Including Mental Health in the Sustainable Development Goals

The United Nations member states are currently negotiating the Sustainable Development Goals (SDGs). Health is a crucial prerequisite for sustainable human development, and there can be no health without mental health. Mental health plays a key role in efforts to achieve social inclusion and equity, universal health coverage, access to justice and human rights, and sustainable economic development.

We, the FundaMentalSDG initiative, call upon you to support the inclusion of mental health, and to promote three edits to the Open Working Group (OWG) draft Goal 3, which are fully aligned with the WHO Global Mental Health Action Plan 2013-2030:

1. Edit the title of Goal 3 to: Ensure healthy lives and promote physical and mental health and well-being for all at all ages

2. Edit target 3.4: ‘By 2030, reduce by one third preventable premature mortality from non-communicable diseases through prevention and treatment in full accordance with the WHO Global Action Plan for the Prevention and Control of Non-Communicable Diseases, and promote mental health and well-being in full accordance with the WHO Mental Health Action Plan 2013-2020.’

3. Edit target 3.8: ‘Achieve universal health coverage for physical and mental disorders, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

We further ask you to support the two indicators, as proposed by the UN Sustainable Development Solutions Network:

1. Indicator 23: Probability of dying between exact ages 30 and 70 from any of cardiovascular disease, cancer, diabetes, chronic respiratory disease, or suicide

2. Indicator 28: Proportion of persons with a severe mental disorder (psychosis, bipolar affective disorder, or moderate-severe depression) who are using services

Why we need a global Mental Health Target in the SDGs

HIGH PREVALENCE: 1 in 4 people experience mental illness

The WHO estimates that 1 in 4 people will experience an episode of mental illness in their lifetime and that as a consequence ca. 600 million people worldwide disabled. Most of these people live in Low and Middle Income Countries (LMICs) and four fifths of them are receiving no treatment.

GLOBAL EMERGENCY: Human rights violations, stigma and discrimination

Worldwide people with psychosocial disabilities experience most severe human rights violations, many are chained, caged in small cells, physically abused and discriminated. This failure of humanity is a global emergency and requires immediate and sustained action.

GROWING BURDEN OF DISEASE: Reduced lifespan by up to 20 years

Mental and behavioural problems are the biggest single cause of disability in the world, more than cardiovascular diseases and cancer combined. In addition, in high income countries men with mental health problems die 20 years and women 15 years earlier than other people. In low income countries the situation is even worse.

#FundaMentalSDG

#FundaMentalSDG is a global initiative taken by international leaders in mental health. Its goal is to strengthen mental health target in the post-2015 SDG agenda because there can be no sustainable development without health, and no health without mental health. FundaMentalSDG proposes three edits to the OWG draft Sustainable Development Goal 3, which are fully aligned with the WHO Global Mental Health Action Plan 2013-203
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GOAL 3: Ensure healthy lives and promote *physical and mental health and* well-being for all at all ages

3.1 By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

3.2 By 2030, end preventable deaths of newborns and children under 5 years of age

3.3 By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

3.4 By 2030, reduce by one third preventable premature mortality from non-communicable diseases through prevention and treatment *in full accordance with the WHO Global Action Plan for the Prevention and Control of Non-Communicable Diseases*, and promote mental health and well being *in full accordance with the WHO Mental Health Action Plan 2013-2020*.

3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents

3.7 By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes

3.8 Achieve universal health coverage *for physical and mental disorders,* including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

3.9 By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

3.a Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate

3.b Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all

3.c Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States

3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks

*This document shows the OWG SDG draft (of 19.07.14), including the proposed edits by FundaMentalSDG in italics & highlighted.*
Supporting Organisations of FundaMentalSDG

- ADD freeSources
- The Alan J Flisher Centre for Public Mental Health, at UCT/Stellenbosch, South Africa
- Africa Mental Health Foundation
- American Psychiatric Association (APA)
- APP-Action on Postpartum Psychosis, UK
- Austrian Society for Social Psychiatry (Österreichische Gesellschaft für Sozialpsychiatrie)
- Awakenings Foundation, the Community Psychiatry Centre of the Semmelweis University, Budapest, Hungary
- BasicNeeds, UK
- Bipolar UK
- Butabika National Referral Mental Hospital, Uganda
- Careif Centre for Applied Research and Evaluation International Foundation
- CBM, Christofel Blindenmission, Germany
- Centre for Chronic Conditions and Injuries, Public Health Foundation of India, India
- Centre for the Economics of Mental and Physical Health, King’s College London
- Centre for Global Initiatives
- Centre for Global Mental Health, UK
- Department of Psychiatry, Razi University Hospital, La Manouba, Tunisia
- Department of Psychiatry, Federal University of Sao Paulo, Brazil
- Department of Psychiatry II, University of Ulm and BKH Günzburg, Germany
- Department of Psychology, University of Kwa Zulu Natal, Durban, South Africa
- Dept of Psychiatry, Queen’s University, Canada
- Department of Psychology, University of Kwa Zulu Natal, Durban, South Africa
- Faculty of Medical Sciences, Nova University of Lisbon, Portugal
- EMERALD, EU Programme on Mental Health System Strengthening
- Gede Foundation, Nigeria
- Gulbenkian Global Mental Health Platform, Portugal
- HealthnetTPO, The Netherlands
- Human Rights in Mental Health – FGIP, The Netherlands
- iFred, USA
- in2mentalhealth
- Institute of Psychiatry, Psychology & Neuroscience, King’s College London, UK
- London School of Hygiene and Tropical Medicine (LSHTM)
- Maudsley International, UK
- Member Care Associates
- Mental Health Innovation Network
- Mental Health First Aid, Australia
- Mental Health Foundation, UK
- MIND, UK
- Movement for Global Mental Health
- MQ Transforming Mental Health
- National Network of Depression Centers
- Peter C. Alderman Foundation, USA
- The Professional Board of Psychiatrists, Hungary
- SCARF Schizophrenia Research Foundation, India
- SHINE - Supporting People Affected by Mental Ill Health
- StrongMinds
- TPO Nepal
Supporting Organisations

- The World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA)
- World Association of Social Psychiatry, UK
- Wold Medical Association
- World Federation for Mental Health, USA
- World Psychiatric Association
3 October 2014

Dear Professor Thornicroft,

On behalf of the Secretary-General, I wish to thank you for your letter dated 15 September 2014 where you underscore the importance of mental health in the Post-2015 development agenda. This is indeed an issue of high importance, and of which we must not lose sight in the ongoing deliberations. I commend your international consortium, FundaMentalSDG, for this important contribution.

As preparations for the synthesis report get under way, I wish to underscore that it is the Secretary-General’s utmost priority to respect the work done by Member States and the equilibria found within the Open Working Group. In this regard, your constructive suggestions towards a transformative development agenda are greatly appreciated.

The Secretary-General continues to count on your active engagement as the international community endeavours to advance sustainable development and create a just world where all people live with dignity.

Yours sincerely,

Amina J. Mohammed
Special Adviser of the Secretary-General
on Post-2015 Development Planning

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Kofi Annan calls for the tackling of depression to be made a global priority

Former UN secretary general says failure to confront mental health problems undermines human rights of millions

James Kingsland

The former UN secretary general, Kofi Annan has called for the tackling of depression to be made a global priority, with mental health incorporated into a new UN Millennium Development Goal after the deadline for achieving the current goals passes in 2015.

“The failure to tackle depression undermines the fundamental human rights of millions and millions of people,” he said. “This begins with the denial of even the most basic levels of treatment and support.”

Annan said the collective failure to confront the condition, which affects almost 7% of the world’s population – 400 million people – was not a result of a lack of knowledge about treatment, but a failure to recognise the scale of the problem and put in place resources to overcome it.

“The challenge is to find the global vision and leadership to maximise the benefit for...
individuals and families.”

