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Making mental health a global development priority:

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Health, Nutrition and Population Global Practice



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**“Moving the Needle:
Mental Health Stories from Around the
World”**

**ORGANIZED BY THE WORLD BANK GROUP,
WITH THE SUPPORT FROM
THE PUBLIC HEALTH AGENCY OF CANADA AND THE
EMBASSY OF CANADA**

**APRIL 19, 2018
WASHINGTON, D.C.**

“Almost no one in society is left untouched by mental illness. Directly or indirectly, sometimes without even knowing it, mental illness affects nearly everyone at some point in their lives In the past century, the world has come together to tackle smallpox, polio and measles, with the results to prove it. One hundred years from now, I can only hope that the same can be said of mental illness.”

- The Honourable Ginette Petitpas Taylor, Minister of Health, Canada, addressing the “Moving the Needle” Symposium, World Bank Group – International Monetary Fund Spring Meetings, April 19, 2018

“Every day, millions of men, women and children around the world are burdened by mental illness. Yet mental health too often remains in the shadows, as a result of stigma and a lack of understanding, resources, and services.

Two decades ago, we faced a similar situation with HIV and AIDS. People affected by AIDS faced severe stigma, and there was a widespread failure of policymakers to acknowledge or address the growing number of people dying in the world – especially in Africa – from the lack of access to affordable treatment.

It was unjust, it was wrong, and it was unleashing a health and development catastrophe. So, a group of us decided to raise our voices and bring HIV and AIDS out of the shadows, and we demanded action.

Today, we are here to bring mental health into the spotlight and squarely on the global development agenda where it belongs.”

- Jim Y. Kim, President of the World Bank Group, World Bank Group – International Monetary Fund Spring Meetings, April 2016

“The global fight to transform mental health care will be won in ordinary communities, by ordinary people. Won in homes, schools, workplaces, local clinics, and small residential care facilities. Won by families, lay caregivers, nurses, psychologists, and patients providing peer support, as well as by psychiatrists.

What will this great victory look like?

It will look like normal life. Like individuals and families living happily, building strong relationships, working productively, where before they could not.”

- Healing Minds, Changing Lives: A Movement for Community-Based Mental Health Care in Peru. A Report by the World Bank Group and Cayetano Heredia Peruvian University, 2018

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The WBG team would like to highlight the vision and global leadership of the Honourable Ginette Petitpas Taylor, Canada's Minister of Health, who inspired and supported the organization of the event as an important step to promote the achievement of mental health parity as a core element of the Universal Health Coverage (UHC) and Sustainable Development (SD) agendas.

For additional information about the event or related documentation, please visit the WBG global mental health website:

<http://www.worldbank.org/en/topic/health/brief/mental-health>

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Executive Summary

The Context

An unprecedented opportunity exists today to advance sustainable development by protecting and restoring people’s mental health, a cornerstone of their human capital. For decades, governments around the world have worked to integrate mental health services as part of a basic package of essential social services. Yet the epidemiologic and economic impacts of mental disorders were underestimated, and mental health tended to remain at the margins of the development agenda. Today, fresh evidence shows that mental and substance-use disorders impose vast social and economic costs and threaten the Sustainable Development Goals (SDGs). A movement is emerging to place mental health where it belongs: at the heart of health and development action.

The Event

On April 19, 2018, the World Bank Group (WBG), with the support of the Public Health Agency of Canada and the Embassy of Canada, organized a high-level symposium on global mental health challenges and options at the Embassy of Canada in Washington, D.C. The event was entitled “Moving the Needle: Mental Health Stories from Around the World.” Convened as part of the 2018 World Bank Group-International Monetary Fund Spring Meetings, “Moving the Needle” built on a groundbreaking global mental health conference co-organized by the WBG and the World Health Organization (WHO) two years earlier.

“Moving the Needle” welcomed more than 80 expert participants from 30 organizations and agencies. Participants included policy makers, technical experts, researchers, advocates, and representatives of civil society organizations and development agencies.

The symposium had three objectives:

- Share recent experience and illustrate the progress that has been made in addressing mental health as a sustainable development priority;
- Review new initiatives in global mental health, alternative financing platforms, and key institutions across different social, economic, and political sectors;
- Assess lessons that could be applied across countries to close the mental health gap.

Panel discussions focused on integrating mental health into agendas for Universal Health Coverage (UHC) and the SDGs. Practitioners offered frontline insights into mental health care delivery solutions. Global leaders discussed country examples and examined new strategies, including innovative financing mechanisms and scalable models for community-based mental health services. The event incorporated multimedia components and contributions from groups of people affected by mental health issues. Francis, a seven-minute virtual-reality documentary on the personal experience of mental illness and healing, brought closure to the event.

Key Messages

Participants in the symposium agreed on the following key messages:

- The SDGs are a significant opportunity to make progress on mental health, pursuing an integrated response.
- In their varied contexts, many countries around the world have begun to make notable gains in delivering mental health interventions.
- The success stories and persistent challenges noted during the event highlighted the importance of country ownership and leadership in enabling a multi-sectoral, human-capital approach to mental health.
- Particularly in settings with large populations of displaced persons, addressing mental health as an integrated part of national and humanitarian programs is a key priority.
- It is urgent to leverage innovative approaches and achieve greater integration among stakeholders, particularly with respect to sustainable service delivery and sustainable financing at the community level.

Moving Forward

Participants are positioned to disseminate these messages and take them forward in policy and practice. Today, countries and partners are building a movement to bring mental health from the periphery to the center of health and sustainable development. The argument to increase mental health financing is strengthened when leaders examine investment options through the lens of human capital. The symposium's results can inform this effort and help "move the needle" toward the recognition of mental health as a cornerstone of wellbeing, productivity, and prosperity for individuals, communities, and nations.

The Context of the Symposium

Mental health and substance-use disorders impose a heavy disease burden and threaten to undermine progress toward the Sustainable Development Goals (SDGs). For decades, the epidemiological and development impacts of mental disorders were gravely underestimated. By incorporating health losses due both to premature mortality and to disability, the Disability-Adjusted Life Years (DALYs) metric has helped clarify the vast burden imposed by mental and substance-use disorders. We now know that these conditions are the sixth most important cause of DALYs and the top cause of years of productive life lost due to disability.^{1 2} Major depression is the single most important cause of ill health and disability worldwide. These data are prompting informed health policy makers to raise mental health high on their list of priorities. But this effort has just begun.

In most countries, the response to mental health needs remains starkly inadequate.³ Millions of people suffering from mental illness do not seek help due to stigma and lack of services. Around 80 percent of people with severe mental disorders in low- and middle-income countries receive no treatment. The corresponding figure for developed nations is around 40 percent — still an unacceptable proportion. In the face of these systemic failures, families bear the brunt of untreated mental disease and disability. Even where formal services exist, their quality is often poor. In primary care settings, most mental diagnoses are missed, and treatment, when available, is symptomatic. Quality of care may be little better in specialized mental health units, which too often operate as custodial rather than therapeutic institutions. Chronically ill patients are isolated from community care, and human rights violations abound. The situation is even worse in prisons.

Mental disorders generate vast social and economic costs. In 2010, depression alone was estimated to have cost the global economy some \$800 billion in lost economic output, a sum expected to double by 2030. These losses are not inevitable, however. Wise policies can halt them. They are largely the product of insufficient investment and the resulting constraints in access to mental health promotion, treatment, care, and support. The social costs of mental illness and substance use compound the impact of poor physical health, with severe consequences for individuals, families, communities, and economies. The pervasive lack of resources for mental health care is even more acute in the poorest regions—where people also experience the greatest mental health needs. As a result, the heaviest burden of unmet mental health needs falls on the countries that can least afford it. Yet the cost of investing in proven mental health interventions is surprisingly low.

Investment in mental and physical health is a critical contribution to health capital (the value of a person's lifetime health), and hence to human capital. Human capital contributes to the wealth of nations and the well-being of societies. Human capital includes far more than the number of years of schooling completed by workers. It also encompasses the earnings gains derived from schooling, which depend on learning quality. And it reflects how long people are able to work

¹ Institute for Health Metrics and Evaluation. GBD Compare. Available at: <https://vizhub.healthdata.org/gbd-compare>.

