

Mental Health Among Displaced People and Refugees:

**Making the Case For Action Under Humanitarian
Response and Development Programs**

Discussion Brief

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"It was as if God had decided to put to the test every capacity for surprise and was keeping the inhabitants of Macondo in a permanent alteration between excitement and disappointment, doubt and revelation, to such an extreme that no one knew for certain where the limits of reality lay."

Gabriel García Márquez

"One Hundred Years of Solitude"

1982 Nobel Prize in Literature-winning Colombian author

***And I've always been strong
But I've never felt so weak
And all my prayers have gone for nothing
I've been without love
But never forsaken
Now the morning sun
The morning sun is breaking***

Bruce Springsteen

"The Depression"

"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 Yong Kim, President, World Bank Group

High-Level Opening Panel

"Out of the Shadows: Making Mental Health a Global Development Priority"

Flagship Event at 2016 IMF/WBG Spring Meetings

Washington D.C., April 13-14, 2016

"I decline to accept the end of man. It is easy enough to say that man is immortal simply because he will endure: that when the last dingdong of doom has clanged and faded from the last worthless rock hanging tideless in the last red and dying evening, that even then there will still be one more sound: that of his puny inexhaustible voice, still talking. I refuse to accept this. I believe that man will not merely endure: he will prevail. He is immortal, not because he alone among creatures has an inexhaustible voice, but because he has a soul, a spirit capable of compassion and sacrifice and endurance."

William Faulkner

"Speech at the Nobel Banquet at the City Hall in Stockholm, December 10, 1950"

1949 Nobel Prize in Literature-winning United States author

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

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

Executive Summary

The current global crisis of forced displacement poses multiple humanitarian and development challenges. Forcibly displaced people's mental health needs have often been neglected in response plans. Yet meeting these needs is critical to help displaced persons overcome trauma and rebuild their lives. Without appropriate mental health care, forcibly displaced people will often be unable to benefit fully from other forms of support that are provided to them.

In 2010, mental, neurological, and substance use disorders (MNS) were the leading cause of years lived with disability in the world. These disorders also impose high costs on economies. While they are prevalent in all settings, mental disorders can be triggered or exacerbated by extreme adversity, including violence and forced displacement. Common mental health diagnoses among refugee populations include depression, post-traumatic stress disorder (PTSD), and generalized anxiety disorder. Refugee children and adolescents suffer most, with studies finding PTSD rates from 50-90 percent in this population.

MNS disorders can be successfully treated. Evidence-based treatments for depression and anxiety disorders include time-limited psychosocial therapies and antidepressant medications. Anti-stigma campaigns can be powerful tools in confronting barriers to support for people with mental disorders.

Mental health and psychosocial support services at the community level, including for displaced people and refugees, should not be stand-alone interventions. They work best as part of an integrated platform of social, educational, and health services. Evidence shows that non-specialist workers in primary-care and community settings can deliver mental health services successfully. MNS services are cost-effective.

Projects funded by the World Bank Group (WBG) and other organizations utilize a bottom-up, multidisciplinary approach to re-integrate displaced populations after conflicts and natural disasters. As part of this approach, development efforts in post-conflict and post-disaster societies should include mental health services integrated into primary health care structures. Priority mental health interventions in these contexts: (a) have a strong evidence base; (b) aim to improve people's daily functioning; and (c) help protect the most vulnerable from further trauma. Examples exist of how disaster and emergency contexts have been used to make sustainable improvements in mental health systems in low- and middle-income countries. Investing in mental health as part of early recovery can strengthen the long-term availability of services for survivors—and improve development outcomes.

A shared commitment is needed from national and international actors to champion mental health parity in the provision of health and social services, including in humanitarian emergencies. High priority should go to identifying alternative sources of financing for mental health parity in health systems. For example, raising tobacco taxes can expand a country's resources to fund essential services for the population and strengthen human capital, including among displaced people. By investing in care for MNS disorders, we can help ensure that relief and development programs yield the greatest benefits for refugees and host communities over the short-and medium-terms.

1. The Challenge

The current crisis of forced displacement is posing serious humanitarian and development challenges across the world. The World Bank Group and the international community at large cannot ignore these challenges, given their scale and complexity. As documented in a recent World Bank report,¹ about 65 million people – one percent of the world’s population – live in forced displacement and extreme poverty. In contrast to economic migrants, who move in search of better opportunities, and to persons affected by natural disasters, the forcibly displaced are fleeing conflict and violence. Forcibly displaced people include refugees and asylum-seekers (currently about 24 million people) and internally displaced persons (about 41 million). These are the highest numbers of forcibly displaced people since World War II.

Host countries often have limited resources even before taking in refugees. The refugee influx can quickly overwhelm existing capacities, including health, housing, educational, and social welfare systems and services. Inflows of displaced people can cause social and economic challenges and disruptions to host communities. However, refugees can also bring skills, expertise, and labor that can benefit communities in the longer term.

The international community can act to reduce vulnerabilities among the forcibly displaced during a crisis and then help them rebuild their lives. Such action can also mitigate the impact of forced displacement on host communities and governments. This requires action to support economic activity, job creation, and social cohesion, as well as to strengthen and expand essential services.

2. Mental Disorders: An “Invisible” Burden

Mental, neurological, and substance use disorders (MNS) account for a significant proportion of the global disease burden. Yet MNS illnesses often remain “invisible.”^{2,3} MNS disorders include a heterogeneous range of conditions that owe their origin to genetic, biological, psychological, and social factors. They can have their onset across the life course. MNS disorders often run a chronic course, are highly disabling, and are associated with significant premature mortality.⁴ These forms of illness also hamper development in countries around the world.^{5,6} MNS disorders include anxiety disorders, autism, dementia, depression, epilepsy, illicit drug use and alcohol use disorders, intellectual disability, migraine, and psychotic conditions (schizophrenia and bipolar disorders), among others.

Within the MNS spectrum, mental disorders are syndromes characterized by clinically significant disturbance in an individual’s cognition, emotion, regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.⁷ As such, these disorders affect mood, thinking, and behavior. They contribute to behavioral or mental patterns that may cause suffering or a poor ability to function in life. Such features may be persistent, relapsing and remitting, or occur as a single episode.

The World Health Organization (WHO) estimates that mental disorders account for 30% of non-fatal disease burden worldwide (Figure 1) and 10% of overall disease burden, including death and disability.⁸ Some researchers argue that the global burden of mental illness tends to be underestimated because of five main causes: overlap between psychiatric and neurological disorders; the grouping of suicide and self-harm as a separate category; conflation of all chronic

pain syndromes with musculoskeletal disorders; exclusion of personality disorders from disease-burden calculations; and inadequate consideration of the contribution of severe mental illness to mortality from associated causes.⁹

According to a recent report,¹⁰ absolute disability-adjusted life years (DALYs) caused by MNS disorders increased by 41 percent increase between 1990 and 2010: from 182 million to 258 million DALYs. The proportion of the global disease burden caused by these disorders increased from 7.3 to 10.4 percent. With the exception of substance use disorders, which increased because of changes in prevalence over time, this increase was largely caused by population growth and aging. The report also indicates that, in 2010, MNS disorders were the leading cause of years lived with disability (YLDs) in the world.

In 2010, DALYs for MNS disorders were highest during early to mid-adulthood, explaining 18.6 percent of total DALYs for individuals aged 15 to 49 years, compared with 10.4 percent for all ages combined. Within the 15-49 age group, mental and substance use disorders were the leading contributor to the total burden caused by MNS disorders. For neurological disorders, DALYs were highest in the elderly. Overall, males accounted for 48.1 percent and females for 51.9 percent of DALYs for MNS disorders. The relative proportion of DALYs for MNS disorders to overall disease burden was estimated to be 1.6 times higher in high-income countries (HICs) (15.5 percent of total DALYs) than in low- and middle-income countries (LMICs) (9.4 percent of total DALYs), largely because of the relatively higher burden of other health conditions, such as infectious and perinatal diseases, in LMICs. However, because of the larger population of LMICs, the report noted that absolute DALYs for MNS disorders are higher in LMICs compared with HICs.

Box 1: Social Determinants of Mental, Neurological, and Substance Use Disorders

A range of social determinants influences the risk and outcome of MNS disorders. In particular, the following factors have been shown to be associated with several MNS disorders:

- 1. Demographic factors, such as age, gender, and ethnicity**
- 2. Socioeconomic status: low income, unemployment, income inequality, low education, and low social support**
- 3. Neighborhood factors: inadequate housing, overcrowding, neighborhood violence**
- 4. Environmental events: natural disasters, war, conflict, climate change, and migration.**
- 5. Social change associated with changes in income, urbanization, and environmental degradation**

The causal mechanisms of the social determinants of MNS disorders indicate a cyclical pattern. On the one hand, socioeconomic adversities increase the risk for MNS disorders (the social causation pathway); on the other hand, people living with MNS disorders drift into poverty during the course of their life through increased health care expenditures, reduced economic productivity associated with the disability of their condition, and stigma and discrimination associated with these conditions (the social drift pathway).

Understanding the vicious cycle of social determinants and MNS disorders provides opportunities for interventions that target social causation and social drift. In relation to social causation, the evidence for the mental health benefits of poverty-alleviation interventions is mixed but growing. In relation to social drift, the evidence for the individual and household economic benefits of the prevention and treatment of MNS disorders is compelling, and supports the economic argument for scaling up these interventions (Lund and others 2011).