Speaking at a forum in London on Tuesday about the global depression crisis, Annan praised the World Health Organisation (WHO) for stressing the importance of good mental health, but said that even in developed countries help for people with depression often lagged badly behind help for those suffering from physical conditions. In less-developed countries, he said, support and treatment could be non-existent.

“Too often and in too many societies those with mental health [problems] face discrimination and isolation,” he added. There was a lack of resources and trained mental health providers, he said, “but we also have to deal with the social stigma and lack of community understanding associated with mental disorders. This is all the more shocking given that depression can affect all of us. There will hardly be one extended family where one member has not suffered from depression.”

The forum, organised by the Economist, brought together psychiatrists, policymakers and business leaders to discuss the global crisis of depression, which in 2010 was estimated to cost $800bn (then £520bn) a year in lost productivity and healthcare costs, a sum expected to double over the next 20 years. The WHO estimates that depression is already the leading cause of disability worldwide.

The UK health minister, Norman Lamb, welcomed Annan’s call to put mental health on the UN’s development agenda.

“Faced with the statistics, no one can underestimate the extent of the problem or the challenges that lie ahead of us,” he told the meeting. But Lamb said that in the UK and elsewhere there was an imbalance of resource allocation between mental and physical health. “Mental health always tends to lose out. That in my view has to change.”

Ahead of the meeting, Prof Simon Wessely, president of the Royal College of Psychiatrists, told the Guardian that the mental health problems of patients with serious physical conditions such as cancer, heart disease and diabetes were too often ignored. He said that in the UK, the NHS was organised in such a way that physical and mental health problems were addressed separately, despite research showing that tackling psychological issues such as depression not only improved patients’ quality of life but also improved physical outcomes.

Ideally, physical and mental issues should be addressed concurrently, he said, but the way services were delivered in separate hospitals by different professionals mitigated against this. “We have separated out the mental and physical,” he said. “The truth is that for many generations we’ve considered the physical side of illness to be more important than the mental side.”

Other key speakers at the forum included David Haslam, who chairs the National
Institute for Health and Care Excellence. Haslam agreed that there was a tendency to organise treatment around single conditions. He said that for patients with chronic pain, heart disease and breathing difficulties, in particular, depression was often a significant factor in their lives that went untreated.

“I suspect that for a long time there was almost a naive feeling that people with long-term conditions were probably fed up with having long-term conditions, but now people are realising that it's actually much more significant than that and needs treating very seriously.”

Wessely pointed to research at King’s College in London showing that integrating psychological therapies into diabetes services not only reduced levels of depression but also improved diabetic control. Other research, recently published in the Lancet, found that treating depression in patients with cancer improved quality of life at relatively little cost compared with the expense of cancer drugs.

“It’s a fantastically cost-effective treatment,” he said. “Of course, it doesn’t cure cancer and no one says it does, but in terms of improving the quality of life of cancer patients this was absolutely phenomenal.”
The importance of mental health in the Sustainable Development Goals

Nicole Votruba1 and Graham Thornicroft2

The United Nations’ draft Sustainable Development Goals (SDGs) only briefly mention mental health. In the context of a growing burden of disease due to mental disorders and psychosocial disabilities, the inclusion of a clear mental health target and indicators in the SDGs will acknowledge the needs and rights of hundreds of millions of people. It will mobilise international funding and policy development, and support other SDGs; it will also strengthen mental health structures, governance and services in low- and middle-income countries. We argue that for a just, sustainable and inclusive post-2015 development agenda, it is vital that the United Nations includes a clear mental health target and indicators in the SDGs.

Mental disorders and psychosocial disability are among the greatest global health challenges and yet are largely ignored in international development strategies. One in four people experience a mental health problem in their lifetime, and most of them (85%) live in low- and middle-income countries (Wang et al, 2007). Millions of these people worldwide face stigma, discrimination and severe human rights abuses every day (Thornicroft, 2006).

Since 2000, the Millennium Development Goals (MDGs) have motivated nations and organisations to take action for development; however, they made no reference to mental illness. In his review of the MDGs, the Secretary-General of the United Nations (UN), Ban Ki-Moon, stated that more must be done to secure the well-being, dignity and rights of those at the margins (Ki-Moon, 2013). The UN’s Post-2015 Development Agenda is intended to provide ‘a life of dignity for all’ and to improve health, including mental health (United Nations, 2013). While the MDGs have had some success in promoting basic development, we now need to tackle an issue that was left out: mental health. It is vital that the UN includes a clear mental health target and indicators in its new Sustainable Development Goals (SDGs), for the following reasons.

The case is clear

Mental disorders and psychosocial disabilities are globally under-financed, in both government spending and development aid. In most middle- and low-income countries, government investments in mental health services and human resources utterly fail to respond to the level of need (Saxena et al, 2007). This is why most people with mental disorders do not have access to effective treatment (World Health Organization, 2011). In low-income countries, this treatment gap is up to 98% for more severe illnesses (World Health Organization, 2008). This is a breach of the fundamental right to access healthcare, as set out in the Convention on the Rights of Persons with Disabilities.

Amina J. Mohammed, a special advisor to Ban Ki-Moon, stated that with the new SDGs the voices of people will be ‘lifted up and brought to … attention’ (Mohammed, 2013). Most people who suffer from mental disorders and psychosocial disabilities cannot raise their voice, either because they are figuratively ‘locked in’ by their mental illness or because they are literally locked in, in mental health institutions or prisons, or locked out by their societies. Making mental health a target in the SDGs will help to strengthen their fundamental rights and give these people a voice.

Referring to the core values of development

The Rio+20 Conference in 2012 reaffirmed the values of global development: freedom, peace and security. When aiming to support these values, we need to recognise that many people with mental illness remain vulnerable, either in our communities, because of exclusion from normal citizenship, or in hospitals, where their human rights are more likely to be violated, for example by degrading conditions, neglect or inhumane treatment.

Including a mental health target in the SDGs responds to one of the core ideas of development, to ‘leave no one behind’ (Ki-Moon, 2013). For the new SDGs to be inclusive, they must focus on the needs of the least privileged people. People with mental health problems are among the most marginalised communities in the world; up to now they have been largely overlooked by global development, as well as national policies. A clear mental health target will include these hundreds of millions of people in development, and strengthen their fundamental rights and freedoms.

Motivation and mobilisation

Including mental health in the SDGs will motivate and mobilise nations, organisations and donors to take action, and allocate resources, for mental health development. Global development budgets have increasingly provided for the need to address psychosocial disabilities. The World Health Organization, the European Union and several high-income donor governments have focused on
scaling up services for mental health in low- and middle-income countries.

Globally, the average yearly spending on mental health is currently less than US$2 per person, but in low-income countries it is less than 25 cents per person (World Health Organization, 2011). This is clearly insufficient to treat even basic mental disorders. A mental health target in the SDGs will help to mobilise internal and external investment for psychosocial disability treatment and services, and it will attract international donors to invest in mental health systems, services and projects.

Measurability and accountability

Including mental health in the SDGs will also motivate countries; it will give governments a clearer focus on inclusive health policy-making and support good governance. This requires the global use of a small set of agreed indicators of mental health system performance. The use of measurable indicators of change will also help governments attract international donor funds to strengthen their service provision.

We therefore need a mental health target and indicators in order to measure progress and hold ourselves to account. As Lynne Featherstone stressed when she was the UK’s under-secretary of state for international development, hundreds of millions of people with disabilities currently ‘simply don’t count’ (Jones, 2014) and will be left out if we do not record data. Monitoring average development is not enough: progress must be measured specifically for people with mental and psychosocial disabilities.

A clear target and indicators will help to define responsibilities and mechanisms to which nations and donors can commit. It will enable the global community to monitor progress and to hold nations and organisations to account for the delivery of mental health services and policies.

