.2.1 Action against stigma and discrimination: Stopping stigma). They are also important for reducing stigma among service providers. Stigma among primary care providers likely contributes to low rates of detection of mental health conditions in primary care.

A pilot study in Nepal suggests that involving people with lived experience as co-facilitators in mhGAP training programmes for primary care workers may be effective in reducing stigma *(210)*. Interestingly, the study also found that primary care workers who are co-trained by people with lived experience may be more likely to diagnose mental health conditions accurately.

## Networks to enable engagement

Peer-led networks and organizations have a key role in enabling people with lived experience to engage with their care. Networks can be a vital source of mutual support for mental health service users. And they often also supply encouragement, resources and formal infrastructure for the systemic advocacy and self-advocacy that is needed to facilitate change.

Through peer-led organizations, people with lived experience have helped educate communities, inform and influence policy-makers, denounce stigma and discrimination and fight for improved services and legal rights *(211)*.

During the COVID-19 pandemic, peer-led organizations have been particularly valuable in giving voice to people with lived experience. The Global Mental Health Peer Network (GMHPN) and partners, for example, surveyed people with lived experience on the psychosocial consequences of the pandemic and advocated for greater equality and equity in the pandemic response *(212)*. At a national level, user organizations have stepped in to provide extra support services: for example, the Psychiatric Disability Organization Kenya offers psychosocial support for prison staff *(7)*.

The *Comprehensive mental health action plan 2013–2030* calls for action that helps organizations of persons with mental health conditions to participate in reorganizing, delivering, and evaluating and monitoring services. In practice, supporting these organizations may include, for example, efforts to:

- encourage their creation;
- build their capacity to effectively advocate for human rights;
- establish mechanisms to ensure their full participation in policy-making;
- involve them in monitoring and evaluating mental health services; and
- include them in capacity-building efforts for stakeholders.

For more information on supporting the participation of people with lived experience in directing and delivering services, see: www.who.int/publications/i/item/who-qualityrights-guidance-and-training-tools.

# 4.3 Enabling social and economic development

Mental health is an essential, if often neglected, issue in social policy and economic development. Poor mental health puts a brake on development by reducing productivity, straining social relationships and compounding cycles of poverty and disadvantage. Conversely, when people are physically and mentally healthy, and reside or work in mentally healthy environments, they can study or work productively and contribute to their communities, to the benefit of all.

Growing evidence shows that transforming the mental health agenda requires not only enhanced access to quality services and care. It also requires greater attention to, and investment in addressing, the underlying social and economic realities of life that shape people's mental health. Countries are already committed to addressing these realities through the SDGs of the 2030 Agenda for Sustainable Development. The links between mental health and the SDGs are complex and, in many cases, bidirectional (see Table 4.3). Progress towards achieving the SDGs has the potential to promote and protect mental health *(15)*. At the same time, improved health outcomes, including mental health outcomes, are important to realizing the SDGs' full ambition.