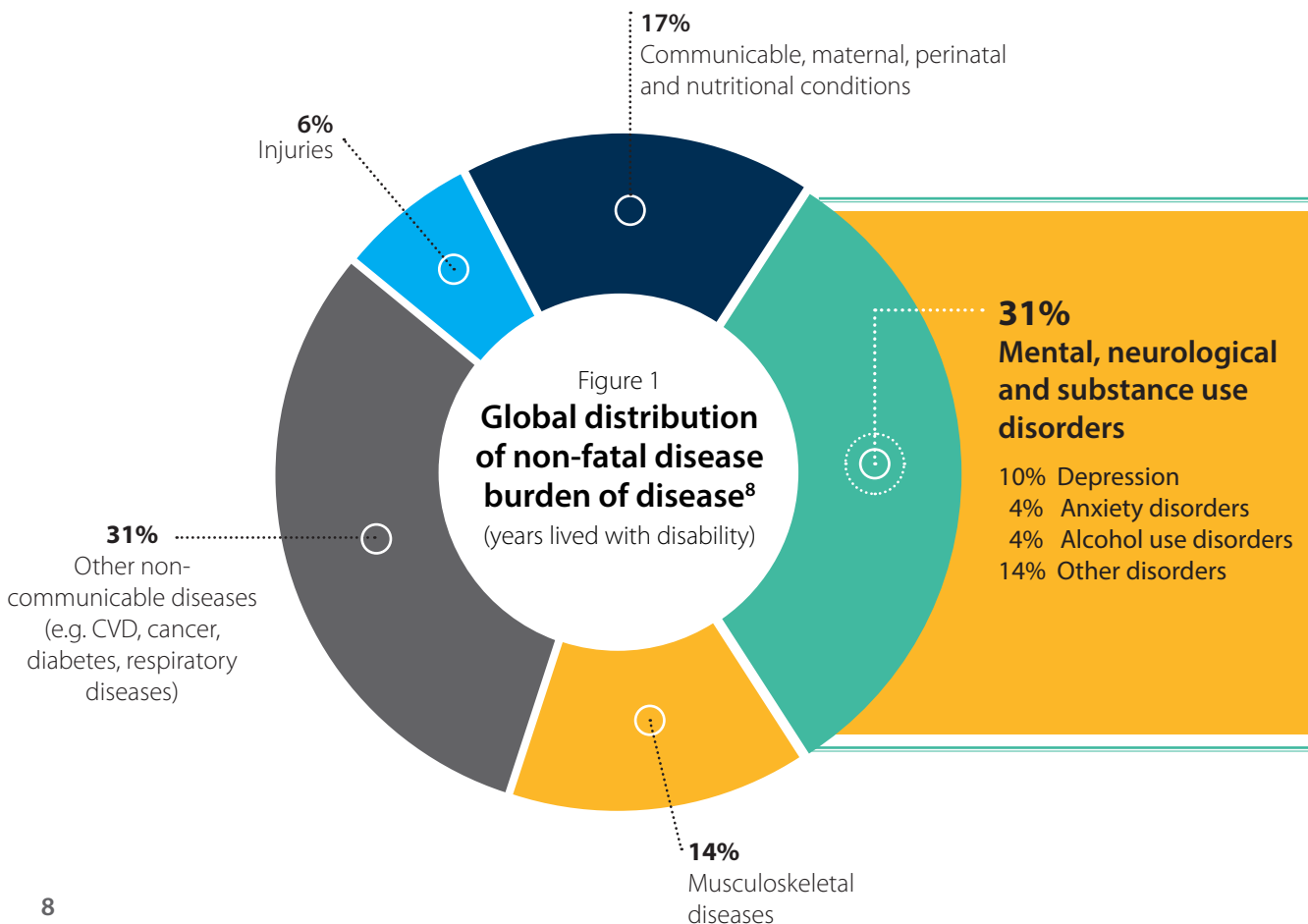
Source: Adapted from Patel, Vikram, Dan Chisholm, Tarun Dua, Ramanan Laxminarayan, and Maria Elena Medina-Mora. 2016. *Disease Control Priorities, Third Edition: Volume 4. Mental, Neurological, and Substance Use Disorders*. Washington, DC: World Bank.

The 2015 Global Burden of Disease (GBD) studies also confirm the large contribution of mental and substance use disorders to global disability. Depressive disorders and anxiety disorders are among the ten leading causes of global years lived with disability (YLDs) for both sexes. (These two types of conditions ranked fourth and eighth, respectively, as sources of YLDs.¹¹) Depressive disorders and anxiety disorders are also among the 30 leading causes of global disability-adjusted life years (DALYs) for both sexes (ranking 15th and 28th).^{12,13} Suicide, which is frequently caused by mental disorders, also exacts an enormous toll on society. In India, for example, it has overtaken complications from pregnancy and childbirth as the leading cause of death among women aged 15 to 49.¹⁴

There is also frequent comorbidity and a notable link between mental disorders and other costly, chronic medical conditions. Relevant chronic conditions include cancer, cardiovascular disease,

diabetes, HIV, and obesity, as well as a host of risky behaviors.¹⁵ Those with mental disorders are more likely to engage in unhealthy behaviors such as smoking, alcohol use, poor nutritional choices, and lack of physical activity. Mental disorders greatly increase the risk of a person’s developing another chronic disease,¹⁶ and are associated with reduced health care-seeking and poorer compliance with medical regimens. At the same time, those suffering from chronic diseases are also more likely to develop mental health problems.

The WHO “Mental Health Action Plan 2013-2020”¹⁷ emphasizes that homelessness and inappropriate incarceration are far more common for people with mental disorders than for the general population, and this tends to exacerbate their marginalization and vulnerability. It is clear that mental disorders are closely linked with physical health and affect both a significant portion of the overall population and disproportionate numbers of the vulnerable and underserved.



3. The Economic and Social Impact of Mental Disorders

Not only do mental disorders represent a significant disease burden, they are also very costly to country economies. The global cost of mental disorders was estimated at approximately \$2.5 trillion in 2010; by 2030, that figure is projected to rise by 240 percent, to \$6 trillion.¹⁸ In 2010, 54 percent of that burden was borne by low- and middle-income countries; by 2030, the proportion is projected to reach 58 percent. Worsened by low levels of investment and effective treatment coverage, mental disorders have serious economic consequences and may limit the impact or effectiveness of development assistance.

Studies done in high-income countries have found that the costs associated with mental disorders total between 2.3 and 4.4% of gross domestic product (GDP) (Table 1).¹⁹ Roughly two-thirds of those costs are indirect, associated with the loss of productivity and income due to disability or death.

Spending on mental health can be among the highest areas of health expenditure, representing between 5 and 18 percent of total health expenditures for a selection of countries able to break down total spending (Germany, Hungary, Korea, the Netherlands, and Slovenia). While these figures suggest high spending on mental health, the investments are still likely insufficient, given the high prevalence of mental health conditions and the social and economic burden they inflict. The proportion of total public health expenditure allocated to mental health care is often very small. For example, mental disorders are responsible for 23 percent of England's total burden of disease, but receive 13 percent of National Health Service expenditures.

The indirect costs of mental health are particularly high. These include the economic consequences attributable to disease but which are not captured in the cost of medical services directly related to the disease. Calculations of indirect costs incorporate, for example, the value of lost production due to unemployment, absences from work, and "presentism" (the loss in productivity that occurs when employees come to work, but are unwell and consequently function at less than full capacity). These calculations also include the losses associated with premature mortality.

Table 1: Direct and indirect costs of mental disorders: Results from selected studies¹⁹

Country	Year	Direct Costs (Billions)	Indirect Costs (Billions)	Total Costs (Billions)	% of GDP
CANADA	2011	CAD 42.3	CAD 6.3	CAD 48.6	4.40
ENGLAND	2009/10	GBP 21.3	GBP 30.3	GBP 51.6	4.10
FRANCE	2007	EUR 22.8	EUR 21.3	EUR 44.1	2.30
GLOBAL	2010	USD 823	USD 1,670	USD 2,493	4.00

4. Mental Health of Displaced Populations and Refugees

Traditionally the refugee experience is divided into three stages: preflight, flight, and resettlement.²⁰

The **preflight phase** may include, for example, losses of family members, livelihoods, and belongings, paired with possible physical and emotional trauma to the individual or family, the experience of witnessing extreme violence, and social upheaval. Adolescents may also have participated in violence, voluntarily or not, as child soldiers or militants.

Flight involves an uncertain journey from the home area to the resettlement site and may involve arduous travel, refugee camps, and/or detention centers, often including further losses and traumatic stressors. Children and adolescents are often separated from their families and at the mercy of others for care and protection.

The **resettlement process** includes challenges such as the loss of culture, community, and language, as well as the need to adapt to a new and foreign environment. Children often straddle the old and new cultures, as they learn new languages and cultural norms more quickly than their elders. All of these experiences may play a role in the acquisition of, or protection from, mental health conditions in each individual within a refugee population.

Mental disorders can be triggered by extreme adversity, such as massive displacement. Conflict exposes displaced populations and refugees to violence and high levels of stress,²¹ causing dramatic rises in mental illness that can continue for decades after armed conflict has ceased, as documented in multiple studies.²² Armed conflict and violence disrupt social support structures and expose civilian populations to high levels of stress. Consistent with the findings of earlier Global Burden of Disease (GBD) studies, GBD 2015²³ confirmed the large contribution of mental and substance use disorders to global

disability, and a positive association between conflict and depression and anxiety disorders.