² World Health Organization. Depression: Let's talk. Available at: http://www.who.int/mental_health/management/depression/en/

³ Dantes, O., and Frenk, J. 2018. "Neither myth nor stigma: mainstreaming mental health in developing countries." *Salud Pub Mex* 60(2): 212-217.

productively (which depends on their health conditions).⁴ The different dimensions of human capital complement each other. For example, proper nutrition and relational stimulation, in utero and during early childhood, have been shown to improve people’s long-term physical and mental well-being and to boost cognitive and socioemotional skills. Along with physical health, there is a need to focus on mental and substance-use disorders and their negative consequences, including domestic violence, social alienation, and suicide. The consequences of mental ill-health can compromise or destroy human capital gains at all stages of the life-cycle.

The societal benefits of human capital extend beyond individual productivity. Stronger human capital, including mental health, reduces the probability of crime; increases social participation; and builds social cohesion by making people more tolerant of others and more trustworthy. This can mitigate risks of social instability by giving people knowledge and skills to access opportunities that require cooperation. Cognitive behavioral therapy programs, for example, nurture skills such as recognizing emotions, self-control, and navigating difficult emotional situations.

Recent research shows that strong social relationships and good mental and physical health are what matters most to people’s happiness.⁵ People feel deprived not only when they lack material comfort, but when they cannot enjoy life. And, across global regions, mental illness is more commonly identified as a cause of extreme distress than are poverty or unemployment.

Countries and partners worldwide are launching a movement which will bring mental health from the periphery to the center of the global health agenda. Today, a growing global consensus recognizes mental health progress as a key determinant of economic dynamism and sustainable development. Countries and their partners are joining forces to secure mental health as a cornerstone of personal wellbeing, social stability, and shared prosperity.

⁴ Kim, J.K. 2018. “The Human Capital Gap. Getting Governments to Invest in People.” *Foreign Affairs* 34:4.

⁵ Clark, A.E., Fleche, S., Layard, R., Powdhavee, N., and Ward, G. 2018. *The Origins of Happiness: The Science of Well-Being Over the Life Course*. Princeton, NJ: Princeton University Press

Symposium Objectives

Held during the 2018 World Bank Group (WBG)-International Monetary Fund (IMF) Spring Meetings, the “Moving the Needle” symposium aimed to help accelerate the transformation of mental health policy and practice by bringing scientific evidence and country experience before high-level decision-makers.

Participants advocated the rapid scale-up of mental health services in primary care and community settings, workplace wellness and health programs, and other social protection and support mechanisms. This includes programs targeted to vulnerable populations, such as women and children, adolescents and young adults, displaced populations and refugees, and indigenous populations.

The symposium had three objectives:

- Share recent experience and illustrate the progress that has been made at international level in addressing mental health as a sustainable development priority;
- Review new initiatives in global mental health, alternative financing platforms, and key institutions across different social, economic, and political sectors;
- Assess lessons that could be applied across countries to close the mental health gap.

Symposium panel discussions focused on the importance of integrating mental health as part of the Universal Health Coverage (UHC) and Sustainable Development Goals (SDGs) agenda. Practitioners offered insight into the provision of mental health care, while global leaders presented country examples and examined innovative management strategies, financing mechanisms, and scalable models.

High-Level Opening Session

Moderator: **Eliot Sorel**, George Washington University

Kirsten Hillman, Deputy Ambassador of Canada to the United States, introduced **the Honourable Ginette Petitpas Taylor, Canada's Minister of Health**, describing Minister Taylor as “one of the most prominent champions of mental health in Canada.”

Minister Taylor noted that mental health issues affect almost everyone at some point in their lives. It is therefore crucial to shine a light on stigmatization of the mentally ill and to unite people to improve mental health. For instance, at the international level, Canada recently set forth a resolution to recognize and eliminate stigma against drug users in social services. At home in Canada, the Minister was encouraged by the success of the “Bell, Let's Talk” campaign, which is now the most used hashtag in Canadian history.

“I have seen first-hand,” Minister Taylor said, “how mental illness affects not only individuals, but also their families, caregivers, friends, and communities. This personal experience taught me a valuable lesson. Almost no one in society is left untouched by mental illness.”

She stressed that mental health is not just a health-sector issue, but a complex social phenomenon that needs to be solved with a “whole government” approach, including sectors such as housing and education.

In Canada, healthcare delivery faces distinctive challenges, such as reaching remote and vulnerable communities. For example, there is a high rate of suicide among Canada's indigenous populations. For the first time in history, the national government and the provinces have begun a formal collaboration on mental health. Now, Taylor argued, the Sustainable Development Goals (SDGs) provide us with a global framework to galvanize progress. Global momentum for improving mental health is affecting all sectors. The Minister emphasized her personal determination to play a part in this work, and Canada's substantial commitment to it at a national and international level.

The full text of The Honourable Ginette Petitpas Taylor's remarks is included in Annex 1.

Timothy Grant Evans, Senior Director for the Health, Nutrition and Population Global Practice, The World Bank Group, described mental health as a core component of human capital, which has been a key interest of the World Bank since the 1970s. During WBG President Jim Kim's tenure at the Bank, this interest has broadened and deepened. The concept of human capital implies a commitment to development as something more than progress in “hard infrastructure” and “natural infrastructure.” Human capital is one-third of the World Bank's focus and includes education, health, and social protection.

Mental health, said Evans, must be a development priority for society as a whole. The cost of inaction is too high. Continuing to put this message out, he went on, is key to ensuring that senior decision-makers are part of the solution to the problem of inadequate infrastructure for the promotion of mental health.

Picking up Minister Taylor’s argument, Evans stressed the need to move beyond an understanding of mental health as “just” a health sector issue. It is multi-sectoral: it involves nutrition, education, the work-place, the justice system, and many other social institutions. Mental health and wellbeing, Evans argued, will come about through the progressive realization of the SDG targets. We need, he concluded, to take a “pentavalent” approach: moving forward on many possible targets just as is commonly done in vaccine development. Mental health is a true 21st-century challenge, requiring innovative approaches in financing, service delivery, and the creation of strong leadership in communities, within institutions, and among young people who will collectively “move the needle.”

Carissa F. Etienne, Regional Director for the Americas, World Health Organization/Pan American Health Organization (WHO/PAHO), stressed that mental health should not be a luxury, but is a necessity for human development. “Today,” she said, “forty years after the declaration of Alma-Ata, there is no better time to make sure that mental health is an integral part of our vision of ‘health for all’”

At World Health Day 2018, PAHO sought to raise awareness of health as a basic human right, and to advocate for the provision of healthcare without discrimination and undue financial burden as a critical responsibility of national governments. Mental health issues take a toll on individuals, shortening people’s lives. But their impact extends far beyond people living with mental illness, reaching families, communities, societies, and economies. That is to say, mental health affects every human being, either directly or indirectly, and it is therefore important to raise awareness that mental health is an integral and fundamental component of universal healthcare.

Etienne highlighted the significance of direct payments for mental health at the point of care. This is a barrier to access, she said, and she urged participants to work with countries to eliminate such payments. Further, the stigma that continues to prevent people from asking for and getting care must be addressed. Delivery needs to shift from the traditional psychiatric hospital setting to a community/primary care setting, providing integrated, comprehensive, and continuing care for all patients. Failing to address mental health is not an option, if we want to place human development at the center of the sustainable development agenda.

The full text of the Regional Director Carissa F. Etienne’s remarks is included in Annex 2.

Christine Hogan, WBG Executive Director for Antigua and Barbuda, Belize, Canada, Dominica, Grenada, Guyana, Ireland, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, the Bahamas, emphasized the boundary-crossing nature of mental illness. It transcends income and geography, she said. While often hidden, the effects are stark: mental health reduces life expectancy as much as smoking and accounts for 40 percent of the global burden of disease. While mental pain is as real as physical pain, the services to address it are lagging far behind across all countries.

Research over the last two decades has made clear that the unmet burden of mental illness and distress is a serious impediment to the global development agenda.⁶ It is also clear that mental

⁶ Patel, V., Boyce, N., Collins, P.Y., et al. 2011. “A renewed agenda for global mental health.” *Lancet* 378 (9801): 1441–1442.

health's impact has been systematically underestimated.⁷ We have an opportunity to focus now on mental health as a development challenge, said Hogan. It requires a multisector approach, creativity, innovation, and even disruptive strategies. While the endgame is clear, scaling and financing resources are still very much needed. This burgeoning cooperation between the World Bank, the Canadian government, and other partners holds promise and power.

The full text of Christine Hogan's remarks is included in Annex 3.

Key Messages of the Session:

- Mental health affects everyone, everywhere – progress has been made, and there is renewed momentum stemming from the SDGs, but much must still be achieved;
- The high burden of mental illness in the world today exacts a heavy human cost. It impacts all people, either directly or indirectly;
- Addressing mental health is not just a moral imperative, but a sustainable development priority;
- Mental health should be driven forward through innovative and creative multi-sector engagement and the integration of mental health services into the Universal Health Coverage.

