WFMH WORLD MENTAL HEALTH DAY 2021

Mental Health in an Unequal World: Together we can make a difference

WORLD FEDERATION FOR MENTAL HEALTH

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A Call to Action for World Mental Health Day 2021

ANTÓNIO MANUEL DE OLIVEIRA GUTERRES

United Nations Secretary General

UNITED NATIONS NATIONS UNIES

THE SECRETARY-GENERAL

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MESSAGE ON WORLD MENTAL HEALTH DAY 2021

10 October 2021

Around the world, the COVID-19 pandemic is taking a terrible toll on people's mental health.

Millions of people face grief over lost family members and friends. Many more are anxious over unemployment and fearful of the future. Older people may experience isolation and loneliness, while children and adolescents may feel alienated and distressed.

Without determined action, the mental health impact may last far longer than the pandemic itself.

We must act to redress the glaring inequalities exposed by the pandemic – including the inequality in access to mental health services.

In high-income countries, over 75 percent of people with depression report that they do not receive adequate care.

And in low- and middle-income countries, over 75 percent of people with mental health conditions receive no treatment at all.

This is the direct consequence of chronic under-investment, as governments spend an average of just over 2 percent of their health budgets on mental health.

This is unacceptable.

At long last, we are beginning to see recognition that there can be no health without mental health.

Member States have endorsed the World Health Organization's updated Comprehensive Mental Health Action Plan.

The United Nations family, together with partners across the global mental health community, are introducing new guidelines and developing new tools to improve mental health.

These are positive steps – but we have a long way to go.

On World Mental Health Day and every day, let us commit to work together with urgency and purpose to ensure quality mental health care for all people, everywhere.

SECTION A

A message from the president

WFMH WORLD MENTAL HEALTH DAY 2021

President's foreword

DR INGRID DANIELS

President of the World Federation for Mental Health

World Mental Health Day, a programme of the World Federation for Mental Health (WFMH), provides us with the opportunity to raise awareness about global mental health concerns, disparities, inequities and social injustices which prevail and impact on the mental health of all. The WFMH first launched World Mental Health Day in 1992 with the support of the World Health Organisation and Carter Center as active partners for this global event. World Mental Health Day creates the opportunity for everyone to call for action and advocate for an equitable mental health dispensation for all global citizens. It provides the global community with an opportunity to come together and raise our concerns and advocate for solutions and redress.

This year's theme "**Mental Health in an Unequal World: *Together we can make a difference***" was chosen by a global vote reflecting the feelings, views and concerns of the global community about the position of mental health in our world today.

Historically, mental health has been less favoured and under-prioritised creating huge treatment gaps and disparities in mental health care. Inequalities in mental health have deprived many people with a lived experience of mental disorders from living fully integrated and dignified lives. The relationship between equity and mental health is well understood however little has been done to address the inequities and disparities. The world is increasingly polarised, with the wealthy becoming wealthier while the number of people living in poverty notably increasing. The increase in poverty and its devastating social determinants for mental health has been further exacerbated by the socio-economic impact of the COVID-19 pandemic. Growing inequalities due to race and ethnicity, sexual orientation and gender identity, lack of respect for human rights and, stigma and discrimination against people with mental health conditions have created visible societal divide and injustices. Such inequalities have had a direct impact on peoples' mental health in every country.

This theme chosen for 2021 will highlight that mental health care and the inclusion of persons with mental disorders in all spheres of life remain unequal. It is a well-known fact that 75% to 95% of people with mental disorders in low- and middle-income countries are unable to access mental health care at all and access in high income countries is not much better. The COVID-19 pandemic

has exposed those social determinants of mental disorders and inequalities in our society which result in the negative consequences for mental health. Health inequities are grossly unfair and unjust often violating human rights and fails to protect of the most vulnerable. The inequalities in mental health care can no longer be ignored. We require regional, country and individual commitment to address the harm caused by the layers of systemic and historical inequalities and injustices which impact of the mental health of all.

The excellent contributions received for this year's WMHD educational materials will provide us with the necessary information, insight into the challenges and disadvantages caused by these inequalities and will assist in strengthening and recommending strategies and calls for greater equity.

All our efforts and collaboration in raising awareness on WMHD will unite us to place the spotlight on our global concerns. This is our moment to coherently create global awareness and move forward the solutions. Mental health is everyone's business and together we have a responsibility to make a significant difference and create a world where there is mental health equity, equality and social justice for all. A world in which every global citizen is protected, respected and able to live their lives with dignity.

> ***"Achieving health equity requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."*** **Robert Wood Johnson Foundation (2019)**

SECTION B

Introduction

WFMH WORLD MENTAL HEALTH DAY 2021

Mental health care for all: let's make it a reality

DÉVORA KESTEL

Director, Mental Health and Substance Use
World Health Organization

By 10 October 2021, the world will have grappled with the COVID-19 pandemic for over 18 months. Billions of people have been affected. Many people face economic turmoil, having lost their incomes and livelihoods. Countless have struggled with serious concerns about their physical health, or the health of those they love. There has been widespread fear of infection, death and loss of family members. Numerous individuals and families have been distanced from their social support networks and communities. Throughout the pandemic, we have seen the consequences of these issues on people's mental health, and each of us understands how COVID-19 has impacted our well-being.

Still, these impacts have not been evenly distributed. We know that many groups are at greater risk. Health-care and other frontline workers and first responders have been frequently exposed to complex stressors in overwhelmed systems. Children and adolescents continue to be forced to adjust to disrupted education and remote learning. People living with physical and mental health conditions have faced both disruptions in care and exacerbation of existing conditions. And people caught up in fragile humanitarian settings confront incredible adversity compounded by the pandemic. Moreover, while many countries today are experiencing slow returns to some normality, with social spaces re-opening, restrictions loosening and access to and uptake of vaccination increasing, others continue to struggle with increasing rates of transmission and overwhelmed hospitals and health systems.

COVID-19 has put the spotlight on the inequality that exists all around us. One example is the unequal access to mental health care. Across the world, far too few people have access to quality mental health services. In high-income countries, nearly 75% of people with depression report not receiving adequate care. In low- and middle-income countries, more than 75% of people with men-

tal health conditions receive no treatment at all for their condition. Despite these inequalities, governments spend on average just over 2% of their health budgets on mental health and international development assistance for mental health has never exceeded 1% of development assistance for health.

Yet, in the face of these grim realities, there remains reason for hope. Momentum is growing internationally to advance the mental health agenda and governments around the world have recognized that access to these services must be scaled up at all levels. In May 2021, this sentiment was officially expressed with the World Health Assembly's endorsement of the updated appendices of the World Health Organization's Comprehensive Mental Health Action Plan, now extended to 2030. This plan extends and builds upon the ambitious objectives laid out in its predecessor and represents a renewed commitment to take action on mental health from nations around the globe. In endorsing this updated Action Plan, Member States agreed to targets relating to expansion of service coverage, increasing the number of community-based mental health facilities and integrating mental health into primary care.

In addition, they agreed to develop and strengthen mental health services and psychosocial support as part of universal health coverage and in preparedness and response to emergencies, with a particular focus on improving the understanding and acceptance of mental health conditions, vulnerable populations and use of innovative technologies. This represents one of many powerful calls to action during the pandemic that have been made to bring about equal and universal access to mental health services for those in need. Others include those of the United Nations Secretary-General, numerous heads of state and government, UN agencies, nongovernmental organizations and countless professional associations, civil society actors, and community-based groups. The collective voice and support for mental health is loud and growing.

Fortunately, many of the tools, approaches and strategies necessary to increase access to mental health care are already available and have been shown to be effective when there is active engagement, commitment and investment. Throughout the pandemic, we have seen numerous examples of countries already taking action to improve access to quality and effective mental health services despite the challenges of COVID-19. Many have continued the upward trajectory that began well before COVID-19, sometimes many years before, to improve the mental health care available to their populations. Meanwhile, others have been motivated to act by the immense suffering brought on by the past 18 months. Throughout, innovative and scalable solutions have been developed to promote access. These initiatives represent key advances in the global effort to increase quality mental health care.

Nonetheless, there remains much work to be done. We must seize this historic opportunity for action with both hands and not let go. Mental health cannot be ignored any longer.

On World Mental Health Day, the focus on mental health is global. It is an opportunity for all those of us with responsibility for improving access to mental health care to take a critical look at what we can do better. It is a time to listen to the experiences of people from across the world who have been doing their best to take care of their mental health in the most challenging of circumstances. And it is a day to look around us and offer our support to people who are struggling.

Mental health care for all: let's make it a reality.

- World Mental Health Day 2021 website
  https://www.who.int/campaigns/world-mental-health-day/2021
- WHO Comprehensive Mental Health Action Plan 2013-2030
  https://www.who.int/publications/i/item/9789240031029
- WHO mental health website
  https://www.who.int/health-topics/mental-health#tab=tab_1

Mental health in an unequal world: Together we can make a difference

PROFESSOR GABRIEL IVBIJARO MBE JP
WFMH Secretary General

The theme for World Mental Health Day 2021 **'Mental Health in an Unequal World: Together We Can Make a Difference'** is very important because of the global challenges that we all face.

This theme was chosen by a global vote including WFMH members, stakeholders and supporters because the world is increasingly polarized, with the very wealthy becoming wealthier, and the number of people living in poverty still far too high. 2020 highlighted inequalities due to race and ethnicity, sexual orientation and gender identity, and the lack of respect for human rights in many countries, including for people living with mental health conditions. Such inequalities have an impact on people's mental health. Poverty, described by the WHO in 1995 as 'The world's most ruthless killer and the greatest cause of suffering on earth' continues. The gap between the rich and the poor continues to widen, irrespective of nation and we cannot continue to turn a blind eye.

We know that access to mental health services remains unequal, with between 75% to 95% of people with mental disorders in low- and middle-income countries unable to access mental health services at all. Access in high income countries is not much better. In addition, lack of investment in mental health is disproportionate to the overall health budget and contributes to the mental health treatment gap.

Many people with a mental illness do not receive the treatment that they are entitled to and deserve. Mental health service users together with their families and carers continue to experience stigma and discrimination. The gap between the 'haves' and the 'have nots' grows ever wider and

there is continuing unmet need in the care of people with a mental health problem.

Research evidence shows that there is a deficiency in the quality of care provided to people with a mental health problem. It can take up to 15 years before medical, social and psychological treatments for mental illness that have been shown to work in good quality research studies are delivered in everyday practice to the patients that need them.

The stigma and discrimination experienced by people who experience mental ill health not only affects that person's physical and mental health, stigma also affects their educational opportunities, current and future earning and job prospects, and their families and loved ones. This inequality needs to be addressed because it should not be allowed to continue. We all have a role to play to address these disparities and ensure that people with lived experience of mental health are fully integrated in all aspects of life.

People who experience physical illness often experience psychological distress and mental health difficulties. An example is visual impairment. Over 2.2 billion people have visual impairment worldwide, and the majority also experience anxiety and/ or depression and this is worsened for visually impaired people who experience adverse social and economic circumstances.

The COVID 19 pandemic has further highlighted the effects of inequality on health outcomes. No nation, however rich, has been fully prepared for this. The pandemic has and will continue to affect people, of all ages, in many ways: through infection and illness, sometimes resulting in death bringing bereavement to surviving family members; through the economic impact, with job losses and continued job insecurity; and with the physical distancing that can lead to social isolation.

We need to act, and act urgently.

The 2021 World Mental Health Day campaign **'Mental Health in an Unequal World'** provides an opportunity for us to focus on the issues that perpetuate mental health inequality locally and globally. We want to support civil societies to play an active role in tackling inequality in their local areas. We want to encourage researchers to share what they know about mental health inequality including practical ideas about how to tackle this.

When WFMH was formed in 1948 the world had emerged from war and was in major crisis and much of this was tackled by collaboration between WFMH, WHO, UN, UNESCO and other global stakeholders and citizens with an interest in mental health wellbeing.

We are again in the midst of another global crisis that is resulting in widening health, economic and social inequalities. The 2021 World Mental Health Day campaign provides an opportunity for us to come together and act together to highlight how inequality can be addressed to ensure people are able to enjoy good mental health.

Be a partner, be an advocate.

SECTION C

WFMH WORLD MENTAL HEALTH DAY 2021

Why child and adolescent mental health should be on all our minds

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COVID-19 illuminates the urgency of a global and population-wide approach to child and adolescent mental health. Three key ideas have converged to forge a path forward. 1) The evidence is overwhelming that early risk for lifelong poor mental health is much more widespread than previously thought. 2) The societal costs of inaction in childhood are life-lasting and substantial. 3) We are more equipped now than at any time in history to dramatically reduce risk factors in child and adolescent populations.

Children only thrive when they feel safe and protected, when family and community connections are stable, and when their basic needs are met. Poverty, Adverse Childhood Experiences (ACEs) and humanitarian crises are serious threats to this primary attachment. A dense network of relationships in the family, community, and school provides a second buffer against risk factors for mental health issues in children. This secondary attachment is important for all children and especially for those where the attachment with a primary caregiver is either absent or inconsistent.

Around the world, mental disorders among children and adolescents are far more prevalent than previously thought. Diagnosable mental health conditions affect about one in seven (14 per cent) of children and adolescents aged 6–18. A fifth of adolescents aged 12–18 have a mental health condition. Suicide is tragically claiming the lives of up to 700,000 people every year (1 person every 40 seconds) and it is the fourth leading cause of death among young people aged 15–19. And we know that half of all mental health conditions start by 14 years of age, but most cases, while treatable, go undetected and unmanaged.

Global vaccine coverage against childhood disease leaped from 20% to 80% in the 1980s and led to a dramatic reduction in child mortality. The departure point for that leap was a recognition that most child death in the world had been rendered preventable by advances in science and technology. Today we have enough evidence to recognize that many of the risk factors in childhood for poor mental health are also preventable. This is first and foremost a human and child rights and public health imperative. It also makes huge sense economically in terms of potential for productivity and learning, but also for prevention of associated costly social problems such as addiction, violence, and crime.

If we could agree on a low cost, evidence-based essential package of parenting support, we could potentially disrupt the inter-generational transmission of adversity and equip parents to protect children impacted deeply by poverty, humanitarian crises, and other severely distressing events or experiences. Such a package would include skills, problem-solving and self-awareness delivered in real time with primary caregivers and infants, starting during pregnancy and with a particular focus on the early years, and followed up at key stages during the development cycle-including adolescence. This could be reinforced by an intentional policy of building kindergarten, school and community commitments to ensure all children are seen, soothed and safe and have the conditions of connection and belonging.

To achieve these two population-level objectives and provide tailored services that support varying and often complex needs, governments should prioritise investment in mental health for children. This means investing in competent mental health and psychosocial support workforce across health, education, and social services, to leverage a whole-of-society approach to mental health prevention, promotion and treatment. On the continent of Africa, one mental health worker is available for every 100,000 citizens for example, yet we know that mental health makes up 30% of the non-fatal global disease burden according to WHO. International development assistance that prioritises mental health can also help break the cycles of conflict and instability that hinder progress.

Increased expenditure is essential. Alone, it is not enough. We also need increased conversation, trust and understanding of mental health, but also real action, particularly in many middle and low-income countries where there have been limited public conversations about mental health. We need global and community level conversations that takes away the shame, judgement and stigma, promotes understanding and knowledge, and helps communities and families understand and take action to promote child and adolescent protective factors and focus on effective family and community-based solutions.

In collaboration with partners such as WHO, UNICEF has made mental health an advocacy priority across 190 countries. We support the advocacy with concrete technical support to countries implementing policy shifts and reforms that protect the mental of children and their caregivers. For example in Ecuador, UNICEF has developed safe parenting support groups, which aim to increase awareness on the importance of preventing violence against children, as well as how to deal with anxiety and stress and how to develop safe spaces at home to talk to and support their children. We are also tackling the challenge of stigma. Following the Beirut blast in Lebanon, UNICEF prioritized child and adolescent mental health, working closely with the National Mental Health Program

(NMHP), integrating mental health into school curriculums for adolescents, as well as developing a training guide for social workers to address mental health and psychosocial needs of children, adolescents and families. UNICEF also worked with the NMHP to address stigma surrounding child and youth Mental Health, organizing eight interactive sessions with youth on coping with COVID-19- reaching an estimated 2 million people.

Alongside key partners, UNICEF played a leading role in building interagency understanding of the impacts of COVID-19 and consensus on the strategic response interventions for the protection of children and on the mental health and psychosocial wellbeing of children, caregivers, and frontline workers.

The COVID-19 pandemic has underscored just how critical mental health and well-being are for all children, adolescents, caregivers and families, in all countries. But the magnitude of the mental health burden the world faces is simply not being matched by the response it demands.

In October, building up to World Mental Health Day, we will launch our flagship *State of the World's Children Report* at the Global Mental Health Summit in Paris and will be calling on governments to:

- **Commit** to increase investment in child and adolescent mental health across all sectors, not just in health, to support a whole-of-society approach to mental health prevention, promotion and care.
- Promote **connection**, through integrating and scaling up evidence-based interventions across health, education and social protections sectors - including parenting programmes that promote responsive, nurturing caregiving and support parent and caregiver mental health; and ensuring schools support mental health through quality services and positive relationships.
- **Communicate**, by taking a leading role in breaking the silence surrounding mental health, through addressing stigmas and promoting mental health literacy, and engaging children and young people in policy and programme design and implementation.

Like the vaccine movement of the 1980s we need a focused global push to end preventable risk for all children everywhere, especially the most vulnerable. We hope many of you will join us in delivering that outcome.

In October, UNICEF will launch our flagship State of the World's Children Report, providing a comprehensive analysis and examination of child and adolescent mental health. Read the report from 5th October: http://www.unicef.org/reports/state-of-worlds-children-2021

The International Committee of the Red Cross. Mental Health and Psychosocial Support Approach

Armed conflicts, natural disasters and other emergencies have an impact on mental health and psychosocial wellbeing. Rates of mental health conditions increase extensively (Charlson et al., 2019); however, there is a gap in access to mental health and psychosocial care. The International Committee of the Red Cross (ICRC), works to ensure that people affected have access to mental healthcare that meets universally recognised standards. The ICRC aims to address mental health and psychosocial needs in an integrated manner, assessing and responding to the needs of individuals and communities in a culturally appropriate and multidisciplinary way.

Introduction

Mental health conditions are among the leading causes of ill-health and disability worldwide (Rehm & Shield, 2019). In armed conflicts and other situations of violence, these rates can increase such that prevalence rates of mental health conditions (depression, anxiety, post-traumatic stress disorder, bipolar disorder, and schizophrenia) are estimated to be 22% at any point in time in conflict-affected populations (Charlson et al., 2019). In developing countries, health systems face many challenges, which can worsen in situations of armed conflict and/or violence. Conflict also contributes to degraded living conditions, and this adds to mental health and psychosocial support needs. As a result, people affected by armed conflict and other situations of violence can develop new mental health conditions, and/or pre-existing mental health and psychosocial needs may resurface or be exacerbated.

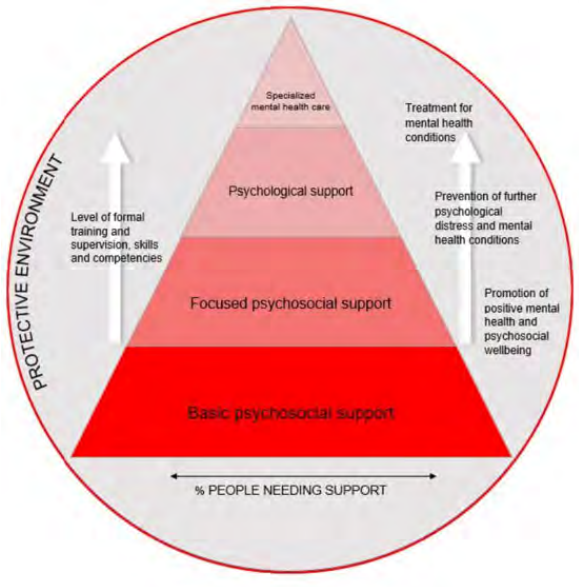
Access to mental health care is unequally divided. Research has also shown that the ratios of psychiatrists per capita in the Global North are around 10-16 per 100,000; in contrast, the numbers of psychiatrists in Africa are 0.33 per 100,000; Western Pacific around 0.32; and Southeast Asia around 0.2 (Jenkins et al., 2010). As a result, there is no equity of access.

The International Committee of the Red Cross response to mental health and psychosocial needs

The International Committee of the Red Cross (ICRC) works to ensure that people affected by conflict and other situations of violence have access to mental healthcare[1] that meets universally recognised standards. In 2020, ICRC ran over 230 mental health and psychosocial support (MHPSS) projects worldwide. These programs were adapted to support the specific needs of the people impacted by the negative effects of the COVID-19 pandemic. ICRC also developed new MHPSS support services, such as, a hotline in Gaza for people affected by COVID-19.

The ICRC MHPSS teams operate under a set of established guidelines (ICRC, 2017). The guidelines provide an organisational framework to implement a combination of international evidence-based mental health recommendations with best practices from the expertise of ICRC working in various contexts of armed conflict and other situations of violence around the world.

The ICRC aims to address psychological and psychosocial needs, promote coping mechanisms, increase functioning and decrease psychological distress. MHPSS teams work in an integrated way to address the needs at individual, family and community levels. Using this aim, in December 2019, a Movement-wide MHPSS Policy was adopted at the 33rd International Conference [2] of the International Red Cross and Red Crescent Movement[3]. This Policy provides a framework for MHPSS work and differentiates between basic psychosocial, focused psychosocial, psychological support and specialized mental health care. See *Figure 1* for the framework. The framework encompasses the continuum of care from social support to psychiatric support, adapting the interventions at each level.



Specialized mental health care – the top layer of the pyramid – includes specialized clinical care and treatment for individuals with chronic mental health conditions and for persons suffering such severe distress and over such a period of time that they have difficulty coping in their daily lives. Examples of activities include treatment centres for survivors of torture and alternative approaches to drug therapy. Services are provided within State health-care and social welfare systems and in detention facilities.

Psychological support – the third layer of the pyramid – includes prevention and treatment activities for individuals and families who present with more complicated psychological distress and for people at risk of developing mental health conditions. Examples of activities include basic psychological interventions, such as counselling or psychotherapy, which are usually provided in health-care facilities with accompanying outreach work or in community facilities, where this is culturally acceptable.

Focused psychosocial support – the second layer – includes promotion of positive mental health and psychosocial wellbeing and prevention activities, with a specific focus on groups, families and individuals at risk. Examples of activities include peer support and group work. Focused psychosocial support can be provided by trained and supervised Red Cross and Red Crescent staff and volunteers and/or trained community members.

Basic psychosocial support – the first layer of the pyramid – promotes positive mental health and psychosocial wellbeing, resilience, social interaction and social cohesion activities within communities. Activities in this layer are often integrated into health, protection and education sectors and should be accessible to 100% of the affected population, where possible. Examples of activities include psychological first aid (PFA) and recreational activities. Basic psychosocial support can be provided by trained Red Cross and Red Crescent staff and volunteers and/or trained community members.