Most of those exposed to emergencies suffer some form of psychological distress. Accumulated evidence²⁴ shows that the prevalence of common mental disorders such as depression, anxiety, and post-traumatic stress disorders (PTSD), increases from a baseline of 10 percent to 15-20 percent among crisis-affected populations, while severe mental disorders, such as psychosis or debilitating depression and anxiety, can increase from 1-2 percent to 3-4 percent. Such mental health problems have especially severe consequences in humanitarian settings, where they affect the ability of affected populations to function and survive.

The more common mental health diagnoses associated with refugee populations are depressive and anxiety disorders, including PTSD, generalized anxiety, panic attacks, adjustment disorder, and somatization.²⁵ The incidence of disorders varies with different populations and their experiences. Researchers studying settled refugees have found rates of PTSD and major depression of 5-15 percent or 10-40 percent, depending on the study. Children and adolescents often have higher prevalence, with various investigations revealing rates of PTSD from 50-90 percent and major depression from 6-40 percent. Risk factors for the development of mental health problems include the number of traumas, delayed asylum application process, detention, and the loss of culture and support systems. On the other hand, protective factors include a supportive environment where affected populations can access basic needs, maintain or form new social connections and relationships, and are supported in pursuing educational and economic opportunities.

If mental health issues are not effectively addressed, the long-term mental health and psychosocial wellbeing of the displaced population and refugees may be affected. Many Cambodians, for example, continue to suffer mental disorders and poor health almost four decades after the Khmer Rouge-led genocide of the late 1970s.²⁶

5. How Should We Address Mental Health Needs in Conflict- and Post-Conflict-Related Situations?

Mental health is an integral part of overall health, but has received inadequate attention from health care planners and from society in general, worldwide. Despite their enormous social burden, mental disorders continue to be driven into the shadows by stigma, prejudice, and people's fear of disclosing an affliction because a job may be lost or social standing ruined. In other cases, these diseases go untreated because health and social support services are either not available at all, or are out of financial reach for the afflicted and their families. The vast majority of low- and middle-income countries allocate less than 1 percent of their health budgets for mental health.

Mental disorders tend to be more acute and often unattended in conflict and post-conflict situations, where large segments of the population may have lived through long periods of armed conflict and ethnic confrontations.²⁷ Many have been the subject of harassment, sexual abuse and rape, incarceration, and torture.

Unlike physical wounds and losses, conditions such as depression, anxiety (including post-traumatic stress disorder), and traumatic brain injuries, which affect mood, thoughts, and behavior, are often invisible. They persist unrecognized, unacknowledged, or ignored in humanitarian and development-assistance programs, undermining efforts to help rebuild and sustain the lives of displaced populations.

Most countries are ill-equipped to deal with this "invisible" challenge – which is amplified today by conflict and refugee crises in the Middle East and other parts of the world. Refugees and displaced populations often face significant barriers in accessing quality mental health services. Obstacles include lack of knowledge

about available services; lack of transport or other resources to access services; language and cultural barriers between refugees and service providers; and limited follow-up supports.

Addressing mental health needs is important at all times. But it is critical in times of crisis and recovery. Examples exist of how disaster and emergency contexts have successfully been used to make sustainable improvements in mental health systems in low- and middle-income countries.²⁸

Displaced people have not only experienced traumatic events, but have also lost many of their assets and risk further depletion of human and social capital. People may have experienced the killing of loved ones, family separation, abandonment of children and the elderly, and may have been subjected to torture, rape, and other forms of violence that can leave deep mental scars.

Refugees in host communities also face continuing hardships that may affect their mental health. Ongoing stressors such as lack of access to employment, disruption of educational aspirations, bullying of children at school, as well as social isolation and uncertainty, can increase mental illness risks. Some studies of conflict-affected populations have shown that daily stressors in the host environment were actually more predictive of developing mental health problems than was past trauma.²⁹

6. Collaborative, Multisectoral Approaches

WHO's Mental Health Gap Action Plan (mhGAP) aims to scale-up mental health services in low-income and middle-income countries.³⁰ The mhGAP plan, together with the report and commentary prepared after the 2016 WBG/WHO "Out of the Shadows" event,^{31 32} emphasize that evidence-based interventions have been effective in promoting, protecting, and restoring mental health—far more effective than the institutionalization approaches of the past.

Mental health and psychosocial interventions and programs can improve economic, social, and human development, and strengthen health systems. Properly implemented, these interventions represent "best buys" for any society, with significant returns both in terms of health and economic gains. Some key interventions are deployed within the health sector (e.g., treatment with medicines or psychological interventions), others outside it (e.g., psychological interventions delivered through social services, or providing timely humanitarian assistance to refugees). A growing focus on mental health and psychosocial program implementation is consistent with their inclusion in Sustainable Development Goal 3,³³ ensuring healthy lives and promoting wellbeing for all ages, and in Priority 4 of the 2015 Sendai Framework, which identifies mental health as an essential aspect of disaster risk reduction.³⁴

A collaborative response is required to tackle mental health as a development challenge. Such a response would involve multidisciplinary approaches that integrate health services at the community level,³⁵ in schools, and in workplaces to explicitly address the mental health and psychosocial needs of displaced people and host communities. The model would include services to address alcohol and other drug use problems. It would also include innovative social protection and employment schemes that facilitate the

reintegration of affected persons into social and economic activities. An example is Canada's RISE Asset Development program, which provides seed capital and lends at low-interest rates to people with a history of mental health and addiction challenges.³⁶

7. Essential Mental Health Interventions at the Community Level

Effective, scaled-up responses to improve the mental health and psychosocial wellbeing of conflict-affected populations require adaptation to specific contexts. The most successful approaches mobilize multi-layered systems of services and supports. They encompass the provision of food, shelter, water, sanitation, basic health care, and other essential services; action to strengthen community and family supports; emotional and practical support through individual, family or group interventions; and ongoing care through community-based primary health care systems.

Most common mental disorders, such as anxiety and depression, are prevalent and disabling. Fortunately, these illnesses also respond to a range of safe and effective treatments. However, owing to stigma and inadequate funding, these disorders are not being treated in most primary-care and community settings. The Interagency Standing Committee³⁷ has provided guidance on tiered action in emergency settings, including for camp coordination and management, that is human rights-based and takes a "do no harm" approach. This allows a focus on affected individuals as whole persons, addressing both their physical and mental health needs, while reducing the risk of stigma and discrimination among families and communities. This is important since mental disorders are highly co-morbid with other priority conditions (e.g., maternal and child health conditions, HIV/AIDS, and non-communicable diseases such as cancer and diabetes).

To inform the design of context-specific interventions in emergency settings, the mapping of the problem is of paramount importance. Mapping includes gathering information on mental health as part of current governmental policies and plans. It also requires assessment of mental health and psychosocial information about the affected population (e.g., access and utilization of mental health services, culturally specific understandings of mental health problems, and help-seeking behaviors). The mapping exercise must include both persons with disorders induced by the crisis and those with preexisting disorders.³⁸ Such assessments can also clarify the current availability of mental health services in affected settings.

New kinds of tools are offering program implementers additional guidance on how to consider the complex articulation of systems of care in contexts with especially limited resources and potentially competing priorities. The continuum of action spans service-delivery science, quality-improvement methods, implementation science, and “mixed” qualitative and quantitative methods, along with formal randomized controlled trials and anthropological research. All these approaches contribute to our knowledge of what works in context. Implementing organizations such as **Partners In Health (PIH)**, **International Medical Corps (IMC)**, or World Vision are actively adapting this kind of knowledge to practice in post-disaster and emergency settings.

As illustrated in Table 2 below, PIH experience in countries such as Haiti, Liberia, Peru, and Rwanda^{39,40} shows that many effective, evidence-based interventions can be implemented at the community and facility levels to deal with anxiety and depression—two of the most common forms of mental disorder—along with psychosis. Adapting knowledge from WHO’s mhGAP and existing evidence, PIH has worked to develop a mental health service-delivery planning matrix

to achieve universal health coverage. This matrix includes a care delivery “value chain,” adapted from the business literature. The resulting “Total Health For All”⁴¹ approach integrates primary care, mental health, and public health. The model supports understanding of how various activities fit together as part of a coherent care delivery process. Implemented at community and facility levels, the interventions can be grouped into an essential package of services that includes:

- **Promotion and prevention**, including stigma reduction interventions
- **Case finding** (e.g., psychological assessment, diagnosis)
- **Treatment** (e.g., counseling, psychosocial interventions such as cognitive behavioral therapy, and treatment with essential medicines such as antidepressant and antipsychotic medications)
- **Follow-up** (e.g., monitoring of symptoms)
- **Reintegration** (e.g., social and economic interventions).

Core, cross-cutting components of the system include sustained supervision in clinical, programmatic, and academic spheres for local implementation teams, as well as a focus on patient safety, quality of care, outcomes measurement (monitoring and evaluation), and the use of data to drive performance improvement.