Session One: Global Perspectives

Moderator: **Pamela Collins**, University of Washington

Vikram Patel, Harvard University, and **Shekhar Saxena**, The World Health Organization, discussed mental health in the era of sustainable development, a subject they will touch on in their forthcoming Lancet Commission publication. Patel lamented that the burden of mental and substance use disorders is rising in all countries, but especially in lowest income countries, with an adverse effect on young people and the elderly. As far as mental health goes, he noted, all countries are developing. We know how to deliver interventions in a low-resource context, but despite this knowledge little is being done to translate this work on the ground.

We are now at an inflection point, said Patel. We can leverage the SDGs and the increasing political momentum. The Lancet Commission can put more energy into mental health. Saxena stressed that the way we think about mental health needs to change. We are transitioning from “disorder dichotomies” to a focus on promotion, prevention, and treatment paradigms, narrowing even more to focus on integrating care into the community and universal health care. We can make strides by leveraging technology and must also be aware of the human rights aspect of mental health.

Emily Hewlett, of the Organization for Economic Co-operation and Development (OECD), brought her organization's distinctive perspective on mental health into the discussion.

⁷ Vigo, D., Thornicroft, G., and Atun, R. 2016. “Estimating the true global burden of mental illness.” *Lancet Psychiatry* 3: 171-78.

The OECD has mandated mental health as a high-level priority, recognizing that one in five people lives with a mental disorder, and one in two people will experience mental health issues in their lifetime. The cost of mental ill-health can rise to four percent of Gross Domestic Product (GDP). Yet gaps remain, even in comparatively affluent societies. In Europe, 50 percent of major depression is untreated. The OECD has been working on mental health for more than a decade, and over the past few years members have been pushing harder for a clear policy from their governments. In 2017, 25 OECD health ministers spontaneously called on the OECD to help them better understand mental health and its macroeconomic impact. Even in resource-rich settings, mental health is still under-treated. Data gaps also make it hard to grasp what actions are required. Policy is needed but, most importantly, policies need to be applied.

Key Messages of the Session:

- Evidence suggests that expansion of country-based mental health action is the most sustainable solution;
- The SDGs present a significant opportunity to support progress – while working in an integrated way;
- All countries are still “developing countries” in terms of mental health. To move forward, countries and communities need to bring their own resources to deliver effective interventions.

Session Two: Sharing Country Experiences and Lessons Learned

Moderator: **Sheila Dutta**, The World Bank Group

Inka Weissbecker, International Medical Corps, Ukraine, focused on the experience of Ukraine, a post-Soviet country with high levels of corruption, political instability, and conflict. Ukraine has a high burden of mental disorders and substance use disorders, especially depression and alcoholism, compounded by risk factors of poverty, unemployment, social isolation, and exposure to conflict. The mental health budget is only 2.5 percent of the total health budget of Ukraine. On the other hand, there is momentum in Ukraine on mental health promotion at a policy level, endorsed by the cabinet.

The challenge in Ukraine is to provide information, policy recommendations, and operational guidance to strengthen the integration of mental health into primary health care and community-based service platforms. This is now happening in three pilot regions (Lviv, Poltava, Zaporizhia), with a focus on common mental disorders (depression, anxiety, PTSD) and alcohol use disorders.

Several obstacles need to be overcome: centralization of mental health in specialized settings, low access to care in remote areas, prevalence of non-evidence based interventions or interventions by unlicensed staff, high levels of stigma and fear of psychiatry, and challenges with sustainability of funding and gaps in coordination. There has been a proliferation of civil society organizations and NGOs in Ukraine, but their interventions may not be in line with best practices. Negative attitudes towards people with mental illness persist – it is estimated that up to 75 percent decline to access care, even when it is available. There are many barriers to accessing care,

including: stigma, lack of trust in the health system, lack of information, cost of treatment, fear of public disclosure, negative help-seeking experiences, and geographical distance.

The national goal, said Weissbecker, is to scale up treatment by 2030, with a target of restoring over 4.7 million years of healthy life. For every US\$1 invested in the treatment scale-up, the country gains US\$2 in restored productivity and added economic value. The total cost per capita of comprehensive mental health services in Ukraine is approximately US\$ 10.90.

A four-part agenda has been proposed for implementation under the Ministry of Health: (1) coordination, communication and information sharing; (2) restructuring of the organization of mental health services as part of the ongoing reform of the primary health care system at the regional and local levels; (3) education and training of human resources; (4) mental health knowledge, awareness, and self-help. Next steps include the formulation of a Mental Health Action Plan, which is currently under development, as well as a pilot project which is being developed in the Zaporizhian region with the support of the World Bank-funded health system reform program. This specifically focuses on: reducing stigma, mental health integration into primary care, evidence-based interventions to treat common mental health disorders, and monitoring and evaluation for potential scale up.

Rabih El Chammay, Ministry of Health, Lebanon, presented the experience of Lebanon, a crisis-afflicted country with a long history of civil war, now facing major challenges related to a large influx of refugees from the civil war in Syria. It is thus an urgent national priority to improve the mental health situation. One is an important number, said El Chammay. One in four people will develop mental health conditions in their lifetime; one person dies because of suicide every forty seconds; one percent of the government health budget goes to mental health programs in low and middle-income countries; every US\$ 1 invested in treatment for depression and anxiety leads to a US\$ 4 return in better health and ability to work.

One in four people living in Lebanon is Syrian because of the civil war in Lebanon's neighbor to the north and east. Conflict and displacement have exacerbated mental health needs in the population. Yet at the moment there is no mental health department at Lebanon's Health Ministry, no national policy, major gaps in legislation, chronic underfunding, under-staffing, high stigma, and low levels of public awareness. In 2014, the National Mental Health Program was established with the support of the WHO, UNICEF, and IMC, and the first national mental health strategy was launched in 2015. The vision is that "All people living in Lebanon will have the opportunity to enjoy the best possible mental health and well-being".

The World Bank has sponsored two programs in Lebanon to achieve this goal. The Lebanon Health Resilience Project, with a budget of US\$ 150 million, provides mental health services at primary health care clinics as part of an integrated package of essential health services benefiting poor Lebanese and the displaced Syrian population. The Lebanon National Volunteer Service Program, with a budget of US\$ 4 million, improves social stability and service delivery in the most vulnerable Lebanese communities hosting Syrian refugees. This project is supporting youth volunteering, soft skills development, and psychosocial awareness activities.

Five domains of action include: leadership and governance, service organization, promotion and prevention, HIS and research, and vulnerable groups. Through the implementation of the mental health framework, Lebanon has learned to merge the humanitarian and development

agendas, while engaging all actors around one roadmap under the collaborative governance model proposed by the Ministry of Public Health (MOPH).

Rafael Alvarez, Mayor of Carabayllo Municipality, Lima, Perú, and **Humberto Castillo** of Cayetano Heredia Peruvian University, focused on Peru's experience at the municipal level. One in five Peruvians will be affected by a mental disorder every year. The prevalence is highest among poor and marginalized population. Care gaps are severe. Only 12.8 percent of Peruvians estimated to need mental health services received them. From 2013 to 2016, public health leaders launched a series of community-focused change initiatives to improve mental health care.

Four key community-based mental health care modalities were deployed in Carabayllo: (1) community mental health centers, (2) mental health in primary health care, (3) a mental health halfway house for vulnerable women, and (4) mental health units in general hospitals. Three of these scored impressive success, while one initiative failed and requires a deep redesign. The heart of the reform occurred in community mental health centers (CSMCs). Twenty-two CSMCs were launched across Perú in 2015, with Carabayllo's being the first in Metropolitan Lima.

Staffed by an inter-disciplinary team of clinicians and social workers, the CSMC delivered more than 20,000 interventions in its first year, and drew patients from far beyond its planned catchment area. The results confirmed large unmet care needs and strong uptake of mental health services in the community.

Community-based mental health efforts in Carabayllo achieved proof of concept, but more can be done. Reforms sought to foster mental health care delivery in local general health care facilities, which entails mental health training for local primary care providers and in-service technical support to primary care teams by mental health specialists. While robust referral networks and collaborative relationships were established, most primary care providers continued to refer patients with mild to moderate health issues prematurely to the CSMC, rather than treating them in the primary care setting. A women's mental health halfway house was implemented collaboratively by the National Institute of Mental Health, operating successfully and at full capacity during the study period, using a minimally restrictive residential care model. There was, however, a failure to establish mental health units in general hospitals. Funds were transferred to the local hospital to implement a mental health and addictions unit, but clinical staff resisted the change. Hospital management facing a generalized budget crisis redirected the funds to other priorities.

