Sectoral Entry Points for Mental Health and Wellbeing

UNITED FOR GLOBAL MENTAL HEALTH
cbm Global Disability Inclusion
LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

CONTENTS

ENTRY POINTS FOR INTERVENTIONS IN ALL SECTORS TO IMPROVE MENTAL HEALTH AND WELLBEING

A. Sectoral entry points

Focus on recovery programmes reaching populations where COVID-19 has caused the most impact – for example:

Education and youth programmes: Among young people aged 10–24, mental health conditions (including neurological and substance abuse) are now the leading cause of disability and among the top five biggest contributors to the global burden of disease. Suicide is the second leading cause of death among 15-29 year olds globally. Disruption to early childhood learning, schools and parenting programmes due to COVID-19 have left children and young people at greater risk of developing mental health conditions.[1]

Social protection: Poverty, unemployment and poor mental health are mutually reinforcing. Programmes that address the economic consequences of COVID-19 can help counteract this cycle. For example, recent evidence suggests that Cash Transfer Programmes (CTPs) can improve mental health and reduce suicide rates among young people.[2]

Gender-based and intimate partner violence: Integrating mental health and psychosocial support into maternal, newborn and child health, family planning, violence reduction and community health programmes can help reach populations who have faced particular challenges during COVID-19, including carers and single parents.

Health services: Restricted movement, service interruptions and health system strain have highlighted the importance of primary care integration and decentralised service delivery of mental health services. Global WHO Rapid Assessments have highlighted service gaps but also ways in which formal and informal social supports, formal and informal, have played a key role in protecting mental health. Important innovations have also been developed that are likely to change the means of providing support forever, including to previously underserved groups.

See the Foreign, Commonwealth and Development Office (FCDO), UK Government Topic Guide on Mental Health and Sustainable Development for further examples and comprehensive summaries of evidence-based approaches for each of these sectors.

B. Where to focus delivery

Assessment at the following levels can help prioritise delivery:

Country level analyses: The WHO Mental Health Atlas series is considered the most comprehensive resource on global information on mental health and an important tool for developing and planning mental health services within countries and regions

Community level analyses: Discussion (e.g. with key members of affected community, service providers, service users) about attitudes toward persons with mental disorders, help-seeking for mental health problems, ways of coping and community support, formal (e.g. health clinics) and informal (e.g. social supports, religious and traditional healers) resources and barriers to accessing services.

Service facilities assessments: Focus on understanding which levels of the health system mental health services exist (if any), to what extent staff are trained in providing mental health services, and which services/settings would be optimal for mental health integration (e.g. discussion with heads of facility, service-users)

The UK Aid funded PRIME programme has developed and validated a comprehensive set of tools to support the assessment and prioritisation process.

Specific principles and examples

Principle 1: Frontline workforce mental health support and training
COVID-19 has highlighted the importance of mental health and well-being of care providers and the need for scalable interventions, such as the WHO's Self-Help Plus, for emergency situations. Frontline workers from any sector can be trained in Psychological First Aid (PFA) training. PFA is a first response to help a distressed person feel calmer and regain their capacity to cope and make decisions, and can be provided in-person or remotely. WHO and Public Health England have both developed resources to support this training, including online.

During response and recovery, frontline staff trained in psychosocial skills can strengthen referral links, and improve acceptability and accessibility of psychosocial care. This is particularly clear in maternal health services: meta-analysis of 13 trials from low- and middle-income countries (LMICs) demonstrated the effectiveness of maternal mental health interventions delivered by non-specialist health and community workers. WHO has identified health worker training as a key principle for Building Back Better for mental health system strengthening following emergencies.

Case study: A Zimbabwe NGO the "Society for Pre and Post Natal Services" has adapted its programming in response to increased stress, anxiety, fear, and reports of gender-based violence among service users. This includes support and capacity building for frontline staff. Community Mental Health workers will receive training from the Ministry of Health's Epidemiology and Disease Control Department on personal protective equipment on the identification of mental health needs. Data on mental health needs will be monitored and used to inform recovery service planning activities.

Principle 2: Task-shifting and decentralised service delivery
Task shifting - the use of trained lay health workers to deliver health care in non-specialist settings – has been highlighted as a key strategy to address the urgent need to build a provider base in developing countries, given the flexible workforce it can provide for service delivery at the communit level, within homes, schools, work places, and care centres.[3] These settings can serve as service outlets for mental health promotion and awareness programmes, and for service provision via community engagement with trained lay mental health providers. Peer, household and community support are even more critical when movement is restricted, or when health services are interrupted or overwhelmed.

The UK Aid-funded PRIME programme has highlighted the importance of training, compensation, monitoring and supervision in the effective delivery of task-sharing approaches[4]

Case study: In Kenya, psychologists were a cadre not previously recognised by public service. As a result of increased mental health needs due to COVID-19, psychologists were approved as a new health cadre. Psychologists were then deployed to public health facilities in each of the 47 counties of Kenya.

Principle 3: Remote delivery and telehealth
One potentially positive aspect of COVID-19 has been the rapid introduction and scale-up of new approaches to mental healthcare delivery in LMICs.[5] In some countries there has been an accelerated move towards telehealth (e.g. via help-lines, social media and messaging platforms, radio, and videos) with countries such as Kenya reporting an investment in tele-counselling that it intended to remain in operation beyond the pandemic.

A recent meta-analysis on the effectiveness of different digital psychological intervention formats for mental health problems in LMICs shows that, overall, these interventions were superior to control and usual care, particularly for those between the ages of 20-35yrs.[6] However, unintended consequences of widening inequalities in mental health care between people who can and cannot get access to the internet and mobile devices must be considered, for example, children and older individuals, and extremely impoverished groups. The WHO Equip project and the IASC have developed guidance for providing psychological services remotely.
Case study: BasicNeeds Pakistan has created an Online Mental Health Rapid Response team of psychologists providing remote counselling during the pandemic through online and phone consultations, in addition to raising awareness through social media using role-play videos to share information on the mental health impacts of COVID-19.