There are examples from refugee countries as well. For example, IMC has successfully scaled up mental health services within primary health care in response to the Syrian crisis. The program spans several countries, including Iraq, Jordan, Lebanon, Syria, and Turkey. IMC’s approach includes: using the WHO mhGAP Intervention Guidelines to train general health care staff; mobilizing community health workers for outreach and follow-up; assigning psychosocial workers to clinics to address multiple needs and deliver scalable psychosocial interventions; and establishing networks and referral pathways among service providers.⁴²

Table 2: Mental Health Value Chain⁴⁰

Training and Supervision: Clinical, Programmatic, Academic/Research					
Safety, Quality, Outcomes Measures (M&E) and Performance Improvement					
Prevention	Case-Finding	Enrollment	Treatment	Follow-up	Reintegration
<ul style="list-style-type: none"> Community stigma reduction School/religious based activities Staff and community education Parent and family education 	Health facility	Health facility	Health facility	Health facility	<ul style="list-style-type: none"> Staff and community education Social interventions Peer support groups Intersectional collaborations
	<ul style="list-style-type: none"> Screening Referral Evaluation 	<ul style="list-style-type: none"> Diagnosis Formulation Mental status exam medical exam laboratory/imaging triage severity 	<ul style="list-style-type: none"> Psychoeducation Choosing treatment plan Medication management Psychotherapy Hospitalization Crisis Management Social interventions 	Ongoing clinical care: <ul style="list-style-type: none"> Monitoring of symptoms and functioning Med adherence support and monitoring of side effects Social interventions Psychotherapy 	
	Community	Community	Community	Community	
	<ul style="list-style-type: none"> Home visits Assignment of sick role Case finding (passive and active) 	Referral to health center by: <ul style="list-style-type: none"> CHW Community member Traditional healer Family members Church School 	<ul style="list-style-type: none"> Psychoeducation Psychotherapy Social interventions Monitoring (medication) 	Ongoing: <ul style="list-style-type: none"> Coordination Symptom monitoring Medication monitoring Adherence support Psychosocial support Psychotherapy Observation 	

Anti-stigma campaigns can be powerful tools in confronting barriers to support for people with mental disorders. Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves.⁴³ Stigma associated with mental disorders can result in social isolation, low self-esteem, and limited opportunities in areas such as employment, education, and housing. Stigma can also hinder patients from seeking help, thereby increasing the treatment gap for mental disorders.⁴⁴ What is more,

stigma associated with mental disorders also influences how these disorders are prioritized and contributes to some clinicians' discriminatory attitudes toward people with mental illnesses.⁴⁵ Thus, stigma has adverse consequences for the quality of mental health services delivered.⁴⁶ Anti-stigma campaigns as well as peer-to-peer support models can help break down stigma and raise awareness. Peer-to-peer models engage those recovering from mental health problems in helping others and encourage them to take on visible, proactive roles in their communities.

A recent global review⁴⁷ provides evidence that social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes in the short term. However, the evidence for longer-term benefit of social contact in reducing stigma is weak. The review's main findings are the following: (1) At the population level, there is a fairly consistent pattern of short-term benefits for positive attitude change, and some lesser evidence for knowledge improvement; (2) for people with mental illness, some group-level anti-stigma interventions show promise and merit further assessment; (3) for specific target groups, such as students, social-contact-based interventions usually achieve short-term (but less clearly long-term) attitudinal improvements, and less often produce knowledge gains; (4) this is a heterogeneous field of study with few strong study designs with large sample sizes; (5) research from low-income and middle-income countries is conspicuous by its relative absence; (6) caution needs to be exercised in not overgeneralizing lessons from one target group to another; (7) there is a clear need for studies with longer-term follow-up to assess whether initial gains are sustained or attenuated, and whether booster doses of the intervention are needed to maintain progress; (8) few studies in any part of the world have focused on either the service user's perspective regarding stigma and discrimination or on the behavior domain of behavioral change regarding stigma, whether in people with or without mental illness. In view of the magnitude of challenges that result from mental health stigma and discrimination, the review finds a need for new, methodologically strong research that will support decisions on investment in stigma-reducing interventions.

Current evidence-based treatments for moderate to severe depression and anxiety disorders include structured, time-limited psychological treatments and antidepressant medications. Numerous randomized trials support the efficacy of psychological treatments, especially in the form of brief treatments based on cognitive, behavioral,

and inter-personal mechanisms. For example, a recent study⁴⁸ assessed the effectiveness of a brief multicomponent intervention incorporating behavioral strategies delivered by lay health workers to adults functionally impaired by symptoms of psychological distress in a conflict-affected setting. The study examined a lay worker-administered intervention consisting of five weekly 90-minute individual sessions that included empirically supported strategies of problem solving, behavioral activation, strengthening social support, and stress management. Researchers found that, compared to enhanced usual care, the intervention may be a practical approach for treating adults with psychological distress in conflict-affected areas. The application of this intervention resulted in clinically significant reductions in anxiety and depressive symptoms at 3 months.

"Task-sharing" models, by which non-specialist providers deliver care, have been adapted from the global HIV/AIDS care movement to the mental health field over the past two decades. These models are now offering hope for the spread and scaling of mental health services in high- as well as low-income countries. There is also a growing body of evidence⁴⁹ demonstrating that non-specialist workers in primary-care and community settings can deliver mental health care with great effectiveness to a variety of populations.

As for pharmacological therapies, several major groups of antidepressants are in common use today, including tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs).⁵⁰ Studies have found strong evidence for the efficacy of antidepressant pharmacotherapy and no evidence of an advantage for any specific drug over another. Antidepressants generally, and SSRIs in particular, have well-documented efficacy in the treatment of anxiety disorders, trauma-related disorders like PTSD, and other disorders related to depression. Similarly, evidence for psychosocial and psychopharmacological interventions for psychosis is adequate.

8. Treatment Settings and Integration with Health and Social Systems

Displaced people and refugee populations are confronted with extraordinary stresses and challenges to their physical and psychological health. Whether mobile or in a camp setting, they can easily fall through the cracks of assistance mechanisms. For this reason, the articulation of mental health and psychosocial services within other government programs, as well as with the development and NGO sector, can provide a critical safety net for these vulnerable populations.

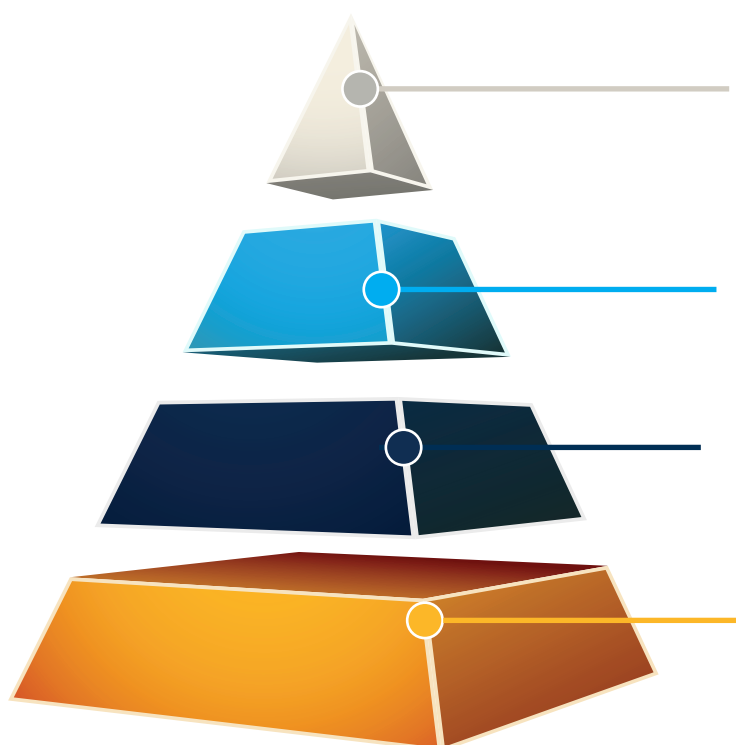
The provision of mental health and psychosocial support services at the community level cannot be seen as a vertical or free-standing intervention offered in a health facility. Rather, it needs to be part of broad, integrated platforms offering a range of community, health, social, and educational services. Such platforms provide basic services and security, promote community and family support through

participatory approaches, and strengthen coping mechanisms. An integrated service model seeks first of all to improve people’s daily functioning and protect the most vulnerable from further adversity. It addresses, for example, the specific needs of vulnerable constituencies, including women, children, adolescents, the elderly, and those with severe mental disorders. In addition, a successful holistic service model can empower affected people to take charge of their lives.

Mental health planners and policy makers need to support, through public awareness and community engagement, care delivery systems that are sensitive to local social, economic, and cultural contexts. This will help ensure that mental health care is appropriately sought and utilized by potential beneficiaries.

The Inter-Agency Standing Committee (IASC) intervention pyramid for mental health and psychosocial support, presented in Figure 2 below, illustrates task responsibility by levels of care.