In cost-benefit terms, the Peruvian experience suggests that community-based mental health treatment is a better alternative than traditional hospital-based treatment. If 90 percent of all outpatient treatments in Lima's psychiatric hospital were shifted to CSMCs, Peru's health system would save US\$ 7,669,519 annually – this sum would cover the cost of operating 21 community health centers. The model of universal health coverage associated with Perú's National Health Reform favored the effective transfer of financial resources for mental health care. Peruvian health leaders' plan is to maintain the political commitment and scale up the number of CSMCs to 100 by the end of 2019 and 300 in 2021.

Tolu Kasali, Ministry of Finance of Nigeria, shone a light on the dilemma of internally displaced persons (IDPs) in Nigeria. The country's IDPs were recently numbered at 1,782,490. The largest IDP population is in the Northeast because of the Boko-Haram insurgency. The

militants operate by killing, abducting women and children, and destroying goods and property. The conflict resulted in over one million newly displaced persons in 2015 alone, and the number of IDPs grew by 4.5 percent (+79,810 persons) from December 2017 to February 2018. Forty percent of Nigeria's displaced people live in camps, while 60 percent live in host communities. Seventy percent of IDPs are vulnerable (women and children), and 28 percent are children under five. Displaced persons experience grief, personal loss in traumatic circumstances, and loss of economic opportunities, along with a potential breakdown of cultural identity and family structures. Mental and emotional scars, though often overlooked, are among the most serious consequences of conflict. Stigma is very real. In this setting, few channels exist for reporting violence or talking about mental health issues.

Settlement in temporary locations for prolonged periods presents major challenges. A hierarchy of basic needs must be met through an integrated approach to rehabilitating IDPs with dignity. Besides survival and safety, food remains the predominant unmet need in 70 percent of the IDP camps. Increasing numbers of displaced persons put added pressure on existing facilities and relief supplies. Safety can only be realized when basic needs of food, water, and shelter have been met.

To deliver effective interventions, practitioners must understand the state of mind of the people the interventions are meant to help. An example would be addressing IDPs' urgent material needs while also providing physical and mental health services, psychosocial support, education, and opportunities for skills acquisition. Such an approach would equip displaced people to survive mentally, physically, and economically. Key to their recovery, we must support IDPs to achieve livelihoods that can provide long-term economic sustainability. A solution gap exists between the early phase of displacement and long-term rehabilitation. A multisectoral, comprehensive, and collaborative approach is required. Some promising experiments are underway. Recently, for example, Nigeria introduced taxes on tobacco and alcohol to reduce health hazards and raise funding for the health sector. Investing in mental health is investing in helping people realize their dreams.

Giuseppe Raviola, Partners in Health (PIH), discussed how creative collaborations have evolved in the last two years, since the "Out of the Shadows" meeting, to allow front-line workers to deliver in very hard conditions. This is so especially in low-income, post-conflict, and humanitarian settings. In Haiti, Partners in Health (PIH) has developed a mental health system, integrated within community networks, HIV care, and primary care. There are seven hospitals and 11 health centers in the catchment area, with an overall mental illness point prevalence of 16 percent. From 2012-2015, in partnership with Grand Challenges Canada (GCC), PIH expanded a new implementation model to address severe mental disorders in rural Haiti. The work aimed to inform the development of a national decentralized mental health plan following the 2010 Haiti earthquake. Community-based care is used as a platform for mental health care, including: access to primary care, free health care and education for the poor, community partnerships, addressing basic social and economic needs (social determinants of health and illness), and serving the poor through the public sector. Through management, partnerships, and integration in low-resource settings, we can scale up and develop mental health programs, Raviola said.

In Perú, PIH effectively partnered with the Ministry of Health to deliver a specific solution (as previously discussed by Rafael Alvarez and Humberto Castillo). In Rwanda, mental health programs were embedded into existing HIV programs, scaled up and developed through effective

partnerships and management. It is important to note that the initial funding was provided by GCC, and when the funding period was over, the programs were self-sustaining. PIH is increasingly embedded in academia, integrating service delivery with research and training. It is critical to scale up community health worker-delivered interventions for common mental health disorders.

Key Messages of the Session:

- Confronting unique contexts and challenges, many countries around the world have made progress in delivering mental health interventions;
- The obstacles and success stories noted during the event highlighted the importance of country ownership and leadership in enabling a multi-sectoral and human-capital approach;
- Country “lessons learned” show a common theme: interventions at the community level are successful for an integrated approach;
- Community mental health centers and other mechanisms of community-based care should be supported to translate commitment at the global and national level into services on the ground, with specific emphasis placed on the most vulnerable populations;
- There is urgency to leverage novel approaches and to achieve greater integration among stakeholders, particularly with respect to sustainable service delivery and innovative financing methods.

Session Three: From Research to Technological Innovation to Service Delivery to Cities and the Workplace: New Initiatives to Advance Global Mental Health Action

Moderator: **Patricio V. Marquez**, The World Bank Group

Moitreyee Sinha, CitiesRise, emphasized that mental health is the world’s leading cause of disability. Despite the magnitude of the problem, there are significant barriers to addressing it. These include: stigma and ignorance, lack of political will, lack of funding/resources, narrowly focused approaches in health, and a lack of collective action. This leads to significant gaps in information, services, infrastructure, and labor.

There are several “bright spots” for mental health, said Sinha, but they operate in silos and are sub-scale. There needs to be a comprehensive movement that creates action where young people live: in cities and communities. Currently 54 percent of the world’s population live in cities; that number is expected to rise to 66 percent by 2050. Two changes are needed in cities: (1) changes on a systemic level and (2) “movement energy.” Cities are convenient and effective platforms because of the co-location of a number of sectors and the concentration of young people. This provides a city-level approach to large-scale change, a platform for cross-sectional collaboration, and a global network of innovators and doers. By 2030 the goal is to impact the lives of one billion young people by turning the tide on depression, anxiety, addiction, and suicide through scaling up best models and approaches.

Cities allow for local and global action at once. At the local level, action follows the trajectory of local priorities. Local platforms collaboratively engage city stakeholders to create

sustainable change. Cities and communities across high, low, and middle-income countries are working on shared principles and targets for young people. CitiesRise has already started preparing first-wave cities to launch local collective action platforms in Nairobi, Chennai, Bogotá, Sacramento, and Seattle. On a global level, the organization enables conversations between different cities to create a global network. Connectivity allows for the acceleration of scaling-up services and helps individual cities develop more global-centric tools. Once customized at the local level, we can build global frameworks and adapt models from around the world to solve complex issues. This creates system integration and can act as an accelerator that supports new models of intervention and in turn can rapidly scale up successful approaches.

Mary De Silva, Wellcome Trust, spoke of Wellcome Trust’s attempt to deepen “mental health science,” which would significantly improve health interventions and positively impact outcomes. The challenge is that not everyone benefits from interventions. Effective solutions exist, but most people don’t have access to them. The main components of Wellcome’s campaign build upon joint implementation science efforts to scale-up existing interventions and improve their effectiveness.

The Wellcome Trust plans to establish and promote a set of common measures and create an open-science global platform to drive new scientific insights in this sector. This will help us understand why, how, and for whom therapies work, to inform the design of new interventions, optimize interventions for delivery at scale, and accelerate impact through global partnership for scaling. This in turn will foster the super-field of mental health science to promote a standardized approach to improving outcomes for people with mental health problems. This creates the vision that mental health problems are effectively treated and managed. Unlike other fields of biomedicine, mental health has long suffered from the lack of foundational infrastructure for research and partnerships, which has impeded scale-up. Being able to place large amounts of standardized data from different projects onto a single platform can enable stakeholders to untangle some of the complexities surrounding mental health.

Beverly Pringle, US National Institute of Mental Health (NIMH), spoke of the U.S. experience. Americans learned the hard way, she said, that without international translation of everyday best practices into policy, achieving impact is difficult or impossible. This is the role of a new field of research: implementation science. Since 2016, NIMH has supported a rapid scale up hub model, now with eleven hubs. The hubs conduct implementation research; answer questions specific to local contexts; expand research capacity; ensure end users are involved over the five-year project lifecycle; and create networks across hubs to share knowledge.

The project cycle addresses six key priorities: (1) identify root causes, (2) risk and protective factors, (3) advance prevention and implementation of early intervention, (4) improve treatments and expand access to care, (5) raise awareness of the global burden, and (6) build human-resource capacity, which in turn will help to transform health-system and policy responses.

