THE RETURN ON THE INDIVIDUAL

THE SCALE OF THE CHALLENGE

An estimated 970 million people around the world had a mental health or substance use condition in 2017 (the most recent year of data) – around 13% of the global population. And the numbers are rising. While the scale of poor mental health may be shocking, most of us have some experience of it. Mental disorders can affect anyone, whatever their age and wherever they live. And our mental health can vary throughout our lives. For some, conditions are relatively mild and last for a limited time. For others, they are more serious and last a lifetime. “Behind the data are real people affected by poor mental health directly and many more affected indirectly – family, friends, colleagues and others.”

Depression and anxiety are two of the most common mental disorders, prevalent across demographics. Estimates from 2017 show 284 million people are living with anxiety and 265 million with depression. An estimated 50 million people are living with dementia, and this number is projected to triple by 2050 – with 10 million new cases each year. In more severe cases, conditions such as these can lead to suicide, which claims the lives of close to 800,000 people every year and is attempted by many more.

The burden of mental disorders is on the rise. Some numbers can seem so large they can be hard to imagine and the individual person affected gets lost. Here, the voices of some of those individuals accompany the evidence of the staggering scale of the problem and the ‘return’ for their lives when others invest in their mental health.
TIMIEBI’S STORY

Due to factors such as stigma and discrimination, the enormity of this crisis is often hidden, leaving the burden with those affected. This was true for Timiebi in Nigeria. She started experiencing poor mental health when she was 12 years old but didn’t realise at the time.

When she was at university, falling behind with her studies, she went to see a counsellor and was diagnosed with depression. It was a pivotal moment for Timiebi. At first, she didn’t believe the diagnosis and thought...

I’m Nigerian. We’re strong and resilient. This isn’t something that Nigerians have.

After experiencing a panic attack, Timiebi started to accept her mental health was suffering. Struggling to write her dissertation and finding it difficult to understand what was happening to her, she moved back home. She reached out to Mentally Aware Nigeria, which was able to help her understand her condition and find mental health support services.

Timiebi thought nobody in Nigeria accessed services like these apart from severely ill and dangerous people. She was given a ticket for her appointment – number 140.

This made her realise many people were struggling with their mental health and how normal it is to reach out for help. It made her feel less alone.

By investing in Timiebi’s mental health, Mentally Aware Nigeria helped her find ways to deal with her condition, improving her life. She said...

For my future, I see me embracing more aspects of my life and my mental health, continuing to talk about it everywhere I go.

Her willingness to share her first-hand experience of poor mental health may now help many more people. The support people need varies greatly. Some choose to live with mental health conditions without treatment or support. But everyone has the right to good physical and mental health and wellbeing. In many countries, this right is not honoured in practice or even recognised.

LOST POTENTIAL

Mental disorders make up a large proportion of the global burden of disease. This is a calculation of ill health and death due to diseases, injuries and risk factors for all regions of the world, measured in disability-adjusted life years (DALYs), the years of healthy, productive life lost to illness, through early death or disability. Figure 1 shows the rising burden of mental health and substance use conditions, Alzheimer’s disease and other dementias, and suicide, across country categories. Depression is ranked by the World Health Organization (WHO) as the single largest contributor to global disability (75% of all years lived with disability in 2015) and anxiety is ranked 6th (3.4%).

The loss of potential behind these figures is huge. Many people living with these conditions are unable to work. They lose the financial and personal benefits a job offers and are unable to contribute to their local and national economies.


FIGURE 1: Disability-adjusted life years due to mental health and substance use conditions, Alzheimer’s disease and other dementias, and suicide, across country categories (Socio-Demographic Index – SDI)
YOUTH MENTAL health

Our mental health can vary throughout our lives, but children and younger people are at particularly high risk of developing disorders. The global burden of mental disorders is highest in younger age groups (Figure 2), especially in the mid to late 20s.

For example, country rankings based on the ratio of child and adolescent psychiatrists for 100,000 children aged 14 or younger largely mirrors the country rankings of the Human Capital Index (HDI).11 Stuart and Annette in Australia lost their 15-year-old daughter, Mary, to suicide. Mary had an eating disorder, which began when she was 12 and continued until the day she died. When she became very unwell, she was admitted to her local hospital for two months. Stuart and Annette feel Mary didn’t get the support she needed to recover and overcome her mental ill health. Their lives have changed forever.