Figure 2: Intervention Pyramid for Mental Health and Psychosocial Support in Emergencies⁵¹



Clinical Services

Example: Clinical mental health care (whether by PHC staff or by mental health professionals)

Focused Psychosocial Supports

Example: Basic emotional and practical support to selected individuals or families

Strengthening Community and Family Supports:

Example: Activating social networks
Supportive child-friendly spaces

Social Considerations in Basic Services and Security:

Example: Advocacy for good humanitarian practice: basic services that are safe, socially appropriate and that protect dignity

Efforts at collaborative, integrated care – an evidence-based approach to care for chronic illness applied in primary care settings – should guide the effective use of resources for delivery of quality mental health care. Such efforts emphasize systematic identification of patients, self-care, and active care management by clinical providers, blended with other medical, mental health, and community supports.⁵²

Given that anxiety and depression play large roles in the health of expectant and new mothers and their children, maternal care settings can be a viable platform for delivering depression care, where early and effective intervention for maternal depression can be implemented. Depressive symptoms in mothers are associated with preeclampsia, preterm birth, intrauterine growth retardation, and low birth weight in infants. The prevalence and severity of antenatal anxiety and depression are higher in low- and middle-income countries.^{53 54} Interpersonal psychotherapy, however, is associated with a reduction in depressive symptomatology in pregnant women.⁵⁵ Importantly, mothers with high levels of psychological distress exclusively breastfeed for a shorter duration. However, WHO considers exclusive breastfeeding the safest and most effective intervention to reduce infant morbidity and mortality. Cognitive behavioral counseling delivered in the postpartum period can reduce the risk that a mother will stop exclusive breastfeeding.^{56 57}

In addition to their impact on overall physical health, mental disorders can exacerbate common co-occurring diseases, such as diabetes, hypertension, cardiovascular disease, and cancer, communicable diseases such as HIV and TB, and major health challenges affecting mothers and children in the pre- and post-partum periods. Mental disorders are also a barrier to patient adherence to TB treatment, and WHO recommends therapeutic relationships and

mutual goal-setting as interventions to improve TB treatment adherence by reducing psychological stress.^{56 57}

There is significant evidence that integrated delivery of mental health and psychosocial support services can be effective for these complex health problems. For example, psychiatric diagnoses are more common in HIV patient groups than other populations and are associated with poor ART adherence. However, antidepressant treatment for depressed HIV patients is associated with improved antiretroviral medication adherence,^{60 61 62} and psychological interventions in this population can lead to improved immune status.^{63 64 65 66}

The reality of comorbidity in affected populations implies the need to develop and implement coordinated mental health promotion, protection, illness prevention, screening, and interventions. These services can be delivered by integrated primary-care, mental-health, and public-health teams in an effective TOTAL Health model, supporting collaboration among public, private, and NGO partners.⁶⁷

The collaborative care approach has proven effective in general population samples and vulnerable sub-populations in high-income countries, and increasingly in LMICs.⁶⁸ Evidence from low-income countries demonstrates the effectiveness of care delivery by community or lay health workers.

As shown in Box 2,⁶⁹ recent efforts in Syria illustrate the types of investments and activities required to build a mental health system responsive to population needs during a crisis.

*Box 2: Mental Health Care Efforts in Syria*⁶⁹

The reality of the conflict:

4.8m Registered Syrians refugees abroad, according to the UNHCR

6.6m Registered refugees inside the country, according to UNHCR

450,000 People killed in the fighting in Syria

In Syria, the World Health Organization (WHO) is working with partners to cope with the emerging needs of the population. Despite the challenges presented by the ongoing conflict, mental health services are becoming more widely available in Syria. Mental health care is now being offered in primary and secondary health facilities in some of the most affected Syrian governorates (Damascus, Rural Damascus, Homs, Suwayda, Aleppo, Al Hassakeh, Hama, Tartous, and Lattakia). This is in contrast to the situation before the conflict, at which time mental health care was provided in at only three hospitals, and only in Damascus and Aleppo.

Key to addressing this gap was training and continuous technical supervision of primary health care physicians on the management of stress, depression, psychosis, suicide, and psychosomatic disorders. The WHO mhGAP Intervention Guide, an integrated guide for the management of priority mental health conditions, was the main tool used. WHO recruited a team of field-based national supervisors to support this process. mhGAP training materials were translated into Arabic and adapted for use in the Syrian context by Syrian mental health professionals, with support from WHO.

WHO supported the training of Syrian health professionals and provision of psychotropic medicines, not only through its Damascus office, but also its sub-offices in Homs and Aleppo, and its field presence in Gaziantep/Turkey.

Key achievements to date include the following:

- Mental health is now seen as a public health priority in Syria.
- A team of Syrian mental health professionals play a leadership role in prevention and treatment of mental health conditions in Syria.
- Mental health services are provided for people with mental disorders at primary-care facilities in Damascus, Rural Damascus, Homs, Aleppo, Hama, Lattaki Hasaka, and Tartus. These services are provided by non-specialist general practitioners under the supervision of specialists, all trained through the WHO mhGAP program.
- A team of psychologists is providing a wide range of psychotherapeutic interventions through multidisciplinary teams at the primary and secondary care levels.
- Psychotropic medication provided through WHO and partners is available at primary and secondary care levels for the first time in the country.
- An inpatient unit for mental disorders has been established for the first time in Syria, in a general hospital in Damascus. Two more inpatient facilities are expected to open soon.

9. Are Mental Health Interventions Affordable and Cost-Effective?

A WHO-led study⁷⁰ estimated the cost of treatment interventions at the community level for moderate to severe cases of depression. Prepared for the WBG/WHO global mental health event at the 2016 WBG/IMF Spring Meetings, the study examined a range of treatment options. These included basic psychosocial treatment for mild cases and either basic or more intensive psychosocial treatment plus antidepressant drug therapy for moderate to severe cases.

The study incorporated key categories of resource use, including:

- **Medication**, with six months of continual generic antidepressants for moderate to severe cases
- **Outpatient and primary care**, including regular visits for all cases, with frequencies ranging from four per case per year for basic psychosocial treatment, up to 14–18 visits for moderate to severe cases receiving antidepressant medication and intensive psychosocial treatment
- **Inpatient care**, with only a few cases expected to be admitted to hospital (2–3 percent of moderate to severe cases only, for an average length of stay of 14 days).

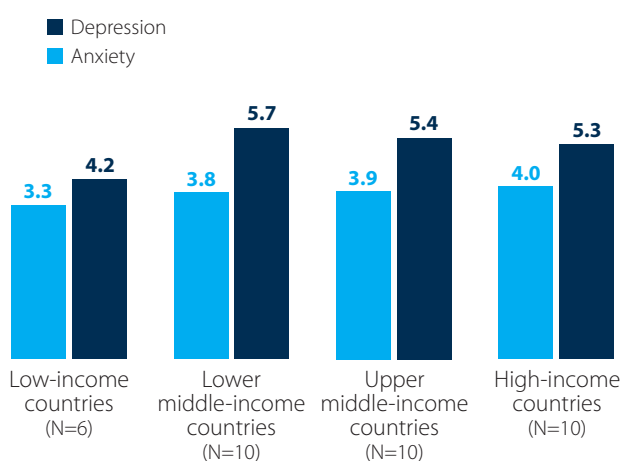
An assumption of the study was that care and follow-up would largely be undertaken in non-specialist health care settings by doctors, nurses, and psychosocial care-providers trained in the identification, assessment, and management of depression and anxiety disorders.

Estimations also included expected levels of program costs and shared health-system resources needed to deliver interventions as part of an integrated model of chronic disease management. These included program

management and administration, training and supervision, drug safety monitoring, health promotion and awareness campaigns, and strengthened logistics and information systems. The latter were estimated as on-cost to the estimated direct healthcare costs. The baseline value for on-cost was 10 percent (and therefore grows in absolute terms during scale-up).

The results of the estimation, which would need to be adapted to the particular conditions of given emergency contexts, show that the cost of scaling up the delivery of these interventions is relatively low. The average annual cost during 15 years of scaled-up investment is \$.08 per person in low-income countries, \$0.34 in lower middle-income countries, \$1.12 in upper middle-income countries, and \$3.89 in high-income countries. Per-person costs for treatment of anxiety disorders are approximately half those for depression. Across country income groups, resulting benefit-to-cost ratios amount to 2.3–3.0 to 1 when only economic benefits are considered, and 3.3–5.7 to 1 when the value of health returns is also included (Figure 3).

Figure 3: Ratio of (economic and social) benefit to cost for scaled-up treatment⁷⁰



10. Dealing with Malnutrition in Conflict and its Psychological Causes

In a study of the 2013 outbreak of violence in Bangui, Central African Republic,⁷¹ researchers found that dealing with malnutrition in such a crisis is more complex than simply curing disease and providing children with therapeutic foods. The reason is clear: often, post-traumatic stress disorder hinders treatment success among a large number of children suffering from life-threatening malnutrition.

The humanitarian relief organization **Action Against Hunger** collected data on more than 1,000 parents of malnourished children between July 2013 and March 2014. The researchers reported that, in 75 percent of cases studied, the parents presented symptoms of post-traumatic stress linked to their exposure to extreme violence. It was found that this condition contributed to behavioral changes, flashbacks, fatigue, isolation, excessive irritability, and feelings of hopelessness and despair, which in turn had a temporary but disabling impact on many mothers' ability to nurse and feed their children. In some cases, this resulted in early weaning that can be deadly in an already challenging environment. Some mothers had also reportedly attempted suicide and infanticide. It was found that children, while too young to fully understand what they have witnessed, may develop physical symptoms such as continuous crying, refusing to eat, bed wetting, sleep disturbances, and poor interaction.

To recognize these signs, malnourished children and their caretakers need to receive psychological and social support from specialized counseling teams. Regular feeding times, medical monitoring, and psychological and motor activities also need to be included as part of daily routines.