Figure 1: The Movement's mental health and psychosocial support framework (International Red Cross and Red Crescent Movement, 2019)

The ICRC ensures programs are adapted to the cultural contexts and have a multidisciplinary

approach. This approach is achieved by regularly consulting the affected individuals and communities in order to better determine their needs and interests. This approach ensures that the activities are adapted to the local culture and delivered in a manner that promotes dignity, and respects religious and cultural practices. ICRC works in a multidisciplinary way with other ICRC services, such as primary health care, hospital services, physical rehabilitation, first aid and pre-hospital services, healthcare in detention, water and habitat, weapons contamination, and economic security. As a result of the ICRC mandate, MHPSS also works together with protection teams that foster prevention activities and the implementation of international humanitarian law (IHL). The ICRC's MHPSS programs aim to build local capacities by training community stakeholders, resident psychologists and/or other mental health practitioners, depending on the context. ICRC's focus is on training, supervision, follow-up, monitoring and evaluation to ensure capacity building of national resources and workforce and sustainability after ICRC leaves the context.

Mental health and psychosocial support programmes: healing the hidden wounds

The ICRC's mental health and psychosocial support projects respond to the needs of different groups affected by armed conflict and other situations of violence. These groups include people affected by emergencies; victims of violence, including sexual violence and children; families of missing persons; helpers (people in frontline humanitarian positions); people who are hospitalised with weapon-wounds and/or physical disabilities; and people deprived of their liberty and/or former detainees. Individuals across these groups present various mental health and psychosocial consequences of violence. For example, trauma-related symptoms from being directly injured or due to exposure to violence, or psychological distress such as symptoms of depression and anxiety. It can also affect community functioning by decreasing the availability of services, resources and support.

Violence can also be used by armed groups with the intention of spreading fear, creating an environment of chaos, and breaking down community cohesion. Affected individuals can feel emotionally and socially isolated; they may also feel that no-one understands their suffering and that they are unable to reach out for help. In many contexts, mental health and psychosocial needs are not well understood and as a result people can face rejection, discrimination and stigmatization. This makes it difficult for them to get the assistance they need and leaves them more vulnerable to further ill-treatment.

The ICRC has developed mental health and psychosocial projects according to the MHPSS framework:

- Mental health activities: – basic psychological support (individual and group) – psychotherapeutic support (individual and group) – specialized care and referrals
- Psychosocial support activities: – psychosocial group activities – information and sensitisation activities – referral pathways

Conclusion

Although MHPSS needs have gained more prominence in recent years, there remains a large gap between the needs and the access to care provided worldwide (WHO, 2017). The ICRC aims to reduce this gap by building local capacities, with a view to stabilising and improving the mental health and psychosocial well-being of individuals and communities. In 2020, ICRC MHPSS projects reached more than 554,000 beneficiaries globally.

Note: The ICRC's Guidelines on Mental Health and Psychosocial Support are available from the ICRC's online shop. They can be downloaded free in English, French Arabic, Spanish, Russian and Portuguese.

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Notes

1. The ICRC uses the term "mental health" to denote psychological well-being. Mental health interventions aim to improve psychological well-being by reducing levels of psychological distress, improving daily functioning and ensuring effective coping strategies. Such interventions are overseen by a mental health professional and target individuals, families and/or groups.
2. The International Conference is a global forum that highlights dialogue and partnership between the ICRC, the Federation and all National Societies and States Parties to the Geneva Conventions. During this time, humanitarian issues of common interest are discussed and decided together.
3. The International Red Cross and Red Crescent Movement comprises the ICRC, the International Federation of the Red Cross (IFRC) and the National Societies around the world.

Delivering Mental Health in an Unequal World – Making NGO's Matter

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Introduction

Non-governmental organisations (NGOs)[1] have played a significant role in providing mental health services often in dire socio-economic conditions and resource poor communities where poverty levels are alarming. Mental Health NGOs are either constituted as formal or informal organisations and are regulated under various legal frameworks. Even though no accurate data is available regarding the number of NGOs on the African continent, their work remains vital particularly since their parallel interventions to address mental health needs within communities have also focused on providing interventions to address the social determinants of mental health and community development. These NGOs have for many years filled the gap and provided mental health interventions where governments have failed to intervene to ensure that access to mental health care is made available.

Mental Health NGOs are largely driven by their mission, vision and objectives and human rights approaches to ensure equity and social justice to the most marginalised and vulnerable people. Their role has often been to challenge the inequalities, lack of access and limited investment in mental health and to hold governments responsible to ensure equality in care. They are often formed voluntarily by ordinary people, parents and others when gaps in mental health services, neglect in care, discrimination and violations against those with mental health needs are perpetrated.

Effective paradigm shifts in providing accessible bio-psychosocial community-based interventions can only be achieved by working strategically in an integrated mental health services delivery model, which includes strategic partnership arrangements with NGOs. NGOs are also able to engage easily and respectfully with service users, carers, traditional healers and community leaders/struc-

tures required to implement effective multi-sectoral approaches to integrate and sustain community-based mental health programmes.

Regulatory Framework

Most formal NGOs are legally constituted and regulated according to every country's specific legal requirements and frameworks. Even though they operate independently, they are governed by and function under government departments such as those of social development, welfare (or both) and health.

In South Africa, a non-profit organisation (NPO), also known as an NGO, is registered with the Non-profit Directorate and regulated by the South African Non-profit Organisations Act No. 71 of 1997. [1]. The Act defines a non-profit organisation as "a trust, company or other association of persons – established for a public purpose; and the income and property of which are not distributable to its members or office-bearers except as reasonable compensation for services rendered" (RSA Non-profit Organisations Act No. 71 of 1997, p. 2).

Organisations operating within this legal framework are part of civil society and are established not-for-profit or gain. NGOs function independently, but may deliver essential humanitarian services on behalf of, and in partnership with, State entities and may or may not receive State subsidies. These subsidies generally provide partial funding and do not necessarily consider annual inflationary escalations, resulting in the NGOs having to carry the cost and financial burden for the implementation of the mental health and other services. In South Africa, the value of these subsidies varies from one provincial department to another and is inconsistently allocated. However, many NGOs across Africa operate with little State support, if any.

Role of Mental Health NGOs in Providing Mental Health Care

Mental health NGOs play a significant role in implementing community-based mental health services. A national study conducted in 2018 explored the perceptions about NGOs as critical partners for mental health provision [2]. The study, which recruited social workers from the 17 mental health NGOs affiliated with the South African Federation for Mental Health noted the following as shown in Figure 1.

Figure 1: NGOs as Critical Partners in Mental Health Service Provision

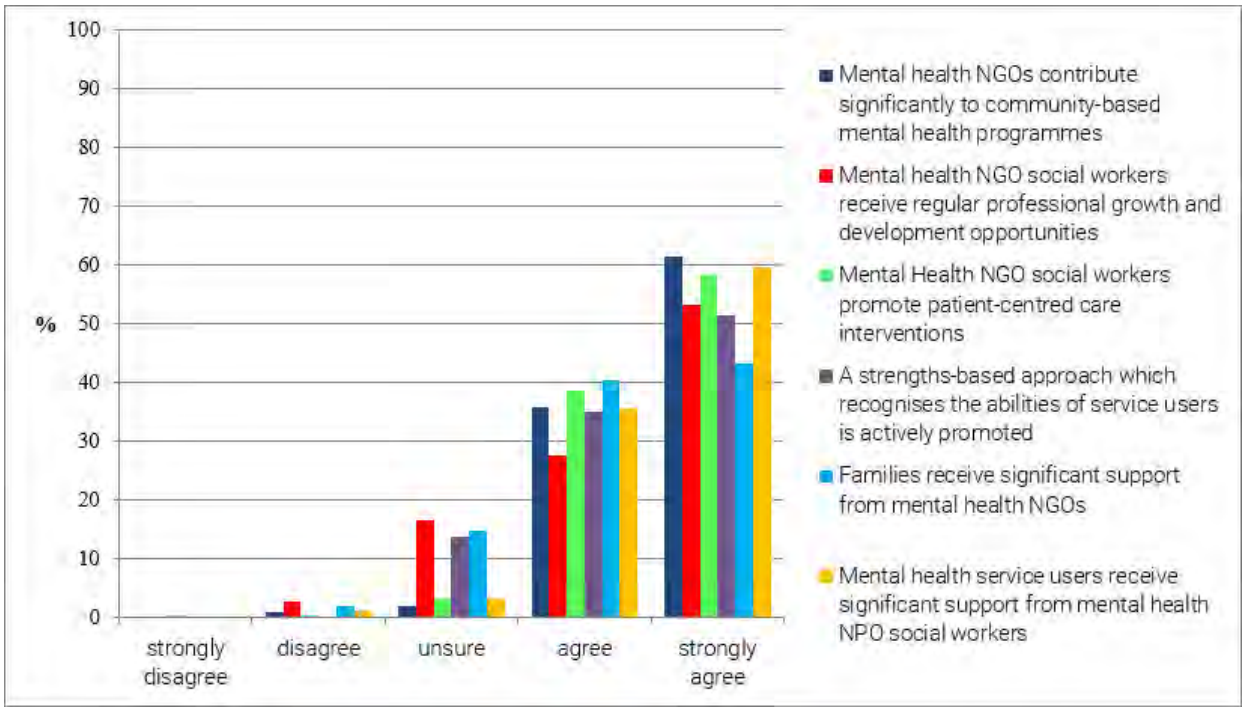

Figure 1, highlights that the majority of social workers (97.3%, n=106) agreed that mental health NGOs contribute significantly to community-based mental health programmes. It also indicates that the majority of social workers (96.8%, n=106) agreed that social workers actively promote patient-centred care interventions, whilst 86.3% (n=94) agreed that a strengths-based approach, which recognises the abilities of service users, is actively promoted.

Mental health social work practice focuses less on the diagnosis, problems and limitations associated with the condition and more on functional abilities and supportive interventions - a practice which identifies and strengthens abilities and capabilities. In so doing, this links the abilities of users with opportunities for recovery and reintegration. Hensley [3] stated that "Adherence to patient-centred care has also been associated with higher satisfaction and in some cases better outcomes in terms of patients' experience of physical symptoms and adherence to care regimens" (p. 135). Patient-centred or user-centred care places the mental health service user at the centre of the intervention and fosters empowerment, respect, joint decision-making and dignity for the user, despite their diagnosis, educational level and social circumstances.

Figure. 1 above shows that the majority of social workers (88.5%, n=91) agreed that families of mental health service users received significant support from mental health NGOs, whilst a majority (94.9%, n=103) agreed that mental health service users received significant support from their social workers.

Pathways to Care

Mental health NGOs play a vital and significant role in the expansion and delivery of community-based mental health interventions. The service delivery objectives of these organisations include the ideal of comprehensive community-based mental health services but a lack of funding constrains their interventions. NGOs tend to focus mainly on counselling, mental health awareness and promotion, and running protective workshops. As shown in Table 1, mental health NGO initiatives in Africa are wide ranging including mental health advocacy, education, promotion, livelihood and community-based treatment and prevention.

Table 1: Selected Mental Health NGO Initiatives in Africa

- Co-ordinating community mental health volunteers and "grandmother" counsellors;
- Selecting, training and supervising peer counsellors;
- Implementing Psychosocial Rehabilitation groups in districts/communities;
- Collaborating with non-specialist health workers, traditional structures, village committees and primary health care clinics;
- Training other NPOs working in resource-poor communities to provide counselling and other psycho-social interventions with back-up tele-mental health social work and or Skype support to these NGOs;
- Strengthening advocacy groups and empowerment networks;
- Providing public education and awareness campaigns in partnership with service user advocacy bodies – these could be initiated through school awareness programmes, embedding mental health in the Life Orientation Curriculum, Mental Health Apps, radio, talking books, mobile clinics and other awareness strategies;
- Offering MindMatters Programmes –comprehensive whole-school mental health intervention and prevention programmes;
- Engaging in lobbying and advocacy for the rights of service users;
- Collaborating with other State or NPOs to ensure holistic service provision;
- Improving collaboration with the police and justice system;
- Initiating collaborative poverty alleviation and food sustainability projects with Agri partners
- Facilitating employment opportunities through self-employment initiatives, supported employment, Learnerships, transitional employment and independent initiatives;
- Participating in district and provincial multi-sectoral mental health structures to co-ordinate mental health services.

The aforementioned initiatives are delivered in dynamic, rich and inclusive intervention expansion models tailored for limited-resource settings.

NGOs have greater flexibility to design and develop best practice innovative mental health services and are not limited by the bureaucracy that is characteristic of State entities. Within these path-

ways of care, good practices have emerged to upscale and increase access to mental health particularly during the COVID-19 pandemic. Cape Mental Health, the oldest mental health NGO based in Cape Town, South Africa is one such organisation where innovative practice to increase access to resource poor communities has excelled in this regard.

Despite the challenges and initial dislocations in social and health care critical best practice interventions have emerged. The pandemic created the opportunity to shift, reinvent and reorganise the way in which Cape Mental Health provided mental health care from facility to home and face to face counselling to virtual interventions to retain contact, reduce isolation and continue virtual interactions with beneficiaries and all who required mental health support. Cellular phone applications, virtual IT technology and other platforms became vital tools for migrating daily mental health services remotely to over 6000 beneficiaries. Online counselling, COVID-19 crisis and case management were provided by a dedicated team of social workers. Another example of the daily virtual activations, at Special Education and Care Centres for children with severe and profound intellectual disability, were identified as a best practice mental health innovation during the COVID-19 pandemic by the Mental Health Innovations Network [4]. Interventions by social and health professionals need to be revised and an exchange on further innovative alternatives stimulated to address some of the huge inequalities.

Another best practice intervention is the Zimbabwean Friendship Bench Project, a mental health innovation provided by lay "grandmother counsellors" also known as "gogos" who provided mental health problem-solving interventions on village or park benches outside primary health care (PHC) clinics to over 27 000 individuals with common mental disorders. These are offered mostly to individuals who would ordinarily not seek assistance. This low-cost intervention has been highly successful, consistent with evidence from a study by Chibanda and colleagues [5] that found that "Patients with depression or anxiety who received problem-solving therapy through the Friendship Bench were more than three times less likely to have symptoms of depression after six months, compared to patients who received standard care" (p. 2618).

Conclusion

It is apparent that neither State departments nor mental health civil society organisations are able to provide comprehensive mental health services as independent entities. Multi-sectoral district-based mental health approaches are required to co-ordinate and include all role players, particularly mental health service users, in mental health service delivery to effectively address the injustices in mental health. This would bring together both medical as well as social approaches to care, thus supporting integrated comprehensive community-based models that underpin recovery in mental health [6]. Mental health NGOs evidently contribute significantly to community-based mental health programmes and contribute a wealth of innovative interventions that promote patient-centred care and strengths-based approaches. Their interventions are culturally-sensitive and tailor-made to the context of local communities and cultures. Their interventions are often multipurpose and cost effective in addressing the inequalities and social injustices experience by

people with the lived experience.

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Delivering Mental Health in an Unequal World - Making NGO's Matter – Some case examples

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KEY MESSAGES

- Globally, inequalities in funding mean that many people lack access to mental health services which meet their needs, and COVID-19 has increased demand for services in non-healthcare settings.
- MHNGOs address these inequalities by expanding access to person-centred services in innovative ways and new settings, by contributing to research and by advocating for change.
- Lived experience, peer support and collaborative partnerships are drivers of NGO innovation and success in expanding access, meeting service user needs, conducting research which is relevant to service users and advocating for equality.

Introduction

Around the world, many people lack access to quality mental health services which meet their needs and respect their dignity and human rights [1]. Mental health attracts less than 2% of global health expenditure and there is shocking inequality between high- and low-middle-income countries (LMIC), who spend less than $2 per person annually, mostly on psychiatric institutions[2]. This inequality results in shamefully high treatment gaps for easily treatable disorders[3] owing to a lack of healthcare professionals, poor access to services and an over-reliance on a biological model of mental healthcare, when what is most effective and efficient is an integrated and collaborative approach[4]. Access to services is not the only issue. Stigma prevents many people from seeking help from traditional mental health services, especially in LMIC [5], and results in fewer people

choosing to train as mental healthcare professionals[6].

NGOs harness the power of lived experience and civil engagement to address inequalities by expanding access to innovative person-centred services and advocating for change in policy and public attitudes. NGOs are defined as citizen organizations which aren't motivated by profit[7], including social enterprises[8] which seek profits to reinvest in social purpose. NGOs can act as[7]: 1) Implementers, providing services; 2) Partners with government or private sector to provide services; 3) Catalysts, driving change through advocacy. NGOs are values-driven and more trusted by the public than government or private enterprise to do the right thing and work to improve society[9], including acting to alleviate the social determinants of mental ill-health[10].

Globally, mental health NGOs (MHNGOs) have developed effective community-based services which increase access[5, 11, 12] and launched person-centred treatment alternatives which have "recrafted a new narrative for mental health"[13]. COVID-19 has further increased the demand for services in non-mental health settings[14] such as schools and workplaces, which are being met by MHNGOs and innovative social enterprises. MHNGOs are free from political or corporate obligations to act as catalysts, advocating for what is just[15] and MHNGO staff have been found to have less desire for social distance than health professionals and the public[16]. NGOs, including MHNGOs, are increasingly contributing to medical research which is more equitable and relevant[17], which will improve healthcare quality and access, shape policy and increase the voice of service users.

This article discusses five international case studies which illustrate how MHNGOs matter, now more than ever.

Case Study: Bearapy

Enoch Li, Managing Director

Bearapy is an award-winning consulting and training social enterprise, with a Mission to promote workplace mental health as a strategic goal and upskill executives and teams in mental wellbeing applications. Our business revenue funds social impact in the community, particularly in China and Asia-Pacific. Everyone on the team has lived experience of a mental health condition, or of caring for or supporting someone who does. This is essential in running effective training, sharing experiences and enabling conversations about the issues.

When we founded Bearapy, "mental wellbeing" was not yet recognized being as important as it is today. The rhetoric was about illness and mainly discussed by medical professionals. I wanted to change mindsets and behaviours, and approach it as education and prevention, not treatment. I wanted the private sector to take responsibility and act. This meant changing company culture and leadership styles. I wanted to have budget control, instead of writing fundraising proposals. So, I applied consulting firm approaches in change management, company culture and team collaboration to workplace mental health, and brought playfulness into the delivery. I also brought the hu-

man side; having lived through depression and suicide attempts.

Our major challenge is creating market demand – many companies don't think about the significance of employee wellbeing and aren't willing to find budget. Another challenge is finding social impact investment that is not tech focused, which is still nascent in China. However, since inception, we have upskilled thousands of executives in companies, start-ups, and governmental organizations in workplace mental health skills, and advised senior leaders on strategic approaches to overhaul mental health initiatives in their organisations. Feedback shows that our sessions are having a real impact on employee engagement with mental health in the workplace:

> *"Your talk was a wake up call and an eye-opener. Straight after, I asked HR if I could attend the Mental Health First Aiders training. I want to help those around me and help me as well remain mentally healthy."*

Our social impact work relies on our committed volunteers and involves thought advocacy through conferences, talks, media and collaboration with other organizations – this is our soul, made possible by the revenue we generate. Together, these two elements mobilize the change we want to see.

http://bearapy.me/

Case Study: The World Dignity Project

Claire Brooks, Co-Founder, Research Director

The World Dignity Project is a global NGO whose mission is to ensure equality of treatment and dignity in service user experience for those with a mental health condition. 'Dignity' is in common use in mental health services but is hard to define because of its complexity [18] and patient dignity remains 'understudied' [19]. Worldwide, patient dignity is undermined by stigmatising behavior from healthcare professionals and by other aspects of the mental health patient experience [20-22].

To highlight this shocking situation, Professor Gabriel Ivbijaro launched the World Dignity Project in 2015, by proposing a Taxonomy of Dignity from a Service User Perspective[23] (https://theworld-dignityproject.org/research/) and unveiling the first global symbol for Dignity in mental health [24].

The taxonomy of dignity was developed specifically and uniquely to inspire the symbol design process, by describing the different narratives, including the emotional responses and social processes which mental healthcare workers, patients and care-givers associate with dignity in mental health and identified three core narrative components:

1. Embrace Me. This narrative has an external perspective: how others see and treat me.

2. Journey of Hope. This narrative has an internal perspective: how I see myself and approach my mental health condition.

3. Universal Dignity. This narrative reflects the idea of human dignity embodied in the Universal Declaration of Human Rights.

Further research has been conducted to define the aspects of service user experience which contribute to or violate dignity, and a global Strategic Empathy®[25] project, which will involve healthcare professional and service user in co-creation of patient experience guidelines, will rollout in 2022.

The World Dignity Project is a coalition of volunteers including individuals with lived experience, mental health professionals, academics and civic leaders. Our goals are:

- Driving public awareness of the importance of dignity for mental health service users and encourage wider discussion around mental health and stigma, by gaining visibility for the Dignity symbol and what it means.
- Helping mental health professionals to tackle self-stigma and promote dignity by increasing understanding of the service user experience through research, scientific publications and contributing to Continuing Professional Development through events such as the joint conference with the WFMH in June 2022 (https://www.wfmh2022.com/).
- Engaging policy makers and influencing them by contributing to advocacy efforts such as World Mental Health Day.

To join the movement, go to: http://theworlddignityproject.org/

#WhatisDignity?

Case Study: Mental Health America

Kelly Davis, Associate Vice President of Peer and Youth Advocacy

Founded in 1909 by Clifford W. Beers, Mental Health America (https://www.mhanational.org/) is the United States' leading community-based nonprofit dedicated to addressing the needs of those living with mental illness and promoting the overall mental health of all. During his stays in public and private institutions, Beers witnessed and was subjected to horrible abuse and started a reform movement based on his lived experience. Guided by our history of lived experience leadership, peer support has been a critical resource and is essential to our work as an organization. Among our initiatives, we focus on expanding access to peer support through our programs, policy advocacy, and local organizations.

Similar to Beers, I had access to a number of mental health resources and spent much of my early life trying to figure out what was "wrong" with me. After a decade, I was diagnosed with Bipolar Disorder and given the message: "*Lower your expectations for your life and keep your mental health challenges to yourself.*" It was not until I connected with people in the peer support community that

I learned that these messages did not have to be true.

Peer supporters are people with lived experience of mental health conditions and/or substance use disorders who receive training to support others in living the lives they want. Research shows that peer support improves hope, social connection, empowerment and self-care, and reduces depression, substance use, and hospitalizations[26]. The peer support movement taught me that I could advocate for my needs and take steps to support my wellbeing in community with others. I was not alone or ashamed but part of a movement of people using their challenges to make the world better for others.

We must rethink mental health services. People with lived experience tell us that a medical model focused on individual-level interventions does not meet their needs. Peers, peer supporters, and peer-run organisations must be central to how we build solutions. Leaders must invest in peer support skills training, creating community-based models of care which integrate peer specialists. It is a pivotal time for how we invest in wellbeing for all. Lived experience must be the starting point for how we build a better way.

Case Study: Phoenix Health and Wellbeing

Gill Trevor, Founder and Director

Phoenix Health and Wellbeing (https://www.phoenixhealthandwellbeing.org.uk/) is a charity and social enterprise based in West Yorkshire, UK. It was set up in 2013 to make complementary therapies accessible to people with low incomes and chronic mental and physical health issues.

As a marketing executive who retrained as a therapist and then volunteered in care homes, founder Gill Trevor saw that complementary therapies are powerful in improving quality of life, but individuals on low incomes can't access them. Phoenix Health and Wellbeing offers therapeutic support on a sliding scale with contributions of £5-30. Phoenix now supports about 400 people per year, referred to us by healthcare professionals, who register with us and form a receptive market for other services.

Phoenix can provide subsidised support by generating revenue via social enterprise to cover costs. Roughly 90% of income is derived from social enterprise with the remainder coming from fund-raising events and donations. Our social enterprise offers the same complementary therapies as our charitable service and also offers workplace wellbeing and stress management programmes. The management team includes people with lived experience of mental health issues.