TABLE 4.3

## Mental health is linked to each of the SDGs

| SDG | | LINKS WITH MENTAL HEALTH |
|---|---|---|
| 1 | No poverty | • Mental health conditions are closely linked to poverty in a vicious cycle of disadvantage. |
| 2 | Zero hunger | • Poor nutrition impairs cognitive and emotional development in children.<br>• Food insecurity increases the risk of mental health conditions in adults. |
| 3 | Good health and well-being | • Mental health is an integral part of general health and well-being. |
| 4 | Quality education | • Mental health is important for learning; and learning environments are key determinants of mental health.<br>• People with mental health conditions experience barriers in accessing education. |
| 5 | Gender equality | • Inequity and gender-based violence are risk factors for mental health conditions. |
| 6 | Clean water and sanitation | • Socioeconomic deprivation and poor access to facilities creates multiple life stressors and is linked with a range of mental health conditions. |
| 7 | Affordable and clean energy | |
| 8 | Decent work and economic growth | • Work practices and environments are determinants of mental health.<br>• People with mental health conditions experience barriers in accessing decent work. |
| 9 | Industry, innovation and infrastructure | • Employment and economic growth is an important protective factor against mental health conditions. |
| 10 | Reduced inequalities | • Discrimination and inequitable treatment of people with mental health conditions is pervasive and causes psychological stress. |
| 11 | Sustainable cities and communities | • Well-planned urbanization can benefit mental health through improved access to work, education and housing as well as safe environments and green spaces.<br>• Exposure to community-level violence is a risk factor for mental health conditions. |
| 12 | Responsible consumption and production | • Socioeconomic deprivation and poor access to resources are linked to a range of mental health conditions. |
| 13 | Climate action | • Climate change and environmental events cause human suffering and can undermine mental health. |
| 14 | Life below water | • The availability of natural resources on land and at sea impacts people's health, including their mental health. |
| 15 | Life on land | |
| 16 | Peace, justice, and strong institutions | • Conflict and violence is a major threat to mental health, while mental health may contribute to reduced violence. |
| 17 | Partnerships for the goals | • Mental health is a universal concern.<br>• Lessons from mental health partnerships can be applied to the SDG agenda. |

Source: Lund et al, 2018 *(52)*.

A holistic approach to mental health promotion, protection, care and recovery provides for greater equality of opportunity (with respect to education, income and social inclusion) as well as service access, especially for those exposed to or living in precarious or vulnerable situations.

In short, the benefits of better mental health extend beyond psychological well-being itself, from social equity and inclusion to economic growth and prosperity.

## 4.3.1 Social equality and inclusion

As discussed in Chapter 2 Principles and drivers in public mental health, our mental well-being is constantly being shaped and re-shaped by the environment in which we find ourselves. Someone whose life is marked by diminishing opportunities, social exclusion and economic insecurity will have a different mental health trajectory to that of someone who grew up in, and continues to have, a stable, supportive home, work and social environment. Analyses in Europe reveal that, on average, men and women living on the lowest incomes are twice as likely to report poor mental health compared with those with the highest incomes *(213)*.

Accordingly, a key requirement for successful mental health transformation at the population level is to reduce or eliminate local and national disparities or inequalities as they relate to mental health. This is a goal in itself and the benefits of successful action against such inequalities can be added to the case for investing in mental health.

The *Comprehensive mental health action plan 2013–2030* identifies implementation options for addressing disparities; and these were further highlighted by the World Mental Health Day in 2021, the theme of which was “Mental Health in an Unequal World” *(214)*. Proposed strategies include actions against interpersonal violence, inimical immigration policies and racism; and actions for child protection, decent working conditions and social inclusion.

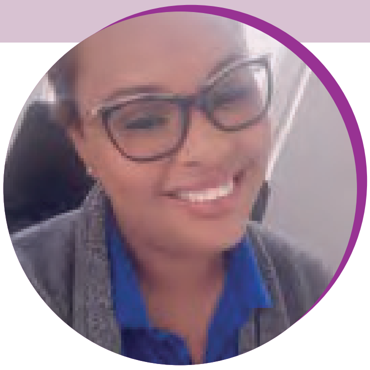
Addressing disparities requires a major step up in multisectoral action to address the social and structural determinants of mental health to achieve social justice (see section 6.1.3 Making structural changes for mental health). It requires a transformation in the social exclusion of people with mental health conditions, who are often denied basic social and civil rights (see section 4.2.1 Action against stigma and discrimination).

It also requires a transformation in access to care to ensure that mental health services are available to all people in society, at all stages of life. Too often, services focus on adults to the neglect of services for children, adolescents and older people. Gender differences need to be considered in every area of mental health intervention, with special attention paid to survivors of gender-based violence and to gender-identity minorities, who often find mental health services discriminatory (read Kat’s experience).