Overall, besides adequate nutrition, psychosocial stimulation from a caregiver is required to support a child's optimal physical, motor, cognitive, and language development, as well as mental health. Psychosocial stimulation refers "to the extent that the environment provides physical stimulation through sensory input (e.g., visual, auditory, tactile), as well as emotional stimulation provided through an affectionate caregiver-child bond."⁷² It is recommended that nutrition programs targeting displaced populations combine nutrition, maternal mental health, and psychosocial stimulation interventions.⁷³

11. Dealing with Multidrug-resistant Organisms among Refugees and Hosting Populations.

As discussed in a new study,⁷⁴ displaced populations and refugees pose additional, often overlooked, challenges to the social and healthcare systems in receiving countries. In addition to good hygiene practices, safe food, and sanitary and vaccination programs that are needed to control the risk of infectious diseases outbreaks in refugee camps and their spread to receiving communities, findings from the study suggest the importance of strengthening screening procedures and infection control measures in hospitals where refugees are admitted to prevent the spread of multidrug-resistant organisms (MDRO). For example, the study evidences that refugees tested in some receiving countries showed prevalence of methicillin-resistant staphylococcus aureus (MRSA) infection of up to of up to 13.5%—MRSA is caused by a type of staph bacteria that becomes resistant to many of the antibiotics used to treat ordinary staph infections. This observed prevalence rate was found to be far higher than those of "traditional risk groups" for MRSA, such as hemodialysis patients and patients depending on outpatient home-nursing care or residing in nursing homes. The adoption of screening and

special infection control measures is therefore required to ensure the provision of adequate medical care and safety for all hospital patients regardless of country of origin and of the staff in the health facilities.

12. Mental Health Care Over the Long Term

Projects funded by the World Bank Group and other organizations utilize a bottom-up, multidisciplinary approach to re-integrate displaced population groups after conflicts and natural disasters. Incorporating integrated care and treatment for mental illness into these existing projects would help to overcome barriers to securing employment among the poor and vulnerable. Further investment in education, social protection, and employment training would help prevent social exclusion and build social resilience by serving the unique needs of vulnerable groups.

To the above end, development efforts in post-conflict and post-disaster societies should include expanding mental health services that are well integrated into primary health care systems. Box 3 provides case examples of countries/regions that have seized opportunities during and after emergencies to build better mental health care.⁷⁵ They represent a wide range of emergency situations and political contexts, and provide evidence that it is possible to take action in emergencies to create better mental health systems for the long term.

Building out mental health services that are well integrated into primary care and public health in countries hosting refugees, and in post-conflict and post-disaster societies, would require treating mental and substance use disorders like other chronic health conditions. After all, these are disorders of the brain, an organ of the human body just as important as the heart, liver, or lungs.

Nor, in fact, are they truly separable. As discussed above, untreated mental disorders can negatively affect risk, patient management, and outcomes in such co-occurring diseases as tuberculosis and HIV, diabetes, hypertension, cardiovascular disease, and cancer.

In moving forward, a firm commitment is needed from national and international actors to champion mental health parity in the provision of health and social services, as part of dedicated development support and assistance programs (see Box 4 on Peru's recent experience). This is crucial in order to help displaced people and refugees overcome their vulnerabilities, build mental resilience, and take full advantage of poverty-reduction programs, economic opportunities and legal protections, particularly with regard to stigma and discrimination.⁷⁶

If the World Bank and WHO are to fully embrace and support the progressive realization of universal health coverage, we must work to ensure that prevention, treatment, and care services for mental disorders at the community level, along with psychosocial support mechanisms, are integrated into existing service delivery platforms, are accessible, and are covered under financial protection arrangements.⁷⁷

Box 3: Country/Regional Examples of Sustainable Mental Health Care after Conflicts and Emergencies⁷⁵

Afghanistan: Following the fall of the Taliban government in 2001, mental health was declared a priority issue and was included in the country's Basic Package of Health Services. Much progress has been made. For example, since 2001, more than 1,000 health workers have been trained in basic mental health care, and nearly 100,000 people have been diagnosed and treated for mental health conditions in Nangarhar Province alone.

Burundi: Modern mental health services were almost non-existent prior to the past decade, but today the government supplies essential psychiatric medications through its national drug distribution center, and outpatient mental health clinics are established in several provincial hospitals. From 2000 to 2008, more than 27,000 people were helped by newly established mental health and psychosocial services.

Indonesia (Aceh): In a matter of years following the tsunami of 2004, Aceh's mental health services were transformed from a single mental hospital to a basic system of mental health care, grounded by primary health services and supported by secondary care offered through district general hospitals. Now, 13 of 23 districts have specific mental health budgets, compared with none a decade ago. Aceh's mental health system is viewed as a model for other provinces in Indonesia.

Iraq: Mental health reform has been ongoing since 2004. Community mental health units now function within general hospitals, and benefit from more stable resources. Since 2004, 80–85 percent of psychiatrists, more than 50 percent of general practitioners, and 20–30 percent of nurses, psychologists, and social workers working in the country have received mental health training.

Japan: A series of catastrophic earthquakes in Japan, including the 1995 Hanshin-Awaji earthquake, the 2006 Niigata Chuetsu earthquake, and the 2011 Great East Japan earthquake, has provided evidence that mental health and psychosocial support can also be effectively integrated into humanitarian response and disaster risk management.

Jordan: The influx of displaced Iraqis into Jordan drew substantial support from aid agencies. Within this context, community-based mental health care was initiated. The project's many achievements built momentum for broader change across the country. New community-based mental health clinics helped more than 3550 people in need from 2009 to 2011.

Kosovo: After conflict, rapid political change generated an opportunity to reform Kosovo's mental health system. A mental health taskforce created a new strategic plan to guide and coordinate efforts. Today, each of Kosovo's seven regions offers a range of community-based mental health services.

Somalia: The governance structure in Somalia has been fragmented for more than 20 years, and during most of that time the country has been riddled with conflict and emergencies. Despite these challenges, mental health services have improved. From 2007 to 2010, chains were removed from more than 1700 people with mental disorders.

Sri Lanka: In the aftermath of the 2004 tsunami, Sri Lanka made rapid progress in the development of basic mental health services, extending beyond tsunami-affected zones to most parts of the country. A new national mental health policy has been guiding the development of decentralized and community-based care. Today, 20 of the country's 27 districts have mental health services infrastructure, compared with 10 before the tsunami.

Timor-Leste: Building from a complete absence of mental health services in 1999, the country now has a comprehensive community-based mental health system. Today, the Timor-Leste National Mental Health Strategy is part of the Ministry of Health's overall long-term strategic plan. Mental health-trained general nurses are available in around one-quarter of the country's 65 community health centers, compared with none before the emergency.

West Bank and Gaza Strip: Significant improvements in the mental health system have been made over the past decade, towards community-based care and integration of mental health into primary care. In 2010, more than 3000 people were managed in community-based mental health centers across the West Bank and Gaza Strip.

In the United States, as well as countries such as Chile, Colombia, and Ghana, attempts to promote treatment equality for mental disorders including addiction programs have run up against clauses that deny health insurance coverage for pre-existing conditions, a common barrier. When this hurdle is overcome, the next barrier has included determination of what is covered and funded at the provider level. This leads to a host of additional questions, such as what conditions to cover, how to select a menu of evidence-based treatments to be offered by service providers at different levels of care (as is commonly done for other health conditions), and how these services will be funded and reimbursed without perpetuating indirect medical discrimination through high deductibles, copayments, and lifetime limitations in coverage.

There are countries, such as Canada, that show that well-designed frameworks, built upon broad consultations involving local, regional, and national groups, agencies, governments, and vulnerable population groups such as Indigenous peoples and people with lived experience, and that enjoy the highest level of political commitment, can serve as good roadmaps for advancing the mental health agenda over the medium term. The **“Changing Directions, Changing Lives: The Mental Health Strategy for Canada”, along with the “Advancing the Mental Health Strategy for Canada: A Framework for Action (2017–2022)”** adopted to accelerate uptake and implementation of the strategy, offer some lessons for designing and implementing comprehensive national mental health strategies.

A key aspect of the Canadian mental health strategy is its humanistic orientation. It positions people living with mental health problems and illnesses and their families as the drivers of change in mental health. It also recognizes that success depends on the commitment of governments to set policies and fund services, as well as of other actors to regulate, accredit, monitor, and deliver services.

The framework for action is structured around four pillars that are geared to improve the mental health and well-being of people in Canada and the services they need:

- **Leadership and funding:** the mobilization of commitment and support from the highest political level is critical to better resource the mental health response and increase the capacity to deliver quality, evidence-based, and integrated services and better meet the needs of diverse population groups. While funding is important, it is emphasized that leaders need to focus on achieving parity between physical and mental health care, better integrating mental health and physical health, and fostering collaboration across the health, social, education, and justice sectors.
- **Promotion and prevention:** given the multisectoral nature of mental health problems and illnesses, upstream efforts are needed, placing more emphasis on holistic prevention strategies, promotion of mental wellness, increased awareness and education about positive mental health across the lifespan, and a more refined focus on the social determinants of health in a culturally competent and safe manner. Promotion and prevention must be complemented with efforts to uphold human rights, social inclusion, and eliminate stigma and discrimination.
- **Access and services:** making timely access to evidence-based, integrated, person-centered, holistic, high-quality mental health services across the continuum of care should be a priority. People with lived experience and their caregivers must be engaged at all service points and in the policy development process to truly improve the availability and quality of mental health services.
- **Data and research:** aside from developing benchmarks and ongoing evaluation of system performance, as well as the translation of evidence-based mental health knowledge into policy and practice, this pillar includes support

for comprehensive, innovative, interdisciplinary research and evaluation on mental health problems and illnesses and mental health programs and treatments; facilitating the involvement of people living with mental illnesses in research; improving data collection systems and population-level monitoring to collect comprehensive information on mental health, wellness, illness, service access, and wait times and ensure that publicly-funded data is available to researchers and policy makers.

These pillars are in line with WHO's Mental Health Action Plan 2013-2020, adopted by the World Health Assembly, consisting of all ministers of health, including of Canada.