Phoenix does not receive statutory or grant funding, which enables the management team to be dynamic, introducing new services and products without time-consuming commissioning meetings. It does however mean that our existence is dependent upon the success of our social enterprise. This weakness became evident in the current pandemic. In Lockdown 1 we had to close our premises. At that time all of our services were provided face to face, so our income stopped virtually

overnight. We quickly introduced online services for counselling and stress management which continue to be very popular and now form a part of our standard service offering.

Now we are looking for a financial investor to enable us to take the next leap. It is a delicate balance to grow commercially without losing sight of the very people who we are here to support but we feel that involving all stakeholders will enable this. Indeed, we are confident, having recently received a Queen's Award for Enterprise, that we will be an attractive proposition to investors.

Case Study: iFred

Kathryn Goetzke, Founder

iFred is a nonprofit dedicated to shining a positive light on mental health through stigma prevention, research and education. Kathryn Goetzke started iFred in honor of her late father who died by suicide when she was a freshman in college, and to understand her own lived experience with PTSD, ADHD, depression, anxiety, addiction, and a suicide attempt.

iFred's focus is eradicating mental health stigma by using the framework of moving from hopelessness (despair and helplessness) to hope (positive feelings and inspired actions). Hopelessness is a predictor of suicide and a primary symptom of depression and anxiety. Higher levels of hope correspond to decreased anxiety and depression, greater psychological wellbeing, improved academic performance and enhanced personal relationships. By teaching hope skills to children, teens and adults, iFred enables people to live more successful, happy lives.

iFred's *Hopeful Minds* program has reached nearly 250,000 children globally through free, downloadable curriculums (https://hopefulminds.org/). A study by Ulster University found that the program has a significant positive impact on child and adolescent wellbeing and a range of protective factors against mental ill-health and suicide[27]. Hope has been demonstrated to be a robust source of resilience to anxiety and stress, and there is evidence that hope may function as a transdiagnostic mechanism of change in psychotherapy[28].

Partners are key to the effectiveness of *Hopeful Minds* because without strong partnerships, NGOs can easily fall apart when the Founder steps away. Also key, is working on prevention as much as intervention. If we wait until a person is in a major depressive episode, the cost of treatment is much greater.

Mental health, and hope, are human rights. We must work collectively to ensure all have access to care.

Conclusions

MHNGOs, including social enterprises, play an essential role in addressing inequalities of access

to mental health services that meet service user needs in innovative ways and in non-healthcare settings. MHNGOs also play a critical role in relevant and effective mental health research and advocacy. The case studies demonstrate that the passion and understanding of service user needs that comes from lived experience, peer support and collaborative partnerships drives innovation and success. However funding and social investment are an even greater challenge as the world emerges from the pandemic.

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Supporting young people and promoting their self-esteem during the covid 19 pandemic

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KEY MESSAGES

- Let's characterize the pandemic as a health, education, social and economic crisis to force a mindset change in the way we view what we have all survived, whilst not forgetting those that did not.
- Let's stop running down the tremendous efforts made by all students whether in schools, further education or higher education during what has been an unprecedented crisis, which has disproportionately hit sections of our communities. Instead, let's celebrate, motivate, and inspire our children, our relatives, our future, as in one way or another, we will all become dependent on them for our very own futures.
- Let's take the opportunities that have resulted from covid to reassess what we do, how we do it and, for what purpose. Excellence takes many forms, so let's evolve our systems, processes and practices to accommodate excellence whilst maintaining quality and standards.

Equality, fairness and opportunity have to be central to developing our young people in order to address existing inequalities and their effects on young people's mental health wellbeing. World Mental Health Day 2021 'Mental Health in an Unequal World: Together we can make a difference,' provides an opportunity for us to consider how we might achieve this.

COVID 19 has had differential effects on different age groups and has imposed many additional challenges on for young people and their teachers, accentuating educational inequalities that have existed over the last 50 years.

Young people are not only having to cope with having limited access to the education, they are also having to cope with the anxiety of the effects of so called 'grade inflation' on their life prospects

and its potential to further devalue the success that they have managed to achieve during the period of the pandemic.

The closure of schools is known to have a negative impact on children, and the impact is worsened where there is socio-economic disadvantage (Cooper et al 1996; Meyers and Thomasson 2017; Tsai S-L et al 2017). So why should young people who have already suffered school closure and it's consequences now have to worry about their certificates and achievements being devalued by applying the pejorative concept of so called 'grade inflation' when instead we should be celebrating young people's resilience during this difficult time.

So called 'Grade Inflation' – does it really exist?

Lockdowns and pandemic restrictions on schooling have led to fears of a 'lost generation': pupils who have missed out on the minimum of expected contact time, guided learning, classroom activities, interactions and opportunities to be assessed on learning, as well as the all-important support and motivation from teachers and each other. Young people have experienced two years of disruption, isolation, and a creeping sense of being the exceptions; a so-called, special group. Special cases who can't be considered to have covered the same extent of the curriculum as previous bodies of students.

Now there are increasing question marks awash in the media over the comparable value of school qualifications being awarded with other years. Can universities — or even employers — be certain of how Covid-19 era grades compare? Is comparison even fair or real? The sheer level of variability involved is a shock to the whole education system. It means passing on the challenge of 'lost' learning to FE, HE and potentially also to employers. Not doing so, may impact a future economy.

The major issue here is what the questioning and uncertainty does to social mobility. Access for all to education has been intended to be the gateway to a free flow of opportunities: a level playing field that, at least in principle, allows for the creation of a more representative and inclusive society. It will be the schoolchildren from disadvantaged backgrounds who will feel the greatest effects from disruption, whose confidence will be most damaged, who struggled with home learning, who won't be able to fill in the gaps in learning with tutors and other ways of bolstering the appearance of CVs with valuable content. These are the students that are most likely to question their own ability and treat any setback or new barrier to higher study at university as confirmation of their lack of potential. In turn, this has the potential to be a mental scar for the longer-term, as a thorn of demotivation.

There is likely to be a fundamental impact on the self-esteem of young people from this situation. For most of us, it's the education system that delivers our sense of achievement, progress, recognition and self-worth, all the way through to adulthood, with reassurance of comparability from one year to another. Instead learning, and gaps in learning, have become a source of anxiety and increased pressure on the need for 'catch up', for more intensity and alertness to what might be missing and how less 'rounded' one may be, when compared to those before. Doubts, interruptions

and any downgrading to this process of character-shaping are a problem for mental wellbeing, already made fragile by the pressures of social media and consumer culture. We already live-in societies which encourage the idea of instant celebrity, quick fixes that lead to fame and glamour, rather than the day-to-day effort of learning. It's already hard enough in this context to persuade young people of the need to invest in themselves.

In the UK, in particular, where grades were this year based solely on teacher assessment, there is now also the accusation of so called 'grade inflation'. In August 2021, a record-breaking 44.8% of A-levels were awarded the highest A* or A grade, compared with 25.5% in 2019; where a different system of awarding grades was used. Among media and the public there has been an acceptance and assumption amongst many that the results are just the product of unreliable, preferential teacher assessments of their students' capabilities. For many of course, there is a view that those best placed to offer a fair and accurate assessment, did so, in the form of Teacher Assessed Grades (TAGs).

Plans for curbing so called 'grade inflation' have already been put in place by the UK government, which expects new leadership for the changes to come from a new head of the national qualifications regulation body Ofqual and through broader consultation.

But is there really such a thing as grade inflation? Perhaps it's just an oversimplified term used to describe a complex issue that has been solved with a relatively simple intervention. Nevertheless, the question remains 'How could there be grade inflation when there has been no consistent year-on-year baseline to make comparisons from?'. 'Inflation' as a concept only works when there is a clear, transparent point of comparison — like last month's or last year's prices or values.

A-levels in the UK have been a state of flux for many years. The exams have been updated and re-structured, with tranches of new versions of subject exams released in 2017, 2018 and 2019. Four years' ago A-level students were used to a modular structure and coursework as the norm, with AS levels contributing to final grades. In 2017 there was the beginning of the changes to where most courses would be assessed by exams (a maximum of 20% coursework for the exceptions).

Then in the first year of Covid-19 in 2020, came the sudden need for a way to replace exams with Centre Assessment Grades (CAGs), the use of an algorithm combining previous attainment with teacher assessment to determine likely exam results. After a backlash from schools, colleges, students and parents and, the threat of legal action, this year saw the reliance on TAGs. It is clear that the only consistency, has been changes in grade definition and how these definitions have been determined.

So there's no actual basis to make judgments about inflation. Indeed, I profess that the term is itself not only unhelpful and misleading but incorrect. You certainly wouldn't be able to character economic inflation in this way so, why should education be any different? But it's too late, as the term has been hijacked by the popular press and, those seeking to undermine educational attainment and, does little other than undervalue all the hard work of our next generation. A mis-use of the term 'grade inflation' has now become commonly accepted parlance for talking about the period. And it's derogatory and insulting to students and to the teaching profession who have done

their best to support and work with students in schools and colleges through extraordinary times. There is now the prospect of a return to exams (in some form) and a major re-adjustment or 'grade deflation' as it will no doubt be characterized. Leaving a generation of young people with questions and questionable results.

However, if there is more Covid-19 induced disruption — or even no exams again in 2022 — then the Higher Education sector will be looking at applications from a whole year of students who have never sat a formal, national exam. There will be a generation that missed out on both GCSEs as well as during A-levels. Universities continue to be on the receiving end of the reforms and revisions. To make sure we're being fair, continuing to support the flow of social mobility and help with transitions, there must be confidence in exam results in FE, HE and among employers. But the constant changes to the nature of A-levels and likely results have made planning for admissions very difficult, and the need for multiple budgetary scenarios as a result. Higher grades have led to crises for some university admissions offices in the UK: the need to reduce numbers of undergraduates and to encourage deferrals on certain courses, where there are either student number caps or limitations in terms of physical resources (space or even teaching staff). One institution, for example, is offering to pay students £10,000 and their campus accommodation for a year, if they defer entry.

A great deal of work is also passed on to HE in terms of support for levelling up and the transition to higher study. Universities have the responsibility of ensuring all students have the same foundation of subject knowledge (which is now very much *not* a given, given the Covid-19 and isolation issues). They need to play an active role in giving students the confidence and tools to catch up or simply refresh their skills; and support students via an extended induction, to meet their peers, socialise and adjust to the particular social norms of university student life. Consequently, there are new and greater demands on university planning and resources, new schemes, activities and calls on staff time.

The risk is that universities resort to introduce localised forms of assessment where there is a loss of grade-quality confidence, to take their own, firmer grip on admissions and to support student number planning. This would however, only undermine A-levels still further and the biggest impact being amongst non-traditional students. These kinds of tests are normally based on psychometrics that disadvantage students from a non-selective route who are unused to the principles involved and the specific type of test experience. Unlike their peers from more affluent backgrounds they are unable to afford paid support for preparation and coaching. Unfamiliar testing just acts another barrier to people who may already be feeling fragile when it comes to their attitude to their abilities and potential — providing another reason to opt for an easier or what they see as a more 'suitable' route into work. There is evidence from the introduction of tougher GCSE exams since 2017 of the disproportionate impact on pupils from disadvantaged backgrounds. Work by Professor Smithers, director of the Centre for Education and Employment Research at Buckingham University, has pointed to how 'lower-ability candidates' have been more likely to "select themselves out" of A-level options after finding the revised GCSEs too challenging.

A nationwide, standard model of assessment for school-leavers is a platform for encouraging social equality. Because it's the students from disadvantaged backgrounds who find new assess-

ments daunting, who tend to undervalue their abilities so will be dissuaded from going to take on a university assessment of any kind — brow-beaten by the idea of being judged by a 'name' university before they've even been given an offer.

Recent years have been a sharp reminder that we live in a shared, interdependent ecosystem. Disruption to school exams has had all kinds of knock-on effects within societies, not least to the social mobility of young people both now and as a legacy for the future. And when it comes to finding solutions, we need to keep in mind the full picture of implications, the benefits of fair, reliable and supportive systems for education and equality. We need to keep in mind the longer-term aftershocks to the global economy from the Covid-19 period. There will only be increased needs for motivated, ambitious young people with the right skills, new expertise in emerging areas of enterprise, equipped to be adaptable. In other words, more opportunities — as long as our education system is able to act as an open channel for all.

So what are the key take-away messages from my piece. Well, let's first of all characterize the pandemic as a health, education, social and economic crisis. In doing so, it should force a mindset change in the way we view what we have all survived, whilst not forgetting those that did not. Then, let's stop running down the tremendous efforts made by all students whether in schools, further education or higher education during what has been an unprecedented crisis, which has disproportionately hit sections of our communities. Instead, let's celebrate, motivate, and inspire our children, our relatives, our future, as in one way or another, we will all become dependent on them for our very own futures. Finally, let's take the opportunities that have resulted from covid to reassess what we do, how we do it and, for what purpose. Excellence takes many forms, so let's evolve our systems, processes and practices to accommodate excellence whilst maintaining quality and standards.

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Making medical students and doctor training relevant to delivering mental health in an unequal world

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In recent years mental health has become a topic of interest for many. It became a focus of attention within the global medical community and in society in general. The quality of care delivery, the education of students, the continuous professional development of doctors working within this field is strikingly variable among countries in the world. Not surprisingly, one finds these aspects reflected in a huge level of differences for doctors with regard to specific training, clinical practice and continuous professional development, but regrettably also in a remarkable level of inequalities of all kinds for patients.

Prior to starting their medical education, medical students vary considerably in their exposure to the type of social and economic inequalities in society that play such a large part globally in the variations in incidence, prevalence and access to care for mental health problems. In the United

Kingdom in 2016, only 4% of medical students came from working class backgrounds- something which is replicated across other high-income countries [1].

These facts might encourage stakeholders to reflect on the question how to set up a training in mental health issues relevant for medical students and doctors. This process must address the particular training environment, respect for patients' needs, taking into account regional, geographical and cultural factors. Probably two major aspects predominate in this reflecting process: the structure and the content of training.

Efforts to bring mental health into primary health care began during the early 1970s. As early as 1974, a World Health Organization (WHO) Expert Committee on Mental Health discussed the development of mental health services in developing countries [2]. Based on the recommendations of the Expert Committee, WHO carried out a collaborative study on Strategies for the Extension of Mental Health Care in Columbia, India, Nigeria, and Philippines which showed that simply trained general health care workers including primary care doctors can help many of those affected by mental illness [3, 4]. Other studies and initiatives followed and notably the Alma Ata Declaration in 1978 mentions mental health as an essential ingredient of primary health care [5].

The title *Mental Health: New Understanding, New Hope* figured on the 2001 World Health Report from the World Health Organisation (WHO) [6]. The next year there followed a position paper: *Mental Health Global Action Programme (mhGAP): close the gap, dare to care* [7]. Recently, WHO published a field test version to support its mhGAP [8]. It's still open for evaluation for the interested reader. Though WHO sketches a global background about mental health, when it comes to training of professionals, it appropriately offers the scene to other organisations.

The Royal College of Physicians and Surgeons of Canada published in 2015 an updated version of its well-known *Physician Competency Framework* [9]. It offers a number of roles a doctor must be able to perform, with a list of key competencies a doctor should acquire. It also adds each time its supporting competencies. This CanMEDS framework is globally seen as a very valuable compass for developing structure in a medical training. One can easily imagine that in countries where other medically trained professionals are performing these roles, these descriptions of competencies can be adjusted accordingly.

With respect to content of training, WONCA, the general practitioners' global association, published in collaboration with the UK Royal College of General Practitioners their document *Core Competencies of Family Doctors in Primary Mental Health Care* [10]. It stresses six important domains with regard to mental health: values, communication skills, assessment, management, collaboration and referral, and reflective practice. It differentiates among more advanced competencies and offers examples supported by key resources and references. Finally, it addresses issues related to policy, training and research.

Though written for general practitioners, in our opinion, this WONCA document is ideal reading material for all trainees across all specialties. This overarching perspective has also been taken by the European Union of Medical Specialists (UEMS) in its *European Training Requirements* (ETRs) series, documents developed by its different specialty related Sections [11]. Following a template,

these documents, approved by European national medical associations as well as different UEMS bodies, describe European Standards in Medical Training for all specialties. Following a proposal from the British Medical Association, approved by the UEMS Council this year, future ETRs shall be completed with a particular position statement *Policies on Safeguarding Children, Adolescents and Vulnerable Adults* [12]. It's a request to all colleagues involved in training, to behave respectfully not only towards the youngsters but also towards adult people with intellectual disabilities as well as people with mental health problems.

The World Psychiatric Association (WPA) published on its website *WPA Recommendations: Principles and Priorities for a Framework for Training Psychiatrists,* prepared by a Task Force chaired by the president of the WPA Section on Education [13]. This document firstly lists a number of roles adapted from the CanMEDS 2015, with particular knowledge, skills and attitudes to be acquired by a future psychiatrist. But the members of this Task Force did realise that one single curriculum for the whole world would be a nonsensical proposal. Therefore, they suggested also a minimum core curriculum describing knowledge, skills and attitudes within a three-year training period.

WPA has also tried to set up a number of online courses but unfortunately saw itself forced to postpone some initiatives due to a lack of financial resources. This is strongly in contrast with the huge amount of information available through different channels on Youtube©. But, as usual, the level of trustworthiness here is hugely variable due to an evident lack of the necessary peer review process.

This is quite different from online courses offered by universities, e.g., the University of Melbourne (UoM). The faculty offers an online course, leading to a Master degree in Psychiatry [14]. However interesting this may be, for those interested from lower income countries, the price will most probably be a limiting factor. For a broader public the same institution offers also a *Graduate Diploma in International Psychiatry,* as the website tells us "developed for medical professionals worldwide who work with mentally ill patients in any capacity..." [15]. It's an initiative jointly developed by the UoM and WPA, offering a compact, six-month program, leading to a diploma after successfully passing an exam. And last but not least, non-medical professionals are suggested to subscribe to a free course on *Foundations of International Psychiatry* [16].

But reality shows that all these initiatives, however worthwhile documents offering guidance on how to provide training may be, developed by all these many associations globally, with many valuable concepts written down and explained, widely accessible through numerous websites, it's all evidently insufficient when it comes to their implementation. The material is there but it doesn't fit the recipient(s). There's a clear mismatch between what can be offered and what is needed.

Would it be useful to give mental health care training a far more prominent place in general medical training? This process can only prove itself successful enough when the training at this level offers relevant theoretical knowledge, allows to acquire culturally relevant attitudes and skills, and shows itself sufficiently adjusted to patients' needs as well as trainees' needs.

Getting to this goal probably requires a task force composed of medical clinicians (i.e., general practitioners, psychiatrists and other specialists), academic medical trainers, specialists in med-

ical education. Such a task force could perhaps deliver a more fruitful outcome when also other, less commonly involved professionals are engaged in this kind of initiative. Wouldn't it be useful to have professionals with a background training in humanities (e.g., psychologists, sociologists, anthropologists), working not only with patients and service users and carers, both 'experts by experience', but also specialists in implementation with whom medical doctors rarely collaborate. It should challenge stigma, towards not only patients but also fellow students and doctors experiencing mental health problems. Such a task force could develop a specific strategy, based upon a perspective commonly shared by this group of stakeholders. Such a strategy should form the basis for small program adjusting changes, evaluated after implementation, and leading to a circular process of gradual quality improvement.

Most probably the coordination of such a task force should be given to governments. But is mental health relevant enough to policy makers, to politicians? In the past, mental health has been addressed quite poorly by them. The ongoing pandemic can have created, is probably still creating some change, even an increasing interest within that particular societal group (17).

20 years later the WHO report's title would indeed become very relevant: *Mental Health: New Understanding, New Hope*.

KEY MESSAGES

- Education about dealing with mental illness and about promoting mental health are essential parts of education of health care workers.
- Trainers of medical students should be aware that prior to starting their medical education, students vary considerably in their exposure to inequalities in society.
- A training is only relevant when it considers the training environment, the patients' and trainees' needs, the cultural background of all involved.
- A valuable training program does not depend on individual trainers only, but needs the involvement of a broader group of many professionals.
- Quality improvement is acquired by implementing small adjusting steps, monitored and evaluated, leading to a continuing circular process

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Realising the Astana Declaration and mental health in an unequal world - the role of family doctors.

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KEY MESSAGES

- Family doctors can play a central role in improving mental health in an unequal world.
- Challenges in translating the Astana Declaration into action are present across differing health systems.
- By working together, we can translate aspiration into achievement.

Introduction

In October 2018 WHO convened a global conference on primary health care in Astana, Kasakhstan. The ensuing Declaration included the following statements:

> *We strongly affirm our commitment to the fundamental right of every human being to the enjoyment of the highest attainable standard of health without distinction of any kind.*
>
> *We are convinced that strengthening primary health care (PHC) is the most inclusive, effective and efficient approach to enhance people's physical and mental health, as well as social well-being.*
>
> *Remaining healthy is challenging for many people, particularly the poor and people in vulnerable situations. We find it ethically, politically, socially and economically unacceptable that inequity in health and disparities in health outcomes persist.*
>
> *Promotive, preventive, curative, rehabilitative services and palliative care must be accessible to all. We must save millions of people from poverty. [1]*

As family doctors we fully endorse this commitment to the fundamental rights of people with mental health conditions. We support WHO in promoting a shift from stigmatizing long-stay mental hospitals, to more acceptable and dignified care in community-based settings.

Primary care, with its emphasis on the connections between mental and physical health, and its unique ability to tackle problems of co-morbidity and multimorbidity, is exceptionally well-placed to enhance mental health within universal health coverage systems. Family doctors are well placed to assess patients' vulnerability, the impact of poverty and disadvantage, and their association with mental and psychological conditions. [2] We can intervene to reduce the mortality and morbidity of people with severe mental illness, who die prematurely, spiraling into homelessness, unemployment and poverty and with greatly increased risk of developing non-communicable diseases such as diabetes. [3]

We agree with the need for mental health promotion, requiring multi-sectoral collaboration to build

a healthy environment with the focus on those factors that reduce chronic stress, poverty and health inequalities. We include potential anti-stressors and supportive actions including social connectivity and (for many) spirituality and religiosity.

We now consider how these principles apply in four health care systems.

Brazil: middle income country

The territorial basis of Brazilian Family Health Strategy (ESF), the cornerstone of Primary Care System in the National Health System, connects each of 40,000 Family Health Teams (FHT) of doctor, nurse, nurse technician and up to six community workers to a community of around 3,750 people. These teams guarantee access for all Brazilians to health care; they also develop health promotion and preventive measures, including socioeconomic interventions, integrated with other sectors such as education, housing, culture and social assistance [4].

However, there are not enough family doctors and nurses to cover all these FHTs, bringing challenges when building a patient-centered approach and an integrated health system. The implementation of new Mental Health Care Internship is developing new models of undergraduate training in mental health. To translate the Astana Declaration into practice we need to expand psychosocial and secondary care teams working within a collaborative care model with PHC professionals. Getting these teams to work together through the Brazilian Collaborative Care model, the Matrix Support, will allow for an Integrated Care System to be implemented where each person can receive the best quality care needed in different levels of the health system [5].

The biggest challenge to actually apply the Astana declaration, in addition to structural inequalities in societies, is the lack of human resources to expand intersectoral actions between the PHC and other sectors [6]. Advocacy for mental health care in those territories could enhance community participation and intersectoral coordination, and reduce inequalities and inequities in relation to the integrated approach to a person with psychosocial suffering and their family members and caregivers.