Currently, only about 60% of countries have a clear mental health policy and only 72% have a mental health plan (World Health Organization, 2011). Including mental health in the SDGs will encourage countries to develop a dedicated mental health policy, plan and legislation. Mental health legislation and governance make systems for people with mental disorders more reliable and accountable.

Economic growth

Mental disorders and psychosocial disabilities are big obstacles to social and economic progress. Mental and behavioural problems account for big obstacles to social and economic progress. Economic growth and success, and guarantee accountability; actors and mobilise funds, help to measure progress and success, and guarantee accountability; it will also contribute to global and regional economic growth. Overall, this will further the social and economic inclusion of people with mental and psychosocial disabilities, and it will promote access to basic mental healthcare, human rights and the foundations for a decent life.

Considering the urgent global situation, and the cross-cutting influence of mental health on the planned SDGs, including a mental health target in the SDGs, and thus making mental health integral to development, is a global imperative. Without including mental health in the SDGs, many hundreds of millions of people will be left behind in development, especially those who are least able to help themselves.

References


Mohammed, A. (2013) A just and sustainable world. The post-2015 development agenda must address the unmet challenges
International partnerships in psychiatry: introductory reflections from a seasoned sojourner

John Cox

The three thematic papers in this launch issue of BJPsych International are intended to inform and motivate College members around the world to reflect on the challenges of bilateral links between high- and low-income countries, on the exhalation of being a new sojourner in a new land – and on the diaspora searching for almost forgotten cultural roots in a home country. They all illustrate the way in which twinning structures between National Health Service trusts, universities and research councils have facilitated these exchanges of personnel between high- and low-income countries which have benefited, at least in the short term, both parties – and facilitated the professional development of both psychiatrists and other health professionals.

They illustrate also the excitement and creative challenge of being caught between two cultures and of how to arrange revalidation and registration in the UK when working abroad. Globalisation, immediate communication by Skype or email, and low-cost travel can give a false sense of the universalism of values and of mental illness attributions which, though consoling in the honeymoon phase of cultural adjustment, may be succeeded by greater awareness of cultural and language difference in the disenchantment phase. Reverse culture shock on return home after a prolonged stay abroad can further complicate revalidation and adjustment to the swiftly changing demands of the National Health Service (NHS).

Julian Eaton and his colleagues aptly describe at an individual level the benefits of their innovative overseas peer group for continuing professional development (CPD), which meets by Skype and provides opportunity to review specific clinical problems when resources are scarce, and mutual encouragement about directed reading in clinical or research domains and, importantly, how to overcome revalidation and appraisal problems.

Athula Sumathipala et al report on the massive contribution to Sri Lankan and UK psychiatry of bilateral partnership between health institutions and universities in the two countries, including an important twin register. There are five times as many Sri Lankan psychiatrists in the UK (250) as in Sri Lanka at the present time (50). The diaspora is crucial to these bilateral links.

The third paper, by Dave Baillie and colleagues, considers the benefits specifically of a multidisciplinary link between the East London Mental Health Trust and Butabika Hospital Kampala (where I held my first consultant post), in Uganda. This present initiative is sustained by the Ugandan diaspora in the UK. The paper describes the mutual benefits of training psychiatric support workers. The authors illustrate the way in which these experiences benefit staff in East London – although they do acknowledge that this can be challenging if the Trust cannot see beyond the local financial constraints or is unsupportive of meeting the needs of a low-income African country whose family values may not mesh with those of postmodern Britain. The British diaspora in East Africa – an element not considered in the papers – as well as the abilities of East African doctors and nursing
Asia-pacific ready to act on mental health target in the SDGs

About 2.6 billion people live in the Asia-pacific region, and it is one of the most dynamic regions in the world, with 60% of the world’s gross domestic product and 47% of world trade. The Asia-pacific region has increasing economic growth, rapid urbanisation and industrialisation, huge expansion of educational and scientific capability, and an increasingly influential voice in world affairs. The region also faces many challenges, including frequent and destructive natural disasters, vulnerability to the effects of climate change, greatly increased rural-to-urban migration, and widening economic inequality. Profound demographic and epidemiological transitions are forcing a shift in focus to ageing populations, chronic and disabling diseases, and the rapidly developing field of brain health. All these challenges have direct implications for mental health; however, the mental health and social systems needed to respond to them are severely underdeveloped.

In November, 2014, the 26th Asia-Pacific Economic Cooperation (APEC) Ministerial Meeting in Beijing endorsed the Healthy Asia Pacific 2020 strategy and adopted the APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific (2014–20). Mental health was identified as a priority in the Joint Ministerial Statement and in the Leaders’ Declaration. APEC is committed to improvement of research and data collection and to promote expanded public and private investment in mental health.

The APEC focus on mental health is of great significance, specifically because APEC is an economic forum. APEC leaders are aware that during the next two decades, the total global economic burden of chronic disease—including mental health—is estimated to be US$47 trillion and have seen that continued neglect of mental health constitutes a brake on economic and social development. This message is important for the final stages in the development of the Sustainable Development Goals (SDGs), targets, and indicators.

The targets set for the SDGs will profoundly affect decisions about priorities and investment by national governments, development agencies, international donors, non-governmental organisations, civil society organisations, and the private sector. FundaMentalSDG, a global initiative formed for this purpose, is vigorously advocating inclusion of a specific mental health target and indicators, a position supported by the UK All-Party Parliamentary Group on Mental Health.

The provisional health goal, “ensure healthy lives and promote wellbeing for all at all ages”, includes the proposed target 3.4 “by 2030 reduce by one third premature mortality from non-communicable diseases (NCDs) through prevention and treatment, and promote mental health and wellbeing”. Although reduction of premature mortality is an essential target, and halving of premature deaths (including death by suicide) by 2030 would be feasible, a growing concern for national governments is the disability burden attributable to non-communicable diseases (including mental disorders) and the costs that disabilities impose on health and social systems. To respond to this universal concern, disability resulting from non-communicable diseases and mental disorders should be measured and reduced. These aims needs to be incorporated in a revised target 3.4. Measurement of progress towards whatever target is used by the UN will need substantial strengthening of the currently weak health information systems in low-income and middle-income countries.

Action to reduce the global disease burden attributable to mental disorders should include promotion of positive mental health and wellbeing, prevention and treatment.
of mental disorders, attention to disabilities and human rights, prevention and control of non-communicable diseases, poverty reduction measures, and improvements in education, housing, and employment, with integration across these domains. Governments in the Asia-Pacific region are responding to these challenges and a coherent development architecture that can support intervention in complex systems is emerging (figure).

Developments in Vietnam show that it is possible, even in a context of very limited financial and human resources and great urban-rural and regional variations in poverty, to put in place a comprehensive suite of mental health and social system governance arrangements, foster leadership, and build evidence for policy and practice. A national strategy on prevention and control of non-communicable diseases is close to completion. A national mental health strategy, informed by the WHO Mental Health Action Plan and closely aligned with the national non-communicable diseases strategy, is being developed. The principles underpinning the strategy include protection of human rights, universal health coverage, a multisectoral and full life-course approach, community engagement, and evidence-informed policies and practice. The strategy will include action to develop national mental health law. On Nov 28, 2014, the National Assembly ratified the Convention on the Rights of Persons with Disabilities. An increase in collaboration between the ministries of health and social affairs will ensure that mental health, non-communicable diseases, and disability can be managed in a more integrated way in both institutional and community settings. Health and social system leadership is being built through both the Melbourne-based International Mental Health Leadership Program and a Vietnam-based leadership programme. To strengthen the quality of the health information system, the Ministry of Health approved the Health Information System Development Strategic Plan in 2014. A national survey of mental health and social affairs services that will provide essential evidence for planning, monitoring, and evaluation has been completed, and a collaborative project that will build the capacity in Vietnam to measure annual burden of disease estimates is in early stage of development.

