World mental health report

Transforming mental health for all

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5 Foundations for change

FRAMEWORKS
KNOWLEDGE AND COMMITMENT
FINANCE
COMPETENCIES

Chapter summary

In this chapter we explore foundations for change towards improved mental health. We focus on four particular components required to secure well-functioning mental health systems and services: effective policy and planning frameworks; public and political knowledge and commitment; sufficient finance and resources, and widespread competencies for mental health care. This chapter also highlights the growing role of digital technologies in strengthening mental health systems and services.

Key messages from this chapter are:

- Key targets for transformation include: plans and policies; leadership and governance; information systems and research; finance; public awareness; and competencies in mental health care.
- Global instruments, ranging from joint action plans to legally binding conventions, are critical to guide action on mental health and provide an enabling context for transformation.
- Three types of political commitment – expressed, institutional and budgetary – are needed to drive the mental health agenda forward and effect meaningful change.
- People with lived experience are important agents of change to improve public awareness of mental health and acceptance of people with mental health conditions.
- Including psychosocial interventions and psychotropic medicines in UHC packages of essential services and financial protection schemes is vital to close the mental health care gap.
- All countries need to expand their specialist workforce and build mental health care competencies among general health care and community providers as well as individuals in the community.
- Digital technologies can strengthen mental health systems by providing tools to inform and educate the public, train and support health care workers, deliver remote care, and enable self-help.

Chapter 4 Benefits of change provided the case for transforming mental health systems, highlighting the potential benefits to be gained. Pockets of progress achieved over the past decade prove that change is possible. The *Comprehensive mental health action plan 2013–2030* provides a roadmap for action by all stakeholders.

In many ways, transforming mental health is about system strengthening: ensuring that each of the core components of a mental health system are fit for purpose. A well-functioning mental health system is built on having trained and motivated mental health workers, well-functioning information systems, and a reliable supply of medical products and technologies, backed by adequate funding, strong leadership and evidence-based plans and policies *(229)*.

Strengthening mental health systems provides the foundations for change. It enables reorganization and scaling up of services and supports. In the sections that follow, we consider what it will take to secure four key foundations for change: effective policy and information frameworks, public and political understanding and commitment, sufficient finance and resources, and widespread competencies for mental health care.

5.1 Frameworks for policy and practice

National and international policy frameworks are used to set out countries' principles, values and objectives for mental health; and they serve to help transformation.

5.1.1 International frameworks

Various international frameworks – ranging from joint agendas and action plans to political declarations and legally binding conventions – have been developed and are being used to guide action on mental health. These include regional frameworks such as: *Scaling up mental health care: a framework for action*, which was adopted by the 68th Regional Committee for the Eastern Mediterranean in 2015; the *2021–2025 European Framework for Action on Mental Health*, adopted by the 71st Regional Committee for Europe in 2021; and forthcoming frameworks by WHO's African Region, WHO's Western Pacific Region and WHO's Region for the Americas.

International frameworks also include global instruments, such as the *Comprehensive mental health action plan 2013–2030*, which provides a roadmap to transforming mental health globally and is central to WHO's work *(3)*. Updated in 2019, this plan is structured around four key objectives (see Chapter 1 Introduction). It outlines actions for Member States, WHO and partners and sets out diverse options for how such actions could be implemented. Delivering on the action plan targets would go a considerable way towards improving mental health worldwide.

> *Delivering on the* Comprehensive mental health action plan 2013–2030 *would go a considerable way towards improving global mental health.*

Another key global framework is the CRPD, which came into force in 2008. Ratified by 182 countries, the CRPD is a legally binding convention to promote, protect and ensure the full and equal enjoyment of all human

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BOX 5.1

International instruments for human rights

Human rights instruments adopted by UN Member States with relevance to the rights to mental health and the rights of people with mental health conditions include:

- Universal Declaration on Human Rights (1948);
- International Covenant on Economic, Social and Cultural Rights (1966);
- International Covenant on Civil and Political Rights (1966);
- Convention on the Elimination of All Forms of Discrimination against Women (1979);
- Protection of Prisoners and Detainees against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1982);
- Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (1987);
- Convention on the Rights of the Child (1989);
- ILO Indigenous and Tribal Peoples Convention (1989);
- United Nations Rules for the Protection of Juveniles Deprived of their Liberty (1990);
- The United Nations Principles of Older Persons (1991);
- Declaration on the Elimination of Violence against Women (1993); and
- Convention on the Rights of Persons with Disabilities (2006).

