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EDITORIAL

Global mental health: a sustainable post Millennium Development Goal?

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The global lifetime prevalence of mental disorders is between 12.2% and 48.6 %,[1] while the burden of disease attributable to neuropsychiatric disorders is more than 13%.[2] Over 70% of this burden lies in low and middle-income countries (LAMICs)[2] and is projected to increase by 2030.[3] Traditionally, mental disorders are seen as contributing significantly to morbidity and less so to mortality. However, suicide is one of the leading causes of death globally for all ages,[4] with nearly 900 000 people taking their own lives each year.[5] Despite these staggering figures, it has been estimated that in LAMICs as many as four out of five people with a severe mental disorder will not receive any form of treatment—known as the 'treatment gap'.[6] In addition, mental disorders receive little global priority and have not received meaningful visibility, policy attention or funding.[7] The World Economic Forum has estimated that the global impact of mental disorders in the next 20 years due to lost economic output is likely to exceed US$16 trillion.[8]

Low income countries spend about 0.5% of their total health spending on mental health, and while middle income countries spend four times as much on mental health (2.4%), the percentage remains pitiful.[7] While the equivalent figure in high income countries (5.1%) is markedly higher, it does not come close to matching the actual burden of mental disorders in these countries.[7] At the policy level, as many as 44% of African countries do not even have a mental health policy while 33% do not have a mental health plan.[7] However, other regions have shown more progress, as described by Caldas de Almeida in this issue of *International Health* (p. 15).[9] Caldas de Almeida argues that while significant progress has been made in improving mental health services and in developing mental health policy in Latin America and the Caribbean, similar problems of insufficient funding, poor consensus among stakeholders and weak user and family groups exist in the region (p. 15).[9]

A not insubstantial portion of the burden of mental disorders in low-income countries is thought to be attributable to many of the failures of human development as targeted through the Millennium Development Goals (MDGs), including poverty, HIV and gender inequality.[10] The evidence on depressive disorders and depressed mood is most well developed in this respect.[9] Yet, global mental health has had difficulty making the case for its centrality across numerous MDGs[11] despite growing evidence that mental ill health and poverty interact in a negative cycle.[12] Lund et al. (p. 43)[13] provide evidence for how implementing the mental health and development model of Basic Needs, an international non-governmental organisation, improved mental health, income generation, quality of life and overall functioning among people living with severe mental illness in rural Kenya. Lund et al. (p. 43)[13] argue that their findings have important implications for integrating the treatment of mental illness with poverty alleviation programmes.

Beyond disease burden, mental health is a fundamental component of people's ability to meet their potential, to engage in meaningful relationships, and to secure and retain gainful employment. As Hanlon shows (p. 4),[14] maternal mental illness has important public health implications with as many as 16% of women experiencing a mental illness during pregnancy and 20% in the postnatal period. While the postnatal figure is high, the prevalence rate of postnatal depression in some contexts may be as high as 34%.[15] Linked to this, is the issue of gender inequality and, specifically, the association between intimate partner violence and common mental disorder. Fisher et al. (p. 29)[16] show how exposure to intimate partner violence in rural Vietnam is associated with increased symptoms of the common perinatal mental disorders of depression and anxiety. Notwithstanding the impact of mental illness on the women, maternal mental illness also has significant impacts on infant

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and child development;[17,18] effects that are often not considered but which may have an impact decades down the line.[19,20]

An important contributing factor to the treatment gap is the extent to which mental illness is stigmatised, leading to significant barriers to accessing care as well as leading to social exclusion.[21] Shidhaye and Kermode (p. 6)[22] show how, in India, stigma prevents people with a mental disorder from seeking care with the result that as little as 10% of people receive any form of evidence-based treatment. However, stigma is not simply about difficulties in accessing care, but is also a significant human rights issue—a failure to take action to mitigate one of the most common and disabling sources of human suffering worldwide.[10] The 'treatment gap' is not only a function of poor health systems and access to treatment but also of the poor detection of common mental disorders. Kagee et al. (p. 11)[23] discuss this issue of non-detection and under-detection of common mental disorders both in the community as well as in those attending public health facilities, and argue for integrating routine screening for common mental disorders into primary care.

A public health approach to mental health care, including integration with the primary health care system, as well as including integrated care of mental illness along with care of other non-communicable disorders is essential according to Farooq (p. 24).[24] However, integrating mental health care into a primary care system presupposes a certain level of health system functioning, something that may not be possible in settings with limited health infrastructure or instability, as Jordans and Tol (p. 9)[25] discuss in their commentary on mental health in post-conflict or humanitarian settings. Siriwardhana and Stewart (p. 19)[26] take up a similar theme in focussing on the implications of forced migration, prolonged internal displacement and then return migration on mental health. For Jordans and Tol (p. 9),[25] the implication is a move beyond simply measuring the impact of traumatic events on psychiatric disorders (which has been the case until now) and instead on measuring the effectiveness of interventions in these settings and how to deliver services in the context of unstable health systems. Braathen et al. (p. 38)[27] present a case study of one family affected by mental disorder in rural South Africa. They describe problems such as the lack of transport, poor formal health systems and the challenges faced in implementing interventions for mental disorders at the interface with traditional and indigenous health care.

There have been a number of recent initiatives that suggest significant movement in fostering improved care for persons with mental disorders, heightened visibility for mental health as well as increased research funding. The last decade has seen the publication of the World Health Report 2001, which focused on mental health for the first time,[28] the WHO Mental Health Policy and Service Guidance Package (2003–2005), the WHO mental health Gap Action Programme (mhGAP) (2008), the PLoS Medicine series on Packages of Care for Global Mental Health,[29] the Lancet series on Global Mental Health (2007 and 2011)[30,31] and the Grand Challenges in Global Mental Health.[32] The Department for International Development in the UK (DfID) has recently funded the Programme for Improving Mental Health Care (PRIME), which aims to generate evidence on the implementation and scaling up of integrated packages of care for priority mental disorders in primary and maternal health care contexts settings in Ethiopia, India, Nepal, South Africa and Uganda.[33] The European Union (under its Seventh Framework Programme: FP7/2007–2013) has also recently funded EMERALD (emerging mental health systems in low- and middle-income countries) that aims to improve mental health outcomes by enhancing health systems in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda. The National Institute of Mental Health in the USA has funded regional mental health 'hubs' in six geographical regions (East Asia and the Pacific; Europe and Central Asia; Latin America and the Caribbean; Middle East and North Africa; South Asia; Sub-Saharan Africa). The aim of the hubs is to expand research activities in LMICs with the goal of providing the necessary knowledge, tools and sustainable research-based strategies for use by government agencies, non-governmental organisations and health care institutions to reduce the mental health treatment gap. Finally, Grand Challenges Canada has invested heavily in global mental health this last year with two rounds of funding (total of Canadian$30 million).

In the next 5–10 years, these initiatives will provide substantial evidence about the integration of mental health care into primary care, how to enhance mental health care systems at population level and provide robust evidence about the treatment of mental illness in LAMICs. It is possible that the increased funding, visibility and advocacy around mental health leading up to 2015, coupled with the recommendations made by many of the papers in this issue, will ensure that mental health is not side-lined in future initiatives as they have been to date with regards to the MDGs[11] and non-communicable diseases.[34] Sustained advocacy for global mental health is essential to not only ensure a place at the post-MDG table, but also to ensure that millions of people living with one of the most common and disabling sources of human suffering[10] receive access to good quality care and treatment.

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