Because these activities are only available to people with access to devices and the internet, the organization has used online training to train 3610 community members as Mental Health First Aiders in the regions of Lahore, Peshawar, Quetta and Karachi to promote awareness and signpost to support in rural and under-resourced communities.

Principle 4: Communications and community engagement
A 2020 K4D review of evidence to mitigate the secondary impact of outbreaks highlighted the importance of community engagement to reduce the coercive nature of some responses, and to mitigate effects borne of fear and stigma.[7] This review noted the use of media engagement and survivor networks to help overcome stigma and help reintegrate Ebola survivors. Existing programmatic platforms and community links can be used to integrate mental health promotion communications focused on stigma related to the pandemic and its effect on mental health.

Resources: The IASC has produced guidance on how to engage community members to develop materials with COVID-19 related MHPSS messages on strategies to maintain well-being, manage anxiety, parenting, and caring for the elderly, disabled persons, and children.

Principle 5: Monitoring and evaluation
Increased mental health needs emerging during the COVID-19 pandemic have resulted in innovation and shifts in public attention and political will. Generating evidence from innovative approaches in addition to capturing the impact of cross-sectoral interventions for cross sectoral outcomes will be critical to building the investment case for innovations to be embedded in routine, sustainable practice. The FCDO mental health Topic Guide contains examples of indicators that could be added to log-frames to capture the impact of broader development programming on mental health and psychosocial outcomes.

Case study: A recent example how mental health impacts for a cash transfer programme in response to COVID-19 were measured and used to optimise programme design is available here.

1 Lee, J, Mental health effects of school closures during COVID-19, The Lancet Child & Adolescent Health 2020; 4;6:421
2 Bauer A, Garman E, McDaid D et al.Integrating youth mental health into cash transfer programmes in response to the COVID-19 crisis in low-income and middle-income countries. The Lancet Psychiatry 2021; 8, 4:340-346
3 Keynejad RC, Dua T, Barbui C, Thornicroft GJE. WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide: a systematic review of evidence from low and middle-income countries. Evidence-based Mental Health. 2018;21(1):30-4
4 Padmanathan P, Da Silva M. The acceptability and feasibility of task sharing for mental healthcare in LMICs. PRIME Policy Brief, 2013.
5 Adepoju P. Africa turns to telemedicine to close mental health gap. The Lancet Digital Health 2020; 2,11:e571-572
6 Fu, Z, Burger H et al (2020). Effectiveness of digital psychological interventions for mental health problems in low-income and middle-income countries: a systematic review and meta-analysis. The Lancet Psychiatry; 7,10:215-256
7 Kelly, L (2020) Evidence and lessons on efforts to mitigate the secondary impact of past disease outbreaks and associated response and control measures. K4D Evidence review

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.
Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).

ECONOMICS AND THE PRIVATE SECTOR

Economics and the private sector

- Poor mental health costs the world economy approximately US$2.5 trillion per year in reduced economic productivity and direct cost of care.[1] This cost is projected to rise to US$6 trillion by 2030 alongside increased social costs, LMICs are expected to bear 35 per cent of this cost.[2]
- Mental illness will account for more than half the economic burden of disease over the next two decades, higher than cancer, diabetes and chronic respiratory disease combined.
- As many as 20 percent of the world's working population has some form of mental health condition at any given time.[3]
- 12 billion productive days lost each year due to depression and anxiety alone.[4]
- Overall companies on average receive a $5 return for every $1 invested in employee mental health and wellbeing.[5]
- Companies that invest in employee mental health have four times the staff retention of companies who do not effectively manage employee wellbeing.
- COVID-19 is having a significan impact on mental health. In Pakistan, nearly 60% of individuals have experienced anxiety, depression or tension due to COVID-19, driven primarily by financia and employment concerns.[6]

Key Recommendations and Entry Points

- The economic impact of poor mental health is too large to be ignored. **Mental health care urgently needs to be scaled up and integrated into health systems** to offset this impact and accelerate sustainable growth, especially in the context of COVID-19. Mental health can help improve productivity and 'de-risk' investments in other areas of health care (e.g. HIV, TB, maternal and child health).
- Good mental health should be viewed as a key part of building resilient economies, particularly in the context of COVID-19, and therefore i**ncreased mental health investment** is required in COVID-19 response and recovery strategies.
- Given the pivotal role that mental health plays in enabling people to live healthy lives and engage in work and education, it should be seen as a fundamental pillar of human capital. Indeed, it can be argued that it should be explicitly added as a fift component of the Human Capital Index, or at least be explicitly addressed as a key enabler to the successful attainment of its four existing components.
- Whilst the underlying causes of poor mental health are complex and multifaceted, **the workplace represents an effective location** (or platform) for addressing mental health issues through workplace policies and interventions – interventions that can yield substantial financia benefit for employers and represent a sound return on investment.

1. WHO, Mental health atlas 2017. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO. http://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1
2. Bloom, D.E., Cafiero E.T., Jané-Llopis, E., Abrahams-Gessel, S., Bloom, L.R., Fathima, S., Feigl, A.B., Gaziano, T., Mowafi M., Pandya, A., Prettner, K., Rosenberg, L., Seligman, B., Stein, A., & Weinstein, C. (2011). The Global Economic Burden of Non-communicable Diseases. Geneva: World Economic Forum.
3. The Return on the Individual Report, United for Global Mental Health, 2019 https://gospeakyourmind.org//sites/default/files/2020-09/ROI_FullReport_0.pd
4. Marquez PV, Saxena S. Making mental health a global priority. InCerebrum: the Dana forum on brain science 2016 Jul (Vol. 2016). Dana Foundation.
5. Chisholm D, Sweeny K, Sheehan P, Rasmussen B, Smit F, Cuijpers P, Saxena S. Scaling-up treatment of depression and anxiety: a global return on investment analysis. The Lancet Psychiatry. 2016 May 1;3(5):415-24.
6. Bond Mental Health and Psychosocial Disability Group, Covid-19 and mental health: immediate and long-term impacts, 2020 https://www.bond.org.uk/resources/covid-19-and-mental-health-immediate-and-long-term-impacts

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.

Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).

EDUCATION & YOUTH PROGRAMMES

- Among young people aged 10–24, mental, neurological and substance use conditions are now the leading cause of disability and among the top fiv biggest contributors to the global burden of disease. Suicide is the second leading cause of death among 15-29 year olds globally, and the leading cause of death of adolescent girls.[1]

- Onset of half of all mental health conditions is by the age of 14, and three quarters by the mid-20s. Once established, in addition to unnecessary suffering, later treatment is costly and less effective.

- Poor mental health in youth is a risk factor for mental, neurological and substance use (MNS) conditions in adulthood and has important consequences for future employment and productivity. Yet child and adolescent mental health receives just 0.1% of Officia Development Assistance for Health. [2]

- Disruption to early childhood learning, schools and parenting programmes due to the COVID-19 pandemic have left children and young people at greater risk of developing mental health conditions.

- Stress and social isolation are likely to affect brain health and development, with young children at risk of developing lifelong challenges through periods of prolonged exposure to toxic stress, and by deprivation in nutrition, stimulation and health care which can affect brain health and development.

Key Recommendations and Entry Points

- Parenting programmes during infancy and early childhood have been identifie as examples of cost effective evidence-based practice by applying the Assessing Cost-Effectiveness in Prevention Project grading system.[3]

  Case study: In the Amazon basin, community health workers were trained to coach parents in nutrition, early learning and birth registration through the UNICEF/WHO Care for Child Development Programme. The WHO's Carer Skills Training provides evidence-based normative guidance.[4]

- To reduce the risk of suicide specificall , the Lancet Commission recommends "multimodal programmes" that include community and school-based skills training, screening for young people who are at risk, education for primary care physicians and the media, and restricting access to pesticides and other lethal means.

  Case study: The "Integrated Approach to Addressing Depression Among Young in Malawi" (IACD), funded by Grand Challenges Canada used interactive, youth-informed weekly radio programs, mental health curriculum training for teachers and peer educators in secondary schools, and a clinical competency training program for community-based health workers, the innovation created a "hub and spoke" model for improving mental health care for young people. [5]

- School-based mental health programmes have the potential for significan positive effects on students' emotional and behavioural wellbeing, including reduced depression and anxiety and improved coping skills.[6]

- Early child enrichment and preschool educational programs (which promote cognitive stimulation and social interaction) have been shown to improve children's social and emotional wellbeing, cognitive skills, problem behaviors, and school readiness; and have shown evidence of the long-term effects on school attainment, social gains and occupational attainment.[7]

- Microfinanc (micro-credit and micro-savings) schemes in sub-Saharan Africa that incorporate gender empowerment, health and education training components are more effective in terms of mental health benefit over stand-alone programmes.[8]

  Resource: The Disease Control Priorities, third edition (DCP3) included mental and neurological health for the first time, and recommends 'best buys' in public health interventions for mental health, many of which focus on young people. [9]

1. Hawton K, Saunders KE, O'Connor RC. Self-harm and suicide in adolescents. The Lancet. 2012;379(9834):2373-82.

2. Lu C, Li Z, Patel V. Global child and adolescent mental health: The orphan of development assistance for health. PLoS Medicine. 2018;15(3):e1002524-e.

3. https://ijmhs.biomedcentral.com/articles/10.1186/s13033-016-0060-z

4. WHO Carer Skills Training https://www.who.int/mental_health/maternal-child/PST/en/

5. Kutcher S, Perkins K, Gilberds H, et al. Creating evidence-based youth mental health policy in sub-Saharan Africa: a description of the integrated approach to addressing the issue of youth depression in Malawi and Tanzania. Frontiers in psychiatry 2019; 10(542) https://www.frontiersin.org/articles/10.3389/fpsyt.2019.00542/full

6. Barry MM, Clarke AM, Jenkins R et al. A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries. BMC Public Health 13, 835 (2013). https://doi.org/10.1186/1471-2458-13-835

7. Aboud FE. Evaluation of an early childhood preschool program in rural Bangladesh. Early Child Res Q. 2006;21:46–60.

8. Stewart R, van Rooyen C, Dickson K, Majoro M, de Wet T. What is the impact of microfinanc on poor people?: a systematic review of evidence from sub-Saharan Africa. 2010.

GOVERNANCE

Governance

- Peaceful, politically and economically stable, and open societies tend to promote wellbeing. Conversely, rates of mental conditions, alcoholism and suicide increase during periods of insecurity, economic depression and state violence or conflict
- Effective governance, and accountable leadership across sectors and at all levels has a positive effect on many social determinants of mental health, like poverty, access to health care, education, and social security.
- A well coordinated civil society sector can ensure protection of marginalised communities, reducing the tendency for poor mental health associated with exclusion. Accountability of governments (and other duty bearers) to people with mental health conditions, for example through the mechanisms of the Convention on the Rights of Persons with Disabilities is strengthened if there is a vibrant representative network of people affected, who are enabled to have a voice.
- Incorporating and integrating mental health into the health sector is critical to increasing access, while integrating mental health across wider sectors such as education, employment and social welfare helps address social determinants of mental health and ensures a comprehensive and holistic access to rights.
- The WHO's Comprehensive Mental Health Action Plan (extended to 2030) sets out clear targets and objectives in the mental health sector, including governance. The firs objective of the plan is to strengthen effective leadership and governance for mental health, and it features indicators to measure progress. The indicators chosen to track progress in this area:
  - ○ Existence of a national policy and/or plan for mental health that is in line with international human rights instruments
  - ○ Existence of a national law covering mental health that is in line with international human rights instruments.
- The WHO Mental Health Atlas tracks progress on the indicators of the Mental Health Action Plan. The latest version available is from 2017, but a 2020 version will be released soon this year. The 2017 Atlas found:[1]
  - ○ 72% of Member States have a stand-alone policy or plan for mental health and 57% have a standalone mental health law
  - ○ 94 countries equivalent to 68% of those countries who responded, or 48% of all WHO Member States, have developed or updated their policies or plans for mental health in line with international and regional human rights instruments;
  - ○ 76 countries, equivalent to 75% of those countries who responded, or 39% of all WHO Member States, have developed or updated their law for mental health in line with international and regional human rights instruments;
  - ○ Human and financia resources allocated for implementation are limited; only 20% of Member States reported that indicators are available and used to monitor implementation of a majority of the components of their action plans.