Source: OHCHR, 2021 *(230)*.

rights for people with disabilities, including psychosocial disabilities (see section 4.2 Promoting and protecting human rights).

Various other global human rights instruments also promote the rights of people with mental health conditions, both directly and indirectly (see Box 5.1 International instruments for human rights). Together, these international instruments provide powerful tools for legal and social advocacy to transform mental health.

The 2030 Agenda for Sustainable Development, and its 17 SDGs, is another important global framework for mental health *(231)*. SDG3 focuses specifically on health and includes target 3.4 to reduce by one third premature mortality from NCDs through prevention and treatment, and to promote mental health and well-being. Suicide mortality rate is an indicator for this target (indicator 3.4.2).

A major implication of SDG3 for mental health policy and practice is a requirement for a strong public health approach to the needs of those with mental health conditions. But, as detailed by the Lancet Commission on Global Mental Health and Sustainable Development, the SDGs provide a broader framework for transforming mental health because many other SDGs explicitly address the social and structural determinants of mental health (see section 4.3 Enabling social and economic development) *(15)*.

Just as the links between development priorities and mental health are increasingly acknowledged, so too are the links between mental health and other health priorities. In 2018 UN heads of state and governments signed a political declaration on the prevention and control of NCDs (covering cardiovascular diseases, diabetes, cancer and chronic respiratory diseases) that acknowledges the bidirectional links between these NCDs and mental health conditions *(232)*. Accordingly, it provides a new level of political commitment to also prioritize mental health when implementing the NCD agenda. It also provides new impetus to manage mental health conditions alongside NCDs, both within primary health care and within specific NCD programmes (see section 7.2 Mental health integrated in health services).

Universal health coverage (UHC) for mental health

UHC means that everyone everywhere can get the health care they need without suffering financial hardship. Achieving UHC by 2030 is one of the SDGs. Importantly, UHC does not mean free access to every possible health service for every person. Every country has a different path to achieving UHC and deciding what to cover, based on their people's needs and the resources at hand. UHC does however emphasize the importance of access to health services and information as a basic human right.

In 2019, the UN General Assembly made specific mention of "people with mental health problems" in its resolution on UHC *(233)*. That same year, with the launch of the WHO Special Initiative for Mental Health, WHO firmly embedded mental health into its own strategic efforts to expand UHC (see Box 5.2 WHO Special Initiative for Mental Health).

Embedding mental health in UHC is critical to close the huge mental health care gap that exists in many countries.

Embedding mental health in UHC is critical to close the huge mental health care gap that exists in many countries. And it is a fundamental step on the road to mental health reform. In practice, it comprises activities to include mental health needs in parity with physical health needs in all plans and processes developed to achieve UHC.

BOX 5.2

WHO Special Initiative for Mental Health

In 2019, the WHO Special Initiative for Mental Health was established to accelerate access to mental health services through UHC. The goal is to ensure 100 million more people have access to quality and affordable mental health care.

The initiative will initially be implemented in 12 countries to demonstrate what is possible. Eight countries have already been selected: Bangladesh, Ghana, Jordan, Nepal, Paraguay, Philippines, Ukraine and Zimbabwe. In each country, the Special Initiative will be anchored in two broad types of strategic action:

- advancing mental health policies, advocacy and human rights; and
- scaling up interventions and services across community-based, general health and specialist settings.