The political leaders of APEC have expressed a clear will to act decisively on mental health and are ready to promote expanded investment for action. The inclusion of an explicit mental health target and indicators in the SDGs will strongly support achievement of the goals of the APEC Roadmap and will improve the lives of millions of people.

HM is a member of the FundaMentalSDG Steering Group and supports the group’s campaigns to include a mental health target and indicators in the SDGs.

Figure: A coherent health and development architecture


*Harry Minas, Takashi Izutsu, Atsuro Tsutsuki, Ritsuko Kakuma, Alan D Lopez

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Personality disorder and population mental health

Despite increasing rates of diagnosis and treatment of mental state disorders, the burden of disability due to disorders such as major depressive, anxiety, bipolar, substance misuse, and psychotic disorders has not substantially decreased and might be increasing. One potential reason for the insufficient progress in reduction of the prevalence, duration, and associated disability of these mental disorders in the population might be that we have continued to neglect the effect of personality disorder at a population level.

Population-based epidemiological studies confirm that personality disorder is common and is associated with substantial overall disability. Estimated prevalence rates for any personality disorder vary between countries: 4.4% in the UK, 13·4% in Norway, and 9·1% and 21.5% in the USA. Cross-national prevalence data from WHO Mental Health Surveys for any personality disorder in western European developed countries yields an overall prevalence of 6.1% across samples (range of 2.4%–7.9%). Probable cases of personality disorder were associated with functional impairment in all 13 European countries surveyed, a picture consistent with US data.

Substantial clinical and population-based research shows that personality disorder is not only associated with chronic impairments in interpersonal and adaptive functioning, but also that it predicts poor outcomes in diverse psychiatric comorbidities, and poor engagement in and adherence to treatment. Although substantial progress has been made in the treatment of borderline personality disorder, treatment of this disorder has rarely resulted in demonstrable change in functional capacity in patients. Additionally, little attention has been paid to treatments for other forms of personality disorder.

The covert effects of additional disability and morbidity due to personality disorder are underscored by the fact that personality disorder is one of the most common comorbidities in clinical practice. For example, about half of patients receiving treatment for common mental state disorders—namely, major depression and anxiety—also suffer from a comorbid personality disorder. Some of the persistent dysphoria, anxiety, unhappiness, and disability experienced by many individuals who seem to be partial responders to treatment or treatment resistant might be due to the personality factors that serve as predisposing or perpetuating factors for their distress.

There is also potentially a substantial, and yet covert role for the effect of personality disorder on medical comorbidity. Although those with mental disorders commonly also suffer from co-occurring chronic physical illnesses, personality disorder has not been thoroughly investigated as one of these disorders. Population-based epidemiological research has shown that individual personality disorders are associated with an increased risk of a range of physical health comorbidities (e.g., adjusted odd ratios for associations between borderline personality disorder and cardiovascular disease range from 1.47 to 7.2), similar to the association seen between depression and cardiovascular disease.
TWO months ago, the British Psychological Association released a remarkable document entitled “Understanding Psychosis and Schizophrenia.” Its authors say that hearing voices and feeling paranoid are common experiences, and are often a reaction to trauma, abuse or deprivation: “Calling them symptoms of mental illness, psychosis or schizophrenia is only one way of thinking about them, with advantages and disadvantages.”

The report says that there is no strict dividing line between psychosis and normal experience: “Some people find it useful to think of themselves as having an illness. Others prefer to think of their problems as, for example, an aspect of their personality which sometimes gets them into trouble but which they would not want to be without.”

The report adds that antipsychotic medications are sometimes helpful, but that “there is no evidence that it corrects an underlying biological abnormality.” It then warns about the risk of taking these drugs for years.

And the report says that it is “vital” that those who suffer with distressing symptoms be given an opportunity to “talk in detail about their experiences and to make sense of what has happened to them” — and points out that mental health services rarely make such opportunities available.

This is a radically different vision of severe mental illness from the one held by most Americans, and indeed many American psychiatrists. Americans think of schizophrenia as a brain disorder that can be treated only with medication. Yet there is plenty of scientific evidence for the report’s claims.
Moreover, the perspective is surprisingly consonant — in some ways — with the new approach by our own National Institute of Mental Health, which funds much of the research on mental illness in this country. For decades, American psychiatric science took diagnosis to be fundamental. These categories — depression, schizophrenia, post-traumatic stress disorder — were assumed to represent biologically distinct diseases, and the goal of the research was to figure out the biology of the disease.

That didn’t pan out. In 2013, the institute’s director, Thomas R. Insel, announced that psychiatric science had failed to find unique biological mechanisms associated with specific diagnoses. What genetic underpinnings or neural circuits they had identified were mostly common across diagnostic groups. Diagnoses were neither particularly useful nor accurate for understanding the brain, and would no longer be used to guide research.

And so the institute has begun one of the most interesting and radical experiments in scientific research in years. It jettisoned a decades-long tradition of diagnosis-driven research, in which a scientist became, for example, a schizophrenia researcher. Under a program called Research Domain Criteria, all research must begin from a matrix of neuroscientific structures (genes, cells, circuits) that cut across behavioral, cognitive and social domains (acute fear, loss, arousal). To use an example from the program’s website, psychiatric researchers will no longer study people with anxiety; they will study fear circuitry.

Our current diagnostic system — the main achievement of the biomedical revolution in psychiatry — drew a sharp, clear line between those who were sick and those who were well, and that line was determined by science. The system started with the behavior of persons, and sorted them into types. That approach sank deep roots into our culture, possibly because sorting ourselves into different kinds of people comes naturally to us.

The institute is rejecting this system because it does not lead to useful research. It is starting afresh, with a focus on how the brain and its trillions of synaptic connections work. The British Psychological Association rejects the centrality of diagnosis for seemingly quite different reasons — among
them, because defining people by a devastating label may not help them.

Both approaches recognize that mental illnesses are complex individual responses — less like hypothyroidism, in which you fall ill because your body does not secrete enough thyroid hormone, and more like metabolic syndrome, in which a collection of unrelated risk factors (high blood pressure, body fat around the waist) increases your chance of heart disease.

The implications are that social experience plays a significant role in who becomes mentally ill, when they fall ill and how their illness unfolds. We should view illness as caused not only by brain deficits but also by abuse, deprivation and inequality, which alter the way brains behave. Illness thus requires social interventions, not just pharmacological ones.

ONE outcome of this rethinking could be that talk therapy will regain some of the importance it lost when the new diagnostic system was young. And we know how to do talk therapy. That doesn’t rule out medication: while there may be problems with the long-term use of antipsychotics, many people find them useful when their symptoms are severe.

The rethinking comes at a time of disconcerting awareness that mental health problems are far more pervasive than we might have imagined. The World Health Organization estimates that one in four people will have an episode of mental illness in their lifetime. Mental and behavioral problems are the biggest single cause of disability on the planet. But in low- and middle-income countries, about four of five of those disabled by the illnesses do not receive treatment for them.

When the United Nations sets its new Sustainable Development Goals this spring, it should include mental illness, along with diseases like AIDS and malaria, as scourges to be combated. There is much we still do not know about mental illness, and much we can do to improve its care. But we know enough to do something, and to accept that knowing more and doing more should be a fundamental commitment.

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Health equity and mental health in post-2015 sustainable development goals

A major attraction of the Millennium Development Goals (MDGs) and a reason for their widespread acceptance was the clear focus on achievement of equity. However, a major criticism of the goals, in so far as they relate to health, is the absence of a clear and categorical commitment to specific normative goals for mental health. This omission is striking since mental illnesses contribute to nearly a quarter of total years lived with disability across all disorders worldwide, but receive disproportionately low policy and budgetary attention, especially in low-income and middle-income countries, where only 0.5–1.9% of the overall health budget is allocated to mental health.