- Legislation can have a direct negative affect on mental health and stigma. There are 21 countries where suicide is illegal or criminalised, 15 of these are members of the Commonwealth. The 21 countries are: The Bahamas, Bangladesh, Brunei Darussalam, Ghana, Guyana, Kenya, Lebanon, Malawi, Malaysia, Myanmar, Nigeria, Pakistan, Papua New Guinea, Qatar, Saint Lucia, Somalia, South Sudan, Sudan, Tonga, Uganda, United Republic of Tanzania.
- Peace building and mental health are intertwined yet not always formally recognised. In many countries that are or have been conflic affected not only are high levels of ill mental health linked, in part, to the effects of conflic but addressing ill mental health and supporting the development of a mentally healthy population can underpin the re-establishment of good democratic processes.

Key Recommendations and Entry Points

- Address stigma, discrimation and exclusion in the general population and in government and other structures. This enables people with mental conditions and associated disabilities to not be treated like second class citizens

  Case study: The Time To Change (TTC) Global programme (which build on the UK government-funded TTC UK programme demonstrated in a pilot in Nigeria, Ghana, Kenya and India, that attitudes can be changed through a combination of media and empowerment of people with lived experience.[2]

- Mental health services need to be integrated throughout government areas of responsibility including, but not limited to, health, education, welfare,

  and justice systems, as well as the workplace - integration of services must be both cross-governmental and cross-sectoral

- Effective representative initiatives often involve governance structures and management decisions led by service users and survivors, where the organisation is guided by clearly define values. Strong regional representative organisations exist in Africa, Asia/Pacifi and Latin America.

  Case study: Although in general, organisations of people with psychosocial disabilities are relatively young compared to other disability groups, the Pan African Network of Persons with Psychosocial Disabilities, and Transforming Communities for Inclusion (TCI) Asia Pacific have developed clear positions on their rights.[3]

- Countries should have a national policy and/or plan and a national law for mental health that is in line with international human rights instruments, in accordance with the WHO's Comprehensive Mental Health Act Plan.[4] National budgets should be allocated properly for implementation of these plans.

1. WHO, Mental health atlas 2017. Geneva: World Health Organization; 2018. Licence: CC BY-NC-SA 3.0 IGO. http://apps.who.int/iris/bitstream/handle/10665/272735/9789241514019-eng.pdf?ua=1

2. Time To Change Global, Mind UK and CBM Global. https://www.time-to-change.org.uk/global

3. Transforming Communities for Inclusion, Asia Pacifi https://www.tci-asia.org/bali-declaration/

4. WHO Comprehensive Mental Health Action Programme, 2013-2020 (extended to 2030) https://www.afro.who.int/publications/mental-health-action-plan-2013-2020

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.

Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).

HEALTH SYSTEMS

Health Systems

- For many across the world, access to basic, quality mental health care and treatment is still denied or out of reach. In sub-Saharan Africa, only about 10% of people with severe mental illness reach services.
- Mental health systems are overwhelmed with various issues that contribute to the treatment gap, and the lack of human resources for mental health prohibits those seeking treatment to receive adequate care.
- The WHO Mental Health Atlas (2017) reports globally the median number of mental health workers is 9 per 100 000 population with a wide variation (from below 1 in low- and middle-income countries (LMICs) to 72 in high-income countries).
- Restricted movement, service interruptions and health system strain due to the COVID-19 pandemic have highlighted the importance of primary care integration and decentralised service delivery of mental health services as well as the increasingly effective use of digital options for health care delivery.
- Shifting services away from tertiary level facilities to primary and community-level health systems reduces access barriers such as distance from the home and associated costs. All mental health conditions better treated in local environments, and integrating mental health into physical health programmes has the following benefit [1]:
- *Accessibility: Many adults and children with mental health conditions are already presenting to general health-care services, though sometimes with physical complaints.*
- *Acceptability: Treatment in general health-care settings is often considered less stigmatising and less institutionalising than treatment in specialist facilities, and conditions are often better.*
- *Value for money: Task-sharing models offer cost-effective alternatives to specialist services.*
- *Complementarity: Many people experience chronic physical health conditions and mental health conditions concurrently, and treating mental health conditions may also improve adherence to treatment and outcomes of chronic physical health conditions.*
- The WHO mhGAP offers normative guidance for the delivery of mental health care in non-specialist settings to help facilitate integration. mhGAP has now been evaluated in numerous LMICs[2] including through the through the FCDO-funded Programme for Improving Mental Health Care (PRIME) [3] a research consortium in Ethiopia, India, Nepal, South Africa, and Uganda

Key Recommendations and Entry Points

- Build mental health as an **integral part of wider health systems**. This approach reduces stigma, is efficient favoured by service users, and is in line with Universal Health Coverage. The WHO's Special Initiative has been established to demonstrate scaled integration and comprehensive approaches in low- and middle-income countries.

- Ensure **supply chains and workforce issues** are considered as part of health care integration integration efforts[4]. This systems approach, especially when government ownership is prioritised, improves likelihood of effective and sustainable reform.

Case Study: A Cochrane review has shown task-sharing to be effective for mental health care in LMICs[5] This is based on a strong basis of evidence from multiple examples around the world, including in very low resourced settings. Some of these approaches are now being applied in higher income settings.