Canada has also established itself as a leader on global mental health. Many Canadian agencies have been collaborating with international and national partners. For example, since 2012, Grand Challenges Canada (GCC) has invested more than 35 million Canadian dollars to fund over 70 innovative mental health projects in more than 28 low-and middle-income countries. These innovations have led to tens of thousands people receiving mental health care; GCC funded grants have the potential to improve thousands of additional by 2030. GCC has also supported the establishment of Mental Health Innovation Network, which shares information and knowledge for decision making to innovators, researchers, civil society and policy makers.

By defining a broad, multi-stakeholder, social compact to support mental health promotion and mental illness prevention and treatment, Canada's mental health strategy and the framework for action show the importance of alternative "distributive social ethics" or "moral values" in developing public policies. That is, the well-articulated, socially inclusive goals and participatory mechanisms of the strategy

illustrate that broad social goals are the basic parameters that ultimately guide and shape policy and institutional decisions concerning the most appropriate and contextually relevant organizational forms, financing arrangements, and service delivery mechanisms. The strategy also clearly distinguishes the intermediate goals (improved access, quality, efficiency, and fairness) from the ultimate goals of integrated mental health and social systems (improved social and mental and physical health conditions, financial protection, and user satisfaction with the services received), avoiding the risk of confusing the means and ends of policy action.

While recognizing that heterogeneous social, economic, and cultural country contexts preclude the mechanical adoption of other countries' experiences, the transnational sharing of knowledge and adaptation of relevant aspects of those international experiences to specific country realities is one of the benefits of living in an interconnected, globalized world. If inclusive mental health policy, programs, and services are going to thrive across the world to improve health outcomes for people with mental health problems and illnesses and their families, we will do well in recognizing that more than technical processes, their realization will depend, as Canada's experience shows, on social and political decisions as to what kind of society a country wants to have. Canada's contributions at the international level, also set an example for other countries to contribute to global mental health.

Box 4. Bringing Mental Health Services to Those Who Need Them Most: Peru's Carabayllo Experience

"Welcome to my house!" said World Bank Group President Jim Yong Kim during his opening remarks to the Peruvian President, First Lady, Minister of Health, and Mayor of the district of Carabayllo. Dr. Kim felt like he was at home, because he had been a regular visitor to Carabayllo since 1994, when he led an initiative to implement the first community-based approach to control multidrug-resistant tuberculosis (MDR-TB) in a resource-poor setting.

This time, Carabayllo was making history again. Peru's President had recently signed a law that protects the rights of people with mental health problems. The regulation includes a set of community mental health services integrated at the primary health care level, which require the direct involvement of the community and the family of the patients. It is a first step to decentralize mental health services through the implementation of the new model of community care for mental health, including general and specialized mental health care services.

Across six regions in Peru, there are 21 community centers for mental health. The coordinated effort—by the Ministry of Health, the National Institute of Mental Health, local government in Carabayllo, and several international and national organizations—is promoting social participation and is strengthening the network of community-based mental health approaches to implement psychosocial interventions in families with mental disorders. In the past, mental health patients were hospitalized; now, in this new model of health care delivery, patients are ambulatory. Community health workers conduct home visits to beneficiaries and provide psycho-education, support adherence to treatment, and encourage the participation of family members in the recovery of the patient with mental health problems.

Anxiety and depression are common problems in Peru. In Carabayllo, as in other districts with high levels of poverty, social problems like domestic violence, sale and consumption of drugs, gangs, prostitution, assaults, and robberies are common. Community organizations in Carabayllo are trying to implement a comprehensive approach to deal with these complex challenges.

Efforts in Carabayllo include opening the first home for people with severe mental disorders in socially neglected situations. Six therapeutic caregivers, who are community health workers with ad-hoc training, are taking care of eight women, ranging from 21 to 63 years old. Health workers are responsible for overseeing residents' treatment, for providing new skills training, and for enabling the socialization and reintegration of patients into the community. The National Institute of Mental Health is providing technical advice, training, monitoring, and therapeutic support to caregivers.

As we left the district of Carabayllo, I thought about the great challenges the community is still facing to become a healthy society. Undoubtedly, the lessons from the past allow for active community participation, creating a platform for true collaboration among government bodies and community-based organizations.

Source: Bayona, J. 2015. "Bringing Mental Health Services to Those Who Need Them Most". The World Bank Blogs, October 30, 2015. Available at <http://blogs.worldbank.org/health/bringing-mental-health-services-those-who-need-them-most>.

This is not an easy task. Strategies and plans for the medium term are required to integrate mental health care into health services delivery platforms that focus on the whole person, rather than an aggregation of diseases. Even if these policy and service delivery changes were adopted, the need would remain for unrelenting efforts to support affected persons and their families, empowering them to defy stigma, access services, and adhere to prescribed treatments. There is an ongoing imperative to identify entry points across sectors to address the social and economic factors that contribute to the onset and perpetuation of mental disorders.

High priority should go to identifying alternative sources of financing for mental health parity in the health system, and to mainstreaming mental health across system entry points. Development lifts lives, and new and innovative funding approaches for development are “game changers.” Recalling the 2015 Financing for Development Addis Ababa Action Agenda,⁷⁸ one can argue that the development community needs to redouble its advocacy with national governments to raise “sin taxes”: including on tobacco, alcohol, and sugary drinks. These taxes represent a win-win for public health and domestic revenue mobilization.

For example, taxing tobacco is one of the most cost-effective measures to reduce consumption of products that kill prematurely, make people ill with diverse diseases (e.g., cancer, heart disease, and respiratory illnesses), and burden health systems with enormous costs. Hiking tobacco taxes can expand a country’s tax base to fund essential public services for the entire population and strengthen human capital. One clear example is the progressive realization of universal health coverage, including mental health care.⁷⁹ Data from different countries indicate that the annual tax revenue from excise taxes on tobacco

can be substantial. In the United States, for example, as part of the 2009 reauthorization of the Children’s Health Insurance Program, a 62 percent per-pack increase in the federal cigarette tax was adopted to help fund the program. The measure increased the total federal cigarette tax to about \$1 a pack. Federal cigarette tax revenue rose by 129 percent, from \$6.8 billion to \$15.5 billion, in the 12 months after the tax, while cigarette pack sales declined by 8.3 percent in 2009 – the largest decline since 1932.⁸⁰

In the Philippines, the adoption of the 2012 Sin Tax Law confirmed that substantial tax increases on tobacco and alcohol can yield both direct public health impact and new resources for health investments. In the first three years of the law’s implementation, \$3.9 billion in additional fiscal revenues were collected. The additional fiscal space multiplied the Department of Health budget threefold. The Department was able to expand the number of families whose health insurance premiums were paid by the National Government. The number of primary recipients benefiting rose from 5.2 million in 2012 to 15.3 million in 2015. In total, counting family members, about 45 million poor Filipinos benefited—roughly half of the country’s total population.

Both these country initiatives show that increasing taxes on tobacco and alcohol is “low hanging fruit,” a high-yield strategy for raising domestic resources to reach development goals, including expanding mental health care coverage.⁸¹

13. Key Lessons Learned⁸²

- **Mental health and psychosocial problems are extremely common in major crises.** There is always a need for mental health and psychosocial support services (MHPSS) in humanitarian crises. During a humanitarian crisis, prevalence surveys are not needed to justify investing in MHPSS. In some exceptional cases, prevalence surveys, if done well, can be justified for advocacy and scientific knowledge. The dire situation of displaced person and refugees in the world today demands that investments be made to support their mental health and wellbeing. An area that requires priority attention is the mental health and psychosocial needs of children and adolescents. This issue has been prominent on the southern border of the United States and also in the recent large migration in Europe.
- **Activities and programming should be integrated into wider systems** (for example, existing community support mechanisms, formal/non-formal school systems, general health systems and services, social services, trusted protection networks). This reaches more people, is more sustainable and carries less social stigma.
- **Relative priority should be given to those MHPSS projects that** (a) have a relatively strong evidence-basis; (b) seek to demonstrate improvements in people's daily functioning; and (c) are likely to protect the most vulnerable, including people with severe mental disorders, by reducing their exposure to further adversity.
- **Investing in mental health as part of early recovery can make a substantial difference in the long-term availability of services for the most severely affected survivors—and ultimately in development outcomes.** Emergencies are unique opportunities to build back/up sustainable mental health care (See the Resources section, below).
- **Practical tools and guidelines** exist for assessment and response.

14. The Way Forward

Jim Y. Kim, President of the WBG, has called for a collaborative response to tackle mental health as a development challenge by pursuing multidisciplinary approaches.⁸⁴ Successful approaches encompass integrated health services at the community level, in schools and in workplace programs, and initiatives to address the mental health and psychosocial needs of displaced populations.

Addressing mental health as an integral part of the global development agenda adds value by increasing the effectiveness of programs in other sectors such as health, maternal and child health, nutrition, education, social protection, and jobs. Mental health problems are especially common in conflict- and crisis-affected populations. They may impair the ability of affected persons and their families to take advantage of any type development program. Addressing mental health alongside other sectors can unlock additional human potential, contribute to a more inclusive rights-based approach, and help accelerate the positive impact of programs on affected communities.

The WBG could bring four primary comparative advantages to support scaling up mental health services for displaced people and refugees:

(1) Strong influence on the global development agenda; (2) involvement in virtually all sectors, including health, nutrition and population; education; social protection; fragility, conflict and violence; macroeconomics; and finance; (3) ability to support scale-up of effective programs as part of broader development action under IDA18 funding; and (4) public-health and economic expertise.