Other priority groups identified by the *Comprehensive mental health action plan 2013–2030* include homeless people and people in the criminal justice system or in detention, as well as: asylum seekers, refugees and irregular migrants; marginalized ethnic groups, including indigenous people; people with physical and intellectual disabilities; and people affected by complex emergencies. Interventions and support targeted at these groups can help reduce existing inequalities and promote social inclusion, thereby contributing to ensuring interventions to support mental health are universal, yet are calibrated proportionately to the level of disadvantage (proportionate universalism) *(215)*.

In all cases, reaching people living in vulnerable conditions requires mental health (and other) services to be more accessible, closely coordinated with social care and widely known about. Experience suggests that

NARRATIVE



# Reforming mental health care for the LGBTIQ+ community

## Kat’s experience

When I engage with my country’s mental health system, I apply filters to my sexuality. Each time I filter out my sexuality, I feel like I’ve taken several steps backward in my recovery. But I do it because I have experienced homophobic comments and lack of understanding.

My experiences of discrimination have made me outspoken about the need to reform our mental health systems for the LGBTIQ+ community. Our mental health systems must acknowledge the harm they caused, for reformation to begin. The decision to include certain sexualities in international disease classifications, for example, created untold damage. Many countries, including my own, have continued to embrace these classifications. Although some no longer exist in updated publications, the effects of international discriminating policies and diagnoses still linger, particularly in countries where LGBTIQ+ persons have few or no rights.

Beyond acknowledging the harm done, we need equitable action that removes stigma, for example updating Trinidad and Tobago’s Mental Health Act of 1975 to include the need for equitable service delivery for LGBTIQ+ persons. Developing and enforcing zero discrimination policies that help the mental health workforce unpack biases will also help bring about much-needed change.

Additionally, investing in the mental health workforce so that more people in the LGBTIQ+ community are educated in mental health and hired as mental health professionals can help foster a safer mental health system. Further, reshaping our systems to include peer supporters, especially from the LGBTIQ+ community, can ensure that those on their recovery journey are supported by others with similar experiences.

Most importantly, it is time to truly practice the words “nothing for us without us” and give the LGBTIQ+ community – especially those with lived experience of mental health conditions – an equal role in shaping our mental health system from policy development to service delivery. Those with lived experiences can point out what works in our systems because we have engaged with these systems for years. We can also point practitioners towards better solutions. We need to encourage meaningful collaboration between LGBTIQ+ persons with mental health conditions and traditional mental health professionals.

Lived experiences must begin taking priority, especially LGBTIQ+ experiences.

**Kat McIntosh**, Trinidad and Tobago

reaching marginalized groups of long-term unemployed, street sex workers, refugees, irregular migrants, and homeless people can be achieved by establishing outreach programmes, integrating mental health into general health care, coordinating social and health care and disseminating information to both individuals and practitioners *(47)*. A sound organization of mental health services – as described in Chapter 7 Restructuring and scaling up care for impact – is instrumental in reaching marginalized people.

## 4.3.2 Economic benefits

The economic implications of diminished mental health are enormous and extend far beyond the direct costs of treatment (see section 3.2 Economic consequences).

Good mental health enables people to work productively and realize their full potential. Conversely, poor mental health interferes with people's ability to work, study and learn new skills. It holds back children's educational attainment which can impact future employment prospects. Meanwhile, adults living with mental health conditions may find that they are not able to work, or cannot work as well as usual, often for extended periods of time. Carers may be similarly affected.

A survey on household costs associated with mental health conditions in six countries across sub-Saharan Africa and South Asia found that households where someone had a mental health condition were economically worse off than control households. For example, they had lower housing standards, lower household income, fewer assets, and higher health care expenditures *(216)*.

Work losses not only affect individual and household abilities to earn a living but also contribute to wider societal costs through increased unemployment and welfare needs, lost productivity, workplace accidents and reduced taxation revenue.

Researchers estimate that 12 billion productive work days are lost every year to depression and anxiety alone, at a cost of nearly US$ 1 trillion *(217)*. This includes days lost to absenteeism, presenteeism (when people go to work but underperform) and staff turnover.