Guyana: middle income country

Primary health care in Guyana has its challenges, especially as it relates to the management of mental health conditions. Referring all cases to the psychiatric department is overwhelming, given a population of over 700,000 and less than twenty public health psychiatrists. Family medicine was formally instituted in 2015 [7], and with mh-GAP training since 2016 has helped to reduce suicide rates.

There are unique challenges in Guyana in relation to sustainability and consistency in providing medications and human resources. There is a serious brain drain: 89% of university-educated Guya-

nese leave the country, the highest rate in the world. [8]. We have to continuously train doctors and nurses to fill these gaps, which puts a serious strain on our health care system.

In PHC, staff such as psychologists and social workers need to be on board to provide comprehensive care. Mental health needs to be seen as equally important as any other organic illness, in order for there to be equity of care in Guyana. There is still a lot of stigma associated with these conditions.

The Mental Health Unit and the Georgetown Public Hospital are the two main public entities in Guyana that provide mental health care. Working together, monitoring and surveillance are key to addressing the gaps, so that Ministry of Health knows what needs improving. More opportunities should be provided for Fellowship training in Psychiatry to enable our primary care physicians to be more confident and competent in their management of mental health conditions. Resources need to be provided to all ten administrative regions across Guyana.

To ensure comprehensive and holistic care we need more collaboration and advocacy with international bodies.

Saudi Arabia: high income country

A situation analysis (1995-1999) identified that family doctors were unable to identify mental health problems in primary health care and showed that traditional training programs were ineffective (9). From 2002 to 2015 a long-term training program was implemented for primary health care workers and family doctors in primary health care centers, in collaboration with WHO, WONCA and other countries. Beginning in eleven primary health care centres in Eastern Province, this program has been extended across all provinces, with more than 436 training courses across all provinces. In total 1435 family and PHC doctors, 931 nurses, 42 social workers, 31 psychologists have been trained; 253 PHC centres are now able to provides Primary MH care; more than 76,000 patients have been served in over 330,000 PHC visits; and each month more than 2000 patients show improvement in their conditions. One of the most important fruits of this experience was creating an innovative patients' interview approach «5-Step Model» in line with the needs of PHC doctors in the Arab culture (10). This program is now being implemented in Egypt, Morocco and Sudan.

United States: high income country

The US remains without a solid system of national health care, though the Affordable Care Act has afforded access and coverage to millions of individuals and families. On the primary care front, value-based care is gaining momentum and with it stronger demands for reimbursement reform. Events over the past year have forced a reckoning with the stark imbalance in health outcomes for people of color; inequities as a consequence of racism and other key social determinants of health. [11]

The COVID-19 pandemic has offered US primary care opportunity and challenge. Can we make mental health care more accessible, affordable and equitable? [12] Can we recognize how poverty, discrimination, prejudice, and many other traumas affect mental health – and act to eliminate these barriers?

A robust public health system in concert with primary care is key to addressing mental health and well–being. Community engagement can engage people in need, particularly those who are under-served, such as homeless individuals, those whose primary language is other than English, and individuals with serious mental illness. [13,14]

We must provide to those who seek refuge in the US due to violence or conflict in their home countries, utilizing a trauma informed approach – emphasizing resilience and approaching treatment through family, community and cultural contexts. [15] Totally integrated primary and behavioral health care is a recipe for successful care, decreased stigma, and better health outcomes. [16, 17]

With an already stretched primary care system, primary care doctors and their teams encountered enormous stressors, including increased risks of contracting the virus. We need support to improve medical well-being [18-20].

Conclusion

We have highlighted the challenges of translating the Astana Declaration into global action, and recommended what primary care doctors can do to make a difference in promoting equity and equality in mental health in differing health systems. To fully realize the Astana recommendations will take the power of governments as well as private sector foundations. We encourage family doctors to work collectively to turn these aspirations into achievements.

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The role of lived experience in tackling inequalities and improving mental health in mental health services and beyond.

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OBJECTIVE(S)

- To showcase how people with lived mental health experience are making changes in mental health delivery and the challenges they face
- To describe mental health service users expectations and how these can be achieved

KEY POINTS

- Involvement/co-production has been around a long time but its access and impact is unequally distributed.
- Effective involvement and broader community engagement needs to tackle social determinants of mental ill-health to make mental health services sustainable.
- Involvement/co-production is good but it can and must be better.

Introduction

Whether it's called service user involvement, patient and public involvement (PPI), co-production or

involving people with lived experience – engaging people in improving mental health services has been policy and practice in many countries for many years [1]. In other places it is a relatively new approach and in some it doesn't happen at all. Done well it has the potential to improve services and broader public mental health and reduce inequalities; but done badly it can cause damage, distress and do more harm than good [2].

Although a range of terms are used, there may be differences in how people understand the different terms. The following definitions will be used throughout this piece:

- Service user involvement refers to the engagement of people already using a particular service. This may be complemented by carer involvement which refers to involving family or other informal carers.
- Patient and Public Involvement (PPI) will include broader involvement of people who have a lay (non-professional) interest. This may include potential service users and broader communities. The term patient usually implies someone using an existing (mental) health service.
- Co-production refers to involvement in developing something new or joint delivery of an existing service. Co-production would usually involve service users but may also involve carers or people who have previously used services.
- Lived experience has become more widely used recently. Lived experience is usually self-defined and does not rely on being professionally diagnosed or using (or having used) a particular service.

It is also worth noting that there is no consensus on the language and terms used and there will be regional and cultural variations. It is, however, important that there is a common understanding amongst those involved in any piece of involvement.

What does good involvement look like?

Involvement can occur in a range of places and at different stages of service development, delivery and evaluation from national strategy to individual care plans [3].

Involvement at an individual level

At its most basic, and in many ways the most important and potentially empowering form of engagement is in our own care, treatment and ultimately being more in control of our own lives. This is in line with current legal developments in the UK and elsewhere (based in part on international human rights legislation), making shared decision-making between clinicians and patients based on evidence and values the basis of consent in all areas of health and social care [4].

When we think about service user involvement or co-production this is where it starts. Until we feel more in control of our day to day lives, involvement in anything bigger seems like an add-on. The great thing about co-producing care for ourselves is that it allows us to put treatment and support

in the context of our broader lives. This means we can talk about the external factors that may exacerbate or mitigate our good or poor mental health; these are often referred to as social determinants of (mental) health and can include among others: poor housing, debt, other health or disability concerns, experience of bullying, abuse, racism or other forms of violence. All of these are known to have a potentially detrimental effect on mental health and may trigger or worsen mental ill-health but may get ignored if the focus is solely on treatment of diagnosed symptoms. This type of involvement could include self-management and peer support. This is a structured approach designed to enable people with lived experience to support themselves and each other and which may be supported by mental health professionals [5].

Peer support is particularly useful for people who have felt isolated and experienced poor self-confidence which can make getting involved seem daunting. It also offers people with lived experience an opportunity to help others and share our learning with each other which can help to build self-confidence and prepare people for more involvement or co-production. Peer support also enables people to group around particular shared experiences which may be related directly to their mental (ill-)health like self-help for bipolar or hearing voices groups, or it may bring people with other shared experiences together, for example ethnicity, gender or sexuality. Peer groups can also provide an important and supportive way of highlighted and starting to address inequalities.

Involvement at an operational level

Many people will associate service user involvement and co-production with the day-to-day operation of mental health services. In many places this is the most well-established form of involvement. It may require more skills and confidence than involvement in our own care, but it offers people the opportunity to more directly shape the support on offer and benefit more people.

There are many examples of progressive co-produced services that help bridge the gap between purely clinical services designed to deliver treatments and more community-based services which address the social determinants that will be beyond the control of mental health professionals, but still have an adverse impact on mental health [6][7][8].

Because they may require more skills and confidence, it is important to ensure that involvement and co-production at this level supports diversity and is accessible to a wide range of people. It is possible for work with the best of intentions to inadvertently exclude people who experience additional disadvantage (particularly by ethnicity or disability) and thereby increase inequality. It may be more time consuming or even expensive to make engagement accessible, but that time and effort can be a significant contributor to addressing and reducing inequalities.

Getting the basics right

Although there are many types of involvement and many things to consider, there are a few simple things to consider before starting any involvement process.

Be clear about the purpose
Involvement/co-production needs a clear purpose to be effective. Having a clearly articulated and well thought through reason for any engagement will make sure that people know what they are getting involved with and why. It will also allow everyone to understand whether it achieves its aims and if there are lessons to be learned or ways to improve the process.

Be clear about the limits
Just as it is important to understand why you want people involved; clarity about what can and cannot be created or changed as a result of involvement/co-production is essential to ensure that people are comfortable with engagement and the constraints on potential outcomes.
Limits of engagement are inevitable: some come from funding or other financial constraints, some come from technical, legal or other existing guidelines, and some will be practical. If people know and understand these constraints when they get involved, it will help people to focus their energy on what can be achieved and reduce the risk of frustration associated with wasting time or effort on things that are fixed.
Understanding and articulating constraints are important skills for all involved in co-production. It may also be an opportunity to question whether these limits and constraints are fixed and whether they can be removed for future engagement.

Build in regular feedback
Involvement is not a one-off event, it's an ongoing process. People need to be connected throughout the whole endeavour. One-off events are not meaningful involvement and even good processes can feel unhelpful if people can't find out what is going on or what has happened as a result of engagement or co-production. Good feedback that explains what has changed as a result of co-production will enable people to see and understand the benefits and will be more likely to stay engaged and encourage others to join them. Even when things are slow to improve feedback can explain why and may even support better problem solving to improve future results.

Involvement at a strategic level

Involving people in shaping the future is probably the most abstract type of involvement. This might include involvement in governance, in planning and commissioning services, in shaping research, policy and legislation. It can be rewarding, have a good long-term impact but it can also feel intimidating and remote to many people. It is certainly not the best way for everyone to be involved but good quality service user involvement can increase the quality and diversity of thinking [9].

One important way to ensure that involvement and co-production engages as many people as possible and contributes to reducing inequalities is to join up the work across the individual, operational and strategic levels. If people and organisations involved in these different ways are talking to

each other; sharing ideas, skills and learning; and even providing support and mentoring for people who want to develop their own involvement and co-production skills; then we will be able to spread the benefit of involvement to all [10], [11].

Conclusion

Involvement, engagement and co-production are not easy to do well, and there are plenty of pitfalls for the unwary – but they should no longer be seen as an optional extra. Done well they help to improve everyone's mental health, reduce pressures on overstretched services and make them more sustainable, make working in mental health more rewarding and help give meaning to people's lived experience as an asset for public benefit.

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Human Rights and Mental Health Inequality among older persons: Urgent need for a global convention

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KEY POINTS

- Psychosocial burden among the older persons is rising with global population ageing
- The COVID-19 pandemic has widened the marginalization, ageism and health inequality in the older persons
- Dignity, respect, autonomy and equality are the basic dimensions of human rights in the older persons
- The proposed UN Convention for Rights of Older Persons holds promise to restore health equality and dignified care.

Psychosocial morbidity in the older persons

Globally population is rapidly ageing due to reduced fertility as well as mortality. The proportion of older persons (age greater than 60 years) across the world is expected to double by 2050. The neuropsychiatric disorders contribute significantly (6.6%) to the overall disability burden [1]. Though it is often noted that resilience, coping, subjective feeling of fulfilment and well-being improve with age, old age comes with its own unique challenges in terms of both health and social situations. Several physiological changes happen in the organ systems as the age progresses. The ability of the body to resist or counteract stress by maintaining homeostasis reduces. When the psychosocial adversities get added to it, the vulnerability to both physical and mental illnesses as well as disability increases **(Table 1).**

The most common neuropsychiatric disorder observed in old age is the neurocognitive disorder or dementia with a global prevalence of around 5%. The prevalence doubles every 5 years after the age of 60 years [2]. This is closely followed by depression and anxiety disorders. Other psychiatric illnesses like psychosis, obsessive-compulsive disorder, substance abuse, etc. are less common than in younger adults [2]. These disorders in older persons may have atypicality or differential presentations, often resulting in missed diagnosis. Subsyndromal symptoms are much more common in older persons. Apart from the clinical or subclinical illnesses, psychosocial challenges particularly observed in old age are retirement, loneliness, bereavement, social isolation, marginalisation, societal ageistic beliefs and discrimination [3]. These may lead to significant distress and impaired well-being, further compounded by chronic medical illnesses, pain, frailty, immobility, etc. The Coronavirus Disease 2019 (COVID-19) pandemic has led to a whole new plethora of challenges for this population besides the increased propensity for morbidity and mortality [4] **(Table 2).**

Table 1: Causes of disability and healthcare burden in older persons

- Sensory impairment (vision & hearing loss)
- Frailty
- Chronic pain
- Chronic obstructive pulmonary disease (COPD)
- Late-life depression
- Falls
- Diabetes and hypertension
- Osteoarthritis
- Mobility restriction
- Dementia
- Polypharmacy
- Multi-morbidity

Table 2: Psychosocial toll of COVID-19 pandemic on older persons

- Increased fear of infection being a vulnerable population
- Fear of dying alone
- Social isolation
- Loneliness
- Grief and 'survivor's guilt'
- Worsening of pre-existing dementia and depression
- Anxiety
- Limited access to healthcare and social support
- Stigma and ageism
- Rise in elder abuse (especially in institutions)
- Prone to misinformation
- Restriction of mobility and autonomy

Health inequality and human rights gap in the older persons

The global population ageing has also brought to light specific vulnerabilities in older persons. The World Health Organization (WHO) defines healthy ageing as "the process of developing and maintaining the functional ability that enables wellbeing in older age" [5]. It encompasses the ability of an older person to make independent decisions, develop and maintain relationships, stay mobile, meet his/her basic needs and continue participation in society. Diversity and inequity are important considerations in healthy ageing which needs adequate healthcare access and dedicated services for the older persons.

The Sustainable Developmental Goal 3 highlights the need to "ensure healthy lives and promote wellbeing for all at all ages" which focuses on a life-course based approach to healthcare needs. Age is considered to be one of the most important determinants of health and ageing process also involves frailty (cumulative decline in multiple physiological domains), risk of poor health outcomes and limited access to affordable healthcare. Besides the biological changes of ageing and neurological senescence, there are several social vulnerabilities including loss of autonomy, financial and physical dependence, death of loved ones, grief, loneliness and social isolation. Besides, poor diet, restricted mobility, physical inactivity and lack of sensory stimulation can further lead to health inequalities in this population [6, 7].

Older persons due to varying socio-economic circumstances often find it difficult to access and afford quality healthcare, the crevices of which are more widened in mental health, due to lack of awareness, misinformation, under-detection of psychiatric symptoms and increased prevalence of depression and dementia in this population [7]. According to the United Nations Department of Economic and Social Affairs (UNDESA), a large number of older persons across the world are deprived of adequate healthcare access and long-term care. Data on the same is also restricted from the developed nations and it is imperative that the crisis is probably more concerning in the low-and-middle-income countries where health infrastructure is already burdened with popula-

tion ageing and other related challenges. A recent study from India involving 9181 older persons showed that most of them had no source of income in last one year, were dependent, suffered from multi-morbidity, had various disabilities and low instrumental activities of daily living [8]. Various factors that can lead to genesis of health inequalities in old age are depicted in **Figure 1.** These can get further exacerbated through gender, ethnicity and race-based discrimination within the elderly.

There are multiple dimensions to human rights in the older persons **(Figure 2)** which include the right to freedom, right to health as well as reproductive/sexual rights. The ongoing COVID-19 pandemic has indeed been an eye-opener in many ways where the biopsychosocial marginalization of older persons has surfaced leading to an "invisible human rights crisis" [4]. Lack of dignified healthcare, neglect, discrimination in healthcare and elder abuse are the predominant ways in which rights are deprived in them. Based on the WHO data, one in six individuals worldwide over 60 age are the victims of abuse in the last one year and majority are under-reported [9]. The rates have increased during COVID-19 especially in nations with increased population ageing [9]. The serious 'social evil' of elder abuse arises from ageist stereotypes (what we think), prejudice (how we feel) and discrimination (how we act). The risk factors of elder abuse are enumerated in **Figure 3.** The need to focus on dignity and autonomy in healthcare is vital to fight ageism and support dedicated care for the older persons [10]. Similar action areas of ensuring age-friendly environment, long-term and integrated geriatric healthcare and combatting ageism have been resonated in the U.N. International Decade of Healthy Ageing 2021-2030 [11]. This needs to be facilitated by engagement of older persons, giving them a 'voice', connecting interested stakeholders and care providers and finally, promoting ageing research.

Need for rights based and dignified geriatric mental health care in today's world

World Mental Health Day 2021, Mental Health in an Unequal World, provides an opportunity for us to reflect on how we treat older persons with health care needs. Although each new generation of older persons has made a significant contribution to building our contemporary society when they require medical or social care they feel as if they are treated as wasting resources and their previous contributions seem forgotten.

> *Quote (1) from a patient; "When I went to the hospital for my heart condition they did not take me seriously. It was as if I was wasting their time." 85 year old male.*
>
> *Quote (2) from a patient; "My GP told me I needed an urgent scan but I was told by the hospital I would have to wait. I'm sure this would not have happened when I was younger." 82 year old woman.*

Such comments from older persons are not uncommon. Many feel powerless in their suffering and in meeting their needs. Part of this is because of societal expectations of what it is to be old, expectations that should change because people are now living longer in better health and better

maintaining their independence.

We need a framework that respects human rights and dignity of the individual so that when and older person seeks health and social support they are given the appropriate care that they need and deserve when they need it. We also need an enforceable rights framework for older persons that challenges exclusion and lack of participation. The fundamentals of a rights-based approach in policy making should enhance an individual's participation and social care should not be seen as a handout or charitable gift from the government. Participation is important and includes, 'the rights and responsibilities of people to make choices and …have power over decisions that affect their lives' [12].

One way that this can be achieved is for health and social care organisations to include older persons in their governing bodies who will ensure that pathways and services monitor the rights of individuals who are older persons and make their findings public including how they have tackled shortcomings when they occur. Those who commission or pay for health and social care services should include a rights-based framework that specifically includes older persons in the service specifications they develop including mechanisms for monitoring these.

These type of interventions are already happening. Policy makers have started to look at human rights law in framing national health policy and global health governance and this approach is possible even in manging an infectious disease such as COVID 19 [13]. Several such strategies at various levels to ensure health equality and rights-based approach in older persons are summarized in **Table 3**. We can only ensure that their needs are met and their dignity respected and monitored by adopting a rights based approach to the planning, delivery and monitoring of health and social care. Every encounter matters.

Table 3: Strategies to restore health equality and social inclusion for older persons

- Encourage healthy ageing
- Recognize older persons' contribution in society
- Promote community participation in older persons
- Ensure voice of older adults (representatives) in policy and welfare-related committees
- Balance and allocate resources for equitable healthcare
- Develop specialist and dedicated services for the older persons
- Improve public awareness
- Increase healthcare utilization at old age
- Dementia care (prevention, treatment, caregiver education and rehabilitation)
- Affordable and accessible preventive, curative and long-term healthcare
- Legislations to prevent age-based discrimination in any sector
- Encourage social welfare schemes and post-retirement socio-economic independence
- Fighting ageism
- Prevention and prompt reporting of elder abuse
- Funding and conducting longitudinal ageing research

- Fight ageist stereotypes and misinformation
- Integrated care

Healthy Ageing and Human Rights

Healthy ageing and human rights are closely related. The promotion and the protection of the basic human rights is a necessary prerequisite for aging in good health. Human Rights protect people against any kind of stigma and discrimination because of age, promote the development of good health policies, programmes and services and assure the access to health and social care. Human Rights particularly protect the determinants of health that are the conditions in which people are born, grow, live, work and age and which are shaped by the distribution of money, power and resources at global, national and local levels [10,14].

The respect of basic Human Rights is essential to age in dignity. Health ageing is an asset of individuals, communities and populations whose value can change throughout the life course. Human Rights sustains the ethical and the legal framework to support ageing with good health and to protect those losing his/her autonomy and independence as a result of health conditions.

Unfortunately, basic Human Rights are frequently violated. An example of this is happening now during the COVID-19 disaster when this pandemic has put the spotlight on the tensions among the different generations suffering together, which causes discrimination such sd ageism [4,15]. Pandemics, wars and natural disasters may reveal the best and the worst of us while struggling for survival: selfish attitudes or empathy, compassion and solidarity are all present. The present pandemic is an opportunity to recall that intergenerational solidarity is essential: the respect of Human Rights is more needed than never.

Key themes that underpin Human Rights and Healthy Ageing include autonomy, dignity, care, and treatment, safety, and privacy. The Human Rights most relevant to age in good health are summarized in **Table 4**. However, there are many more related rights that can intersect with healthy ageing.

Table 4: Human rights relevant to ageing and old age

- Enjoyment of the highest attainable standards of affordable global health, and the respect of specific needs of people in different stages of life
- Access to justice at any stage of life
- Dignity and quality of life
- A discrimination and stigma-free world
- Safeguarding against violence, undue influence and abuse, freedom from cruel, inhumane, degrading treatment, and punishment
- Participating in the cultural and social life of the community
- Making contributions to the community through work or other activities, and to be protected

during these activities
- Provision of adequate income to meet basic needs for food, housing, clothing, and other necessities
- Accessible leisure and education
- Respect for family, relationships, sexual health, and the right to intimacy
- Confidentiality and privacy
- To practice a spiritual life of one's choosing.

Elder abuse which is a major human rights violation for the older persons and mandates immediate action. Based on the WHO recommendations [9], some salient strategies for its prevention are mentioned in **Table 5**.

Table 5: Prevention strategies for elder abuse

- Public awareness (involvement of media)
- Promote early identification and reporting of elder abuse
- Caregiver education and interventions (especially in dementia and SMI)
- Institutional care (staff-training) and long-term care policies
- Self-help groups
- Emergency (safe) homes
- Organizations/helplines/support for distress calls
- Legislations for appropriate punishment in case of abuse

Human Rights assure each one of us the peaceful attainment of our personal objectives in life, and the promote the feeling that each life counts for the global community.

Way Forward: Urgent Call for a Convention for the rights of older persons

The United Nations (UN) 2030 Agenda for Sustainable Development, a blueprint for global peace and prosperity, details 17 Sustainable Development Goals (SDGs) [16], and is aligned with the UN's Decade of Healthy Ageing (DHA) (2021-2030), bringing together all sectors of society [11]. The COVID-19 crisis has disproportionately impacted older people, largely driven by ageism [17], and highlighted serious gaps in human rights policies, systems and services. Global action is urgently needed to ensure that older people can fulfil their full potential in dignity, equality, in a healthy environment, essential for sustainable development and just and peaceful societies.

Older persons' rights are conspicuously absent in the Universal Declaration of Human Rights (UHDR) [18]. A coherent, comprehensive and integrated international legal framework on the rights of older persons is urgently needed. This framework must respond to the reality of our changing world, specific human rights challenges and protection gaps, faced by older people, and allow them

to reap the full benefits of longevity. The experience of the Convention on the Rights of Persons with Disabilities [19], clearly demonstrates that development of a dedicated legal instrument can effectively contribute to changes in law and practice.