An effective response to the mental health needs of the displaced and refugees would require strengthening partnerships between the WBG, WHO, UNHCR, UNICEF, Public Health Agency of

Canada, and other international and national partners, such as PIH and IMC. Because mental health affects so many aspects of development, external actors must work in partnership with civil society and the private sector, under the leadership of governments, to harness the comparative advantage of each. Support must be well planned and coordinated to enhance synergy and avoid duplication of effort. Bureaucracy should be minimized and processing of aid dramatically accelerated. Most of all, a concerted effort to break the silence surrounding mental health needs is required, and consolidated action must be taken early in crisis and post-crisis situations to ensure timely and effective support for people affected, including displaced persons and refugees.

If this is done, as Toluwalola Kasali observed, we will be helping affected people regain “the ability to dream, desire and work for a future, one very different from their present circumstances.”⁸⁵

Endnotes

- ¹ World Bank 2016.
- ² Marquez, P.V. 2015b; Evans, T., Marquez, P.V., and Saxena, S. 2015.
- ³ Mnookin S., et al. 2016.
- ⁴ Patel, V., Chisholm, D., Parikh, R., Charlson, F.J, Degenhardt, L., Dua, T., et al. 2015.
- ⁵ Marquez, P.V. 2015; Evans, T, Marquez, P.V., and Saxena, S. 2015.
- ⁶ Mnookin, S., et al. 2016.
- ⁷ American Psychiatric Association 2013.
- ⁸ World Health Organization (WHO) n.d.
- ⁹ Vigo, D., Thornicroft, G., and Atun, R. 2016.
- ¹⁰ Patel, V., Chisholm, D., Dua, T., Laxminarayan, R., Medina-Mora, M.E. 2016.
- ¹¹ GBD 2015 Disease and Injury Incidence and Prevalence Collaborators 2016.
- ¹² GBD 2015 DALYs and HALE Collaborators 2016.
- ¹³ The 2015 GBD Study uses the disability-adjusted life-year (DALY), combining years of life lost (YLLs) due to mortality and years lived with disability (YLDs) in a single metric. One DALY can be thought of as one lost year of healthy life.
- ¹⁴ Patel, V., et al. 2012.
- ¹⁵ See for example Sorel, E. 2016.
- ¹⁶ Bloom, D.E., et al. 2011; Marquez, P.V. and Farrington, J. 2013.
- ¹⁷ WHO 2013.
- ¹⁸ Bloom, D.E., et al. 2011.
- ¹⁹ Hewlett, E. and Moran, V. 2014.
- ²⁰ Studies cited at Refugee Health Technical Assistance Center (<http://refugeehealthta.org/physical-mental-health/mental-health/>) include: Birman, D., Beehler, S., Harris, E. et al. 2008; Carswell, K., Blackburn, P., Barker, C. 2011; Lustig, S., Kia-Keating, M., Kight, W. et al. 2004; Murray, K., Davidson, G., Schweitzer, R. 2010.
- ²¹ Mnookin S., et al. 2016; Sorel, E.R., et al. 2005.
- ²² Mnookin S., et al. 2016; Bolton, P., et al. 2002; Chung, R. and Kagawa-Singer, M. 1993; De Jong, J., et al. 2001; De Jong, J., et al. 2003; Dubois, V., et al. 2004; Karam, E.G., et al. 2008; Mollica, R.F., et al. 1997; Mollica, R.F., et al. 2004; Pham, P.N, et al. 2004; Silove, D., et al. 2008.
- ²³ GBD 2015 Disease and Injury Incidence and Prevalence Collaborators 2016.
- ²⁴ WHO & UNHCR 2012; WHO & UNHCR 2015; WHO, UNICEF, UNFPA, UNHCR, & UN Action n.d.
- ²⁵ Studies cited at Refugee Health Technical Assistance Center (<http://refugeehealthta.org/physical-mental-health/mental-health/>): include: Birman, D., Beehler, S., Harris, E. et al. 2008; Carswell, K., Blackburn, P., Barker, C. 2011; Lustig, S., Kia-Keating, M., Kight, W. et al. 2004; Murray, K., Davidson, G., Schweitzer, R. 2010.
- ²⁶ Mollica, R.F., et al. 2014.
- ²⁷ Marquez, P.V. 2014.
- ²⁸ Epping-Jordan JE, Ommeren MV, Nayef Ashour H, Maramis A, Marini A, Mohanraj A, Noori A, Rizwan H, Saeed K, Silove D, Suveendran T, Urbina L, Ventevogel P, Saxena S. 2015.
- ²⁹ There are several studies by Ken Miller on this, e.g. Miller, K. E., Omidian, P., Rasmussen, A., Yaqubi, A., Daudzai, H., Nasiri, M., Bakhtyari, M.B., Quraishi, N., Usmanikhil, S., & Sultani, Z. 2008.
- ³⁰ WHO 2010.
- ³¹ World Bank Group, WHO 2016.
- ³² Kleinman, A., Lockwood Estrin, G., Usmani, S., Chisholm, D., Marquez, P.V., Evans, T.G., and Saxena, S. 2016.
- ³³ United Nations. Sustainable Development Goals, Goal 3. Available at: <http://www.un.org/sustainabledevelopment/health/>
- ³⁴ United Nations Office for Disaster Risk Reduction (UNISDR) 2015.
- ³⁵ American Psychiatric Association (APA) 2016.
- ³⁶ See Rise Asset Development: <http://www.riseassetdevelopment.com/>.
- ³⁷ Interagency Standing Committee 2014. This and other documents accessed at: <https://interagencystandingcommittee.org/product-categories/mental-health-and-psychosocial-support>
- ³⁸ See WHO & UNHCR 2012; WHO & UNHCR. 2015; WHO, UNICEF, UNFPA, UNHCR, & UN Action n.d.
- ³⁹ Marquez, P.V. and Walker, M. 2016.
- ⁴⁰ See Partners in Health Mental Health site: <http://www.pih.org/priority-programs/mental-health>. Cf. Partners In Health (PIH) 2016. Also see PIH Mental Health Planning Matrix to Achieve UHC. Discussed in personal communication

with Giuseppe Raviola, MD, MPH, Director, Mental Health, Partners In Health, October 21, 2016.

⁴¹ Sorel, E. 2015.

⁴² See International Medical Corps (IMC) 2015.

⁴³ Thornicrofts, G., et al. 2016.

⁴⁴ Quinn, N., et al. 2013.

⁴⁵ Sartorius, N. 2007.

⁴⁶ Sartorius, N. 2002; Sartorius, N. 2007; Magliano, L., et al. 2004; Magliano, L., et al. 2011.

⁴⁷ Thornicrofts, G., et al. 2016.

⁴⁸ Rahman, A., et al. 2016.

⁴⁹ Chowdhary, Neerja; Anand, Arpita; Dimidjian, Sona; Shinde, Sachin; Weobong, Benedict; Balaji, Madhumitha; Hollon, Steven D.; Rahman, Atif; Wilson, G. Terence; Verdelli, Helena; Araya, Ricardo; King, Michael; Jordans, Mark; Fairburn, Christopher; Kirkwood, Betty; Patel, Vikram 2016.

⁵⁰ Mnookin S., et al. 2016.

⁵¹ Inter-Agency Standing Committee (IASC) 2007.

⁵² Druss, B., and Reisinger, E. 2011; Katon, W., et al. 2006; O'Neil, A., et al. 2015; Patel, V., et al. 2013; Jamison, D. (in press).

⁵³ Verbeek, T., et al. 2015.

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⁶⁴ Kumar, V., Encinosa, W. 2009.

⁶⁵ Carrico, A., Antoni, M. 2008.

⁶⁶ Based on Partners In Health (PIH), Four Zeros Strategic Plan, analysis and references compiled by Alexandra Rose, MSc GMH.

⁶⁷ Personal communication with Prof. Eliot Sorel, George Washington University School of Public Health, December 7, 2016.

⁶⁸ Layard, R., et al. 2007; Ngo, V., et al. (in press); Pemjean, A. 2010; UK Department of Health 2012.

⁶⁹ Personal communication with Shekhar Saxena, Director, Department of Mental Health and Substance Abuse, and Mark van Ommeren, Public Mental Health Adviser, WHO, November 11, 2016. Syrian conflict data from the Financial Times's article 'It felt like the last goodbye', by Erika Solomon and Geoff Dyer, December 17, 2016, p.6.

⁷⁰ Chisholm, D., Sweeny, K., Sheehan, P., et al. 2016.

⁷¹ Duvergé, S. 2014.

⁷² WHO 2006.

⁷³ McGrath, M. and Schafer, A. 2014.

⁷⁴ Heudorf, U. 2016.

⁷⁵ WHO 2013b.

⁷⁶ Marquez, P.V. 2016d.

⁷⁷ Marquez, P.V. 2016a.

⁷⁸ Marquez, P.V., and Moreno-Dodson, B. 2016; Marquez, P.V. 2016b.

⁷⁹ Marquez, P.V. 2015a.

⁸⁰ Marquez, P.V. 2016c.

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⁸² Personal communication with Shekhar Saxena, Director, Department of Mental Health and Substance Abuse and Mark van Ommeren, Public Mental Health Adviser, WHO, October 18, 2016.

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⁸⁴ World Bank Live. Out of the Shadows: Making Mental Health a Global Development Priority. April 13–14, 2016. <http://live.worldbank.org/out-of-the-shadows-making-mental-health-a-global-development-priority>.

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