Importantly, the initiative takes a case-by-case approach to embedding mental health in UHC and mental health reform, using detailed country assessments and consultations to develop a plan that builds on existing strengths and responds to national priorities so that support can be targeted where it is needed most. Ministries of Health are supported to lead national-level transformation with emphasis on scaling up services to districts and regions. In this way, the initiative hopes to secure sustainable scale up.

Priorities across several countries focus on the building blocks for health system strengthening, for example governance, access to services and information systems. Some countries, such as Paraguay, are also focusing their efforts on the mental health aspects of COVID-19 recovery.

Source: WHO, 2021 *(234)*.

This means including both social and psychological interventions, as well as basic medicines, for mental health conditions in UHC basic packages of essential services and financial protection schemes (see section 5.1.3 Evidence to inform policy and practice). It means ensuring that mental health care is available and accessible through a broad range of health and social care services, including primary health care *(235)*. And it means expanding training throughout the health care system to ensure staff are competent to deal with mental health conditions.

5.1.2 National policy and legislative frameworks

Global frameworks are important and useful in directing efforts to improve mental health. But ultimately it is national policies, plans and laws that shape local action on mental health and enable change. At this level, governments have the lead responsibility to develop and implement frameworks to meet all the mental health needs in their country, to protect the rights of those with mental health conditions, and to promote the mental health and well-being of all.

According to WHO's *Mental health atlas 2020*, the number of countries with established policies, plans and laws in place for mental health is steadily growing (see section 3.3.2 The governance gap) *(5)*. These are important to articulate clear objectives for mental health and to direct practice and implementation.

Mental health legislation that complies with international human rights instruments, whether independent or integrated into other laws, is specifically needed to protect and promote human rights, for example by establishing legal and oversight mechanisms and enabling the development of accessible health and social services in the community.

Human rights-oriented laws and policies are needed to guide transformation in mental health, including shifting from institutional to community-based services. They protect against discrimination and abuse. They emphasize the importance of liberty and enable dedicated community-based mental health services – such as community mental health centres or mental health teams – to be developed and to function, so that those with mental health conditions can avoid hospitalization in custodial institutions. And they can help ensure mental health is included within primary care and other priority health programmes and partnerships, for example for HIV/AIDS, women's health, children and adolescent health, communicable and noncommunicable diseases.

Given the multisectoral nature of mental health determinants, and the importance of mental health programmes in areas such as education, employment, disability, the judicial system, human rights protection, social protection, poverty reduction and development it is essential that laws and policies aimed at improved mental health should be developed beyond the health sector. This includes, for example, developing legislation to protect children from abuse or to protect workers' rights to mental health.

In all cases, identifying and involving stakeholders in the development of mental health laws and policies is important to ensure they are fit for purpose.

Detailed plans of how laws and policies will be implemented are vital. This means:

- establishing timeframes for developing and delivering specific elements of the law and policy;
- allocating budgets;
- estimating human resource needs (both specialist and non-specialist) and making a plan for how these will be trained and placed;
- identifying all activities that need to be done and establishing clear roles and responsibilities for each one; and
- establishing how monitoring and evaluation will be done to assess progress and performance (including on rights compliance) and to enable continuous improvement.

WHO suggests setting up a functional mental health unit or coordination mechanism in the ministry of health, with an allocated budget and responsibility for strategic planning (including situational analysis, needs assessment and inter-ministerial and multi-sectoral coordination and collaboration) to help ensure the development and implementation of effective national policy and legal frameworks *(3)*.

5.1.3 Evidence to inform policy and practice

Relevant and reliable information and research are needed to ensure that transformative policies, plans and evaluations for mental health reform are informed by evidence.