- Invest in **recovery based approaches** - holistic, people-centred approach to mental health care: While reorganising health systems is essential, it is also important for the health sector to engage in efforts to address stigma and encourage communities to better respect the rights and dignity of people with MNS conditions. This includes involving people with mental health conditions in mental health policy, service delivery, and research [6]

  Case study: The QualityRights Gujarat programme has introduced peer support volunteers who have lived experience of mental health conditions and are responsible for organising weekly peer support groups and aiding in recovery planning at public mental health facilities in India[7]

- Collaboration between **the formal and informal health-care sector** is needed to ensure that people with MNS conditions have access to culturally appropriate, safe, and respectful care.

  Case study: Several projects in LMICs have sought to improve collaboration between biomedical and traditional or spiritualist healers; for example, Wayo-Nero in Uganda where community "uncles" and "aunties" liaise between traditional healers and formal mental health-care providers[8]

Case study: What does stepped care look like?

An important means of integrating mental health into other services is by allocating appropriate tasks to workers at different levels of the health system, making care much more widely available and using resources more efficientl . While models vary depending on the context and condition being targeted, the following example describes a common breakdown of tasks:

Mental health specialists • Coordinate services, advocate, and advise government on service development; • Diagnose and treat based on specialised training in pharmacological and psychological interventions; • Accept referrals of relatively complex cases; and • Supervise non-specialist health professionals.

Non-specialist general health professionals • Follow standardised guidelines for assessment and management of priority conditions for non-specialist settings (e.g. mhGAP-IG 2.0); • Consult with specialists and refer relatively complex cases; and • Supervise lay workers and accept referrals.

Lay workers (if available) • Facilitate or provide basic social support and awareness-raising; • Provide basic psychological interventions and/or psychoeducation; • Refer cases from community to non-specialists or specialists, as appropriate

1. Patel V, Belkin GS, Chockalingam A, Cooper J, Saxena S, Unützer J. Grand Challenges: Integrating Mental Health Services into Priority Health Care Platforms. PLoS Medicine. 2013;10(5):e1001448
2. Keynejad RC, Dua T, Barbui C, Thornicroft GJE. WHO Mental Health Gap Action Programme (mhGAP) Intervention Guide: a systematic review of evidence from low and middle-income countries. Evidence-based Mental Health. 2018;21(1):30-4
3. Baron EC, Rathod SD, Hanlon C, Prince M, Fedaku A, Kigozi F, et al. Impact of district mental health care plans on symptom severity and functioning of patients with priority mental health conditions: the Programme for Improving Mental Health Care (PRIME) cohort protocol. BMC Psychiatry. 2018;18(1):61
4. Petersen I, Ssebunnya J, Bhana A, Baillie K, Mha PPRPC. Lessons from case studies of integrating mental health into primary health care in South Africa and Uganda. International Journal of Mental Health Systems. 2011;5(1):8
5. Van Ginneken N, Tharyan P, Lewin S, Rao GN, Meera S, Pian J, et al. Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low-and middle-income countries. The Cochrane Library, 2013
6. Semrau M, Lempp H, Keynejad R, Evans-Lacko S, Mugisha J, Raja S, et al. Service user and caregiver involvement in mental health system strengthening in low- and middle-income countries: systematic review. BMC Health Services Research. 2016;16(79)
7. Pathare S, Kalha J, Krishnamoorthy SJE. Peer support for mental illness in India: an underutilised resource. Epidemiology and Psychiatric Sciences. 2018;27(5):415-9
8. Mugisha J, Muyinda H. Wayo-Nero Strategy. London: Mental Health Innovation Network, 2015

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.

HUMANITARIAN AND CONFLICT SETTINGS

Humanitarian and Conflict Setting

- Exposure to situations of extreme or chronic adversity is a key risk factor for psychological distress, including grief, as normal responses to adversity.
- **Rates of mental conditions** also increase substantially. A recent WHO estimate shows a point prevalence of all mental health conditions in conflict-a fected settings as 22.1%, with 9.1% having a moderate or severe condition.[1] Rates are similar for natural disasters. In addition to distress and a negative impact on wellbeing, depression and anxiety are the most common conditions experienced. Emergency-related conditions like post-traumatic stress disorder increase among those most affected.
- **During the COVID outbreak** specificall , the impact of isolation, loss of income, and increases in gender-based violence were recorded. Similar experiences have been noted in past outbreaks, like the Ebola Virus Disease outbreak in West Africa.[2]
- In addition, people with **pre-existing mental health conditions** are often particularly vulnerable. This is due to not only the stressful experiences, but also failure of social and formal support systems. Increased exposure to risk factors like poverty, poor access to health care and other services makes people with any disability at particular risk, especially where there are weak social safety nets.
- **The majority of distress and diagnosed conditions will resolve** in the months following the end of an acute emergency, as people and communities are resilient. Delayed return to normal life (eg continued lack of shelter and basic needs), or protracted emergencies and conflicts reduce resilience and slow recovery.
- **Long-term stressors and indirect effects**, like the impact of COVID-19 on the economy, or the effect of climate change on sea levels or weather patterns, will also impact on the prevalence of mental conditions. Planning, policy reform, and sufficien resources are needed to mitigate these core drivers, as well as strengthening mental health as a component of wider health and social care systems to account for this.

Key recommendations

- Follow the respected IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings to structure a comprehensive response that responds to the different levels of need.[3] Minimum standards are define in the Sphere Handbook.[4]

  ○ **Focus first o reducing drivers of mental distress**, and put in place protective mechanisms – provision of basic needs in the acute phase, and community and economic strengthening, and peace-building in protracted settings. This will have the biggest impact on population-wide wellbeing, as well as rates of diagnosed mental conditions, reducing demand on services.

  ○ *Case example: cash transfer systems have been shown to improve population wellbeing, including of young people, and people with mental health conditions.[5]*

  ○ **Integrate good basic communication and empathy skills** in first-respons workers (like Psychological First Aid) to support people in distress and identify those who require more support. This also reduces the risk of doing unintentional harm.