Collaboration with end users has led to partnerships with The World Bank and PAHO, an integrated data management system for Latin American stakeholders, a government/multilateral organization advisory board, and an industry advisory board. Cross-hub network research has led to a repository of implementation measures for use in low-resource settings. The NIMH Hub Model acts as an incubator for: getting evidence-based care to high-need, underserved populations, expanding capacity to do research and to use research for policy and program development,

engaging those who will implement and sustain the delivery of innovative evidence-based mental health care, and establishing research networks to accelerate research and publication of results.

Karlee Silver, Grand Challenges Canada, was pleased to see more and more projects thriving with experience surfacing globally to push the work forward. Only ten percent of people with mental health conditions have access to treatment and care. Imagine, she said, that ninety percent have access to high-quality, evidence-based treatment and care instead: “Flip the Gap.” That is the objective of her program, which has brought 921,000 people improved mental health to date. A total of \$42 million CAD has been committed to 85 innovative projects as a support platform with innovations in 31 countries. Seventy-two percent of projects are led by innovators based in low- and middle-income countries, and 24 percent are Canadian-led.

By 2030, three million children are expected to be using interventions that improve early childhood development – reflecting \$55M CAD committed to 155 innovative projects and a support platform with innovations in 30 countries. Eighty-three percent of these early childhood projects are led by innovators based in low and middle-income countries, and 17 percent in Canada.

In Zimbabwe specifically, the initial problem was how to close the massive mental health treatment gap there, in a country where there were only ten psychiatrists and 15 psychologists, with a prevalence of common mental health disorders at 25 percent. To address this, a model called the “Friendship Bench” was developed, whereby a bench was set up outside of primary care clinics and staffed by “community grandmothers.” Much evidence has been gathered to demonstrate the success of the intervention, which has been scaled up to 72 clinics. Patients with depression or anxiety who received problem-solving therapy using this bench were three times less likely to have symptoms of depression, four times less likely to have symptoms of anxiety, and five times less likely to have suicidal thoughts. Not only are neighboring countries adapting this model, but it has also been rolled out in New York. It has treated over 50,000 people and climbing. The next step is to digitize this model. Technology can help reach more people at a reduced cost. Training through a technological platform has been shown to yield equivalent results to training by specialists.

Mariam Claeson, Global Financing Facility (GFF), argued that the GFF should be an opportunity for mental health, as it was set up to close gaps in financing in neglected areas/geographies/interventions. The overall objective is to end preventable maternal, newborn, child, and adolescent deaths and improve the health, nutrition, and quality of life of women, adolescents, and children. Closing the financing gap would prevent 24 to 38 million deaths by 2030. Analysis leads to neglected populations, geographies, and interventions. Claeson stressed the need to focus on fragile, post-conflict, and post-emergency settings – burdens are unevenly distributed across incomes and geographies.

The GFF asks countries to set priorities throughout the lifecycle, and then develop investment cases and mandates for the financing facility to put money behind. A key aspect of fund allocation is co-financing by the receiving countries, which is key for sustainability. For example, the GFF finances health and education to reduce school drop-out rates among female and disadvantaged students in Bangladesh. Strategies include tackling menstrual hygiene, undernutrition, and emotional problems. The solutions: stipends for female students, separate functional toilets for girls, menstrual hygiene in schools and at home, adolescent health and nutrition services for students, teachers, and community, SRHR and gender equity in the

curriculum, and tackling bullying through student and peer counseling. Challenges must be turned into opportunities: prioritization, investment in quality health systems, mobilizing additional resources, and better use of existing ones. There is no longer any justification for countries not to allocate domestic resources to the promotion of human capital.

Garen Staglin, OneMind, said that 40 percent of sick days in the UK were due to mental health and substance-abuse disorders. One in three working-age adults in the US is experiencing a mental disorder. US\$ 44 billion are spent annually in the United States on lost work productivity due to depression alone, and the United States spends US\$ 87.5 billion annually on health care for mental health conditions. OneMind researchers have conducted a global survey of who is leading the charge in workplace mental health and have developed nine pillars of common workplace standards based on the results. The aim is to bring organizations together around a framework to align interest and speak with one voice. Existing programs in the field include: stigma-reduction campaigns, restructuring health benefits, tools to determine whether mental health benefits are accessible, strategies for holistic workplace wellness, and others. This targets costs and burdens like: absenteeism/presenteeism, high disability costs, lost productivity, stress and risk factors, feelings of discrimination and isolation, and privacy and liability concerns. The organization has also developed an ROI calculator for companies to estimate the cost of depression to them. Several CEOs have signed up to multi-year commitments to improve mental health in the workplace. Challenges employers face through OneMind's CHRO analysis include: fighting stigma, creating a care continuum, analyzing losses, and addressing access barriers. Their strategic imperatives for 2018 include: driving commitment, expanding the Network, creating new evidence, and developing new tools. The work is generating great momentum – and it is not just for corporations.

Elisha London, The Global Campaign for Mental Health, stressed the importance of moving from conversation—knowing what works and what research is to be done—to action, scaling up successful models. The Campaign is dedicated to helping transform mental health goals into action at scale through an Agenda for Action, Resources for Action, and Frameworks for Action. The Campaign is currently developing a variety of financing mechanisms to scale evidence-based solutions.

Three working groups have been set up to address the financing of mental health from research to implementation. The groups are looking at: (1) financing options for scaling up integrated service delivery in low- and middle-income countries, (2) a “Healthy Brain Bond” for research, and (3) strategic communications. Initial work focused primarily on the “what” and the “where.” Now attention is turning to the “how” and potential financing mechanisms. This work has been driven by global experts, including The World Bank, the WHO, leading academics, and implementers, facilitated by The Global Campaign for Mental Health, with support from the Boston Consulting Group. Five work streams are working to deliver the Healthy Brain Bond for Research: (1) Financial Structure and Financing Mechanisms, (2) Use of Proceeds, (3) Identification of “Pay for” Metrics and by Whom, (4) Identification of Buyers and Underwriters of Bond, (5) and Development of Governance Structure for Oversight and Fund Distribution. As Paul Dalio recently commented: “If we invest in mental health at the right level, we both relieve a burden, but also, and more positively, invest in opportunities for the future.”

Key Messages of the Session:

- A growing number of organizations support the expansion of global mental health, pursuing activities across the whole spectrum of research, advocacy, financing, and program implementation;
- Developing platforms at the municipal level, with full ownership of national/local governments, is critical to building effective local programs and creating communities of practice that can identify, scale up, and refine effective mental health interventions based on operational research;
- Development partners have a key role to play in knowledge-sharing for mental health interventions to create a cohesive and sustainable agenda;
- Public- and private-sector institutions are both pivotal in the improvement of people's mental health, particularly with respect to achieving wellness in the workplace.

Session Four: Looking Ahead – Challenges and Opportunities

Moderator: **Andrew Jack**, *the Financial Times*

Patrick J. Kennedy, Founder, Kennedy Forum, and former member of the US House of Representatives, stated that it is important to galvanize leadership to pursue just solutions for people living with mental illness. Such solutions are currently lacking in many contexts. Is it discrimination, Kennedy asked, if you aren't treating the brain like any other organ in the body? In the United States, the Mental Health Parity Act, which Kennedy was instrumental in helping to pass, prevents this type of discrimination. To move forward quickly, we should use or adapt existing frameworks. We must also address discriminatory legislation and behaviors. You can't only wait to change hearts and minds, but must also stop discriminatory practices. We can "go global" with this, Kennedy said, by emphasizing the moral imperatives. While we want to bring people along, we can't wait for them to come along: change needs to happen rapidly.

Paula Gaviria, Human Rights Commissioner, Office of the President of Colombia, disclosed how the recent peace agreement in Columbia has brought an end to a 53-year conflict. The agreement specifically outlines the need to address the suffering of victims. The issue now is ensuring that a highly polarized society can be reconciled. The key goal is to work at the community level to affect a collective recovery of communities. Currently, six million people have been identified as victims of the conflict. Of these, three million require psychosocial care. Progress is being made—so far, they have reached 800,000—but the work still has far to go.

Julio Frenk, President of the University of Miami, former Minister of Health of Mexico and Dean of the Harvard School of Public Health, argued that our view of mental health changed through the development of more accurate metrics. For example, we are now looking at disability and not just mortality. This has allowed mental health to move up on the agenda, though only recently. However, this response has not yet solved the urgent needs. Mental health must be brought into the mainstream, based on the idea of parity and integration. Fresh policy approaches are needed, as well. Frenk advocated against vertical programs, calling for a "diagonal" approach, as was done successfully in Mexico.