Since the launch of the MDGs, several important developments have occurred that point to a growing recognition of the need to pay greater attention to mental health in the overall development agenda. The WHO Executive Board resolution of January, 2012, and the more recent adoption by WHO of a Comprehensive Mental Health Action Plan 2013–20 are examples. Notably, evidence for effective and affordable interventions for the most common mental health disorders has also become increasingly compelling. As a result, a post-2015 global effort to set new developmental goals might offer an important opportunity to galvanise this growing international attention to mental health. Such attention would commit governments (including those of low-income and middle-income countries) and international development organisations to scale up treatment and services for psychosocial disabilities. The notion of “no health without mental health”, embraced and promoted by WHO, is an attestation of the primacy of mental health to any consideration of achieving health for all. It is more than an attestation: it is a reminder that if equity in health is a goal, attention to mental health cannot be ignored.

The continuing member-driven process to develop the next arrangements for the post-2015 era has created a set of 17 proposed Sustainable Development Goals (SDGs) and 169 targets of the SDGs and is an important opportunity to correct the omission of mental health in the MDGs. The third proposed SDG aims to “ensure healthy lives and promote well-being for all at all ages”. This goal can only be achieved if the huge gap in treatment of mental health disorders is addressed. With about a quarter of people with mental illness in high-income countries and fewer than one in ten affected people in low-income and middle-income countries receiving effective care, most of the more than 600 million people in the world with mental illness are clearly denied opportunity for healthy lives and social inclusion.

Equally important is the recognition of the salience of mental health to the achievement of a broad range of other SDGs. For example, poor mental health will militate against the achievement of peaceful and inclusive societies for sustainable development and make it difficult for countries to achieve full and productive employment. Mental health problems are also a major cause of early termination of formal education.

We recognise the importance of what will eventually emerge as the post-2015 SDGs in the formation of future global developmental efforts. These goals will define where resources are channelled and where priorities are placed by governments and international donors in the next 15 years. We also note the continuing efforts to identify and define indicators that would help monitor progress towards the achievement of these goals. Clearly, methods of quantification are needed to assess measurable and achievable targets for the SDGs. In this regard, we believe that incorporation of indicators to track the achievement of a specific mental health target is an important step to ensure that this vital aspect of health is not neglected. We propose a specific target for mental health in the SDGs, namely the provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health. We also propose two specific indicators for mental health because of their importance in the assessment of improvement in population-level mental health service and because they can be reliably assessed. The first proposed indicator is a minimum 20% increase in service coverage for people with severe mental disorders by 2020; this service would include a community-oriented package of interventions for people with psychosis, bipolar affective disorder,
or moderate-severe depression. The second proposed indicator is an increase in mental health investment to a minimum of 5% of the total health budget by 2020, and to a minimum of 10% by 2030 in all low-income and middle-income countries.

These targets are achievable for every country that adopts the new SDGs. Scaling up of mental health services needs active integration into primary care. With evidence-based guidelines, such as the Mental Health Gap Action Programme Intervention Guide, countries can achieve this goal by making use of the organisational restructuring of their health systems.

With respect to an increase in budgetary allocation to mental health, although a general increase in the health budget of countries might be desirable, this goal needs an appreciation of the proportional contribution of mental illness to the overall disease burden around the world and a response by individual countries in terms of health-care expenditure and commitment to better mental health.

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10 Thornicroft G, Patel V. Including mental health among the new sustainable development goals. BMJ 2014; 349: g5189.
Including mental health among the new sustainable development goals

The case is compelling

Graham Thornicroft professor ¹, Vikram Patel professor² ³

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The United Nations will soon decide what will follow its millennium development goals, which expire in 2015. The case for including mental health among the new sustainable development goals is compelling, both because it cuts across most of the suggested new goals and because of the unmet needs of the 450 million people in the world with mental illness.¹

Poorer mental health is a precursor to reduced resilience to conflict. It’s also a barrier to achieving the suggested goal of promoting peaceful and inclusive societies for sustainable development, providing access to justice for all, and building effective, accountable, and inclusive institutions at all levels. In addition, conflict is itself a risk factor for adverse mental health consequences,² and in the aftermath of conflict the needs of vulnerable groups such as people with mental illness are often accorded the lowest priority (as documented by photojournalist Robin Hammond, www.robinhammond.co.uk).

The improvement of mental health systems will also have a decisive role in making cities and human settlements inclusive, safe, resilient, and sustainable, and this is especially important given the global trend towards urbanisation with its associated risk factors for mental illness.¹ Poorer mental health is a predictor of reduced resilience to conflict.¹

More generally, people with untreated mental disorders have a negative effect on global wealth because they increase school and work absenteeism and dropout rates, healthcare spending, and unemployment rates.³ Disregarding the needs of the population for mental healthcare impairs productivity,² costing the world in excess of $16tr (£9.5tr; €12tr) a year in lost economic output.⁴ In order to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all, we will have to recognise that mental health problems, especially developmental disorders such as attention-deficit/hyperactivity disorder, are often associated with educational underachievement and that these blight long term economic prospects. Moreover, educational stressors are risk factors for suicidality among school and college students. Mental health is also relevant to the goal of ending hunger, achieving food security, improving nutrition, and promoting sustainable agriculture. Mental illness in mothers is a risk factor for child undernutrition,¹ and poor diet among people with severe mental illness contributes to their worse physical health.²

Ensuring healthy lives and promoting wellbeing for all at all ages is also impossible without a consideration of mental health. Inequality within and among countries cannot be fully addressed unless we recognise that nearly a quarter of the world population—the number who experience a mental illness each year—experience systematic discrimination in most areas of life.³ Indeed, the right to health, as incorporated in the United Nations Convention on the Rights of Persons with Disabilities, is manifestly neglected as the life expectancy among people with mental illness is up to 20 years lower among men and 15 years lower among women than among their counterparts without mental illness.⁴ People with severe infections (such as HIV/AIDS) or non-communicable diseases also show premature mortality if their adherence to medication is compromised by undetected or untreated coexisting mental illness.¹ ¹ The fundamental point is that health must include mental health, as defined by WHO and accepted by all nations, not just in spirit but in reality.
To turn to the arguments for directly meeting the needs of people with mental illness in the new development goals, the basic facts are clear and deeply disturbing. In high income countries about one quarter of people with mental illness receive care, and in low income countries fewer than one in ten do so.\(^1\) Two thirds of people with depression in the UK are not getting any treatment.\(^3\) By comparison, treatment rates for the main non-communicable diseases in low income countries commonly exceed 50%.\(^4\) In other words, the mental health treatment gap is vast in all countries.\(^5\) Any approach to universal health coverage must therefore include the provision of treatment to people with mental illnesses. Together, these contribute to nearly a quarter of total years lived with disability across all conditions worldwide.\(^6\) At present, low income countries allocate about 0.5%, and lower middle income countries 1.9%, of their overall health budget to mental healthcare.\(^7\)

The choice of sustainable development goals matters because national governments and international donors will give these the highest priorities for investment, as they did with the millennium development goals. We therefore call on the United Nations to include within the health related goal the following separate target: the provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health. We also propose the inclusion of two key indicators identified in the WHO Mental Health Action Plan 2013-2020: service coverage for severe mental disorders will have increased by 20% by 2020 and the rate of suicide will be reduced by 10% by 2020.