  - Integrate mental health into basic health care services, especially at Primary Care level, for example using the mhGAP Humanitarian Intervention Guide.[6]

- In high risk areas, reduce future risks, and prepare response by **integrating MHPSS into Disaster Risk Reduction**, Preparedness Plans, health system strengthening, and levels of knowledge in other sectors like education, social welfare and private sector employers.[7]

  - *Case study: A health system strengthening programme in Sierra Leone trained specialist nurses and placed them in primary care, in advance of the Ebola outbreak of 2005/6, which meant that they were able to support people referred by front-line workers, children orphaned by the outbreak, and first responders.[8]*

- **People with pre-existing mental conditions and psychosocial disabilities**, especially those in institutions or reliant on health services must be specifically identified and may require particular attention through relevant service adaptations or community-based supports.

  - Resource: There are many examples of service adaptations to ensure access to care for people with mental health conditions on the WHO/LSHTM Stories from the Field resource on www.mhinnovation.net

- **The mental health and wellbeing of front line humanitarian responders** must be considered as they are at substantially increased risk, especially in protracted emergencies. Adequate breaks, protection from excessive work in high risk settings, and psychological support must be put in place, as well as early identification of risky behaviours, especially excess alcohol use.

1 Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet. 2019;394(10194):240-8

2 Kola L et al. Priorities and future directions in COVID-19 and mental health in low- and middle-income settings. Lancet Psychiatry

3 IASC. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: Inter-Agency Standing Committee, 2007

4 The Sphere Handbook: Humanitarian Charter and Minimum Standards in Humanitarian Response. Geneva: Sphere Association, 201

5 Angeles G, de Hoop J, Handa S, Kilburn K, Milazzo A, Peterman A, Team MS. Government of Malawi's unconditional cash transfer improves youth mental health. Social Science & Medicine. 2019 Mar 1;225:108-19.

6 WHO, UNHCR. mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO, UNHCR, 2015

7 Inter-Agency Standing Committee (IASC) Technical Note Linking MHPSS and Disaster Risk Reduction (DRR). Geneva: IASC, 2021 – in press

8 Gray BL, Eaton J, Christy J, Duncan J, Hanna F, Kasi S. A proactive approach: Examples for integrating disaster risk reduction and mental health and psychosocial support programming. International Journal of Disaster Risk Reduction. 2021; 21:102051.

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.

Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).

INFRASTRUCTURE

Infrastructure

- By 2050, 69% of the world's population will live in cities.[1]
- Living in a city is associated with a risk of increased mental health problems, including an almost 40% higher risk of depression, over 20% more anxiety, and double the risk of schizophrenia, in addition to more loneliness, isolation and stress.[2]
- Factors that lead people to move to cities can also be risk factors for developing mental health problems, e.g. unemployment, family break-up, addiction, homelessness, and needing to seek asylum.
- It is worth noting that people in cities are also usually able to access services more easily than those in rural environments, and many economic and other factors that draw people to cities. Improved transport links and communication can help people in rural areas access services more easily, in addition to more decentralised services.
- The urban environment can create an overwhelming stimulus level (e.g. density, noise, sights, smells, and encounters with other people) that can leave people with elevated stress.
- Cities often offer inadequate environmental protective factors like access to nature, opportunity for exercise and leisure for all ages, positive social interaction, and safety. However, with good design and consideration of these factors, cities can offer environments conducive to mental health, and are often more inclusive and accepting of diversity.

Key recommendations and entry-points

- When conducting a health impact assessment on any infrastructure or urban space development project, potential impact on people's mental health should be included.

  Case study: Several large city programmes like those of the World Economic Forum and the Rockefeller Foundation, have included mental wellbeing in their work. citiesRISE is a programme working with city governments to transform cities to make them work better for mental health, focusing on young people. Similarly ThriveNYC and similar programmes in cities around the world seek to maximise the positive impact of integrated city systems on mental health.

- Follow the Centre for Urban Design and Mental Health's Mind the GAPS framework to embed urban design and planning factors that promote and support good mental health and wellbeing.

o **Green and natural places:** Maximise local access to high quality, well-maintained local nature settings, including via parks, waterways, and transit corridors. Leverage climate adaptation systems and heat-proof city design to maximise safe water features. Use natural features to mitigate air and noise pollution.

o **Active places:** Integrate opportunities for accessible physical activity into daily routines, including walkable and bikeable infrastructure, benches for resting, safe road crossings, accessibility ramps, clear navigation, planning a wide range of facilities within a short walk from people's homes, and accessible public transit.

- **Pro-social places:** Facilitate positive, natural social interactions to support a sense of community and belonging, including attractive and accessible local amenities, physical infrastructure that facilitates walking and social interaction options in comfortable settings (e.g. shade, shelter, benches), and flexible participatory space where people may safely and spontaneously interact with each other. Involve local communities at each stage of design and development of infrastructure and urban space projects.
- **Safe places:** Maximise a sense of safety and security by leveraging planning and design approaches to reduce danger from traffic crime, and weather, and to reduce the risk of people with dementia becoming lost in their neighbourhoods. This includes due consideration before removing/ altering local landmarks.

1. Population Division of the UN Department of Economic and Social Affairs (2018). The 2018 Revision of World Urbanization Prospects.
2. Peen, J., Schoevers, R.A., Beekman, A.T. and Dekker, J. (2010), The current status of urban rural differences in psychiatric disorders. Acta Psychiatrica Scandinavica, 121: 84-93.

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.
Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health). The ‘Infrastructure’ briefin was co-written with Layla McCay, Centre for Urban Design and Mental Health.