Reducing individual, community and structural risks to mental health while simultaneously increasing access to effective care not only improves well-being and social functioning but also leads to a range of economic benefits for affected individuals and their households. Such action can improve participation in, and productivity at, work and school, reduce time spent on informal caregiving, reduce demand for health and welfare services, and increase the potential for savings or investment (see Fig. 4.2). A recent systematic review found that most of the mental health interventions assessed led to improved economic outcomes, mainly in relation to education and employment *(218)*.

Businesses and the wider economy also stand to benefit from investment in improved mental health through greater participation in the labour market and higher productivity, both of which serve to improve a company's bottom line. A study with ten companies in Canada showed that workplace mental health programmes can deliver a positive return on investment within three years *(219)*. For governments too, investing in the population's mental health can lead to savings in welfare support: a recent analysis from Denmark showed that an increase in mental well-being was associated with lower health care costs and sickness benefit transfers *(220)*.

> **12 billion** work days are lost every year to depression and anxiety.

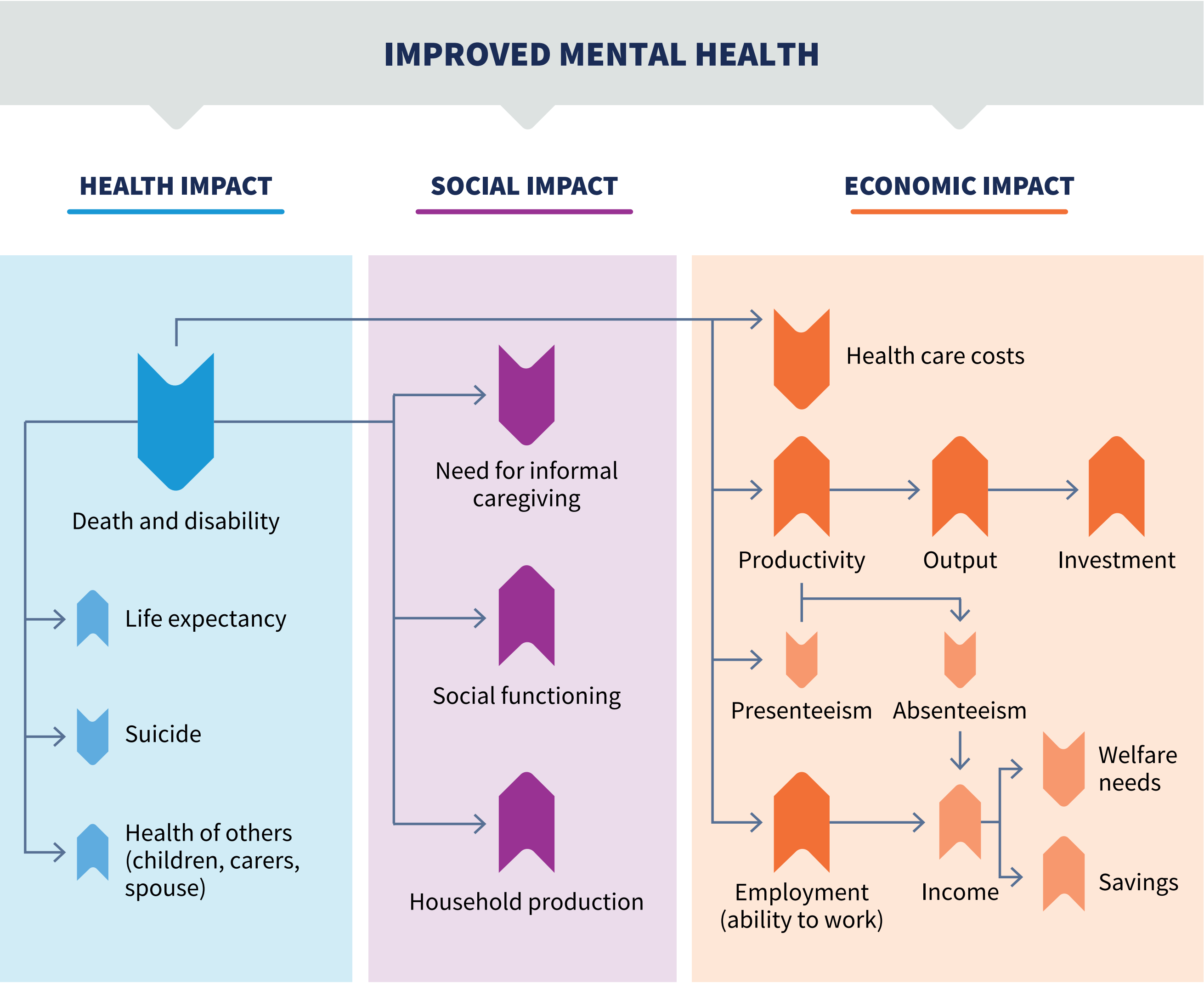
## Economic value and efficiency

The costs and cost–effectiveness of treating mental health conditions have become a very important part of discussions about whether and why countries should invest in mental health.

Accumulated evidence shows that there is a core set of cost–effective interventions for priority conditions that are also feasible, affordable and appropriate even for resource-poor settings.

FIG. 4.2

**Some of the potential social and economic benefits of investing in mental health**



Source: adapted from WHO and UNDP, 2021 *(221)*.