On the UN's 75th anniversary, a global survey identified human rights as a top priority with a specific recommendation to "promote a creation of an UN Convention to protect the rights of older persons" [20]. The UN Secretary-General's Policy Brief on the impact of COVID-19 on older people [21], calls for accelerated efforts to develop proposals for an international legal instrument to promote and protect the rights and dignity of older persons. The UN's Open-ended Working Group on Ageing (OEWG) established in 2010 [22], has an unfulfilled mandate to date to "present to the General Assembly, at the earliest possible date, a proposal containing, inter alia, the main elements that should be included in an international legal instrument to promote and protect the rights and dignity of older persons". Evidently, full commitment is required by all Member States, civil society, NHRIs and older persons to accomplish this goal. In the background of the pandemic era, speedy population ageing and increasing psychosocial morbidity, such an international convention will hold true promise for restoring health equality and human rights of older persons in resonance with the theme of this World Mental Health Day 2021.

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Figure 1: Factors leading to health inequality in older persons

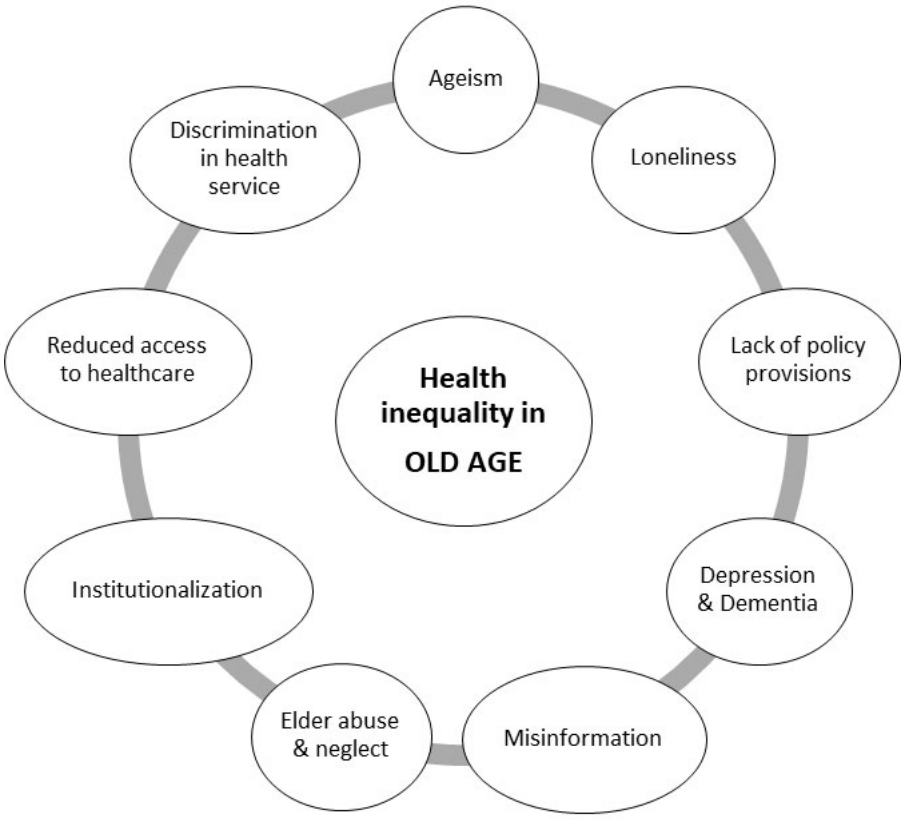
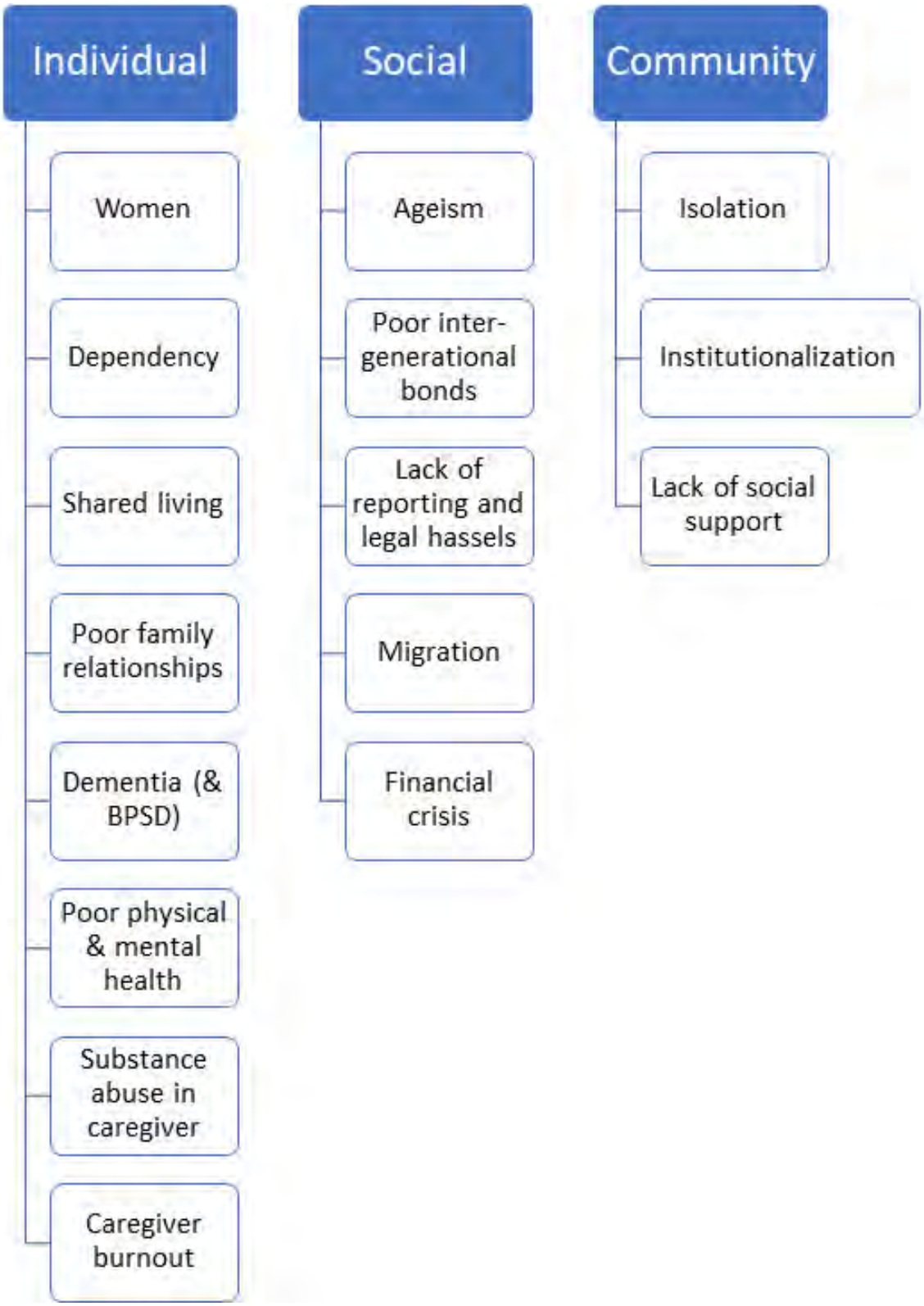


Figure 2: Dimensions of human rights in the older persons

Dignity	Autonomy	Respect
Capacity	Inclusion	Equality

Figure 3: Risk factors for elder abuse



Mental Health Financing in Africa: Building resources to overcome historical inequalities

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The financing of mental health is a neglected priority in sub-Saharan Africa. According to the latest World Health Organization Atlas report, African countries spend $0.10 per capita on mental health (in contrast with $21.7 per capita in the European region)[1]. There is also weak financial risk protection for mental health; in 43% of African countries, people pay mostly or entirely out of pocket for mental health services. These financing deficits are reflected in inadequate human resources to provide mental health care; there are 9 mental health workers for every million people in the African region. In turn this is reflected in a massive treatment gap; more than 90% of people living with a mental health condition receive no evidence-based care.

This dire situation is likely to have been worsened by the COVID pandemic, in at least three important ways. First, the pandemic has had a direct effect on the mental health of populations in low and middle-income countries (LMIC);[2] second the economic impact of the pandemic on employment rates, poverty and food insecurity, may in turn have adversely influenced mental health;[3] and

third the treasuries of African governments and international development agencies now have reduced fiscal space to invest in mental health care systems.

Nevertheless, the current crisis also brings new opportunities. Now, perhaps more than ever before, there is a growing public awareness of the importance of mental health, through discussion in the media and other public fora of the mental health consequences of COVID.

There is also growing evidence for how African countries can better invest in mental health. An example of a set of optimal financing models has been identified by the "Emerging mental health systems in low and middle-income countries" (Emerald) project.[4] Emerald recommended the inclusion of packages of care for mental health in ongoing universal health coverage (UHC) reforms, and suggested approaches for improving the efficiency of current spends and generating new resources.

While approaches to the integration of mental health within the health financing reform process will be unique to each context, core components of such an endeavor should include several common features, as follows:

- A comprehensive understanding of the burden of disease due to mental health conditions and extant treatment coverage is required for adequate needs assessment.
- Developing context-specific investment or business cases for mental healthcare is essential to advocate for increased domestic and international resourcing.
- A budgeted resource plan is needed that explicitly identifies a defined package of care drawing on the evidence base for cost-effective interventions to address mental health conditions.
- Ensuring strong engagement across key governmental and non-governmental stakeholders is vital to ensure political buy-in and consensus. Enhanced governance and planning capacity, as well as improved monitoring and evaluation processes will be key to facilitating these processes. [4].

In addition to financing models, there is also emerging evidence for how efficiencies can be improved to optimize expenditure in African countries. This includes addressing current inefficiencies in the use of resources by shifting from hospital-based models of care to new investments in primary health care and community service provision; the integration of mental health in broader primary healthcare services, including task-shifting mental healthcare to non-specialist providers in tandem with increased training and strong specialist supervision structures; and the provision of early interventions for at-risk populations. [5]

In Ghana and South Africa, work has recently been conducted to develop national investment cases for mental health. In Ghana, preliminary work on an investment case was conducted as part of the Ghana Somubi Dwumadie programme (https://options.co.uk/sites/default/files/learning_product_developing_an_investment_case_21012021.pdf). In South Africa, our investment case for mental health has involved three key steps: [6]

- We calculated the current cost of mental health service expenditure.[5] Among other things,

this showed that the national Department of Health currently spends approximately 5% of its budget on mental health (provincial range: 2.1–7.7% of provincial health budgets); that most of this funding (86%) is spent on hospital services when it could be more efficiently and effectively spent on primary care and community-based services; and that 18% of the total mental health budget is spent on re-admissions to inpatient facilities, reflecting a highly inefficient revolving door pattern of care.

- In consultation with a wide range of stakeholders at national and provincial level, we identified a core package of services, health system inputs and related infrastructure investments that need to be scaled up. This focused on modeling an increasingly decentralized system of care over a 15-year period, with new investments in primary care and community-based care. It also included investments in three other key sectors: (1) in the education sector, in the form of social and emotional learning programmes, to be delivered in schools to promote the mental health and well-being of children and adolescents, and to prevent mental health problems; (2) in the social development sector to address alcohol and substance-use; and (3) in the housing sector to ensure capital investments in community-residential care infrastructure.
- Using an adapted version of the WHO Inter-UN OneHealth Tool, we calculated the return on investment, in terms of healthy life years, prevalent cases and mortality averted, as well as improved economic productivity over a 15-year period. This showed clearly that the cost of inaction to the South African economy far outweighed the cost of investing in the mental health of the population. When expressed as an annual amount, lost workforce productivity estimated for South Africa translates to approximately US$ 10.9 billion annually; or approximately 4% of the country's gross domestic product (GDP). This is in stark contrast to an average annual estimate of US$ 1.8 billion to scale-up mental health services in South Africa over the 15-year period. In short, investing in mental health is not only important from a human rights perspective, but also makes good economic sense.

These new methodological innovations in calculating the costs and the return on investment for scaling up mental health care in South Africa can be adapted to other African countries. They represent a new opportunity to mobilise finances from governments as well as International Development assistance from external organizations, in order to improve the mental health and well-being of African citizens. Recent analysis of international development assistance for mental health in LMIC shows that this assistance is not always well aligned with mental health needs in these countries.[7] The development of African-based mental health investment cases, tailored to the needs of African countries represent a step change, with the potential to fund mental health services in places where it is needed most.

To conclude, there has been growing global awareness about the importance of mental health as both a driver of social and economic development and a worthy goal of such development. The time is long overdue for improved and sustained investment, with the goal of building the mental health and resilience of African populations, particularly children and adolescents, who will face tomorrow's social, environmental and economic challenges.

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Redesigning Community Psychiatry to rise to the challenge of mental health delivery in an unequal world

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Globally, people with mental health conditions have a higher likeliness of premature mortality, with a reduction in life expectancy ranging from 10-25 years (WHO). If left unaddressed, the already underestimated mental health burden, exacerbated by COVID-19, will lead to major societal mental health consequences, such as widespread anxiety and depression, leading to secondary disability. Concrete action is needed to overcome this burden through implementation of conducive mental health legislation, integration of mental health care into medical education, and building capacity within the workforce.

Health inequality is an interconnected issue, enfolding within itself various factors, such as socio-economic status, race and ethnicity, sexual orientation, gender identity, lack of human rights, etc. However, people living with mental health conditions are not only disproportionately affected by the aforementioned, but are most likely casualty to severe treatment gaps, lack of investment into services, poor quality of care and not least, stigma.

World Health Organisation figures show that suicide mortality is on the rise for young people and elderly women in lower- and middle-income countries, especially in areas heavily affected by conflict, amounting to approximately 800,000 deaths per year. Community psychiatry is an effective and pragmatic method to address these issues, alleviate suffering and to support the provision of

well-functioning mental health services.

The 1960s brought forth a shift from institutionalised mental health to community health centres (BJ Beck) and a wider move towards a holistic approach within psychiatry. Asylums were increasingly converted to community health centres and attached to general hospitals (al-Uzri, Dyer). However, much of the emerging world was left struggling with capacity issues and poor supply of trained mental health workforce, which has left heavy implications felt to date. Service development and upskilling workforce are essential to redesigning community psychiatry to meet these needs, however other elements must be in place for it to have a sustained effect on public mental health. Such as, mental health legislation and policymaking, robust research and audit practices, mental health curriculum, established standards of care, and formal recognition of unmet health needs. Furthermore, the need to appreciate the link between changing lifestyles and associated stress leading to increased mental health problems. Covid-19 provided global evidence of how mental health needs increase in times of distress due to social isolation and changes to lifestyle. The paper will outline the main challenges that contribute to mental health inequalities, as well as the steps needed to address these - including concrete recommendations to ensure improved outcomes for mental health professionals and the wider community.

One of the most significant barriers to global mental health is stigma. Stigma in mental health is defined as the "devaluing, disgracing, and disfavouring by the general public of individuals with mental illnesses" (Abdullah). Undoubtedly, stigma poses one of the most substantial challenges to mental health care worldwide. It presents a huge obstacle to access medical care and increases risk of premature mortality. A recent study (Philip et al.) has found that stigma also leads to heightened psychiatric symptoms and hopelessness. Furthermore, even if a patient does overcome the access barrier and seeks care, stigma will worsen compliance around adhering to a treatment plan and settling back into society. Ultimately leading to social isolation and rapid deterioration of mental wellbeing. Secondly, the wide treatment gap means that worldwide approximately 70% of people who need mental health services lack access to care (Wainberg et al.) This is not a phenomenon restricted to low- and middle-income countries and heavily compounds the already existing mental health burden. For example, Uganda is ranked among the top six countries in Africa in rates of depressive and anxiety disorders (Kagaari). The country, which has a population of 44 million people, currently has 30 psychiatrists, with most working in private practice, in the capital city of Kampala. In terms of importance, access and capacity are two issues that firmly move in lockstep. Lastly, training, retaining, and maintaining a competent healthcare workforce has been a huge challenge across the global South. Data shows that over a third of South African medical graduates leave to pursue careers in Europe and North America. Consequently, countries like the United Kingdom, have a largely foreign medical workforce with an estimated 31% of its doctors born overseas. (Pang et al.) The reasons behind brain drain vary and include a lack of funding or government support, poor renumeration, subpar working conditions, and conflict.

The paper recommends three steps to address these challenges with a community psychiatry approach, starting with the most crucial: legislation. Mental health legislation is vital to protect the rights of patients, regulate the role of the health institution, the family, and define governmental responsibilities towards caring for people with mental illness. Appropriate legislation lends itself to

a “rights-based approach” to tackling stigma in mental health, as it is underpinned by moral authority and can depend on enforcement of rights (Smith), lending patients a platform of equality to be treated the same as peers with physical ailments.

Secondly, structural improvements such as incorporating mental health care into medical school curricula, primary care training, and Continuing Medical Education (CME) will help spread awareness of mental illness as well as significantly reduce stigma within the community (al-Uzri, Dyer). Guides such as the WHO mental health GAP (mhGAP) training for non-specialised health settings, have been successfully implemented to support several primary health care settings, aiming to decrease the treatment gap and to strengthen community-based staff capacities to deliver mental health and psychosocial support interventions, and to overcome the scarcity of specialised staff. A systematic review undertaken by King’s College in 2017, has found that mhGAP training had substantial impact on positively improving attitudes towards mentally ill patients, improved attitudes towards psychiatry, greater confidence in managing mental health problems, as well as increased job satisfaction (Keynejad et al). Consequently, building capacity within the mental health workforce is fundamental and must be prioritised within public health decision-making. A way ahead is ensuring that staff have access to quality training opportunities, supervision, and exposure to psychiatric subspecialties. Additionally, keeping sustainability at the forefront of all policy decisions will be key to ensure development and continuity of high-quality community care.

Finally, to fortify legislation and governmental decision-making, there must be formal recognition of unmet health needs to ensure successful integration of mental health education to current training, allow for professional development opportunities, tackle stigma, as well as to ringfence a portion of the health budget to treat the mental health burden. Good quality health data will further aid the process of identifying community needs and improve treatment outcomes. Investment into audit and research is indispensable as it will contribute to effective prevention, increased quality of care, and the development of specialised services.

In conclusion, the overall trend in psychiatry has been to move away from institutionalised mental health towards a community approach. However, capacity concerns and poor access to services persist in many low- and middle-income countries. Further challenges include notable stigma against people with mental illness and inadequate working and training conditions for the healthcare workforce. This is further intensified by the pandemic that brought about social isolation, increased stress, and extreme changes in lifestyles. To overcome this inequality, the paper suggested three steps to address these challenges:

- Advocating for the implementation of mental health legislation,
- Structurally integrating mental health care into medical education,
- Building capacity within existing workforce.

The paper advises formal investment into robust audit and research practices to ensure that health needs are continuously monitored and that adequate services are developed to effectively treat patients.

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The World Psychiatric Association 2020-23 Action Plan

AFZAL JAVED
President WPA

This year's World Mental Health Day 2021 theme 'Mental Health in and Unequal World; Together We Can Make a Difference' coincides with a period during which psychiatry is facing several challenges, and there are many opportunities that can help us consolidate psychiatry as an inspiring branch of medicine.

WPA is the umbrella organization for psychiatrists worldwide and thus has a major responsibility for leading the profession. This leadership can only be achieved through full participation from our membership and engagement of our professional colleagues.

WPA Action Plan for 2021-23 defines emerging needs and priorities, from a worldwide perspective, in some specific areas of mental health. There is an outstanding need to provide access to high quality mental health care in all countries and to support psychiatrists in their important roles as policy makers, direct service providers, trainers and supporters of health care workers in primary and community health care systems.

The key features of the Action Plan are:

- To improve the standing of psychiatry as a medical specialty in clinical, academic and research areas and to promote public mental health as a guiding principle.
- To highlight the specific role of psychiatrists in working with other professionals in health, legal and social aspects of care
- To ensure WPA's positive engagement with member societies and WPA components

The proposed Action Plan looks at targeted areas that need attention and input from various WPA components during the next triennium. It will work within an international perspective focusing specifically on promotion, interventions and teaching and training of mental health professionals. This Action Plan will also build on the previous Action Plan to ensure continuity in the WPA's work.

Salient features of the Action Plan 2020-23 include the following areas:

PSYCHIATRY & PUBLIC MENTAL HEALTH	CHILD, ADOLESCENT & YOUTH MENTAL HEALTH: *From CLINIC TO COMMUNITY*	DEALING WITH CO-MORBIDITY IN MENTAL HEALTH
PARTNERSHIP WITH OTHER ORGANISATIONS	CAPACITY BUILDING	CONTINUATION & COMPLETION OF PREVIOUS ACTION PLANS WORK

Psychiatry & Public Mental health:

Public mental health is assuming an important place in the delivery of general health care. It involves a population mental health approach, which includes assessments, efforts to improve outcomes, coordination of different levels of mental disorder prevention, and mental wellbeing promotion. Evidence shows that programmes improving population mental health through coordinated work with a range of public and other organisations, local communities and individuals show a great impact.

The suggested action plan includes:

- *Raising awareness, acceptance, and prioritization of public mental health in national health policies*
- *Promoting public mental health intervention grant proposals*
- *Ensuring public mental health training programmes*
- *Integrating mental health care into chronic disease management and prevention and engaging with primary and general health care systems*.

Children, Adolescent & Youth Mental Health:

Identifying needs for targeted groups (0-Children, Adolescent & Youth Mental Health: Identifying needs for targeted groups (0-25years of age), including children, adolescents, persons with learning disability, refugees, and young adults with chronic and enduring mental health problems

Mental disorders are the single most common cause of disability in young people. First onset of mental disorders usually occurs in childhood or adolescence, although treatment typically follows several years later. The evidence shows that around 70% of mental disorders begin before the age of 25. The adolescent years are a critical time, when mental health needs promotion, and mental health problems need intervention. If left untreated, mental disorders can impede all aspects of health, including emotional well-being and social development, and leave young people feeling socially isolated, stigmatized, and unable to optimize their social, vocational, and interpersonal contributions to society. There is ample evidence that addressing mental health problems early in life can decrease emotional and behavioural problems, functional impairment, and contact with all forms of law enforcement. It can also lead to improvements in social and behavioural adjustment, learning outcomes, and school performance in later life and prevent development into chronic disorders. The promotion of child and adolescent mental health is a worldwide challenge, but a

potentially rewarding one.

Wars and natural disasters have led to the refugee population reaching numbers not seen since the Second World War. The current data show an increasing prevalence of mental disorders in the younger population going through migration and displacement. International organisations generally focus on providing food and shelter, but much more needs to be done to support this younger population and to address their mental wellbeing.

The failure to address child and adolescent mental health problems, including developmental and intellectual disorders, especially in low-resource settings, adds significantly to major public health issues and inflicts far-reaching consequences. Evidence shows that a substantial proportion of adult mental health problems originate early in life and has long-lasting effects beyond childhood and adolescence. There are significant gaps in what we know about how best to treat mental illness in children and youth. There is inadequate support for research into developmental neurobiology; the causes of mental illnesses; and the most effective, safest and best-tolerated treatments. The stigma of mental illness, together with the outdated models of child and youth mental healthcare, illustrate the negligence of our society.

Digital child and adolescent psychiatry uses innovative technologies to support and enhance the understand, diagnose, and treatment of mental illness. Digital psychiatry ranges from electronic health record (EHR) systems, clinical decision support systems (CDSS) to patient-focused smartphone apps, and innovative digital mental health promotion campaigns.. An increasing body of evidence supports the use of computers and the internet in the provision of interventions for depression and anxiety in children and adolescents. Comprehensive evaluations of the effectiveness and cost-effectiveness of multiple delivery systems to address anxiety, depression, and other disorders are needed in order to shape and disseminate new approaches to DHI.