Making a case for investing in mental health relies in part on having evidence that mental health conditions are prevalent and pose a serious threat to public health (see Box 5.3 WHO World Mental Health Surveys). Putting evidence into context is

particularly important. National and local data on the impact of mental health conditions on health, education, employment, welfare and other sectors, and the effectiveness of community-based care can help place the case for investment within relevant political contexts that drive policy-makers to act (see section 4.3.2 Economic benefits) *(236)*. In Belize, for example, evidence on the specific problems in the national mental health system, and on the effective strategies available for overcoming them, was a key factor in persuading policy-makers and donors to back a radical reform of mental health services in the country over 20 years *(237)*.

In addition to robust data on the prevalence and impact of mental health conditions, evidence that there are effective solutions is essential to counter misconceptions that investing in mental health is not worthwhile.

The UHC Compendium

In every area of health, but perhaps especially in mental health – where resources are usually scarce – it is essential that every intervention is backed by evidence, grounded in analyses of carefully chosen and collected routine data, and sensitive to cultural contexts and local conditions.

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BOX 5.3

WHO World Mental Health Surveys

For more than 20 years, WHO World Mental Health Surveys Initiative has coordinated and carried out rigorous general population epidemiologic surveys to provide information on the global prevalence, burden and unmet need for treatment of mental disorders; and to support policy decisions.

The initiative operates in 29 countries that, when combined, represent all regions of the world and include a total sample size of more than 160 000. All surveys use a common methodology that includes a WHO structured diagnostic interview to assess conditions and treatment, consistent interviewer training and procedures, and standard quality control protocols.

The World Mental Health Surveys have been variously used to estimate the prevalence of mental disorders, evaluate risk factors, study patterns of and barriers to service use, and validate estimates of disease burden. Together, they have been crucial in establishing that mental disorders are very common around the world. In almost all cases, they have given countries their first ever national representative data on the epidemiology of mental disorders.

Sources: Harvard University, 2021 *(238)*; Demyttenaere et al, 2004 *(239)*; Kessler et al, 2007 *(240)*.

WHO guidelines and recommendations identify a range of interventions for managing mental health conditions, whose efficacy and appropriateness has been established through systematic reviews of the best available evidence and consideration of values, preferences, and feasibility issues from an international perspective *(241)*.

- **Psychosocial interventions** involve interpersonal or informational activities, techniques, or strategies to improve health functioning and well-being *(242)*. For mental health, these include psychoeducation, stress management (including relaxation training and mindfulness), emotional or practical social support (including psychological first aid), and various other social and rehabilitative activities, including peer support and supported employment and housing *(203)*. These also include psychological treatments such as behavioural activation, problem-solving therapy, cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and eye movement desensitization and reprocessing (EMDR).
- **Psychotropic medicines** can, where appropriate, be used to reduce the symptoms of priority mental health conditions and improve functioning. Psychotropic medicines on the *WHO model list of essential medicines* include medicines for psychosis, bipolar disorder, anxiety disorders, depression and obsessive-compulsive disorder *(243)*.

Based on extensive reviews of research, WHO has compiled the UHC Compendium to help countries decide what to include in UHC service packages. This global repository includes more than 3 500 evidence-based interventions across all areas of health, including more than 200 health actions for mental health conditions *(179)*.

Mental health actions listed in the compendium address the spectrum of promotive, preventive, diagnostic, curative, and rehabilitative interventions. They are largely based on the mhGAP Evidence Resource Centre, which contains the background material, process documents, and the evidence profiles and recommendations for WHO guidelines for mental, neurological, and substance use disorders *(159)*. Most of the clinical interventions listed in the compendium are included in the widely used mhGAP Intervention Guide (mhGAP-IG) for non-specialized health care settings (see Box 5.4 mhGAP Intervention Guide: eight steps in clinical practice).

For many people living with mental health conditions, being able to choose and access psychological treatment and other psychosocial support is essential.

Importantly, clinical recommendations listed in the UHC Compendium and in the mhGAP-IG include a mix of psychosocial and pharmacological interventions. Too often, discussions on mental health in UHC coverage packages focus exclusively on medicines. But for many people living with mental health conditions, being able to also choose and access psychological treatment and other psychosocial support is essential.