WHO's menu of cost–effective interventions for mental health identifies a selection of mental health interventions for which cost–effectiveness information is available *(222)*. At a population level, the menu identifies universal and indicated school-based social and emotional learning programmes and regulatory bans on highly hazardous pesticides (which are commonly used in suicides in several LMICs) as cost–effective and affordable population-based interventions (see Chapter 6 Promotion and prevention for change) *(222)*. At the individual level, the menu lists a range of cost–effective clinical interventions, which are also included in the WHO

**5 to 1 benefit to cost ratio**
for scaling up treatment for depression and anxiety

UHC compendium (see section 5.1.3 Evidence to inform policy and practice). Of course, cost–effectiveness alone cannot provide the basis for priority setting and WHO's menu stresses the importance of human rights and equity when selecting mental health interventions.

The returns on investment for clinical interventions can be substantial, especially for depression and anxiety. For example, one global modelling study carried out for 36 large countries indicates that a linear increase in treatment coverage between 2016 and 2030 could secure 43 million extra years of healthy life, at a value of US$ 310 billion, and generate a further US$ 399 billion in productivity gains *(217)*. With the cost of scaling up treatment estimated at US$ 147 billion, this provides a benefit cost ratio of five to one (see Fig. 4.3). The highest rewards for investing in depression are predicted in lower-middle-income countries *(217)*.

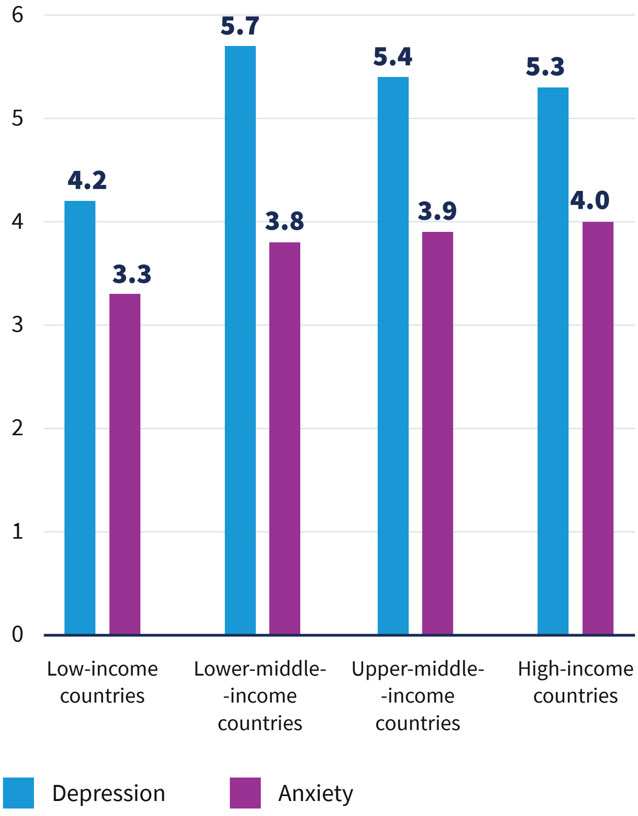
Other modelling studies show that integrated mental health packages that combine multiple interventions for promotion, prevention and care can bring significant and large-scale returns, especially when productivity gains and the value of wider social benefits are considered (see Table 4.4).