Investment in children’s mental health brings a substantial return and tends to align with country development beyond economic growth. For example, country rankings based on the ratio of children aged 14 or younger and the Human Capital Index (HDI) are inversely correlated. In low and middle-income countries, only 1 in 5 children have access to mental health care.

Half of all mental health conditions start by age 14, and three quarters by the mid-20s.12 Suicide is the second leading cause of death for young people aged 15 to 29.

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MENTAL ILL HEALTH IN LATER LIFE

As we age, changes in our physical and mental health can place a burden on us, our families and our wider communities, often with complex requirements for health and social care, and other services. Across the world, people’s mental health deteriorates as they age as most people also undergo a decline in their cognitive abilities. Some develop more serious conditions like dementia, a syndrome in which there is a decline in memory, thinking, behaviour and ability to carry out daily tasks. The estimated proportion of people aged 60 and over with dementia at any time is between 5 and 8 per cent.

Investing in measures to reduce the incidence of dementia is important to the individuals affected and society. To date, there is no cure for dementia or treatment to alter its progressive course, but many potential new treatments are being investigated. WHO and other organisations have issued guidance on preventing dementia, including ensuring people have good physical health and combating risk factors such as depression and social isolation.

THE GAPS IN TREATMENT QUANTITY AND QUALITY

For those people who seek treatment or support with their mental health, there are far too many barriers in their way – stigma and discrimination, a lack of resources, and a lack of trained health workers, teachers, peer support workers and carers. The result is a big treatment gap.

In countries with the largest populations, including China (home to a third of the global population) and India, 80 per cent of people with mental health or substance use conditions do not seek treatment. In low and middle-income countries (LMICs), between 76 and 85 per cent of people with mental disorders receive no treatment, and in high-income countries (HICs), this percentage is between 35 and 50. In the USA, a study found 82 per cent of older people said it was important to have their thinking or memory regularly checked, but only 16 per cent said they received regular cognitive assessments.

For some, not seeking conventional treatment or support is a positive choice and they find other ways to manage or improve their mental health through informal networks such as friends, family or religious leaders. But many do not seek treatment because of stigma, a lack of funds, or a lack of appropriate services.

When people do seek treatment, services can be of poor quality or even harmful, due to a lack of investment and outdated practices. 1 in 5 people with depression reported receiving minimally adequate treatment, and in LMICs this figure is 1 in 27. Studies analysing data from HICs, including Australia, Canada, England and the USA, have shown that despite the increased availability of treatment, the prevalence of mental disorders has not decreased. This underlines how wider societal factors need to be addressed as well as providing high-quality health services.

Mental health services are overwhelmed by the issues that contribute to the treatment gap, and a lack of human resources means those seeking treatment do not receive adequate care. In 2014, mental health workers accounted for only 1 per cent of the global health workforce. 45 per cent of the world’s population lived in a country with fewer than one psychiatrist per 100,000 people. Some governments have prioritised the development of a workforce as a key strategy to improve mental health services, but based on evidence from countries such as the UK, it is likely they are highly inadequate to address the needs of people of all ages. The workforce is a key building block of any health system; these systems simply fail if not well resourced. To address this failure in nearly all countries, governments need a comprehensive approach.

The WHO Mental Health Atlas reports the median number of mental health workers globally is 9 per 100,000 people, with a wide variation (from below 1 in LMICs to 72 in HICs). In Africa, there is not even 1 mental health worker (0.9) per 100,000 people. The WHO Mental Health Atlas reports stigma among health workers towards those with mental ill health is also high, which further impacts on people seeking support.

Filling the gap in treatment and support will take investment in mental health. The current investment model that favours high-cost, high-treatment and support workers 22 are not available globally, but based on evidence from countries such as the UK, it is likely they are highly inadequate to address the needs of people of all ages. The workforce is a key building block of any health system; these systems simply fail if not well resourced. To address this failure in nearly all countries, governments need a comprehensive approach.