For each intervention and health action listed in the UHC Compendium, information is given on relevant health programmes, life-course stage and SDG goals.

Many of the mental health interventions in the compendium are not only effective but also cost–effective and are on the *WHO menu of cost–effective interventions for mental health* (see section 4.3.2 Economic benefits) *(222)*.

In practice, the choice of intervention and how it is implemented should be based on the type of mental health problem being experienced and, in the case of children and adolescents, on the developmental stage of the person experiencing it. And even though mental health

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BOX 5.4

mhGAP Intervention Guide: eight steps in clinical practice

Priority mental, neurological and substance use conditions currently targeted by WHO's mhGAP are: depression, psychosis (including schizophrenia and bipolar disorder), epilepsy, dementia, disorders due to alcohol or drug use, child and adolescent mental and behavioural disorders and conditions related to stress (for example, PTSD) as well as self-harm/suicide. For each of these, WHO has developed (and continues to update) management recommendations using the well-established Grading of Recommendations Assessment, Development and Evaluation (GRADE) method. The recommendations cover both psychosocial and pharmacological interventions.

The mhGAP Intervention Guide (mhGAP-IG) turns these evidence-based guidelines into simple clinical protocols that can support decision making on the ground in non-specialized health care settings. Additionally, a broader programme of action builds partnerships across all stakeholders to adapt and adopt the protocols at scale.

The mhGAP-IG describes the essentials of mental health clinical practice, including assessing the person's physical health and assessing and managing mental, neurological and substance use disorders. In particular, it identifies eight steps in clinical practice.

1. Develop a treatment plan in collaboration with the person and their carer.
2. Always offer psychosocial interventions for the person and their carers.
3. Use pharmacological interventions when indicated.
4. Refer to a specialist or hospital when indicated and available.
5. Ensure that an appropriate plan for follow up is in place.
6. Work with carers and families to support the person.
7. Foster strong links with employment, education, social services and other relevant sectors.
8. Modify treatment plans for special populations, including children and adolescents, women who are pregnant or breast-feeding and older adults.

Sources: Dua, 2011 *(241)*; WHO, 2016 *(244)*.

conditions exist on a continuum (see section 2.1.2 Mental health exists on a continuum), health care providers need a diagnostic framework to clinically assess, treat and ensure payment for the care of mental health conditions.

International Classification of Diseases, 11th Revision (ICD-11)

Using medical nosology is important to ensure that mental health is included in health statistics and in health services planning and implementation. For example, if a country is developing a UHC basic package of services, it must be able to list clearly defined mental health conditions to decide what intervention to include for what condition. And in many countries, both public and private health insurance providers usually require a diagnosis before covering the costs.

WHO's ICD-11 is the gold-standard global tool for coding diseases, causes of death, injuries and health conditions, informed by an extensive review of the evidence *(245)*. It includes a fully revised chapter on mental, behavioural and neurodevelopmental disorders that has been designed to make mental health diagnoses more accessible, also in non-specialist settings *(246)*.

Unlike most other diagnostic systems in mental health, this ICD-11 chapter is especially designed to ensure it is clinically useful and globally applicable, in addition to being valid and reliable *(247)*.

Mental health information systems

Health management information systems, including those for mental health, provide valuable data on needs, services use and resource demands. These can be used to track trends and clusters of cases, identify at-risk groups and measure mental health outputs and outcomes (including coverage). They can also be vital to inform service provision, resource deployment and management guidelines *(248)*.

For mental health information systems to be useful in informing policy and planning and improving mental health outcomes:

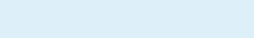
- the indicators must be relevant and feasible to collect;
- the data must be regularly reviewed and used to identify trends; and
- the health system must allow for practical changes to be made on the basis of data collected.

Where these conditions are manifest, health information systems can enable decision-making in all aspects of the health system and ensure the delivery of equitable, effective, efficient and good quality interventions.