Some of the proposed work will thus include:

1. Supporting epidemiological work exploring the prevalence of mental health problems in the targeted population
2. *Promoting early detection for psychosis and developing crisis intervention centres for adolescents*
3. *Screening and brief intervention in primary care for substance and alcohol misuse among adolescent and youth populations*
4. *Developing school-based social and emotional learning programmes to prevent psychosocial and conduct problems in childhood; preventing school dropouts; and promoting programmes for school mental health. Parenting interventions for preventing persistent conduct disorders in children and dealing with mental health problems among youth*
5. *Workplace screening for early detection of mental health problems among the young workers and promoting wellbeing in the workplace*
6. *Implementing collaborative care for mentally ill patients with other medical co-morbidity*
7. *Conducting a series of educational -multidisciplinary symposiums highlighting the challenges and opportunities which digital child and adolescent psychiatry*

Dealing with co-morbidity issues in psychiatry and developing strategies to engage with other medical and health professionals

Comorbidity is one of the most important issues facing health systems in the world today, and the single disease approach cannot address this problem appropriately. Patients with multiple long-term conditions are becoming the norm rather than the exception, and the number of people with comorbidities is set to increase in coming years.

Comorbidity in mental illnesses is gaining significant importance in our day-to-day practices. There are two key populations with comorbidities, and each of these populations requires a distinct approach:

- Those who have comorbidities mostly due to increased life expectancy and therefore a longer exposure to risk factors.
- Those who have comorbidities mostly from more intense exposure to risk factors, particularly smoking, alcohol, physical inactivity and obesity. This intense exposure is due to a combination of life challenges, including persistent and widening inequalities.

Patients in both groups face complex physical, social and emotional problems and are more likely to have mental health difficulties. It is important to address these issues of comorbidity as a priority. While many lives may be saved in the short term from improved management of comorbidities, the system-wide action that is needed to address comorbidities will take longer to implement, and the benefits will be seen over a longer period.

The WPA needs to discuss these issues from a worldwide perspective and focus on promotion, interventions, teaching, and training of mental health professionals in these areas. Proposed actions include:

1. Supporting epidemiological work exploring prevalence of other medical co-morbidities in the targeted population
2. Developing guidelines for programmes involving joint work with non-psychiatrist professionals
3. Early detection for co-morbid conditions in mentally ill patients and early recognition of mental health problems in the context of chronic medical illnesses
4. Screening, preventing, and initiating early treatment of such disorders.
5. Capacity building, with strategies for teaching and training psychiatrists and other mental health professionals and non-psychiatrist colleagues about joint work
6. Planning joint research activities and developing policy documents for improving mental health care in sub-speciality settings

Developing partnerships for collaborative work

and strengthening partnerships with mental health organisations

Health is a complex phenomenon, which needs joint work among different health professionals to benefit patients and provide the best available care.

There are mutual benefits to all stakeholders working jointly if patients are the prime beneficiaries of such efforts. Psychiatrists adhere to the principles of joint work based on fundamental principles of shared vision, equity, transparency, mutual benefit and respect. Trust, transparency, and accountability are key to getting joint-work projects off the ground

The WPA would therefore like to explore opportunities for partnerships with medical professionals such as general physicians, neurologists, paediatricians, geriatricians, cardiologists, diabetologists and other allied specialities in medicine; NGOs; and non-medical mental health organisations.

Proposed activities may include:

- *Collaboration and liaison with mental health organisations, NGOs, and other non-medical mental health organisations in identifying initiatives for joint work*
- *Inviting other organisations to WPA congresses and developing links for joint work in teaching, training, and capacity building*
- *Planning joint research activities and developing policies for improving mental health care in sub-speciality settings*
- *Developing capacity building and training policies in global mental health*

Developing Capacity building and training policies in global mental health

The optimal approach to building capacity in mental health care around the world will require partnerships between professional resources and promising health-related institutions.

These partnerships need to be sustainable, develop quality in clinical care and research, and build a productive environment for professionals to advance their knowledge and skills.

Fostering the continuous improvement of psychiatric education and training among medical students is an equally essential step in this process and a premier objective of the WPA

Continuation and completion of previous WPA Action Plans

Previous WPA Action Plans, particularly the 2017-2020 Action Plan, set out strategies for expanding the contribution of psychiatry to improved mental health across the globe. Three characteris-

tics frame the strategic intent of the Action Plan: continuing WPA's contribution to developing the profession of psychiatry; addressing critical mental health topics; and attracting new investment to support this work.

Mental health promotion, prevention and treatment of mental illness are also incorporated into the plan.

The plans formulated in 2017-2020 will be implemented through current partnerships and new funding. This plan is actualized through a strategic framework based on three dimensions:

- Impact on population groups
- Facilitation of activities
- Partnerships and collaboration.

The identified population groups are young girls and women and all young people having mental health problems resulting from adversities.

Way Forward

All areas covered in the proposed Action Plan are high priority. However, due to time limitations and scarcity of resources, only specific areas may be addressed. During the current triennium, expert working groups will start pilot projects in different areas of the Action Plan. Once the findings of these pilot projects are available, we will seek funding to implement these ideas in different settings and countries.

It is hoped that the 2020-23 Action Plan will generate interest among all WPA components to develop guidelines and directions for future work and seek higher mental health services budgets from relevant sources.

WPA is optimistic that it will receive support, active input, and advice from our membership in setting these priorities and making a real difference in mental health.

Mental Health in an Unequal World: – Digital Transformation – Leaving No-one Behind

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KEY MESSAGES

To address inequality and support mental well-being health services, local and central government should design and deliver pathways to digitally enabled services that promote inclusion and access to welfare among disadvantaged groups and communities.

Governments and health services must in equal measure:

- simultaneously address issues of exclusion, cohesion and wellbeing when designing digital

services
- simultaneously plan digital strategies, when designing welfare policies and practices
- develop and implement pathways for digital inclusion that enable all citizens to benefit from the digital revloution

The Need for Digital Inclusion

The Covid-19 pandemic has exposed an issue highlighted decades ago; "digital exclusion" which not only affects proper access to higher education but also access to healthcare and social welfare services. Local authorities and other public services, on the front lines of many interventions to ameliorate the effects of the pandemic and lockdowns, suddenly had to confront the challenge of supporting groups that do not have access to or use the internet. Numerous mental health services responded to the challenges faced by the COVID 19 pandemic by providing web-based interventions, leading to a decline in face-to-face support services, increased online psychoeducation, e-Therapy, online self-help resources, online support groups, video-conferencing and increased use of SMS and other mobile telephone based technologies which have turned out to be a preferred alternative.

Although the younger population in areas with access to appropriate internet infrastructure have embraced such web and telephone-based technology, this is not the case for many, an unintended consequence of the exclusion of several groups, including those with Severe Mental Illness (SMI) further amplifying existing mental health related inequalities (Spanakis et al 2021). Data from the UK states that 5% of the population (2.7 million people) do not use the internet (Ons.gov.uk) and for those with severe mental illness ('SMI') conditions such as schizophrenia and bipolar disorder, the percentage is considerably higher i.e. 17.5% of people with SMI engaged with a community psychiatric rehabilitation team were able to use a computer and 14.4% of this group were able to use the internet (Tobitt et al 2019).

Even regarding those who are well versed with IT and are tech-savvy, there is still a great deal of work required to be done in order to gather information regarding the most efficient method to deploy technology and IT Resources to support mental health interventions. We know that web based psychological interventions have low utilisation, low adherence and a high number of drop-out rates (Mohr et al 2013; Christensen et al 2009) and this can be improved by the provision of professional guidance and support.

Those who are digitally literate can use this as an important resource, and in 2015 more than 7 billion people globally had access to mobile telephone technology, with 70% of them residing in low and middle-income countries. Challenges faced by these programmes include the use of multiple platforms that are not well-connected, no clear plans to improve the scale of access, poor integration with existing platforms, absence of standardized tools and lack of a proper evidence base to support e-interventions resulting in citizens expressing a lack of faith in engaging with such systems (WHO 2018).

During 2017, 76% of European Citizens were accessing the internet on a weekly basis, meaning that approximately 24% of citizens and 47% of older adults were not using this technology. In the United States of America, 98% of people aged between 18 to 29 years were using the internet regularly, compared to only 66% of people aged 65 years and over (Gann 2019). [By the way, more recent data says 75% of over 65s in the US are online but fewer with only a high school education https://www.pewresearch.org/fact-tank/2021/04/02/7-of-americans-dont-use-the-internet-who-are-they/]. If we are to tackle the poor life expectancy faced by individuals with mental illnesses through the digital revolution, then we must ensure that we do not create a set of 'digital haves' and 'digital have-nots.' To avoid this, we must upskill the population to improve digital literacy, improve access to digital technology and care delivered through these methods.

In the UK, the local government has a role to play and the case example presented illustrates some issues and solutions.

Digital Inclusion and The Local Government – The UK Case-Study

Digital inclusion is an important concern for humanitarian and legal reasons. During the COVID-19 pandemic, as well as the life-threatening consequences for those lacking access to the default "digital" methods, the adoption of such non-inclusive channels for carrying out public functions and services can also contravene established legal and public administrative principles, within which such laws exist.

In the UK, public bodies must comply with several laws; particularly with the Human Rights Act 1998, the Equality Act 2010 and its Public Sector Equality Duty at s149, the Data Protection Act 2018 (including restrictions on profiling and automated decision making), and laws concerning public functions or services being exercised. In the UK, Local government authorities must meet the Principles of Good Administrative Practice to:

- ensure people can access services easily, including those needing reasonable adjustments,
- deal with people promptly and sensitively, taking account of their individual circumstances,
- responding to the users of said services requires flexibility and where appropriate coordinating a response with other service providers,
- recognise and respect the diversity of service users and adopt an inclusive approach.

There is evidence that a response to the pandemic that depended heavily on digital channels of communication fell short on these standards in several cases and reasons for this *inter-alia* include:

Government Strategy

The UK government's strategy expected the provision of IT resources and equipment to lead to widespread use of online public services and assumed that once people use online services, they will continue to do so.

This government's digitisation strategy was described as a 'grand idea' or a 'dream' which proved 'unrealistic' and 'idealistic', and furthermore failed the citizens because it exhausted public funding and widened the gap between frequent internet users and those who remain digitally excluded.

It provided digital public services that were simultaneously more centralised, standardised and impersonal, undermining and contradicting the principles of the 'duty of care' at the core of welfare services resulting in a loss of identity of public services, losing the force that traditionally binds citizens together.

Closure of public services and spaces

During the pandemic there was uneven benefit from digital changes to administrative procedures because the closures of public spaces such as libraries and community centres widened the disparities in the distribution of these resources. Disadvantaged groups and certain communities become isolated and disconnected from the civic facilities and interactions that traditionally sustained cohesive communities.

The type of data that members of the community as a whole have access to, drastically depends upon their societal status, their ethnicity, age, class, health status, gender, professional capacity and social networks, these all may vary considerably person to person. The entire experience of being online and accessing e-services varies depending upon a person's background and status. Issues of inclusion extend beyond resolving the concern of access to technology and online services; it is about access to types of 'social capital' that aims to bridge the digital divide. A bottom-up approach to digital development can promote greater and far more meaningful and interactive employment and usage of the options offered.

Putting Caring Relationships at The Centre of Digital Strategies

The Covid-19 pandemic emphasised the continuing need for caring relationships and interactions, and mobilised keyworkers and care professionals to take a proactive approach and reach out and identify the needs of the community, among those who remain digitally excluded.

Cases were shown regarding people who remained isolated and disconnected from their families in temporary accommodation, as they had no means to claim welfare support and no funds to

charge their phones or connect to the internet. Students had to submit their coursework in a series of text messages directly sent to the teacher, highlighting how disparities attributed to poverty are exacerbated by digitisation.

Solutions during the pandemic were ascribed to the resourcefulness of local governments, which supported community initiatives, conscientious professionals, engaged citizens and cohesive communities. Sufficient and suitable capability was mobilised at short notice to meet local needs and many of these initiatives took a hybrid approach, mixing face-to-face and virtual interactions. Community actions supported by digital technology, provided evidence that digitisation is about the meaningful application to beneficial purposes that boost resilience. Public services need to formulate digital strategies within the context of their unique ethics, purpose and design to offer valuable assistance and facilities.

A bottom-up approach towards digital development can promote greater and far more meaningful and interactive engagement regarding the services offered.

Digital innovations are required to intelligently calculate and address the causes and effects of multiple layers of social shortcomings into their core design to enable equitable access, engagement and participation.

Culturally diverse and socially disadvantaged urban communities may face additional challenges when accessing digital service provisions, and pressure for accelerated technology-led development risks aggravating pre-existing divisions. Poverty, educational and cultural differences and inequalities call for a significantly more nuanced and participatory approach to service provisions with communities placed at the centre of the conceptualisation and development of digital and other infrastructures.

Some potential solutions

- The private sector under 'corporate social responsibility' needs to take a more proactive and long-term approach to community partnerships, that move beyond transactional services and includes stakeholder consultation and engagement in decision-making processes regarding IT resources, and explicitly their design, distribution, application, and delivery.
- Local authorities ought to take a capability-based approach and utilise existing skills, abilities and community infrastructure to facilitate inclusion via volunteering and organised community initiatives.
- Public services, private sector initiatives and local authority welfare-support need to take into consideration and represent within their digital services to offer the culture, ethics, values, preferences, meanings and lifestyles of local communities to appeal to their needs and to promote inclusion.
- In other words, digital options are obligated to enable normal and routine processes, activities and interactions, appeal to the meanings and enhance the quality of life of the citizens.
- Public services need to formulate digital strategies capable of offering valuable welfare and

support to citizens and register ongoing collaborations and commitment.

- Functions should be designed with most marginal communities and communities with a pre-disposed risk to exclusion in mind.
- The private sector needs to take a more proactive and long-term approach to engage in decision-making processes regarding IT resources, specifically; their design, distribution, application and delivery.
- Inclusive digital services can facilitate informal 'warm hands' care in local cohesive networks which are very important during Covid-19.

The Role of ICT (Information and Communication Technology)

- Local authorities have a share in the responsibility to act as a trusted party in connecting community networks and other infrastructure into a coherent and efficient system.
- Local authorities should be involved in outreach activities throughout the community and should employ multiple means and methods to promote social inclusion through access to services, be it digital or otherwise.
- The significance and appeal of a combination of digital and face-to-face interactive options and opportunities were found to promote inclusion.
- Data driven humanitarian responses address basic needs and crisis such as food shortages, but there are concerns that the data available may not be representative of the population or the coverage may be limited.
- Data driven initiatives promote inclusion when they represent local cultures, ethics, values, meanings, preferences and ways of life in their digital services because they tend to attract unexpected stakeholders (people are inclined to voluntarily register their involvement because they see their needs being represented).

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Sustaining the Political Momentum on Mental Health and Psychosocial Support

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On October 5-6, 2021 the Government of France is hosting the Global Mental Health Summit, "Mind Our Rights Now!". This article is written by the organisers of a workshop that will be held during the summit; the focus is sustaining political momentum. More information about the summit.

Sustaining and increasing political momentum on mental health and psychosocial support (MHPSS) requires four things:

1. Keeping mental health and psychosocial support a priority on the political agenda and securing sustainable funding

2. Mental health policies and processes follow a rights-based approach

3. Addressing the underlying social determinants of mental health

4. Transparent and independent monitoring and accountability mechanisms track progress

Keeping Mental Health and Psychosocial Support on the Political Agenda and Securing Financing

From 2019-2021 MHPSS has risen up the political agenda globally (and in some cases nationally) leading to an increased prioritisation by global institutions and some national governments. Demand for greater political action on MHPSS looks set to continue as a result of the short- and long-term impacts of COVID-19 and as the stigma surrounding MHPSS is addressed (particularly by young people and the courageous work of people with lived experience). Civil society groups, UN agencies and other visionary leaders are mobilising to respond.

This year the focus of World Mental Health Day is Mental Health in an Unequal World. it is not enough for mental health to rise up the political agenda. These political efforts need to be sustained through strong leadership combined with the necessary policy reforms and targeted financing that will be galvanised through a mix of advocacy, campaigning and communications across sectors. Achieving progress needs to be underpinned by mental health and psychosocial support professionals - including members of the World Federation for Mental Health - who are able and willing to advocate themselves for change, working fully in partnership with people with lived experience.

A significant gap remains in financing for MHPSS. The World Bank, regional development banks, the Global Fund to Fight AIDS, TB and Malaria and a host of other international organisations will need to better prioritise mental health. However, ultimately MHPSS has to be a funded priority of national authorities and services and support provided free at the point of care if Universal Health Coverage is to be achieved. Efforts to develop and use investment cases for MHPSS that demonstrate the return on investment beyond the mental health programmes and systems are a key part of this work along with advocacy aimed at national parliaments as well as local authority budget holders, and international donors.

Adopting a Rights-Based Approach

The Convention on the Rights of Persons with Disabilities (CRPD) has created renewed awareness on the need to uphold human rights standards in the provision of MHPSS for adults, children, families, and communities. There has been some momentum in achieving the adoption and implementation of a rights-based approach to MHPSS since 2017, driven by people with lived experience, but far more action is needed. To uphold the right to optimal MHPSS as well as the rights of women, men, girls and boys with psychosocial disabilities on equal basis with others, mental health legislation, policies and practice require urgent reform around the world to ensure a rights-based approach. While increased investment and more services are needed, the problems of mental health provision cannot be addressed by simply increasing resources. Instead, it requires - as WHO highlighted in its recent guidelines - a move towards more balanced, community-based, person-centred, holistic, and recovery-oriented practices that respect people's will and preferences, are free from

coercion, and promote people's right to participation and community inclusion.

Progress has been seen at international, regional and national level. The Human Rights Council has issued various resolutions urging States to take active steps to fully integrate a human rights perspective into mental health and community services. WHO Quality Rights launched new guidance on rights-based community level services in an event that was incredibly well attended by key stakeholders and has received significant attention both in social and traditional media. In June a virtual meeting on Mental Health and Psychosocial Support in Francophone Africa concluded with a commitment to create an international french speaking community of practice. Various countries have also committed to prioritising rights-based approaches, e.g., Victoria, Australia, has embarked on a reform process which includes the immediate reduction of seclusion and restraint in mental health, with the aim of eliminating these practices within ten years. But there remains considerably more work to be done from low-income to high-income countries. A major concern is the decision of the Council of Europe's Committee on Bioethics to adopt a draft Additional Protocol to the Oviedo Convention, which would allow for the continued use of coercive measures.

Addressing the underlying social determinants

The impact of COVID-19, alongside wars, famines and natural disasters, shows that, in the context of mental health, there is a need to heal not just individuals but whole societies. COVID-19 has impacted peoples' livelihoods, education and social infrastructure across the lifespan; all these factors contribute to poor mental health.

To address this requires the integration and prioritisation of the social determinants of mental health including social, political, economic and environmental factors in national and sub-national plans. This means fully involving people of all ages with lived experience in the development and implementation of these initiatives. They often face disproportionate barriers to accessing education, employment, housing, and social protection. It is accelerating momentum in these areas that will result in better mental health for all at all ages and stages.

There has been a dramatic rise in the numbers of people reporting mental ill health – partially linked to COVID-19 but more generally linked to poverty, inequality, discrimination and violence. The WHO has reported substantial impacts on mental health services due to the impact of COVID-19.

A lack of prioritisation of mental health nationally and locally, combined with poor services and infringements in human rights, have led civil society, particularly youth-led groups, to increasingly use social media to demand change and provide their own peer to peer support. Action needs to now take place to develop cross-sectoral strategies for the integration of mental health that prioritise social and economic interventions to prevent poverty, inequality, discrimination and violence, and promote more tolerant, peaceful and just societies. This will help redress the challenge of improving mental health in an unequal world.

Transparent and independent monitoring and accountability

Monitoring and accountability are essential to driving and sustaining momentum. The personal advocacy and the detailed reports of the Special Rapporteur on the Right to Physical and Mental Health, and the Special Rapporteur on the Rights of Persons with Disabilities have been key to providing detailed analysis and holding individual countries to account. Indicators and benchmarks are needed to monitor progress towards all aspects of the right to health, not just access. Meaningful participation of persons with lived experience is an important aspect of accountability.

The lack of a global monitoring, evaluation and accountability framework that can be used by a range of actors - grassroots CSO to global institutions - to hold governments to account has been a critical gap in global mental health. A partnership between Harvard University, the WHO, The Global Mental Health Peer Network, Unicef and UnitedGMH has been formed to deliver this framework, called the Countdown Global Mental Health 2030 ('Countdown 2030'). The first interactive dashboard and annual report was published in September 2021. It demonstrates how social and economic determinants impact MHPSS and in future it can contribute to efforts to drive independent monitoring and accountability for progress on mental health.

Recommendations

1. All stakeholders must work towards the integration and prioritisation of mental health in:

- The COVID-19 response and recovery plans; and future pandemic preparedness
- MHPSS implementation and advocacy across sectors such as Social Welfare, Education, Gender and Health
- Universal Health Coverage plans nationally and internationally to ensure better outcomes for physical and mental health
- Communicable disease plans and programmes including the Global Fund Strategy 2023-2028 and its implementation

2. A rights-based approach must be championed and upheld through the development of community-based services that respect and promote human rights; the reform of national legislation and policies in line with the Convention on the Rights of Persons with Disabilities and other international human rights standards; and the active and meaningful participation of persons of all age groups with lived experience in policy decision-making.

3. Efforts to address the social determinants of mental health should be prioritised in all sectors and levels of government as a cross-cutting issue and in a concrete manner, ensuring that MHPSS and social inclusion interventions are systematically designed and implemented to foster participation and provide holistic support.

4. Independent monitoring and accountability mechanisms and reports, such as those of the Special Rapporteurs for the Right to Health and for the Rights of Persons with Disabilities, and the Mental Health Countdown 2030 dashboard and report, should be used by all stakeholders to help ensure political momentum delivers better mental health for all.

For more information see:

- www.unitedgmh.org
- www.hi.org
- www.sodisperu.org
- www.unicef.org

SECTION D

Regional Position Statements

WFMH WORLD MENTAL HEALTH DAY 2021

"In search for the missing link": Equality and Equity in mental healthcare in the Asia-Pacific

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Introduction: The context of global mental health inequalities

"The future depends on what you do today." — Mahatma Gandhi

Mental health has never been a priority in most countries of the Asia Pacific region. It has long been ignored resulting in poor mental health infrastructure and poor resource allocation. In many countries of the region, mental health budget constitutes less than 1% of the health budget. Similarly mental health has been ignored in medical and higher education. There are fewer opportunities for mental health professionals in most of Asia Pacific. Thus, there has been cascading adverse effects on the mental health of the population. But as Mahatma Gandhi had said, the future of mental health in the region depends on what we do today. The World Federation of Mental Health (WFMH) has a paramount role in achieving this mission.

The world has never been an equal place at any time in history. But globalization and neo-liberalisation appear to have deepened this inequity in various regions of the world in a diverse manner over the last few decades. The impact has been particularly negative among populations within the labour markets in the low-and-middle-income countries (LMIC) [1]. The change in labour markets has contributed to work intensification, long working hours, increased workload, work pressure and poor work-life balance [2]. Work life balance has been reported to play a crucial role in promoting satisfaction and better mental health in employees [3, 4]. Individuals and professionals who work for a longer duration have been associated to have increased disability-adjusted life years (DALYs) and years lost to disability (YLD) [5, 6, 7]

Coincidentally stress related illnesses are also predicted to become the leading causes of the global disease burden within the next decade [8]. While it can be argued that globalization has led to this poor work-life balance, it doesn't appear to be the only cause of stress-related illnesses. The differences in the work environment in different countries can often specially be attributed to their social welfare policies, psychosocial safety climate and labour market policies. Countries with a high social expenditure and where the social policy superseded the economic policy appeared to have a better psychosocial safety climate. The other indicator of the psychosocial safety climate was union density, which was also related to worker health, life expectancy, income equality and gross domestic product (GDP) at the national level [9, 10]. Lack of awareness of worker psychosocial well-being has also hindered the development of policies in certain regions of the world.