Mainstreaming of mental health, said Frenk, can occur along five dimensions: (1) integrate mental health into treatment of NCDs; (2) develop an integrated view of mental health (moving away from biological/sociological reductionisms on mental health, both need to be addressed); (3) address the whole range of conditions related to mental health (there are in fact two-way links between physical and mental health); (4) migrate from the idea that mental disorders have to be treated in secluded clinical spaces; and (5) integrate a comprehensive treatment approach (including pharmaceuticals and psychotherapies), with attention to human rights principles.

The “diagonal” approach in Mexico was highly successful, Frenk noted. It focused on priority areas and built improvements around them that then spilled over into other areas. Vertical programs compete for resources, so integrated approaches are more cost effective. In fact, mainstreaming mental health care into primary care and general hospitals was a first key step to de-stigmatization, as mental health became part of mainstream health care. In addition, introducing a new kind of health insurance in Mexico offered an opportunity to include mental health coverage. We must learn from this experience and scale it globally.

John Balafoutis, The World Bank Group Treasury, pointed out that a need for substantially increased financing characterizes a variety of social issues today. Many institutions, including the World Bank Group, are trying to find the best ways to combine various sources of financing to achieve optimal outcomes and provide the needed resources to address multiple issues. Balafoutis described three broad types of financing: (1) pure private-sector financing, (2) blended financing, and (3) public/donor financing. Capital markets can provide an enormous quantity of financing for social issues. An example is “green bonds,” which are the most established types of Social Impact Bonds (SIBs). These bonds raise money from investors to fund new and existing projects with climate-change or environmental benefits.

There is an increasing interest in green bonds today. Since 2008, the World Bank has issued the equivalent of over US\$ 10 billion in green bonds through more than 130 transactions in 18 currencies. The World Bank can act as an issuer, promoter of market integrity and transparency, an advisor, an investor, and a guarantee provider in this space. Public institutions and donors have limited amounts of capital and are increasingly looking for ways to increase the amount of capital they can deploy by leveraging private resources. Blending World Bank financing with other financing sources is a key part of the World Bank’s strategy. Examples of new mechanisms include: IBRD loan buy-downs, IDA credit buy-downs, and mechanisms such as the Pandemic Emergency Financing Facility. There are many ways to leverage both public and private financing sources to raise capital for social issues. The World Bank is focused on using its capital to leverage additional private financing sources and thus maximize impact.

Anette Dixon, Vice-President, Human Development, The World Bank Group, defined human capital as “the ability of a country to be productive and drive growth through its people.” She argued that there is a clear line of sight between health, education, and human capital. Mental health imposes a huge disease burden. For example: children of depressed mothers are at a greater risk of stunting. There is a major push now to encourage countries to invest in mental health from the human capital side. This must be added into how we think about country assets. In technologically advanced countries, 70 percent of wealth is comprised of human capital. In the rest of the world, the figure is only 40 percent. By measuring human capital, we can spark a

stronger demand for more investment domestically. However, speeding progress also requires a large input on the part of the international community.

Key Messages of the Session:

- Country ownership and leadership are essential in ensuring program sustainability through innovative “diagonal” approaches;
- A heavy burden of mental health conditions weighs on fragile and conflict-affected states. In post-conflict states, the road towards societal reconciliation can be long. Systematic action on mental health can speed this restorative process;
- Leaders increasingly recognize mental health as an essential development input. Multiple types of financing can be mobilized to support mental health action. The argument to increase mental health financing is strengthened when leaders examine investment options through the lens of human capital.

Overarching Event Messages and Closing

Brian Hansell, Founder and President, Paul Hansell Foundation, Canada, passed the #ConvoPlate to participants. These are hand-painted stoneware plates that are circulated within communities to get people talking about mental health. The Paul Hansell Foundation was created in honor of Brian’s son, who lost his life to suicide. On an annual basis, suicide claims the lives of 800,000 people. The population of Washington, D.C. is 700,000. The comparison may help us grasp the magnitude of what is at stake in confronting this issue.

The Paul Hansell Foundation engages young people in art therapy to create a “conversation plate,” which can then be passed from person to person to stimulate discussion about mental health, inspire everyone to do something to look after their mental health, and raise money for mental health action. There are currently 500 plates in circulation, which have catalyzed tens of thousands of conversations over the past two years. There have been several very high-profile plate passes. For example, the plates have been brought to the House of Commons in Canada twice, and the Royal Family have been in possession.

Closing Remarks were delivered by the Hon. Kirsten Hillman, Deputy Ambassador of Canada to the United States

After the conference a viewing stand was set up to allow participants to watch the virtual reality video, “**Francis: Global Faces of Mental Health**”, by **Zoe Adams**, CEO of the Strongheart Group.

Annex 1: Remarks by the Honourable Ginette Petitpas Taylor, Minister of Health of Canada

Good afternoon. It's exciting to be in Washington today.

Thank you to the World Bank Group for convening such a distinguished panel to discuss this important issue, and thank you to each of you for the work you do in promoting mental health.

Promoting positive mental health is a passion of mine, something I've been consumed with long before I became Canada's Minister of Health.

For over two decades, I worked as a social worker. My first job was actually with the Canadian Mental Health Association.

I have seen first-hand how mental illness affects not only individuals, but also their families, caregivers, friends and communities.

This personal experience taught me a valuable lesson. Almost no one in society is left untouched by mental illness.

Directly or indirectly, sometimes without even knowing it, mental illness affects nearly everyone at some point in their lives.

Having worked on the front lines for over two decades, I now find myself in a very different position.

As Minister of Health I have resolved to act, by shining a light on stigma and uniting people – inside and outside of government – in the quest for positive mental health.

Led by Prime Minister Justin Trudeau, our government has made improving mental health a top priority.

This comes with some uniquely Canadian challenges – namely that delivery of health care is largely handled by our provinces and territories. Yet this only made us more resolute, and last year we reached an agreement with every province and territory to invest directly in access to mental health and addiction services.

While we only have 13 provinces and territories in Canada – not 50 like you – this is a first in the history of our country.

It demonstrates the commitment of all levels of government – sometimes of different political stripes – to improving mental health, and addressing areas of greatest need, including services for youth and Indigenous peoples.

Our government is also supporting programs that address risk factors for mental illness, such as intimate partner violence, child maltreatment, and problematic substance use.

For example, to build resilience in vulnerable children and families, we are designing maternal and child health programs to support positive parenting, family bonding and healthy relationships.

Despite this progress, access to health services in Canada continues to be a challenge, particularly in rural and remote communities.

Suicide continues to be an important public health issue — even more so in some Indigenous communities, where suicide rates are heartbreakingly high.

All of this points to the need for a healthcare system where mental health services are widely available and supportive, no matter where people live, which our Government is working to address.

Yet it goes beyond funding. As I mentioned earlier, I want to shine a light on the stigma that surrounds both mental health and substance use disorder, because it is a major challenge we face.

Stigma is more than words. It has a major impact on the quality of life of people with mental illness, which all too often makes it harder for those in need to seek treatment.

At home, we are raising awareness of stigma surrounding people who use drugs, and are working to include the crucial perspectives of people with lived and living experience.

Having spent years in the field, I know that by listening to these voices, we can help people understand the dangerous effect of stigma on those with substance use disorder, their families and their communities.

One Canadian success story did not come from a government initiative — I'm sure that's a surprise! — but rather from a private company that decided to champion mental health.

The Bell “Let's Talk Day” is an annual event that encourages conversations about mental health among both prominent individuals and Canadians, centering on the need to fight stigma.

This event has grown in prominence every year, to the point where #BellLetsTalk is the most used hashtag in Canadian history and four out of five Canadians say they're more aware of mental health issues than before.

Yet championing mental health doesn't stop at our borders.

Joined by nineteen of our allies at the United Nations Commission on Narcotic Drugs, Canada recently achieved consensus on a resolution on stigma towards people who use drugs.

The resolution aims to recognize — on an international level — the stigma that people who use drugs encounter when they seek healthcare and social services, and eliminate it.

Our goal is to create a society where people can access health and social services without fear of discrimination and prejudice.

But we know there is still more to do.

Part of the answer lies in recognizing that mental health is not just a health issue.

Many of the levers to address mental health issues fall outside the health sector — such as adequate housing, education, and a sense of community.

All sectors of society have a role to play. This is why we are addressing mental health at a World Bank Group event today, a valuable opportunity to discuss it not only as a health and wellness issue, but also one with an economic impact.

The economic impact of mental illness on individuals and society is a major global challenge for sustainable development, one that necessitates engaging everyone, most notably vulnerable and marginalized populations.