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THE TRUE COST OF EMERGENCIES

Our mental health and wellbeing are affected by the environment in which we live. The determinants of health include a range of social and economic factors, including poverty, income inequality and exposure to humanitarian emergencies and conflict. People who experience a humanitarian emergency (such as conflicts, natural disasters or public health emergencies) are at increased risk of developing mental health disorders. The UN estimates that in 2019 nearly 132 million people in 42 countries will need humanitarian assistance resulting from conflict or disaster, and nearly 69 million people worldwide have been forcibly displaced by violence and conflict, the highest number since World War II. The latest WHO research suggests one in five of those affected are living with mental health issues, from mild depression or anxiety to psychosis, and one in ten are living with a moderate or severe mental disorder. Protracted conflicts in countries from Colombia to Yemen are leading to higher rates of mental ill health and stress, and contributing to higher rates of distress for people of all ages.

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JOSEPHINE’S STORY

Similarly, epidemics and other public health emergencies can change the environment around us and affect our mental health. The 2014 Ebola outbreak in Liberia changed Josephine Karwah’s life forever. She was diagnosed with Ebola and went to an Ebola Treatment Unit (ETU) operated by Médecins Sans Frontières, where she first received treatment and mental health counselling.

Returning to her community, Josephine entered a world that was not the same as before Ebola. The stigma surrounding the disease, including baseless myths about contracting the disease, permeated her community, making her return to normal life impossible. At this time, she was introduced to the Carter Center, which was working to transform the mental health system in the country. The Carter Center helped Josephine through counselling and access to services. She is now living what she refers to as ‘normal’ life in the community and is studying biology.

Countries like Liberia that have weakened health systems due to years of political instability and lack of investment cannot handle the increased burden when a public health emergency hits. They must be supported to rebuild and maintain public health systems to ensure better care for people like Josephine in the future.

Further information on the changing situation and updates on mental health materials can be accessed through the WHO. Recently the advice provided by WHO in conjunction with the IFRC recommends a ‘Whole of Society’ approach. This involves promotion of self-care strategies; reassuring people it is normal to experience fear and anxiety and identifying ways people can support others; and providing clear, concise and accurate information about COVID-19, including how to access help if one becomes unwell.
**SODIKIN’S STORY**

When Sodikin in Indonesia first started experiencing mental health challenges, his family didn’t know how to support him. He would get angry and smash things. First, his family took him to a faith healer, then a mental hospital a day and a half walk from their home. They were given medicine to help his condition, which worked for a little while, but when he needed his prescription repeated, nobody could provide it. After being sent back and forth between the local healthcare centre and hospital, his family gave up.

That’s when the shackling began. Sodikin spent more than eight years in shackles in a tiny hut outside of his family home, until an NGO came to rescue him. He had to be carried out of the hut because his muscles had wasted away so much he couldn’t walk. He stayed at a shelter for seven months while he healed. Sodikin is now the main breadwinner in his family.

People with mental disorders can be detained in mental health services against their will in involuntary, forced, coerced admission, or admission without consent. Those detained against their will may also be forced to have treatment. They may lose their rights to own property or make legal contracts. WHO reports...

People with dementia are frequently denied the basic rights and freedoms available to others. In many countries, physical and chemical restraints are used extensively in care homes for older people and acute-care settings, even when regulations are in place to uphold the rights of people to freedom and choice.

Forced treatments, shackling and other human rights abuses continue to be prevalent across the globe, making people with mental health conditions particularly vulnerable and marginalised.

**FUNDING MENTAL HEALTH CARE**

The Sustainable Development Goals (SDGs) aim to bring about a better future for all. SDG3 explicitly mentions good health and wellbeing. This, together with widespread agreement on WHO’s Mental Health Action Plan 2013–20 has focussed attention on how to fund the prevention and support of mental illnesses, primarily from national sources.

Estimates for the shortfall in funding for mental health range from US$1.88 per person in low-income countries to US$2.62–3.70 per person in lower-middle-income countries. In 2004, the National Sample Survey Organisation in India found the equivalent of US$280 million was spent on getting treatment for psychiatric disorders, 90 per cent of which was borrowed from a variety of sources, including household savings.

Universal health coverage (UHC) aims to provide access to health services for all, without people suffering financial hardship. It provides a mechanism through which mental health services in the broadest sense could be resourced. WHO recommends using UHC to ensure neither prevention or treatment of mental illness are left behind. Countries are currently being encouraged to develop their own plans to deliver UHC for all by 2030. This is a vitaly important moment to ensure mental health is integrated into national health budgets and plans for the foreseeable future.

Extended cost-effectiveness analyses have been developed that account for the broader benefits of mental health interventions in a UHC context. These can be used to evaluate the benefits of and targets for investment at national or local levels. For example, for mental, neurological and substance abuse disorders, an investment of US$1.21 per capita in Ethiopia and US$1.57 in India equated to 1,500 and 3,000 healthy life-years per 1 million people respectively.