Social stratification in various societies appears to result in inequalities in capabilities, which in turn leads to unequal empowerment and access to resources, thereby contributing to inequalities in health. Hence, relative poverty and socio-economic position may play a major role in the inequities in health. Income inequality may also maintain and increase the social divisions and inequality to resources, by its negative effects on one's health [11]. Inequities are particularly high with respect to mental health. One of the reasons for high mental health inequality is setbacks in the understanding of the relationship between mental health and the other existing inequalities in the

society [12, 13].

In addition, psychiatry as a discipline, tends to limit itself to the field of medicine and not beyond, by its classification of mental illnesses in such a way that only individuals who require medical or psychological management are identified. This approach might also influence the popular 'bio-psycho-social' model in a negative way such that the psycho-social interventions in the model are reduced to predominantly helping an individual in understanding the biological model of the illness and getting treatment for the illness. This might unjustly medicalize the distress that the individual undergoes because of their social identity, deprivation and various other psycho-social factors, and subsume it under the illness or completely negate the plausibility of its correlation with the illness. Such an approach might also oversimplify these psycho-social issues as functional difficulties in individuals, and thereby trivialize and maintain these factors.

While it can be debated that it is beyond the scope of psychiatry to deal with these issues, an approach to ignore them might only help the individuals cope in environments which are unjust and even cruel to them. While the above lies in the context of 'social causation', the concept of 'social drift' is also to be noted [14]. Persons with mental illness also get displaced and disempowered in society and may face inequality in their lives. Due to the above factors and many more explained below, addressal of inequality has become quintessential in improving population mental health and overall wellbeing. This warrants a thorough understanding of the inequalities, their association with mental health, and the challenges in tackling them. Aptly enough, the World Federation for Mental Health (WFMH) has set the theme *"Mental Health in an Unequal World"* for this year's World Mental Health Day (2021).

Mental health in the Asia-Pacific: A strategic and economic area of importance

Even though there is some ambiguity on what constitutes Asia-Pacific (APAC), the term has gained popularity since the late 1980s in political relations, climate change, socio-economics and commerce [15]. In spite of the inter-nation heterogeneity, most countries are emerging as markets experiencing rapid growth and the consequent urbanization has marked effects on psychosocial health. The APAC generally includes South Asia, East Asia, Southeast Asia, Oceania and Australasia, and is home to around 2.6 billion people, being considered one of the most dynamic global regions. APAC contributes 47% of global trade and 60% of world's GDP [16]. Besides the rapid industrialisation, economic growth and scientific expansion, this region also has certain unique challenges. Some of them are vulnerability to climate change, frequent natural calamities, increasing rural-to-urban migration and ever-widening socio-economic and health inequality.

Epidemiological and socio-demographic transitions are leading to an increased focus on non-communicable disorders (including psychiatric illnesses), population ageing and healthcare equity. The proportion of the budget dedicated to healthcare in this region is low compared to the Western countries [17]. Even though all of these have direct and indirect implications for mental health, and

related research has increased over the last few decades, mental health systems, service delivery, policies and legislations still have a long way to go to address these growing challenges. Some of these common challenges with regards to mental health in the APAC region are highlighted in **Table 1.** Some or all of the countries in this region face challenges as the quality and standard of mental healthcare varies widely across and within the countries.

Table 1: Mental healthcare challenges across the Asia-Pacific Region

- Low mental healthcare budget expenditure
- Vulnerability to disasters and rapid climatic changes
- Mental health funding mainly by government resources with low involvement of private agencies and insurance companies
- Lack of trained mental health workforce
- Limited availability of funding, service provisions and medications
- Barriers to mental health research
- Most nations have mental health policies or plans, few have legislations
- Stigma and discrimination related to psychiatric care, medical misinformation and lack of community acceptance

Discourse on mental health assumes a renewed significance as APAC is predominantly an economic forum, in terms of identity. According to the UK All-Party Parliamentary Group on mental health [18] the total financial burden of chronic diseases worldwide (including mental disorders) is an estimated USD 47 trillion. APAC leaders have also highlighted that "continued neglect of mental health constitutes a brake on economic and social development." Even though this region shelters nearly half of the estimated population of individuals experiencing mental illness worldwide, community mental healthcare continues to be an ongoing challenge [19]. The difficulties include inadequate funding and trained workforce as well as lack of integration among various levels of healthcare and limited public-private collaboration [20]. Most importantly, the shortage of trained mental health professionals is a critical limiting factor.

The World Mental Health Day theme of 2021 *"Mental Health in an Unequal World"* aptly puts to light the concerns of the APAC region and the need to implement changes right from the individual to structural level. This position statement thus calls for action to reduce the mental disorder burden in this region and to promote psychological health and wellbeing. This includes principles of preventive psychiatry, rehabilitation for disabilities, social inclusion of people who are mentally ill, human rights-based approach, and poverty reduction measures. These measures are not limited to just the health sector but cut across the domains of education, employment, housing, food security, sanitation, and fundamental rights. The measures discussed here are both in line with the FundaMentalSDG (a global initiative for aligning the sustainable development goals (SDG) with mental health priorities and target indicators) [21] as well as the WHO Mental Health Action Plan 2013 – 2020 (which resonates with the national noncommunicable diseases strategy) [22]. The core principles of both these action plans need to be considered for interventions in the APAC re-

gion. These include human rights protection, dignified mental healthcare, community engagement, psychological first-aid, universal mental health coverage, life-course based multisectoral approach, developing national mental health laws/policies and evidence-informed service delivery. The various intersecting dimensions of mental healthcare in the APAC are depicted in **Figure 1.**

Figure 1: Various inter-related dimensions of mental health in the Asia-Pacific region.

Existing community models of care in the Asia-Pacific region

As mentioned above, the APAC nations are geo-politically and socio-culturally unique. As a result, Western community-based mental healthcare models cannot be directly adopted for interventions

in these areas. While a commonality is desired, it will be reductionistic to create rigid recommendations based on a singular community care model, that cannot be translated to reflect the diversity of this region. As [19] mentions, *"for constructive change to occur in the region, innovative, culturally appropriate and economically sustainable pathways for community treatment models need to be explored, developed and shared."* Besides the regional mental health organizations and their strategies within the APAC such as South-Asian Association for Regional Cooperation (SAARC) Psychiatric Foundation, Asian Federation of Psychiatric Associations (AFPA) and the Australasian Federation, there is the Asia-Pacific Community Mental Health development (APCMHD) project, which comprises of 14 nations/regions in the area.

The APCMHD works in collaboration with the WHO Western Pacific Regional Office and is led by Asia-Australia Mental Health (a consortium of the Department of Psychiatry, University of Melbourne) and St. Vincent's Health (part of the WHO Collaborating Centre for Mental Health, Melbourne) [19, 23] The project aims to promote evidence-based practice of community mental health in the APAC region with cross-national collaboration and sharing of knowledge. A network of key representatives from the ministries of health and mental health bodies in various participating nations are involved to jointly develop best practice guidelines.

Some of the key principles of community-mental health care models in the APAC region based on this project and examples of best practice from the component nations are highlighted in **Table 2.**

Table 2: Best-practice models in community mental healthcare across the Asia-Pacific which can be used to address mental health inequalities [11, 19, 24, 36-39]

NO.	PRINCIPLE	FEATURES	EXAMPLES
1	Community-based care in hospital system	Community outreach teams Primary-tertiary collaboration (hub-spoke model) Facilitate early discharge and social integration Liaison with general hospital and primary care Day care services, rehabilitation and community education	• Bahagia Ulu (Perak, Malaysia) • Kyonggi Provincial Mental Health Program (Korea) • The Regional Psychiatric Service Network (Taiwan)
2	Equitable mental healthcare access	Access to basic level of psychiatric care, medication and family support Curative, preventive, promotive, vocational services Stigma reduction, financial support, social welfare benefits Target vulnerable groups (older people, homeless, low SES, etc.)	• National Mental Health Service Model Reform Program / 686 Program (China) • Community Mental Health Nursing (CMHN) (Indonesia)
3	Continuity of care	Prevent chronic institutionalisation Strengthen self-efficacy, personal abilities and quality of life Social skills training, housing support, supported employment Telephonic review	• The Extended-Care Patients Intensive Treatment, Early Diversion and Rehabilitation Stepping Stone (EXITERS) (Hong Kong) • Fight from the Nest Group (Sudachi-kai) (Japan) • Ger Project – WHO and SOROS Foundation (Mongolia) • Long-term Care Services for Psychiatric Patients Pilot Project (Taiwan)
4	Empowering service-users/carers	Enable joint decision-making in treatment Patient autonomy and independence Patients and carers as sources of experience and advocacy Self-help groups	• House of Bethel (Japan)

5	Networking	Partnerships with NGOs, community groups, volunteers, etc. Collaboration with all involved stakeholders	• Mental Health Care model (Cambodia) • Community-based Mental Health (CSSKTT) (Vietnam)
6	Integration into public healthcare system	Cost-effective model of care in settings with limited resources Training healthcare workers in community/primary care in basic mental health Tele-training	• District Mental Health Programme (DMHP) / National Mental Health Programme (NMHP) (India) • Taipei Model, Taipei City Psychiatric Center (TCPC), Taiwan
7	Mental health education and promotion	Improve knowledge-attitude-practice Stigma reduction Community mental health awareness programs Create mental resilience and mind literacy	• DMHP (India) • Community Based Mental Health Program (CMHP) (Thailand) • Mental Health Promotion Project (Mongolia) • Mental Health Literacy Program, Mental Health Association (Taiwan)
8	Dealing with psychiatric emergencies	Adequate and timely crisis interventions (emergencies, homelessness, during disasters, etc.) Tele-psychiatric practice and monitoring Suicide prevention	• Seoul Metropolitan Mental Health Centre (SMM-HC) (Korea) • Crisis Mental Health Intervention (CMHI) (Thailand)
9	Early psychiatric interventions	Disability and relapse reduction Attention to education, social skills and social participation Chronic mental illnesses	• Early Psychosis Intervention Programme (EPIP) (Singapore) • Early Assessment Service for Young People (EASY) (Hong Kong) • Early Assessment and Intervention Service for Developmental Delay Children (Taiwan)
10	Patient-centred and rights-based approach	Recovery oriented services Socio-culturally sensitive interventions Comprehensive and flexible models of care (in-patient, community, outpatient and home-based) Multidisciplinary care (GP, psychiatrist, CP, PSW, psychiatric nurse, allied professionals)	• Prevention and Recovery Care (PARC), Victoria (Australia) • Community Psycho-Geriatric Programme (CPGP) (Singapore) • National Mental Health Service Model reform program / 686 Program (China)

Challenges and the need for Action

Mental health is influenced by numerous factors including genetic constituency, parenting, perinatal factors, adverse childhood experiences, quality of life, stressful events, income equality, accessibility to education and mental health services, social stratification, culture, labor market policies, human rights perspective, and economic policies. Hence, the presentation of mental health issues and the challenges that are associated with their management differs from one region to another. But the approach to mental illnesses has almost always utilised or adapted the western classificatory systems to define and manage mental illnesses. While there is no doubt that it is by far the best system available to define mental illnesses in a categorical way, and is in turn a valuable tool for the diagnosis and treatment of the respective mental disorders, it does not take into account the cultural and social factors of the various regions and cannot be regarded as an universal system. This becomes especially important as distress may be experienced and expressed in different

ways, depending upon the culture and practices of a region. More importantly, it has the potential to universalize the socio-economic positions of individuals in the western countries, which may not be the case worldwide. This might especially be detrimental in addressing the sociogenic causes of distress and disability, which are more prevalent in the LMIC and often invisible in nature. Hence, there is a need to make region specific plans and actionable goals.

The current understanding of the relationship between inequality and mental illness appears to be reductionistic in reducing the same to a bidirectional relationship between poverty, and increased incidence of mental illness and disability. The generic measures of poverty may not be sensitive or specific enough to detect, define and determine the inequalities in the society [14]. Hence, there is a need to define these inequalities and social determinants as warranted in different regions through validated instruments. Social inequalities are multi-dimensional and cut across various aspects of living. How each of these attributes can potentially affect psychosocial wellbeing is summarized in **Table 3.** Likewise, the definitions of mental illnesses need to be modified to be more holistic to include these parameters. These two changes might help in more accurately defining the above relationship and providing appropriate data. Besides the shortcomings of the available measures, there is a severe lack of data related to mental healthcare inequalities in most LMIC, affecting the policy making [25]. There is an incognizance towards mental health at various levels in the government; social determinants among the psychiatrists; psychiatric illnesses and treatment among the population. Although there are efforts being made worldwide to address few of these issues, they have not been able to make any drastic changes in reducing the mental health gap or attenuating the existing inequality. One major reason for the above, especially in LMIC is that the minimum spending on mental health from their total health expenditure is less than the recommended minimum [25]. This can again be attributed to the above factor of incognizance at various levels, especially when aggravated by disasters or pandemics such as COVID-19 making it a vicious cycle **(Figure 2).**

Table 3: Different dimensions of social inequalities and how they affect psychosocial well-being [14] **[with permission from Routledge]**

DIMENSIONS OF SOCIAL INEQUALITY	ATTRIBUTES AFFECTING MENTAL HEALTH
Poverty	• Debt • Income inequality • Substance abuse • Marital breakdown • Increased rates of crimes
Unemployment	• Impaired autonomy and confidence • Reduced social networks • Compromised social status • Relative poverty
Poor quality of workplaces	• Lack of job security • Insufficient pay • Social exclusion • Absenteeism • Inflexible work environment / poor physical work environment • Lack of safety at workplace (especially for women)

Low levels of education	• Decreased emotional and cognitive skills • Risk of substance abuse • Trauma and bullying • Reduced mental health awareness • Accentuates income inequality
Cultural/group-based discrimination (age, sex, gender, ethnicity-based; BAME communities; LGBTQI+)	• Racism and violence • Social discrimination/prejudice • Othering • Bullying and hate crimes
Migration	• Heightened income inequality in migrant workforce • Social identity crisis • Social injustice • Lack of policies/crisis interventions • Societal apathy • Increased mental health problems in asylum seekers, refugees, immigrants (depression, post-traumatic stress disorders, existential threats, eviction)
Social stigma	• Lack of knowledge (ignorance) • Maladaptive attitudes (prejudice) • Self-stigma and discrimination • Social isolation • Reduced access to mental healthcare
Adverse childhood and adulthood experiences	• Socio-economic disadvantage • Any form of abuse • Familial discord • Parental substance abuse • Substance use disorders • All the dimensions mentioned above
Disability and aging	• Social drift • Frailty • Sensory and cognitive impairment • Loneliness • Ageism • Elder abuse and institutionalization
Ecological	• Urbanization • Lack of adequate housing/transport facilities • Homelessness • Maladaptive neighborhood environments • Pollution • Lack of public space/greenery

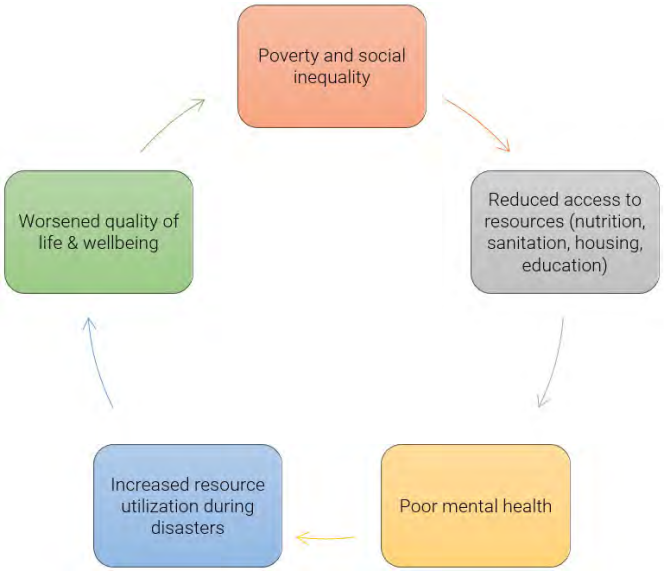

Figure 2: The vicious cycle of poverty and social inequality amplified by disasters or pandemics such as COVID-19.

There is a need to conduct research on, publish and advocate for studies on health economics, especially cost-effective studies for a better understanding of the same, enabling adequate allocation of resources to mental health to attain the targets. There is also a need to ensure proper distribution of the allotted resources, taking into account the various deficits in the health and social infrastructure as these deficits might hinder the accessibility of resources. Hence, it is important to strategize the means and modes of distribution accordingly. For instance, allocation of more resources to inaccessible communities might reduce the stigma associated with mental illnesses and would help in moving towards universal access. There is a need to re-examine the correspondence of psychiatry to mental health, and to include and promote other human sciences such as sociology and anthropology in the context of mental health. This would not only provide more workforce to the cause of mental health, but also encourage collaboration. Another known is for the branch of mental health to lay more emphasis on positive psychology and the concept of functional recovery. Both of these concepts may be more associated with disability rather than psychopathology; and are likely to be more inclusive of sociogenic factors of distress. To summarize, addressing social inequalities in mental health can achieve benefits beyond the health sector alone **(Table 4).** This assumes socio-economic and political importance in the context of the APAC region.

Table 4: Benefits of addressing inequalities in mental health

- Budget savings in mental health and allied sectors
- Better social functioning and productivity
- More employment and income
- Better educational attainment
- Improved physical health and quality of life
- Reduced crime rates, violence and substance abuse
- More affordability and access to mental healthcare for vulnerable groups
- Reduced hospitalizations
- Decreased health-damaging behaviours
- Reduced all-cause morbidity and mortality
- Mitigate stigma and discrimination

There are a few challenges that might be associated with any steps in addressing the above needs as follows. The effects of globalization might need addressal at an international level; work-life balance might be difficult to address merely through a change in labour policies, given the demand for jobs, unemployment and cultural factors; cultural factors might be deep rooted and may be a hindrance at many levels of interventions; disparities within a region due to socio-economic position of an individual or a community might require specific interventions that may differ from one region to another; addressal of sociogenic causes might require multiple sectors to coordinate actively; the same might be required for the support of an individual when he is ill and on the path to

recovery; an adequate budget to mental health would be essential; distribution of the resources in population-dense and diverse APAC countries might need an intricate approach; due to poor social capital, a huge proportion of the population is subjected to detrimental effects of climate change, disasters, and pandemics, and preparedness for the same is essential.

Effects of the COVID-19 pandemic

The crevices of mental health inequalities have widened during the ongoing COVID-19 crisis. The COVID-19 pandemic has not only exposed the social and structural inequities in the Asia Pacific region, but also accentuated it [26]. The economic and social impacts of the pandemic have been severe such that the cost incurred in various responses to the pandemic may not be within the capacity of many countries in the region [27]. With two-thirds of the population in the Asia Pacific region informally employed, a huge proportion of this population have lost their jobs, and many find themselves socially insecure. This is especially true with the international and internal migrant workers, who lost their employment and had to return to their home countries and towns. This unprecedented reverse migration has caused many individuals to lose their livelihoods, be exposed to the virus, be stigmatized, and also not receive adequate care due to the lack of health insurance. The households which were below poverty line are at risk of adopting various destructive coping strategies, leading to further decrease in their economic status. The pandemic is also likely to reverse the gains in poverty reduction which the region has attained in the past few years. Many who are employed in low-skilled services and whose alternative livelihoods are limited due to various reasons such as lack of digital literacy or internet access might fall below the poverty line. Women in the region have also been disproportionately affected by the COVID-19 pandemic, with closure of schools and the amount of unpaid work increasing drastically; domestic violence at home; discrimination at the workplace as being less competitive due to their dual role of domestic work and employment. This has led to women losing their jobs and also their engagement in socio-political activities and decision making, which in itself is very poor in the region, leading to further inequalities [28]. The COVID-19 pandemic has significantly impacted the economic conditions of the APAC countries, resulting in the likelihood of further decreases in the budget allotted to health and the concomitant setbacks in welfare policies and increased inequalities. In addition, the likelihood of stringent economic policies in the coming years might lead to further poor work-life balance and a downward spiral of mental health. All these factors have led to increased psychosocial problems throughout the APAC region **(Figure 3).**

Figure 3: Various intersections between the COVID-19 pandemic and psychosocial wellbeing.

Region specific actions needed in the Asia-Pacific

A multifaceted problem necessitates a multifaceted approach. Region specific strategies for addressing mental health inequalities should be multi-layered and should involve the active participation of all relevant sectors in the community and cross-nation collaboration. The best practice models in **Table 2** depicted above are examples of how the same principle can be modified and adapted in different areas based on culturally relevant settings. Exchange of knowledge about regional practices and policies can help reduce mental health inequalities in various regions of the APAC, but that strongly involves strengthening community-based care. Ideally, the mental health issues prevailing and that which are predicted to happen in the next few years require a response similar to the COVID-19 pandemic.

The concept of disaster preparedness must be integrated into the objectives of mental health prevention and promotion. This is especially important to countries in the Asia Pacific, considering how they were disproportionately affected by the pandemic and the reasons for the same. Although the SARS-CoV2 virus affected the whole world in the same way, the consequences faced, and the measures taken to contain the virus were not the same for everyone. APAC contains regions which have inequities in wealth, limited accessibility to health care services, social security, social capital and poor welfare policies. Some countries have struggled to handle the situation, and the effects of the pandemic on the inequities and overall well-being of these individuals have been deleterious [27, 28, 29] Various mental health priorities that have emerged in the region during this pandemic crisis are listed in **Table 5.**

Table 5: Disaster mental health priorities in the Asia-Pacific region

- Economic empowerment of people who are under-privileged
- Address structural inequalities (gender, sexual, race, ethnicity, religion, migration, socio-economic)
- Psychological first aid (evidence-based)
- Prevention and management of abuse (children, domestic, elder)
- Disaster appropriate behaviours for betterment of public health
- Besides the first responders, mental health promotion of other public (especially the population with lack of resources) also need to be prioritised
- Mental health promotion and education
- Improving knowledge-attitude-practice (KAP) gap in general public
- Involving lay counsellors, primary level health-workers and general physicians in screening and treatment of common mental health disorders
- Community engagement
- Involvement of media for mental health promotion
- Target high-risk groups
- Capacity building of existing mental health systems and helplines
- Optimising tele-psychiatric services and guidelines
- Psychosocial wellbeing geared policies
- Cross-nation collaboration and research

If not for the semantics of the definition of a pandemic [30], psychiatric illnesses like depression warrant to be named as a pandemic or at least require a response equivalent to the same. The management of mental illnesses are as challenging (if not, more) as the COVID-19 pandemic, due to the factors listed above and how they require a multisectoral and parallel response. Like the COVID-19 pandemic, an early, adequate, equity-centric and evidence-based strategy at various levels is required to manage mental illnesses, without which the consequences of the same in the upcoming years on the psycho-social and economic conditions might be severe. The following multi-level strategies to address mental health inequities are proposed to give a framework of the

actionable goals that could be adopted in the region. **Figure 4** is a summary and schematic representation of the same.