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**Proposed UN sustainable development goals**

- End poverty in all its forms everywhere
- End hunger, achieve food security and improved nutrition, and promote sustainable agriculture
- Ensure healthy lives and promote wellbeing for all at all ages
- Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
- Achieve gender equality and empower all women and girls
- Ensure available and sustainable management of water and sanitation for all
- Ensure access to affordable, reliable, sustainable, and modern energy for all
- Promote sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all
- Build resilient infrastructure, promote inclusive and sustainable industrialisation, and foster innovation
- Reduce inequality within and among countries
- Make cities and human settlements inclusive, safe, resilient, and sustainable
- Ensure sustainable consumption and production patterns
- Take urgent action to combat climate change and its impacts
- Conserve and sustainably use the oceans, seas, and marine resources for sustainable development
- Protect, restore, and promote sustainable use of terrestrial ecosystems, sustainably manage forests, combat desertification, and halt and reverse land degradation and halt biodiversity loss
- Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable, and inclusive institutions at all levels
- Strengthen the means of implementation and revitalise the global partnership for sustainable development
EDITOR’S CHOICE

Mental health: a worthwhile goal

Trevor Jackson deputy editor, The BMJ

When the United Nations comes to choose its new set of sustainable development goals, it should be sure to include mental health, argue Graham Thornicroft and Vikram Patel in The BMJ this week (doi:10.1136/bmj.g5189). They set out a range of reasons for why the case is compelling. First among these is that “poorer mental health is a precursor to reduced resilience to conflict.” Not only that, but conflict is itself a risk factor for adverse mental health, they add, and in the aftermath of war people with mental illness are often accorded the lowest priority. At a time when some of the most seemingly intractable conflicts continue to wreak and destroy lives—in Syria and Iraq, in eastern Ukraine, and across the border between Israel and Gaza—Thornicroft and Patel’s call is particularly pertinent.

As doctors from southern Israel and Gaza, Mark Clarfield (doi:10.1136/bmj.g5023) and Izzeldin Abuelaish (doi:10.1136/bmj.g5106) must surely recognise the importance of Thornicroft and Patel’s argument. While Clarfield, an Israeli geriatrician, and Abuelaish, a Palestinian associate professor of global health, come from opposite sides of the political divide, they reflect on the common ground they share through medicine. Clarfield writes: “We must make peace. I will talk to my people. Please: I implore you to talk to yours. Our patients need us to do so. Let us never forgot that we are both doctors.” Abuelaish, three of whose children were killed by shellfire in 2009, replies: “We must find a way to stop the bloodshed, and as doctors we have a voice.”

If Clarfield and Abuelaish do ever get the peace that they and the world strongly wish for their region, declaring mental health one of the new sustainable development goals might help further. For Thornicroft and Patel argue that improving mental health systems will also “have a decisive role in making cities and human settlements inclusive, safe, resilient, and sustainable, and this is especially important given the global trend towards urbanisation with its associated risk factors for mental illness.”

But in order to improve health systems, planners need to estimate future healthcare needs, and this, according to John Appleby’s latest Data Briefing (doi:10.1136/bmj.g5184), depends on successful population projections. But these are difficult to get right, he says, and several past projections have greatly underestimated total population numbers. The reason for this, says Appleby, is that it has proved hard to predict how births, deaths, and migration (often a consequence of war) will change. “What is particularly striking is how consistently wrong projections of deaths have been—and all in the same direction, overestimating the number of deaths.” In other words, we (in the West at least) are living longer.

Population projections underpin not only estimate of future healthcare needs, as Appleby points out, but also government spending and tax revenues, housing demand, and road, rail, and air transport needs. But where and how we live and travel are also strongly relevant to our health, as Anthony A Laverty and Christopher Millett discuss in their editorial (doi:10.1136/bmj.g5020) on healthier commuting, linked to a research paper that found that those who walked or cycled to work had a lower body mass index and a lower body fat percentage than those using private transport (doi:10.1136/bmj.g4887). Laverty and Millett’s message for health professionals is to tell patients to “leave your car at home.”

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Why is mental health such a low priority for the UN?

With mental health issues affecting one in six, it’s time for the UN to update its development goals

• Austerity or opportunity? How mental health services can thrive

Graham Thornicroft and Vikram Patel
Guardian Professional, Tuesday 2 September 2014 08.30 BST

Treatments available for mental health problems are as powerful as those for diabetes, write Graham Thornicroft and Vikram Patel. Photograph: Hugo Philpott/PA

Imagine a health problem that affects one in six of us, that has a deep and damaging impact on our family and working lives, where effective treatments are available, and yet where only about a quarter of people with this condition get any treatment. Is this a scandal of neglect affecting people with cancer or heart disease diabetes? No – this is the real situation for people with mental health problems in Britain today. These conditions span the range from autism to alcohol use disorders, and from depression to dementia. More than 50 years ago when mothers suffered from post-natal depression in England, they were given electroconvulsive therapy to aid their recovery. Yet there is little evidence that we treat provide better mental health treatment now than we did then.

In global terms, the United Nations plays a leading role in identifying which health conditions are the highest priority. In 2000, 189 countries made a commitment to help achieve the eight millennium development goals (MDGs) by 2015. Three of these goals were to do with health: to reduce child mortality; to improve maternal health; and to combat HIV/AIDS, malaria, and other diseases. None referred to mental illness.

In the field of mental health we work with colleagues in many countries of the world and repeatedly find that Ministry of Health staff tell us that it “is not a priority”. The consequence is that although mental health problems are responsible for almost a quarter of all the disability in world, the poorest countries dedicate just 0.5% of their health budgets to mental health. But this under-investment is not because resources are scarce in these poor countries, where up to two-thirds of people with physical illnesses
such as diabetes do get treatment. The scale of this neglect of people with mental illness is truly breathtaking.

Governments and international donors do listen to the priorities agreed by the United Nations. There is a very important opportunity now to make sure that the new goals, for the period after 2015, will clearly address the needs of people with mental illness. Now in the final stages of their drafting, these sustainable development goals (SDGs) refer to 17 areas of health, economic or environmental progress. At the moment just one phrase of one “target” of one “goal” mentions mental health at all, with no specific indicators given about how to measure progress. Why is mental health seen as such a low priority by the United Nations?

This is negligent because mental health problems affect so many people across the world, and have such wide ranging ways to exclude people from the mainstream of life. For example, it is true to say that poverty is a trigger for mental health issues, and that they can trip people into poverty. Without treatment people with mental health problems are less productive in their jobs, more likely to be unemployed and to rely on state or family support. Indeed the World Economic Forum estimates this loss of global economic output as in excess of $16tn.

Some policy makers say, “but we don’t have effective treatments that can be put into practice”. This is wrong. The World Health Organisation has produced practical treatment guidelines for use in primary care in low income countries, based upon the very best evidence of what works. We know that the treatments available for mental health problems are as powerful as those for high blood pressure, diabetes or rheumatoid arthritis.

The fundamental point is that any serious attempt to address health must include mental health.

The new SDGs being developed by the United Nations need to acknowledge the vital role of mental health. We therefore call upon the United Nations to include within the overall health goal a specific target for “the provision of mental and physical health and social care services for people with mental illness, in parity with resources for services addressing physical health.” The stigmatising exclusion of mental health from the global health agenda must end now.

#FundaMentalSDG is an initiative which aims to include a specific mental health target in the post-2015 SDG agenda.

Prof Graham Thornicroft works at the Centre for Global Mental Health, King’s College London. Prof Vikram Patel is at Centre for Global Mental Health, London School of Hygiene & Tropical Medicine; Sangath and the Public Health Foundation of India.

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Treating mental illness is a global task, say experts

Psyciatrists say changed priorities can reduce poverty, chronic disease and underachievement

Charlie Cooper

Sunday, 31 August 2014

The world’s leading psychiatrists have launched a historic bid to include mental health in the UN's post-2015 development goals.

The eight Millennium Development Goals (MDGs), established at the start of the 21st century, have guided the world’s response to global poverty and ill-health, leading to remarkable gains in the fight against TB, malaria and HIV.