Fortunately, we have a framework to help galvanize action in this area – the United Nations Sustainable Development Goals set out targets to ensure the physical, mental and social well-being of people worldwide.

Global momentum to improve mental health is increasing. Governments, civil society and the private sector are starting to mobilize.

We must build on this momentum.

And Canada is determined to play its part.

We must consider how we can better work together to take meaningful action on mental health and well-being, driving progress faster and more effectively than any one country.

This is why today's discussion is so important.

Unfortunately, I can't stay for the rest of the session, but I'm sure the discussion will be engaging and thought-provoking.

I look forward to continuing these discussions with some of you at the 71st World Health Assembly in May in Geneva.

In the past century, the world has come together to tackle smallpox, polio and measles, with the results to prove it.

One hundred years from now, I can only hope that the same can be said of mental illness.

Thank you.

Annex 2: Remarks by Dr. Carissa F. Etienne, Director, PAHO/WHO

I would like to express my sincerest thanks to the World Bank Group for this invitation and for organizing this very important event.

Just two weeks ago, we celebrated World Health Day 2018 under the theme of “Universal Health: Everyone, Everywhere.”

The goal of this year’s campaign is to raise awareness of health as a basic human right and of the critical responsibility that national governments have to ensure that their health systems have the capacity to provide access and coverage for all people, without discrimination and without creating financial hardship and difficulties.

Esteemed Ladies and Gentlemen, while these are ideas that are gaining ground around the world, I would like to emphasize that it is equally important to raise awareness that mental health is an integral and fundamental component of universal health.

In my region, the Americas, mental disorders—including substance use disorders—are the single most important cause of disability.

We know that people with severe mental disorders die 10 to 20 years earlier than the general population, primarily from preventable causes.

We also know that mental disorders are a strong risk factor for suicide, which claims nearly 65,000 lives every year in our Region.

These are not just numbers. All of us know someone who has suffered from mental health problems and indeed, many of us may also have experienced some form of mental illness ourselves. We all know too well that mental health problems take a toll not just on individuals, but on their families—and indeed, on entire communities, societies and economies.

This means that providing mental health services is not a luxury, but a necessity for health and human development.

Our Region still has a long way to go, even though many of our countries are making progress towards ensuring access to quality mental health services. Let me share just a few areas in which advances are being observed.

For a number of years, we have been working with our Member States to reform mental health services by promoting a model of care that puts people and communities first. This means shifting the delivery of mental health care from the traditional psychiatric hospital to community-based services that provide integrated, comprehensive, and continuous care for patients, with support for and participation by their families.

Secondly, we have been promoting integrated primary care that treats ‘the whole patient,’ particularly with respect to chronic diseases that often coexist with depression, anxiety, and alcohol use disorders.

We are also working with countries to overcome financial barriers, as an integral part of our efforts toward universal health. This means progressively eliminating direct payments for service at the

point of care, which is the single most important barrier to access for most people and particularly for those with mental health disorders.

Finally, despite much progress, stigma continues to prevent many people from seeking care and contributes to under- diagnosis and under-reporting.

Countries in our region are developing different strategies to achieve these goals. Some countries, such as Belize, Brazil and Chile, have made significant progress over the years, while others such as the Dominican Republic, Perú and Guyana are in the midst of intense reform processes.

I do look forward to sharing these and other experiences with all of you today and in the future, as we come together to give new energy to efforts to advance mental health.

Today, 40 years after the declaration of Alma-Ata, there is no better time than to make sure that mental health is an integral part of our vision of “health for all”

Thank you very much.

Annex 3: Remarks by Christine Hogan, WBG Executive Director for Antigua and Barbuda, Belize, Canada, Dominica, Grenada, Guyana, Ireland, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, the Bahamas

Merci/Thank you Hon Minister, Deputy Ambassador, Dr. Carissa, Tim and Friends. It is terrific to be able to take part in today's important discussion.

The timing of this event is opportune and perhaps long overdue.

As we all know, mental pain is as real as physical pain. Yet, health care systems to deal with mental health lag far behind, even in Canada.

As we are going to hear today, mental illness is a hidden problem. It is blind to income – affecting rich and poor; those in advanced economies and those in the poorest countries alike. We know it reduces life expectancy as much as smoking does. In the developed world, one in six of all adults suffers from depression or a crippling anxiety disorder, and mental illness account for nearly 40 percent of all illness.

We also know that ill mental health is not only limited to persons with severe mental disorders confined to psychiatric hospitals. Many of us, our parents, partners, brothers and sisters, sons and daughters, friends have felt a sense of loss or detachment from families, friends and regular routines. Many also experience nervousness and anxiety about changes in personal and professional lives, as well as real or imagined fears and worries that distract, confuse and agitate.

While these episodes tend to be transitory for most people, some of these conditions force others to take frequent breaks from work or a leave of absence because they are stressed and depressed, or because the medication that they are taking to alleviate a disorder makes it difficult to get up early in the morning or concentrate at work. And on occasion, because of these disorders, some fall prey to alcohol and drug abuse, further aggravating their alienation from loved ones and daily routines.

Apart from the personal toll, the social and economic costs of ill mental health are staggeringly high.

Mental illnesses are behind a large share of worker sick days.

It affects educational achievement and income generation.

It is bad for taxpayers, since in some countries mental illness accounts for nearly half of all the people who live on disability benefits.

And it is bad for health systems and insurers as mental health problems add 50 percent to a person's bill for physical health care.

Poor mental health also impacts on economic development through lost production and consumption opportunities at both the individual and societal level.

And nowadays, unfolding conflict and violence and the burgeoning crisis of displaced populations and refugees in many parts of the world, or the unattended effects of natural disasters or disease outbreaks such as Ebola virus in West Africa, compound mental health needs of large numbers of the affected populations. Again, the mental health aspect of these crises is rarely talked about.

Today's event provides an opportunity to focus on the fact that mental and substance use disorders are a development challenge and not only a health challenge. And, like other development challenges, they demand a multi-sectoral response rooted in government-wide policies and energized by the active participation of firms and enterprises, religious and other civil society organizations, and particularly the affected and their families who grapple with stigma and discrimination. They also demand creativity, innovation and perhaps even disruptive approaches!

The end game is clear -- individuals, communities, organizations and systems that possess the capacity to assist affected and vulnerable populations to bounce back from the shock and disruption of ill mental health and offer them opportunities to reintegrate, participate and contribute to community life.

We all know that confronting mental disorders will require new sources of financial resources. And we also know, it requires courage, thought leadership and voice. Courage to not lose sight of the fact - observed in recent assessments -- that more people are in misery due to mental illness than to poverty, unemployment, or physical illness.