In South Asia and sub-Saharan Africa, the cost of scaling up delivery of an integrated package for epilepsy, depression, bipolar disorder, schizophrenia and heavy alcohol use has been calculated at US$ 3–4 per capita. The return on that investment is estimated at 500–1 000 healthy years of life for every million dollars spent *(223)*.

Elsewhere, the cost of implementing a care package in non-specialist settings has been estimated to be even lower. Studies in Ethiopia, India, Nepal, South Africa and Uganda calculate it to be less than US$ 1 per capita. These studies suggest that, over a ten-year scale-up period, the additional amount that would need to be invested each year is less than US$ 0.10 per capita *(224)*.

FIG. 4.3.

**Returns to investment in scaling up treatment for depression and anxiety (benefit to cost ratios)**



Source: Chisholm et al, 2016 *(217)*.

TABLE 4.4

## Investing in mental health delivers significant returns

| CASE STUDY | MODELLED BENEFITS OF INVESTMENT |
|---|---|
| **JAMAICA**<br>**Investment: US$ 115 million to scale up treatment for depression, anxiety and psychosis 2015–2030** | • Increased coverage of psychosocial treatment from 15% to 50%.<br>• Overall benefits of more than US$ 434 million to the economy, including productivity gains and the value of wider social benefits.<br>• Return on investment of more than five to one for clinical treatment of anxiety and depression. |
| **PHILIPPINES**<br>**Investment: US$ 2.7 billion (US$ 2.57 per capita per year) for integrated package of promotion, prevention and care over ten years** | • Universal school-based social and emotional learning interventions to prevent depression and suicide are predicted to have the highest return on investment, resulting in US$ 9.5 for every US$ 1 invested.<br>• Other predicted high return investments include scaled-up treatment of epilepsy (6.6 to 1) and depression (5.3 to 1). |
| **SOUTH AFRICA**<br>**Investment: 9% of projected budget in 2035 to scale up interventions for common and severe mental health conditions, epilepsy, dementia, and alcohol and drug use disorders** | • Highest returns predicted for scaled-up treatment of perinatal, adult and childhood depression, with returns of 4.7, 4 and 3.6 respectively.<br>• By the end of the scale-up period, approximately 2.2 million years of healthy life would be restored, with close to 2.5 million prevalent cases averted and more than 44 000 deaths avoided.<br>• Overall savings for psychosis and dementia did not exceed costs of scale up, but health and human rights benefits were enormous. |
| **UZBEKISTAN**<br>**Investment: US$ 398 million 2021–2030 to scale up evidence-based interventions for common and severe mental health conditions as well as epilepsy and alcohol use disorders** | • Projected benefits of US$ 382 million in restored productivity plus improvements in health itself that were valued at US$ 701 million.<br>• Scaled-up treatment of epilepsy, treatment of depression, and universal, school-based social and emotional learning interventions to prevent depression and suicide, offer the highest returns on investment in terms of restored productivity, and a gain of US$ 8.7, 3.4, 3.0 respectively, for every US$ 1 invested. |

Sources: PAHO, 2019 *(225)*; WHO Regional Office for the Western Pacific, 2021 *(226)*; Besada et al, 2021 *(227)*; WHO Regional Office for Europe, 2021 *(228)*.