But despite an appetite for using information systems to support decision-making around service planning, this rarely happens in LMICs (see Box 5.5 Mental health management information systems in LMICs) *(249)*.

ICD-11 is designed to ensure it is valid, clinically useful and globally applicable.

The *Comprehensive mental health action plan 2013–2030* commits countries to strengthen their surveillance systems for monitoring mental health, self-harm and suicide. It suggests that countries disaggregate data by facility, sex, age, disability, method and other relevant variables; and that they use these data to inform plans, budgets and programmes.



CASE STUDY

BOX 5.5

Mental health management information systems in LMICs

A survey of mental health management information systems in six African and Asian countries (Ethiopia, India, Nepal, Nigeria, South Africa and Uganda) found that all countries collected some mental health indicators through their routine health management information system, but that these data were limited in scope and variable in their categorization of mental health conditions.

In general, the information systems surveyed focused on reporting mental health diagnoses rather than providing system level indicators on quality and use of services. Where data on mental health were collected and reported they took too long to reach policy-makers to be able to influence decisions.

Introducing a separate mental health information system is unrealistic and undesirable in many LMICs where mental health is still largely neglected and resources remain in short supply. But routine information systems can be strengthened to deliver better quality mental health data. For example by providing better support and training in mental health information management, including selecting relevant standardized indicators for mental health.

Source: Upadhaya et al, 2016 *(250)*.

Research for mental health

In addition to robust information systems, evidence-based mental health policies and services also require locally relevant research that is timely, relevant, reliable, well-designed and conducted, accessible and innovative.

Various initiatives have established research priorities for mental health at a global level. For example, the 2011 Grand Challenges in Global Mental Health, which established 25 research priorities for mental health involved researchers, advocates, programme implementers and clinicians from more than 60 countries and was instrumental in directing substantial research funding for mental health *(251)*.

Global prioritization initiatives for mental health research such as the Grand Challenges highlight the importance of research aimed at finding better interventions, methods of care or even cures for mental health conditions. But they also identify other areas of importance, including research on: the determinants of mental health; the prevalence and global burden of mental health conditions; the feasibility and affordability of interventions; and the effectiveness and appropriateness of different interventions in different contexts.

At a national level, the *Comprehensive mental health action plan 2013–2030* emphasizes the importance of developing a prioritized and funded research agenda that is based on consultation and cooperation with all stakeholders and sectors; and that includes robust mechanisms for translating knowledge into practice.

Of course, not all research is done to specifically inform a given policy or with the intention of being directly applied in practice. And it is often the accumulation and replication of data that eventually gets adapted and adopted into policy or into clinical guidelines or recommendations, rather than a single piece of research. Notwithstanding, where research starts with the intention of practical application, there is much that researchers can do to support the translation of knowledge into practice and guide mental health transformation.

They can, for example, ensure that their research reflects local and national realities. Data collected for the *Mental health atlas 2020* shows that less than 5% of health research outputs globally focused on mental health; and most of that was concentrated in high-income countries (see section 3.3.1 The data gap). Addressing global research imbalances and helping to close the data gap is important to ensure LMICs have the information they need to identify and target their own mental health needs and priorities. That means conducting clinical research in LMICs and ensuring a central role for LMIC researchers in designing and managing the research. It also means paying greater attention to mental health systems research, rather than basic or clinical research, to better understand how to transform services so they meet the mental health needs of all those who need care *(252)*.

Researchers can do much more to involve people with lived experience in research design and delivery. People with lived experience and their organizations can facilitate global networks for research collaboration. They can help design and carry out culturally-validated research. And they can help evaluate services to ensure research is credible and genuinely useful to service users and carers *(253)*.

Ensuring that mental health research evidence can be put to use – including by policy-makers, managers, clinicians and mental health planners – is essential *(254)*. Planning research collaboratively with stakeholders, sharing regular updates and findings, assessing potential implications and jointly considering how to use evidence as it emerges, holds enormous potential for translating knowledge into practice, including by conducting implementation science.