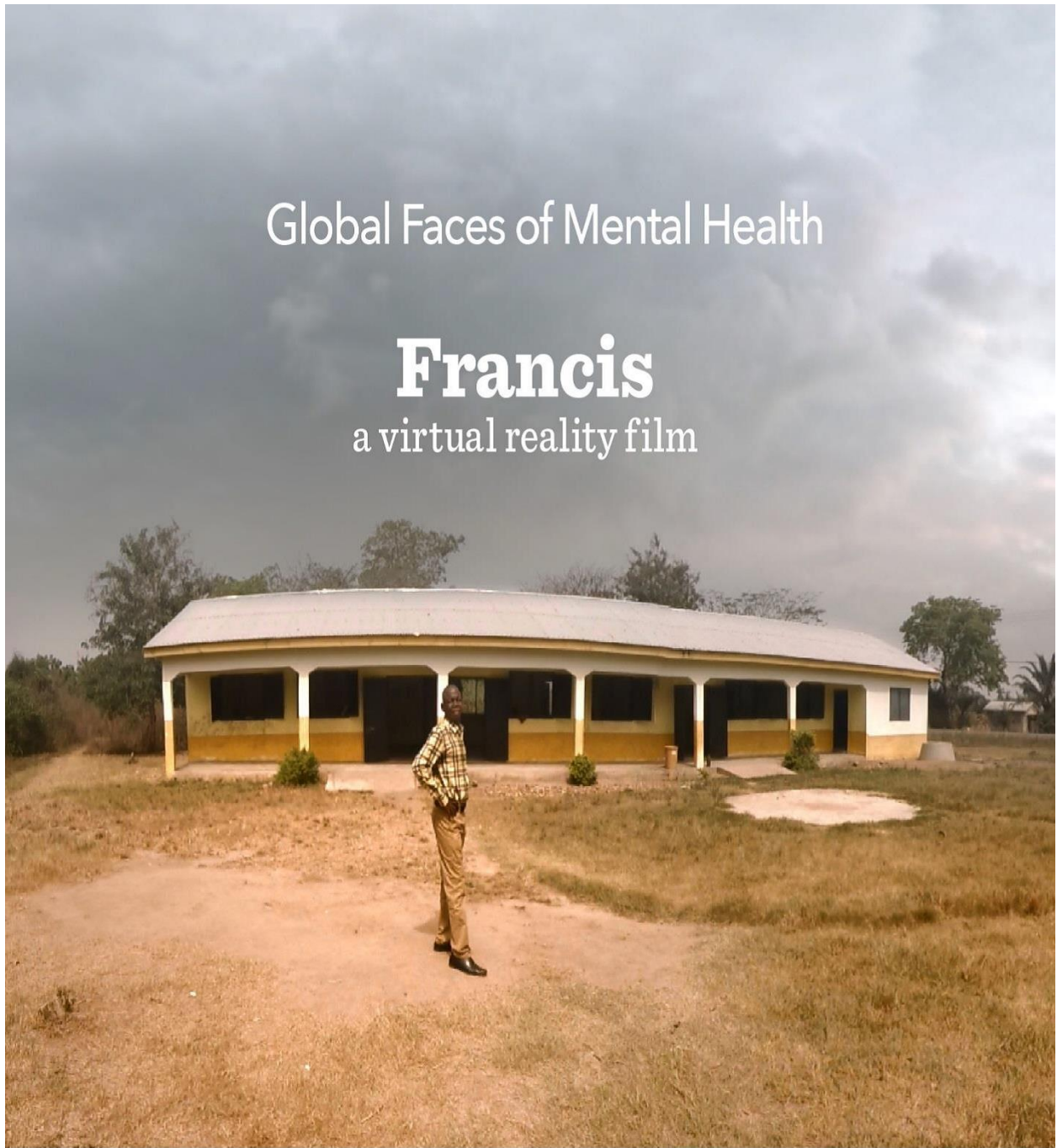
So, in 2018, as the World Bank continues with its mission to end global poverty, improve access to quality education and improve health outcomes around the world, today is evidence that mental illness is an important part of the mission.

Partnerships like the one showcased today, will contribute to advancing the World Bank's efforts and help to advance the mental health agenda globally based on cross-cutting and multidisciplinary approaches that build social resilience.

I want to salute the World Bank Group, the Public Health Agency of Canada and the Embassy of Canada's teams for their dedicated effort to make this "invisible disability" visible! And, for organizing this event.

All the best with the discussions. Many thanks.

Annex 4: *Francis*: A Virtual Reality Film



About the VR Documentary:

Moving mental health out of the shadows and squarely onto the world agenda as a global health and development priority is one of the focal areas of our non-profit organization, Strongheart Group. As such, it is our honor to contribute to the April WBG/WHO global forum on mental health a virtual reality film to forward and support the objectives of this important convening.

“Francis” is a beautifully powerful, five-minute virtual reality film based on the true story of a man named Francis. The film depicts Francis living a life that mattered to him as a husband, father and school teacher in Ghana, when he experienced an onset of mental illness. (Although the film is set in Ghana, there is no mention of Ghana.) His family was worried for him and did what was known to them. They took him to a traditional healer. The solution determined best for Francis was to pinion his leg to a log and put him locked away in a small room, isolated from his family and community. For two years Francis remained there, unable to move. Until one day, a friend from teaching was worried about him and brought a community nurse to him. Francis was diagnosed, treated, and supported in reintegrating into his community. Francis fully recovered and returned not only to his family but to his classroom. The film is framed, around Francis’s story, by a narration and visuals that show the global expanse of the issue.

Why use virtual reality “VR”? I think that this article (http://www.nytimes.com/2016/01/21/opinion/sundance-new-frontiers-virtual-reality.html?_r=0) captures it really well, “No matter how enlightened any one of us may be, we are fundamentally limited to our own points of view — but it is human nature to try to broaden our perspective...the medium (VR) has an extraordinary capacity to convey the kinds of feelings of presence and place...” that can cause a viewer to relate with a subject matter on a deeper level. For the viewer, being immersed in the virtual reality world creates a visceral response to the witnessing of Francis doing well, then his downfall, followed by his full recovery that enables a more personal level of care and interest. The core message that comes through is the devastating impact on an individual’s life, their family and also their community when there is a lack of effective treatment and then the positive, sustainable results that can occur when governments and community-based programs work together, implementing science-based treatments, and working inclusively with families and communities. While conveying the gravity of the issue, the film hits a hopeful, inspiring note and creates an emotional imperative for mental health treatment to be recognized as key to global development.

As VR has quickly become the innovative, new medium for storytelling - including explorations into its use in investigative journalism as PBS is doing here - <http://www.pbs.org/wgbh/frontline/announcement/frontline-releases-ebola-outbreak-a-virtual-journey-on-facebook-360/> - it is with great joy that the Strongheart Group provides this contribution of the film "Francis" to the WBG/WHO April forum in support of bringing the invisible issue of mental health "out of the shadows."

“Francis” was created by a top team of media professionals including social change strategist Zoë Adams, Oscar-nominated filmmaker Cori Shepherd Stern, award-winning documentary director and branded short content creator Judy Korin, and award-winning creative director Chris Gernon. “Francis” features the extraordinary work of photojournalists from across the world including internationally known photographer Nyani Quarmyne, whose powerful

images originally brought the story of Francis to the world, and powerful investigative journalism work by the Fellows of the The Global Reporting Centre.

The overarching aim of the virtual reality film “Francis” is to help move mental health out of the shadows and squarely onto the world agenda as a global health and development priority.

Zoë Adams, CEO, Strongheart Group, <http://strongheartgroup.org/francis/>

Annex 5: Panelists and Speakers

High Level Opening Session:

Kirsten Hillman, Deputy Ambassador of Canada to the United States

Honourable Ginette Petitpas Taylor, Canada's Minister of Health

Timothy Grant Evans, Senior Director, Health, Nutrition, and Population Global Practice, the World Bank Group

Carissa F. Etienne, Regional Director, Pan America Health Organization (PAHO)/ World Health Organization (WHO)

Christine Hogan, WBG Executive Director for Antigua and Barbuda, Barbados, Belize, Canada, Dominica, Grenada, Guyana, Ireland, Jamaica, St. Kitts and Nevis, St. Lucia, St. Vincent and the Grenadines, the Bahamas

Moderator: **Eliot Sorel**, The George Washington University

Session One: Global Perspectives:

Vikram Patel, Harvard University

Shekhar Saxena, World Health Organization (WHO)

Emily Hewlett, Organization for Economic Co-operation and Development (OECD)

Moderator: **Pamela Collins**, University of Washington

Session Two: Country Experiences and Sharing Learnings:

Inka Weissbecker, International Medical Corps, Ukraine

Rabih El Chammay, Ministry of Health of Lebanon

Rafael Alvarez, Mayor of Caraballo Municipality, Lima, Perú

Humberto Castillo, Cayetano Heredia Peruvian University

Tolu Kasali, Ministry of Finance of Nigeria

Giuseppe Raviola, Partners in Health

Moderator: **Sheila Dutta**, the World Bank Group

Session Three: From Research to Technological Innovation to Service Delivery to Cities and the Workplace: New Initiatives to Advance Global Mental Health Action:

Moitreyee Sinha, CitiesRise

Mary de Silva, Wellcome Trust

Beverly Pringle, US National Institute of Mental Health (NIMH)

Karlee Silver, Grand Challenges Canada

Mariam Claeson, Global Financing Facility (GFF)

Garen Staglin, OneMind

Elisha London, The Global Campaign for Mental Health

Moderator: **Patricio V. Marquez**, the World Bank Group

Session Four: Looking Ahead: Challenges and Opportunities:

Patrick J. Kennedy, Founder, Kennedy Forum, and former member of the US House of Representatives

Paula Gaviria, Human Rights Commissioner, Office of the President of Colombia

Julio Frenk, President of the University of Miami, and former Minister of Health of Mexico and Dean of the Harvard University School of Public Health

John Balafoutis, the World Bank Group Treasury

Anette Dixon, Vice-President, Human Development, The World Bank Group

Moderator: **Andrew Jack**, Financial Times

Take-Away Messages and Closing:

Brian Hansell, Founder and President, Paul Hansell Foundation, Canada

Kirsten Hillman, Deputy Ambassador of Canada to the United States

Event Rapporteurs: **Gabriella Malek**, the World Bank Group, and **Maxim Polyakov**, Boston Consulting Group