The complexity, challenges and scale of the world’s mental health crisis are huge. But the voice of the individual should not be lost. People with mental disorders must be central to decision making about their own care and support. They are best placed to determine which outcomes are most important to them. A functioning rights-based mental health support system, through the community, public services or workplace, not only brings social and economic returns but would transform people’s lives in ways that cannot be quantified.
CHAPTER ONE

THE SCALE OF THE RETURN FOR THE INDIVIDUAL

What would the world look like if mental health systems were adequately financed? If the world increases spending to the recommended levels, not by tomorrow, but by a steady and consistent increase from now until 2030, the impact could be huge.

New research commissioned by UnitedGMH and conducted by Deakin University in Australia estimates the health impacts following an increase in public mental health investment until 2030 for five mental health conditions: major depression, anxiety disorders, psychosis, bipolar disorder and epilepsy using WHO’s One Health Tool (OHT).

The research explores the impact of a consistent increase in public expenditure for these five conditions up to recommended levels in 2030. The full methodology with limitations can be found here. The full research findings with forecasted economic returns will be subsequently published.

The research looks at this increase as a global total (and by grouping countries as per their World Bank income category to be subsequently published). The treatment coverage increase in line with this expenditure increase was modelled using the OHT and the health impacts of this given by prevalent cases averted, health life years gained and deaths avoided.

The new research shows the number of cases of anxiety, depression and epilepsy alone can be decreased by nearly 60 million between now and 2030. What is more, we see a bend in the curve, one that not only slows the rate of anxiety, depression and epilepsy case increase, but the beginning of an overall reduction in cases across the world. Each case decreased is a Timothea or Graeme who may not experience mental ill health or for whom their recovery will be far quicker.

The results also show a sustained increase of healthy life years over the next decade when adequate government spending on mental health is achieved. These are years that someone like Sodikin or Cecilia can continue to live at home, work to help support their family and contribute to their community.

The research shows an increase of nearly 25 million healthy life years over the next decade when adequate government spending on mental health is achieved. These are years that someone like Sodikin or Cecilia can continue to live at home, work to help support their family and contribute to their community.
Maybe the starkest demonstration of what adequate mental health investment could achieve is the number of lives that could be spared with adequately funded mental health systems.

For example, nearly 200,000 deaths could be avoided in the three mental health conditions of depression, psychosis and epilepsy alone.

The complexity, challenges and scale of the world’s mental health crisis are huge. But investment can make a real difference and prioritising mental health is essential. Behind every number and statistic is a real person, the voice of the individual should not be lost. People with mental disorders must be central to decision making about their own care and support. They are best placed to determine which outcomes are most important to them. A functioning and adequately resourced rights-based mental health support system, through the community, public services or workplace, not only brings social and economic returns but would transform people’s lives in ways that cannot be quantified.
There are 284 million people suffering from anxiety and 265 million from depression worldwide.

One of the most extreme manifestations of poor mental health is suicide which claims the lives of close to 800,000 people every year – with many more attempting to take their own lives.

Depression is ranked by the World Health Organization as the single largest contributor to global disability (7.5% of all years lived with disability in 2015) and anxiety is ranked 6th (3.4%).

In low and middle-income countries, between 76 and 85% of people with mental disorders receive no treatment, and in high-income countries, this percentage is between 35% and 50%.

The estimated proportion of people aged 60 and over with dementia at any time is between 5 and 8%.

That’s an estimated 50 million people living with dementia and this number is projected to triple by 2050.

Half of all mental health conditions start by age 14, three quarters by the mid 20s. Tragically, suicide is the second leading cause of death for young people aged 15-29 years.

15 to 23% of children live with a parent with a mental health condition, requiring support for both parents and children.

The determinants of health include a range of social and economic factors, including poverty, income inequality and exposure to humanitarian emergencies and conflict.

People who experience a humanitarian emergency (such as conflicts, natural disasters or public health emergencies) are at increased risk of developing mental health disorders - at any point in time over a fifth of conflict-affected populations are experiencing a mental health condition.

On average less than 2% of health budgets globally are spent on mental health. This decreases to less than 1% in low-income countries.

It’s #TIMETOINVEST in mental health.