However, no targets for improving the treatment of mental illnesses were included in the MDGs, leading to what psychiatrists have called the "systematic neglect" of millions of people.

In 2015, the MDGs will be replaced by a new set of targets, the Sustainable Development Goals (SDGs), aimed at guiding global policies for the remainder of the century. The UN is soon to decide what to include in the SDGs at the launch summit next year.

A group of 13 senior psychiatrists from the US, Europe, Africa and Asia is now spearheading a campaign to have a specific mental health target included in the SDGs.

One of the UK’s leading experts on mental illness, Professor Graham Thornicroft, told The Independent on Sunday that the UN needed to push countries into ending "a conspiracy of silence" around the neglect of the mentally ill.

"This year, one in six of us will have a mental health problem ... In most countries it is difficult, almost impossible, to speak about mental illness ... We see systematic neglect at every level about mental health issues," he said.

"We know that mental illnesses are not just common, but are contributing to up to a quarter of all the disability in the world. It's remarkable. But in terms of international policy, we have seen this astonishing disregard of the needs of people with mental illness."
Estimates vary, but at least 450 million people are believed to suffer from mental illness. Depression, anxiety, and psychotic illnesses such as schizophrenia are not just problems in themselves, but also increase the likelihood of the sufferer succumbing to heart and lung diseases.

Studies in Australia and Scandinavia have shown that men with mental illness die on average 20 years younger than the general population, and women on average 15 years younger.

"Colleagues working in Ethiopia have shown that there is a big drop in life expectancy for people with mental illness in developing countries as well, where people are often just abandoned by their families and become destitute," said Professor Thornicroft.

The SDG initiative, dubbed #FundaMentalSDG, argues that combatting mental health problems will also help the world to reduce poverty, chronic disease, and educational underachievement – all exacerbated by mental illness.
The importance of global mental health for the Sustainable Development Goals

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Introduction

Currently the United Nations are negotiating the next generation of global development goals: the new Sustainable Development Goals (SDG) for the Post 2015 agenda. The previous 10 Millennium Development Goals (MDGs) (United Nations Millennium Declaration, 2000) have helped to accelerate development in many low- and middle-income countries (LAMICs) (United Nations, 2013). While “[t]here have been visible improvements in all health areas”, as United Nations Secretary General Ban Ki-Moon stated in the introduction to the MDG report 2013 (United Nations, 2013), mental health, although highly relevant to the MDGs, was wholly excluded from these goals. For the new SDGs, the international community now needs to recognise the evidence showing the growing burden of disease and the extensive social and economic global consequences of mental disorders and psychosocial disabilities (World Economic Forum, 2011). Mental health has for too long been a low priority in development. In the future Post-2015 agenda, mental health needs to be clearly included, with a specific mental health target and two indicators.

The significance of mental health for the global burden of disease

In recent years, mental disorders and psychosocial disabilities have been increasingly recognised as global development issues (Eaton et al., 2014). The EU and several high-income governments have acknowledged the critical importance of scaling up mental health services in LAMICs (The Council of the European Union, 2010), and the World Health Assembly has adopted a Comprehensive Mental Health Action Plan (2013–2013) as a framework for scaling up access to services, a formal recognition of WHO’s 194 member states of the global relevance of mental health. The WHO and partners have developed the Mental Health Gap Action Programme (mhGAP) to provide evidence-based resources for governments and civil society to do this in a practical way. Global awareness for mental health conditions is growing, yet more commitment is needed by governments to provide sufficient prioritisation and budgets for services. The UN must react to the compelling evidence: mental health must be considered in the Post-2015 agenda.

A quarter of people in the world are affected

The WHO estimates that one in four people will experience a mental health condition in their lifetime and that approximately 600 million people worldwide are disabled as a consequence (Kohn et al., 2003). According to the World Report on Disability, 1 billion people worldwide experience a disabling condition, 60% of the causes of which are strongly linked to mental, neurological and substance abuse conditions (World Health Organisation, 2011b).

Mental disorders and psychosocial disabilities are one of the most pressing development issues of our time, frustrating the aspirations of families, communities and emerging economies. Most of the people affected by mental health conditions live in low- and middle-income countries (Wang et al., 2007). Contextual factors, including poverty and hunger, conflict and trauma, poor access to health and social care, and social inequity all serve to increase their vulnerability (Kohrt et al., 2012). Yet, in these countries, between 76% and 85% of people with severe mental disorders do not receive treatment for their disorder (World Health Organisation, 2013b).

Increasing impact of mental disorders

The second reason why mental health needs to be considered as single target in the SDGs is that the burden of disease is steadily growing. Recent systematic analyses show that mental and behavioural problems account for 7.4%, and neurological conditions including dementia and epilepsy account for 3%, of the global burden of disease measured using Disability Adjusted Life Years (DALYs). Mental and behavioural problems command nearly one-quarter of the global total (Whiteford et al., 2013). This makes mental disorders and psychosocial disabilities the biggest single cause, more than cardiovascular diseases and cancer combined. By 2030, unipolar depression will be the leading contributor to years lived with disability (World Health Organisation, 2013a).
Mental health conditions can not only cause great and long-lasting disability, but also have high impact on the excess mortality. In consequence, in high-income countries, men with mental health problems die 20 years and women 15 years earlier than people without mental health problems (Lawrence et al., 2013; Wahlbeck et al., 2011). Excess mortality due to mental health conditions is likely to be much higher in low-income countries. This mortality gap is not only a life-threatening consequence of disease, but also a serious human rights challenge and development issue. Also, mental illness is a central cause of suicide (Mathers & Loncar, 2006), now the second highest cause of death among 15–29 year-olds globally (World Health Organisation, 2014).

**Human rights violations, stigma and discrimination**

Further, mental health must be included in the Post-2015 Development Agenda because it is a pressing case of global human rights and a moral duty (Patel et al., 2006). People with mental disorders and psychosocial disabilities often experience social exclusion, stigma and discrimination (Almazeedi & Alsuwaidan, 2014). To change societies’ perceptions, attitudes and beliefs, a public focus on human rights and stigma reduction is essential (Sartorius, 2007). In all regions of the world, people with mental disorders and psychosocial disabilities experience severe human rights violations, including being tied to beds, kept in isolation in psychiatric institutions, or chained and caged in small cells (Thornicroft & Shunned, 2006). The United Nations should recognize this failure of humanity as a global crisis requiring substantive and sustained action. Access to effective treatment can reduce stigma and exclusion, and evidence of effective interventions is now starting to emerge (Thornicroft et al., in press).

**Most people do not receive effective treatment**

Despite this great need, there is clear evidence that the large majority of people with mental disorders and psychosocial disabilities worldwide receive no effective treatment (Patel et al., 2013). Globally, mental disabilities and psychosocial disorders are grossly under-financed (World Economic Forum, 2011). Government spending on mental health compared with the burden of disease is creating an enormous mismatch, and substantially contributing to globally low rates of treatment of people with mental disorders (known as the ‘treatment gap’). Low-income countries spend about 0.5% of their very limited health budgets on psychosocial disabilities, despite their causing 25.5% of the Years Lived with Disability (YLDs) (World Health Organisation, 2011a). In many low-income countries, fewer than 10% of people are able to access services (Wang et al., 2007). Services are often non-existent, or based in large cities, far from people who may need them. In some countries, and for more severe disorders such as schizophrenia, the treatment gap is as wide as 98% (World Health Organization, 2008). In other words, this means fewer than one in 10 people with mental health conditions receive the treatment they need (Wang et al., 2007). This lack of access to treatment breaches the right to health as set out in the United Nations Convention on the Rights of Persons with Disabilities (United Nations, 2006).

Access to treatment must be improved, adherence of human rights standards needs to be secured, and we must no longer accept that the quality of life of persons with mental disorders and psychosocial disabilities should be any less than other members of society.