LIVELIHOODS AND SOCIAL PROTECTION

Livelihoods and Social Protection

- There is a close and reinforcing relationship between poverty and mental ill health, especially in environments where there are few safety nets or social capital.
- Poverty increases the risk of developing mental health conditions, through various mechanisms, including heightened exposure to stress, malnutrition, violence, and other key risk factors.[1].
- People with mental health conditions are also more likely to drift into poverty, for example through loss of employment and increased health expenditure. At the same time, people with mental health conditions are among those most likely to be excluded from employment, and from social protection measures like disability benefits health insurance schemes, livelihoods programmes, and other social protection programmes. [2]
- Among people with disabilities, those with psychosocial disabilities have the highest rates of unemployment: 70–90%.7 In a cross-sectional survey of people diagnosed with schizophrenia carried out across 27 countries, 44% of participants reported discrimination in findin or keeping work.[3]
- Related to the issues of catastrophic spending and unemployment is that of homelessness and mental health. As in the case of poverty more generally, mental health conditions can both precipitate homelessness and develop as a result of homelessness.[4]
- The WHO argues that people with MNS conditions should be targeted as a vulnerable group in international development, in order to break this “vicious cycle” in LMICs.[5]

Key Recommendations and Entry Points

- **Increasing access to health insurance and ensuring parity of mental and physical health in insurance schemes** are both important for reducing catastrophic spending. Mental health system reform can also increase the availability of more cost-effective, accessible care.

  Case study: In approximately 40% of countries in Southeast Asia and sub-Saharan Africa, service users pay out-of-pocket for mental health care, posing financial barriers and increasing the risk of catastrophic health expenditure and drift into poverty.[6] A recent study in rural Ethiopia found over 32% of households of persons with severe mental health conditions experienced catastrophic health expenditure over the past 12 months, compared to 18% in other households. As a result of financial hardship, households were also significantly more likely to reduce food consumption, cut down on medical visits, and withdraw children from school to save money – leading to the intergenerational transmission of poverty. Fewer than 3% of households in the study were enrolled in a social protection scheme.[7]

- **Cash transfers can improve mental health outcomes.** In Mexico, a randomised controlled trial (RCT) of a conditional cash transfer programme showed improvements in cognitive and behavioural functioning among children in low-income communities.[1] In Malawi, unconditional cash transfers have reduced symptoms of depression in youth, particularly among girls.[8]

- **Community-based initiatives and peer-support can improve economic security.** Community-based rehabilitation and inclusive development approaches, including peer-support and self-help groups, have been shown to be effective ways of supporting extremely marginalised people to earn an income, even when they were previously excluded from community economic life or the formal economy.

  Case study: The mental health and development model developed by BasicNeeds, one of few international NGOs dedicated to mental health, has been applied in over a dozen countries. Self-help groups of people with psychosocial disabilities and their carers provide mutual support and also undertake livelihoods activities. An evaluation in North India found this model reduced fees spent on hospital visits, hours spent caregiving and missed work days, and also improved employment, with a slight increase in family income.[9]

1. Lund C, De Silva M, Plagerson S, Cooper S, Chisholm D, Das J, et al. Poverty and mental disorders: breaking the cycle in low-income and middle-income countries. The Lancet. 2011;378(9801):1502-14.
2. Lund C, Breen A, Flisher AJ, Kakuma R, Corrigall J, Joska JA, et al. Poverty and common mental disorders in low and middle income countries: A systematic review. Social Science & Medicine. 2010;71(3):517-28.
3. Thornicroft G, Brohan E, Rose D, Sartorius N, Leese M. Global pattern of experienced and anticipated discrimination against people with schizophrenia: a cross-sectional survey. The Lancet. 2009;373(9661):408-1
4. Funk M, Drew N, Knapp M. Mental health, poverty and development. Journal of Public Mental Health. 2012;11(4):166-
5. Funk M, Drew N, Freeman M. Mental Health and Development: Targeting people with mental health conditions as a vulnerable group. Geneva: Mental Health and Poverty Project, World Health Organization, 2010
6. WHO. Mental Health Atlas 2017. Geneva: World Health Organization, 2018
7. Hailemichael Y, Hailemariam D, Tirfessa K, Docrat S, Alem A, Medhin G, et al. Catastrophic out-of-pocket payments for households of people with severe mental disorder: a comparative study in rural Ethiopia. International Journal of Mental Health Systems. 2019;13(1):3
8. Angeles G, de Hoop J, Handa S, Kilburn K, Milazzo A, Peterman A. Government of Malawi's unconditional cash transfer improves youth mental health. Social Science & Medicine. 2019;225:108-19
9. Raja S, Kippen S, Mannarath SC, Misha SK, Mohammed S. Evaluating Economic Outcomes of the Mental Health and Development Model in North India. BasicNeeds International

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.
Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).

SOCIAL DEVELOPMENT

Social Development

- Depression is the single biggest cause of disability worldwide (by Years Lived with Disability), and more severe mental conditions like schizophrenia or bipolar disorder cause profound social exclusion in most societies in the world. Yet historically, this group has not been paid adequate attention, including in international development.
- The Millennium Development Goals do not address mental health, but due to an increase in attention to the issue, the Sustainable Development Goals include several important references to mental health, both as a part of the title of SDG 3: Health and Wellbeing, and within other SDGs. A key argument of the global mental health community is that 'there is no sustainable development without mental health', based on the intimate links between almost all the SDGs and mental health.
- Initially, global mental health focused on closing the wide treatment gap in low and middle income countries, but recent years have seen a substantial increase in attention paid to social determinants of mental health. Evidence is growing of the links between mental ill health and risk factors like poverty, violence, malnutrition, insecurity, conflict and climate change and environmental degradation.
- Stigma against people with psychosocial disabilities is extremely common in all parts of the world, and results in social exclusion, neglect and often profound human rights abuse.[1] This can include long-term deprivation of liberty, physical violence and treatment based on coercion.
- Stigma is often structural - integral to policy and legislation - so that in many countries, people who are identifie as having had a mental condition are barred from working across many professions, from voting, or from serving on juries. While much discrimination and abuse occurs in informal social spaces, judicial systems, prisons, hospitals and other institutions often serve to control or contain people with psychosocial disabilities.
- The Convention on the Rights of Persons with Disabilities (CRPD) specificall addressed mental health conditions and the psychosocial disabilities associated with them, using a paradigm of disability inclusion. Rights-based approaches to mental health programming, across different sectors, have emphasized holistic interventions that focus on promoting agency, autonomy, and a stronger voice of people affected. The FCDO Approach and Theory of Change for Mental Health was developed with people with lived experience, and has a strong human rights basis.