**Mental health presents cross-cutting issues for health and development**

Finally, mental health is an issue with cross-cutting impact across many of the planned SDGs, and related to many aspects of development (Thornicroft & Patel, 2014). Many aspirational global goals have strong interdependencies with mental health, for example; peaceful and inclusive societies (Goodwin & Rona, 2013) and safety in human settlements (Ouanes et al., 2014), sustainable economic growth (Cruz et al., 2013) and productive employment (Katikireddi et al., 2012), inclusive education and learning opportunities, food security and improved nutrition (Surkan et al., 2011), maternal and child health, healthy lives and well-being, the overall population level (Guszkowska et al., 2014), and a more equal society.

Mental health is not only critical to success in addressing social, political and economic development, it also has direct links to, and impact across, the majority of thematic areas for emerging priorities for the SDGs (Movement for Global Mental Health, 2013).

**Call to the United Nations: make mental health a Post-2015 development target**

Addressing mental health is an essential step in addressing key development issues such as social inclusion and equity, universal health coverage, a holistic and life-course approach to health, access to justice and human rights, and sustainable economic development. We, therefore, call upon the United Nations to include the following target within the Post-2015 SDG Health Goal:

- The provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health.

This target should be supported by the inclusion of the following two indicators:

1. To ensure that service coverage for people with severe mental disorders in each country will have increased to at least 20% by 2020 (including a community orientated package of interventions for people with psychosis; bipolar affective disorder; or moderate-severe depression), and
2. To increase the amount invested in mental health to at least 5% of the total health budget by 2020, and to at least 10% by 2030 in each low and middle income country. (#FundAmentalSDG, 2014)

**Conclusion**

UN Secretary General Ban Ki-Moon stated in his foreword to the 2013 MDGs report “Significant and substantial progress
has been made in meeting many of the targets” (United Nations, 2013). As Jeffrey D. Sachs of the Earth Institute at Columbia University, the chief architect of the MDGs, has recently stressed, the MDGs have been a great success in engaging both LAMICs to an ambitious commitment for development, and high-income countries in exceeding their own investment promises in these countries (Sachs, 2014). Defining the goals in binding agreements has catalysed investment, economic development and political engagement, holding governments accountable will be crucial for progress (Gulland, 2013). This is why we need the United Nations to agree a clear mental health target, with two defined indicators to the new SDGs.

In the emerging global consensus on development priorities, health is increasingly seen as an essential component of overall sustainable development, and as a positive outcome of successful achievement of human rights, social and environmental initiatives (Eaton et al., 2014). Being directly linked, and having numerous interactions with other health conditions (Almas et al., 2014), mental health cannot be separated from other health domains, and is essential for sustainable human development (Prince et al., 2007). In the Constitution of the World Health Organization, mental health is an integral part of health and well-being (World Health Organisation, 2006). The case is compelling: mental health and the extensive global consequences of mental disorders and psychosocial disabilities have been neglected for too long. Such SDGs can be a major step to realising the potential contribution to the development of the quarter of the world’s population who are currently being ignored.

**Declaration of interest**

The authors are supporters of the #FundaMentalSDG initiative established to support the inclusion of mental health target and indicators in the SDG.

**References**


FOR IMMEDIATE RELEASE

INTERNATIONAL LEADERS UNITE UNDER #FUNDAMENTALSDG TO CREATE GLOBAL MOVEMENT IN INCLUSION OF MENTAL HEALTH IN THE UNITED NATIONS (UN) POST 2015 DEVELOPMENT AGENDA

Leaders call for support for global movement in most important mental health initiative addressing world’s biggest single cause of reduced lifespan

09/09/2014 London/ Geneva —

Mental health leaders and advocates gathered in Geneva, Switzerland this past week as the “Preventing Suicide, A Global Imperative” report was publicly released by the World Health Organization (WHO) after the WHO launched implementation discussions of the Global Mental Health Action Plan adopted by the United Nations 66th assembly last year. Today, leaders join together under a new group #FundaMentalSDG to advocate adding clear, measurable mental health targets to the United Nations Post Millennium 2015 development goals currently in development and about to be negotiated by UN member states, following the UN High-level Stocktaking Event on the Post-2015 Development Agenda in New York on 11 – 12 September 2014.

According to the report by WHO, suicide is preventable, mental health disorders are treatable, and yet because we don’t significantly address it we lose over 800,000 lives annually, it is the second leading cause of death globally for youth ages 15-29, and is estimated to cost the United States alone over 100 billion dollars every year. #FundaMentalSDG invites other organizations, institutions, and world leaders to unite by collectively asking the United Nations to include a specific mental health target and two indicators in this critical post-millennium agenda.

The #FundaMentalSDG group was developed as world leaders agree we must take a collaborative, multi-sectoral approach in elevating the work done in mental health. Dr. Shekhar Saxena, Director of the Department of Mental Health and Substance abuse, states in the Global “Mental Health” report: “This report, the first WHO publication of its kind, presents a comprehensive overview of suicide, suicide attempts and successful suicide prevention efforts worldwide. We know what works. Now is the time to act”.

The July 19th 2014 United Nations draft of the Post-Millennium Goals includes an overall Health Goal: ‘Proposed goal 3. Ensure healthy lives and promote well-being for all at all ages’. A recent Editorial in the British Medical Journal (BMJ) by Professors Graham Thornicroft and Vikram Patel, of King’s College London and London School of Hygiene and Tropical Medicine respectively, calls upon colleagues worldwide to include within this Health Goal the following specific mental illness target:

‘The provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health.’

Photo 1: Credits MHaPP/UCT
They also propose that this is directly supported by 2 indicators related to the WHO Mental Health Action Plan 2013-2020, adding that it is very difficult to achieve results without specific measurements:

(1) 'To ensure that service coverage for people with severe mental disorders in each country will have increased to at least 20% by 2020 (including a community orientated package of interventions for people with psychosis; bipolar affective disorder; or moderate-severe depression).'

(2) 'To increase the amount invested in mental health (as a % of total health budget) by 100% by 2020 in each low and middle income country'

According to Thornicroft and Patel’s article in the BMJ, there is compelling evidence to show that improved global mental health is a necessity for overall human and societal development. For example, “poorer mental health is a precursor to reduced resilience to conflict,” and not only that, “it is also a barrier to achieving the suggested goal for promoting peaceful and inclusive societies for sustainable development, providing access to justice for all, building effective, accountable and inclusive institutions at all levels.”

In a Policy Brief produced by #FundaMentalSDG entitled “Call to Action: The Need to Include Mental Health Target and Indicators in the Post-2015 Sustainable Development Goals”, it reviews the high prevalence of mental illness (1 in four people experience mental illness in their lifetime), the global emergency mental illness is causing insofar as human rights violations, stigma and discrimination, and the fact that mental illness can reduce lifespan by 20 years. Further, the brief points out that in low and middle income countries, up to 98 percent of people with mental health problems do not receive any treatment, as evidenced research proofs. Mental health has impact across the whole range of SDGs, and thus can be seen as a cross cutting issue.

#FundaMentalSDG is an initiative which aims to include a specific mental health target in the post-2015 SDG agenda. The initiative is committed to the principle that there can be no health without mental health, and no sustainable development without including mental health into the post-2015 SDG agenda. The #FundaMentalSDG initiative is led by the #FundaMentalSDG Steering Group, composed of leaders in the field of global mental health, drawn from a wide range of service user, caregiver, advocacy, policy, service delivery and research organizations.

To support the initiative, visit www.fundamentalsdg.org/show-your-support and take action today.

For more information, see www.fundamentalsdg.org, www.facebook.com/fundamentalsdg, and twitter.com/FundaMentalSDG and be sure to use hashtag #FundaMentalSDG in communication efforts.

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