Key Recommendations and Entry Points

- **Strengthen the voice of people with disabilities.** As a highly marginalised group, representative organisations of people with psychosocial disabilities are generally in their infancy, but can be an important catalyst for change. Support for organisational strengthening, and ensuring their participation in development programmes, including those focused on disability, can strengthen their capacity to be heard. Influentia partners like FCDO and linked programmes can have an important role on policy change that promotes social and political rights, or improved protection from abuses, including in state health and social care institutions, and the judicial system.

- Case study: The WHO QualityRights initiative provides practical training on rights-based approaches to mental health care, enabling civil society actors to evaluate mental health services, and hold governments to account in relation to quality of mental health care, and human rights.

- **Integrate mental health interventions and measure wellbeing.** Risk factors for mental ill health tend to cluster in particular groups in intersectional ways, based on gender, social status, poverty, or disability. Mental health should always therefore be considered when working with particularly vulnerable groups, with interventions aimed at reducing these risk factors, and supporting people who are affected. Similarly, given the fact that almost all development efforts can be seen as addressing social determinants of mental health, and are closely aligned to issues that people fin important in their lives, appropriate measures of mental health and wellbeing is a valuable addition to monitoring and evaluation.

- **Community-based approaches** that address the wide range of factors that contribute to a full and flourishin life should be a complement to investment in health services. Inclusion in livelihood and social protection programmes, peacebuilding and other community strengthening initiatives, ensures that the prevailing assumptions about people with psychosocial disabilities are challenged, as they are seen to contribute to communities who have previously excluded them.

1. “Like a Death Sentence”. Abuses against Persons with Mental Disabilities in Ghana. Human Rights Watch, 2012

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.
Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).

STATISTICS

Statistics

- Progress in the mental health sector is held back by entrenched misunderstandings, myths and a general lack of knowledge. This reinforces stigma and exclusion.
- Mental conditions score very highly on the Disability Adjusted Life Year metric due to their early onset, high prevalence, chronicity and level of functional impairment. However, DALYs are not a practical means of briefl assessing function, and have been criticised for this purpose.
- Data on mental health conditions including anxiety, depression and self-harm are available for less than 7 per cent of children and adolescents aged 5 and 17.[1]
- Mental health research is overwhelmingly concentrated in high-income countries. Of the total investment of US$18.5 billion between 2015 and 2019, 98.6% came from high-income countries compared to 1.4% from low- and middle-income countries.[2]
- Mental health research is dwarfed by physical health research. Both cancer and infectious disease research received more than twice as much global investment as mental health research, this is hugely disproportionate to the disease burden.
- To date there have not been global measures to track baseline levels of population mental health across countries, let alone the impact of a crisis such as COVID-19. Without these metrics, the true scope of population mental health needs is largely going unmeasured and unattended.
- The current leading global mental health statistics compendium is WHO's Global Mental Health ATLAS.

Key Recommendations and Entry Points

- **Support independent comprehensive monitoring to inform decision making.** The Lancet Commission on Global Mental Health and Sustainable Development highlighted the need for robust and systematic mechanisms for monitoring and accountability to ensure that necessary investments are made, such investments are utilised efficientl and effectively, and mid-course corrections are made as required. The Commission outlined a set of indicators to monitor progress on mental health; indicator domains included mental health systems, services, and health outcomes, broader mental health determinants outside of the traditional health realm (indicators relating to demographic, economic, neighborhood, environmental, social, and cultural determinants), as well as non-health outcomes (including social and economic) and mental health risk protection (including social and financia protection).

  Case study: In response to this call for action, an independent and multi-stakeholder consortium has been formed to lead monitoring and accountability for global mental health within the SDG time frame (2030). The Countdown Global Mental Health 2030 initiative is driven by Global Mental Health at Harvard, WHO, United for Global Mental Health, Global Mental Health Peer Network, The Lancet. Results from the firs study on child and caregiver mental health will be launched in July 2021. Independent, credible and comprehensive monitoring mechanisms need to be supported by the international community, and used in decision-making.

- **Integration of mental health into existing research programmes.** The Washington Group on Disability Statistics have not incorporated a direct question on psychosocial disabilities onto their Short Set. This tends to mean that psychosocial disability is often not included in disability surveys or national census data. Although questions on depression and anxiety are in the Extended Set, these have proven unsatisfactory, and work is ongoing to resolve these shortcomings. The result is that while health/prevalence data shows high rates of mental conditions, this is not reflected in disability data.

- **Advocate for data-driven investment in mental health.** Mental health budgets in sub-Saharan Africa account for only 1-3% of national health budgets, despite mental health contributing close to 10% of the total burden of disease. A similar proportion of Official Development Assistance for Health is dedicated to mental health. Equity considerations enshrined in Universal Health Coverage, supported by evidence of value for money, and efficacy of interventions, demand that there should be a greater parity between mental and physical health.

1 GBD 2017 Disease and Injury Incidence and Prevalence Collaborators, 'Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017; Lancet 2018; 392: 1789–858

2 Woelbert, Eva; White, Rory; Lundell-Smith, Kierstin; Grant, Jonathan; Kemmer, Danielle (2020): The Inequities of Mental Health Research (IAMHRF). Digital Science. Report. https://doi.org/10.6084/m9.figshare.13055897.v2

These briefs of Sectoral Entry Points for Mental Health and Wellbeing in International Development were developed as a resource for development professionals, and are based on the FCDO Topic Guide on Global Mental Health and other related evidence-based sources.
Authors: Julian Eaton (CBM Global and Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), Alice Walker (Centre for Global Mental Health at London School of Hygiene and Tropical Medicine), and James Sale (United for Global Mental Health).