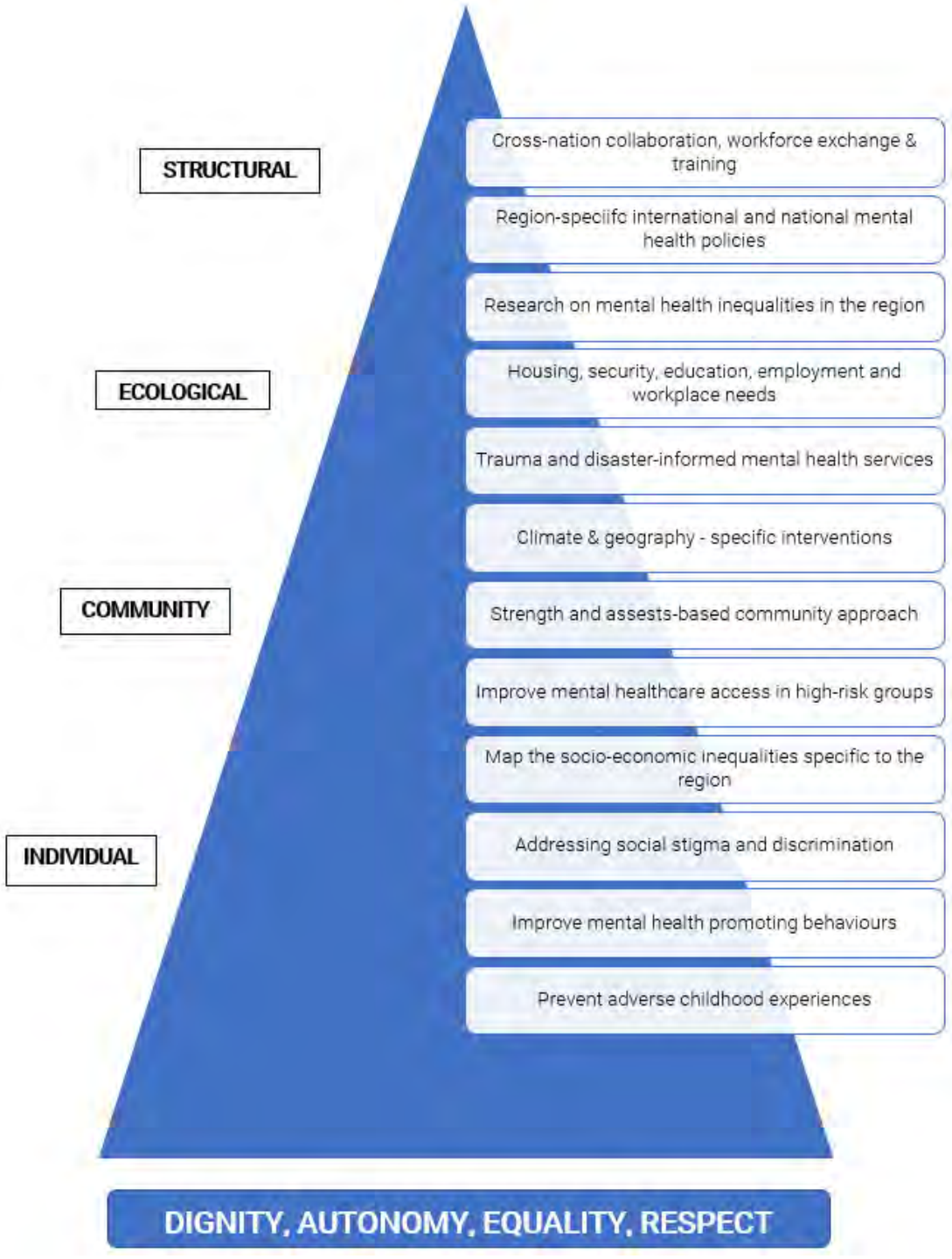

Figure 4: Multi-levelled strategies for addressing mental health inequalities and inequity.

Structural

- In spite of the cultural and region-specific differences, economic status, welfare policies and political approaches might be similar among some countries within APAC.
- Suitable collaborations can be made on this front, for exchange of research, workforce and training that can drastically increase the efficiency of the interventions.
- If the detrimental effects of the economic policies are found to outweigh the benefits, feedback can be given regarding such adverse effects from a mental health perspective.
- Research on mental health should include addressal of the mental health inequalities (and inequity) and needs to be actively promoted by the government.
- Suitable modules for individuals at various levels of administration and the general population should be designed in an easily understandable manner and advocacy activities for accessibility of the modules
- Mental health is everyone's concern, and all sectors and services in government should create a 'mental health wing', thereby actively improving community participation.
- Administrators should be continually educated about the need to improve the social factors such as psycho-social-safety climate, income inequality, etc from a mental health perspective.
- Although it might be difficult and cumbersome to make region specific classificatory systems, region specific criticisms of the classificatory systems can be made.
- The social determinants of mental health can also be region specific, given the varied institutional structures, social hierarchies, relative poverty, etc in different regions.
- Labour market policies need to be discussed, and the positive effects of welfare-oriented policies on the long term need to be emphasised.
- Existing policies are not fully utilized due to poor integration of data across various sectors.
- Technology can be adopted as much as possible to bridge the gaps in workforce as much as possible [25, 26].
- Technology can not only help in linking data across fields like psychiatry, legal services, educational and administrative services, but can also help in transparency and affirmative action.
- The integration of data across various services will also help in the statistical analysis of the inequalities and its contribution to mental health, and best strategies can be framed based on the nature and extent of mental health inequalities.
- A dedicated programme needs to be framed in each region with consumers, carers and healthcare professionals to collaborate, actively research, design and develop or make amendments to policies and strategize action plans.
- Primary prevention should be the heart and soul of the mental health policies and programmes created.
- Mental health programmes should not merely focus on mental illnesses alone but should include indices of mental health and overall well-being, at least with respect to high-risk regions and communities. This may also help to elucidate the relationship between the social factors and overall well-being in the regions.
- Mental Health Promotion into Action is necessary. In the view of 'Mental Health for All', it is essential 'that' the governments and organizations integrate mental health into all policies, to develop local empowerment models, focus on the mental health promotion and primary pre-

vention, build community resilience and social support, and pay close attention to the needs of population across different age groups, economic classes, regions, etc.) [31].
- In addition, mental health promotion education should be the key strategy to tackle inequity and inequality.

Ecological

- Ecological factors are also major influencers of mental health, given their ability to disrupt social support and threaten personal safety. Hence, preparedness and action plans to face the same should be devised and prompt in deployment to reduce the impact to minimum possible [24].
- Poor social security and its perilous effects on mental health were clearly exposed during the COVID-19 pandemic. Measures to improve the social security of all citizens need to be ensured to face such situations, lest they should accentuate the already existing disparities, worsen the well-being, and mental health gap [28].
- The main idea of disaster preparedness includes strengthening mental construction. In particular, implementing mental health promotion education to improve self-care and emotional skills, to build community networks and support, and to create a community resilience model [32].
- Clear strategies also need to be advised for such mental health issues arising due to inadequate social security or capital, lest these issues should be treated like any other mental health disorder neglecting the sociogenic causes and associations.

Community

- Accessibility to mental health care should be ensured by tying both ends of the same - making resources available in the community and promoting health seeking behaviour and awareness among individuals in the community [17, 19, 24].
- Active community participation will help to modify the strategies and agenda in real-time and tailor it to the most suitable action approach for a particular region or community.
- Social stigma and discrimination need to be addressed through public health campaigns, advertisements in mass media and social media. The adoption of mass media by the government can promote collaboration between various individuals and organisations [17].
- Region specific social determinants like racism and institutional structures, and their perilous effects need to be studied.
- There are inequities that are accentuated in certain communities within the region/ country such as women, migrant workers, homeless people, etc.
- These individuals appear to have an even lesser social capital, accessibility and affordability within the society. They are also at a high risk for violence, adverse childhood events and high risk behaviours [33].
- Work-life balance and the overall well-being also appear to be worse in individuals experiencing inequality and inequity, contributing to deterioration in their mental health, irrespective of them developing mental illnesses.
- The differences in the mental health of these individuals need to be identified. Valid scales and

measures have to be developed that can be applied in the community, which would acknowledge these issues and promote action.
- Wherever possible, sociogenic associations of poor mental health outcomes need to be documented and acknowledged, so that they are not avoided as an exception and recognised as a norm.
- Multisectoral coordination is of prime importance in LMIC, as the social expenditure in these countries are less, and individuals are more reliant on their families and individual selves for their expenses.
- Persons with disabling mental illnesses need to be supported by the government in as many services as possible for their fast and best recovery, which might in turn contribute to the overall welfare of the state.

Individual

- Positive psychology approach might be beneficial, given the high risk of adverse events in regions with poor socio-economic conditions [34].
- This might require an increased enrolment of individuals in schools and colleges, which can serve as the locus for psychological interventions.
- Mental health and psychological first aid can be incorporated into most curricula and all sectors can appoint a key-informant, who might support and monitor the mental health issues of individuals.
- More resources should be allotted to individuals who have been socially deprived and who are disempowered, given their higher risk to undergo adverse experiences, and to develop mental illnesses.
- Additional resources should not be restricted to only medical interventions, but should also include psychological and sociological interventions
- Treatment for mental illness without any consideration of the social factors might accentuate the inequities and lead to poor outcomes, due to issues in accessibility and compliance.
- Adverse childhood experiences need to be identified promptly, followed by appropriate early management and intervention. This calls for dedication from mental health professionals and non-mental health professionals with specific role designs.

Implementing change: Strategies in the Asia-Pacific

Implementing the above changes might require strong principles of mental health and social welfare to be laid down in a succinct manner, so that everyone involved in the delivery of the service is clear regarding the same. Principles which might be universally applicable are a strong mental health policy, sustainable integration of various sectors that includes [17, 24, 25]:

- Diverse perspectives in the responses
- Increasing community participation

- Capacity building and preparedness for disasters
- Adoption of technology to bridge the gap in workforces
- Cognizance of mental health impacts of climate change and in high-risk groups
- A social determinants approach with emphasis on women's mental health
- Early childhood development and substance use disorders
- Social welfare policies
- Setting attainable and achievable targets
- Consistent and progressive monitoring of the efforts made
- Strengthening information systems and promoting evidence-based practices

Culturally sensitive research needs to be conducted to identify specific interventions through which these can be implemented. **Table 6** below shows some of the evidence-based approaches to address the mental health inequalities that can be potentially attempted in the APAC region.

Cost- effective models and best practices for community mental health care in the Asia pacific region have also been identified. Establishing community mental health centres; resourcing the community from a tertiary hospital; improving the access to mental health care; community reintegration programmes including social skills training, housing stability and vocational rehabilitation; empowering patients as consumers through focused-group meetings; partnerships with NGOs in improving the community networks; integration into existing services and decentralization of the resources; mental health promotion and stigma reduction paving way for acceptance and active help seeking behaviours; early crisis intervention and preparedness for the same; early detection and management of psychiatric illnesses; and adopting the approach based on the patient's needs have been some of the best identified practices in the Asia Pacific [19].

There are studies reporting that the Asia Pacific region has committed itself to the cause of improving community mental health, has been advocating the human rights perspective and establishing intersectoral links for better outcomes in this domain [35]. But, this can only be considered as the beginning of a great leap that is required to bridge the gap in inequities of mental health services, and improve overall well-being. There are several domains which require relentless efforts such as adoption of local and culture appropriate models, health economics, information strengthening, use of technology, recovery models of management, positive psychology, work-life balance and social welfare expenditure. Also, there are domains which need improvement like community participation, capacity building, evidence-based strategies and public-health campaigns. But what is evident is that this requires a systematic, coordinated and dedicated effort from the specific regions or countries, which clear short term and long-term targets. These targets should also be validated measures of mental health, overall wellbeing, and social security rather than mere presence or absence of a disease. Special targets should be set for the population subjected to undue distress due to their gender, caste, race or religion, which can serve as a measure of improvement of the inequalities, and thereby the welfare of the society by large. Consistent monitoring of the efforts and persevering amendments are expected to keep such a huge endeavour in check. To conclude, mental health in the APAC should broaden its horizons to include the other services and sectors, which have been neglected due to the reification of the concept of mental health to only a

few branches of science. Recognition of mental health as everyone's province, and the synergistic effect of everyone in improving the same shall be the next big step in tackling the inequalities to promote positive mental health and overall well-being in a society.

Table 6: Evidence-based approaches to address mental health inequalities and psychological well being

Reducing adverse childhood experiences	• Community education • Ensure compulsory education for all age-groups • Reduce bullying and violence • Substance abuse interventions • Parental support • Family reunification • Child security and child-friendly spaces • Relevant legislations
Address basic needs	• Safe housing, prevent overcrowding • Ensure adequate nutrition • Employment • Promote healthy population ageing • Social welfare and social security benefits
Mental healthcare access	• Primary-secondary-tertiary collaboration • Improvise tele-psychiatric and tele-psychotherapy services • Mental health insurance • Public-private partnerships • Disability benefits
Strengthening community engagement	• Involve public figures and key stakeholders (youth, elders, local faith leaders, indigenous communities, community groups) • Utilizing community resources • Capacity building • Accessible, acceptable, affordable and culturally appropriate intervention models • Building intergenerational bonds and family support systems • Citizen-led groups for homelessness, SUD, etc.
Tackling inequalities	• Screen and prioritize high-risk groups (age, sexual minorities, homeless, migrants, refugees, low SES, chronic mental illness) • Anti-stigma interventions and community education • Social inclusion and participation among the minority groups • Involvement of media • Prevention of children and elder abuse • Improvise mental health services for the poorer populations
Suicide prevention	• Reducing access to means (policies) • TOT approach / Gatekeeper training • Early identification and management of psychiatric disorders • Life-course approach
Disaster response	• Training and supervision in psychological first aid • Long-term sustainability of services • Trauma-focused research and services • Optimize digital mental health interventions, ensure access to technology • Community outreach • Mental health education • Address mental health impacts of climate change • Collaborative networks (ex: Asia Pacific Disaster Mental Health Network) • Post-pandemic preparation
Policies and legislations	• Target mental health of high-risk groups • Prevent stereotyping and abuse • Prioritize psychological wellbeing and allied areas • Funding for mental health research and training • Workforce building (psychiatrist, CP, PSW, psychiatric nursing, GP, etc.) • Implementation and evaluation of mental health interventions and networks

Collaboration	• Cross-nation training, resource building and research • Sub-region mental health task forces (like South-East Asia, SAARC, etc.) • Leadership and capacity building • Incorporate mental health agenda in national and international policies • Liaise with global public health agencies (such as WHO, CDC, etc.)

SUD: Substance use disorders; SES: Socio-economic status; TOT: Train-the-trainers approach; CP: Clinical Psychologist; PSW: Psychiatric Social Worker; GP: General Physician; SAARC: South Asian Association for Regional Cooperation; WHO: World Health Organization; CDC: Centre for Disease Control and Prevention

Conclusion

The Covid-19 pandemic has posed challenges as never before, to the whole world. Economies have been badly hit leading to job loss for individuals and financial breakdown for many families. People are living in highly stressful times. This must lead to a paradigm shift, not only on how we see our own countries but also the whole world. If there is any one message, it is of global co-operation and collaborative work to rebuild societies and economies across the world. The Asia Pacific region plays an important role in the global economy and is developing rapidly. It faces unique challenges related to urbanization and mental health, and the social inequalities prevalent within the region have been specifically exacerbated by the COVID-19 pandemic. Many countries, especially in the South Asian region are among the worst-hit and continue to face significant challenges in containing the pandemic. During the pandemic and in the post-pandemic aftermath, legislation, service standards and government policies need to be established to ensure equal access and delivery of mental healthcare for better psychological wellbeing and quality of life. Community-based mental health care, involvement of primary healthcare workers, mental health education, tele-psychiatric guidelines and use of technological innovations, and finally multi-disciplinary flexible mental healthcare delivery models are the essential keys. This also involves inter and intra-nation collaboration, resource sharing and research for mutual and global gains in mental health. Sectors such as housing, education, social welfare, and employment also need alignment with mental healthcare reforms if poverty and health inequality are to be targeted. This position statement is in no way absolute but provides a framework of various principles, approaches and strategies of rights-based psychological care in the APAC region. These factors can be adapted in various settings based on the regional socio-cultural context. The process has just begun and there is still a long way to go in restoring equity of mental health in *"an unequal world"*.

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Tackling Social and Health Inequalities to Promote Mental Well-being – A Call to Action

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1. Introduction

Africa is the second-largest continent and the second most populated in the world with a population of 1.4 billion people in 55 countries. Most countries are characterised by low income, high prevalence of communicable diseases, malnutrition, low life expectancy and poorly staffed services. [1] Despite its vast natural resources, Africa remains one of the least developed and economically underprivileged continent [2] Most of Africa was colonised by European countries during 1400–1960 due to its vast natural resources. The scramble for Africa was largely driven by industrialisation and the need to access raw materials of which there were plenty on the continent. According to Ocheni and Nwankwo, this situation necessitated the quest for direct takeover and control of the economy and administration of the African enclaves and states. [3].

Colonisation accounts for many countries on the continent falling into under-developed or low and middle-income groups and has had a particularly devastating impact on mental health. It is, therefore, no surprise that mental health remains a low priority in the region, which has contributed to grave injustices and human rights violations experienced by people with lived experience. Many

African countries have no mental health policies or clear targets to achieve optimal mental health service delivery. [4]

Under-development on the continent has resulted in high poverty levels and economic inequalities. People living with mental illness experience gross mental health inequalities across the continent. Mental health remains a low national health priority in many African countries. The dominant bio-medical approach to mental health interventions with low financial investment remains the preferred option of care and limits holistic person-centred recovery approaches to care within communities. Traditional African tribal or ethnic specific customs and belief systems have often reinforced stigma and discrimination against the most vulnerable. In South Africa, traditional healers are still the first port of call for many who espouse tribal customs. [5] Traditional healers and religious leaders (such as priests) provide a significant proportion of the care received by persons with mental illness. For example, in Ethiopia, about 85% of emotionally disturbed people were estimated to seek help from traditional healers. [6]

Eaton states that on average 90% of people with mental illnesses have no access to treatment, especially in poor and rural areas in Africa [7] In Sierra Leone, for example the treatment gap for mental health services is estimated at over 98%. [8]. The limited access to professional mental health care, in addition to prevailing cultural beliefs, means that there is frequent recourse to care by spiritual and traditional medicine practitioners, some of whom employ abusive practices such as physical restraint, physical abuse and food deprivation.[9]. Treatment remains largely inaccessible and mostly provided in outdated dilapidated buildings. Many countries in the African region are engulfed in conflict and civil strife, with the attendant adverse impact on the mental health and well-being of the affected populations, foremost being post-traumatic stress disorder. [10]

Global recognition of the importance of the role of persons with lived experience of mental health conditions in research, policy reform, co-design of services and its implementation and monitoring and evaluation, as well as service delivery as peer support workers, has gained momentum – placing an emphasis on improving the status quo. However, the role of peer-led interventions in many countries in Africa is seldom integrated into mental health service delivery. Inequality, combined with stigma, discrimination and paternalistic approaches to mental health service provision, creates barriers for people with lived experience to live fully integrated lives with dignity and respect.

2. Mental Health Policy and Legislation in Africa

The effect of mental health being a low priority on the continent has led to most countries having no mental health policy or mental health legislation to regulate care and safeguard the human rights of persons with lived experience. Faydi and colleagues stated that “Approximately half of the countries in the African Region had a mental health policy by 2005, but little is known about quality of mental health policies.” [11]. This raises significant concerns as policy and legislation in mental health reinforces a country’s commitment to ensure that mental health is prioritised – and the absence thereof creates gaps in services, poor resourcing and financial investment, and fails

to take into account human rights protection instruments for this vulnerable group. They noted six gaps that could impact on the policies' effect on countries' mental health systems: lack of internal consistency of structure and content of policies, the superficiality of key international concepts, lack of evidence on which to base policy directions, inadequate political support, poor integration of mental health policies within the overall national policy and legislative framework, and lack of financial specificity [12]. They added that "Mental health policies and plans are essential tools for setting strategic priorities, coordinating action and reducing fragmentation of services and resources. Mental health policies are more likely to achieve the desired effect when they reflect a clear commitment from governments, are consistent with the existing evidence base, and international standards, and reflect a broad consensus among key stakeholders. [13]

Daniels concurs and added that a mental health policy is an instrument aimed at facilitating transformation in mental health. The success of this policy cannot be measured unless mental health professionals and service users actively engage and monitor the implementation. It is recommended that this policy be used as a powerful tool to lobby and advocate for improved funding, collaboration and deployment of non-specialist mental health human resources to decrease the number of individuals who currently have no access to mental health. Formal institutional structures and capacity have been established through a Mental Health Ministerial Advisory Committee to ensure that a coordinated and less hospital-centric approach to mental health is devolved to communities. [14]

Gureje and Alem state that "The development of health policies are critical to maximize scarce public resources and support families in the provision of the best possible care for the mentally ill. The goals must recognize the need for clear strategies to reduce the disablement associated with mental illness and to promote research on mental illnesses and how to prevent or treat them." [15]

3. Mental Health Stigma and Discrimination

Daniels stated that mental illness remains one of the most stigmatised health conditions, which created barriers to treatment and limits full integration into work, education, communities and families. [16] She noted further that the greatest barrier that people with mental illness face is society's attitude towards them.

Stigma takes many forms in communities in Africa, often involving extreme prejudice and discrimination. Within more traditional African communities, these may relate to the perceived reason why people have difficulties and are influenced by forces, witchcraft and supernatural powers beyond their control. For people with lived experience suffering is made worse by the attitudes and prejudices of people around them and the larger community. Stigmatisation often leads to community prejudice that impacts on the whole family.

Prejudice towards people with mental illness in Africa can take extreme forms, affecting multiple aspects of people's lives, including their self-esteem and confidence. In such instances, people may be accused of witchcraft, they may be denied marriage opportunities, and the explanations

for their behaviour may extend to all areas of their lives and in some instances lead to a process of exclusion. [17]

Kenya, for example has multi-sectoral promotion and prevention programmes on mental health at national and county levels that include strategic objectives and priority actions related to promoting "mental health literacy and stigma reduction" [18]

According to Corrigan and Watson, "Many people with serious mental illness are challenged doubly. On one hand, they struggle with the symptoms and disabilities that result from the disease. On the other, they are challenged by the stereotypes and prejudice that result from misconceptions about mental illness. As a result of both, people with mental illness are robbed of the opportunities that define a quality life: good jobs, safe housing, satisfactory health care, and affiliation with a diverse group of people." [19]

Lived Experience Narrative – Godfrey Kagaayi (Uganda)

In 2005, I was diagnosed with depression after going through a chain of traumatic experiences as a child. In my community, people with lived experience with mental health conditions are believed to be wasted, unproductive and violent. Because of these damaging beliefs and attitudes, in many ways, I was isolated and excluded in almost all spheres of life by friends, family and the community at large. Once a family member told me that nothing good will ever come out of me. This statement affected my self-esteem for many years. I was convinced that I am capable of doing nothing with my life to an extent of attempting to end my own life. I am lucky enough that I survived the suicide attempt.

Because of this experience, I founded Twogere, a registered community-based organisation that is on a mission to change the way how people think and behave towards persons with mental health conditions in Uganda. Furthermore, my advocacy work in mental health is being fuelled by the Global Mental Health Peer Network, where I can freely interact with a bunch of really compassionate and understanding friends.

4. Mental Health and Human Rights in Africa

The inclusion of mental health as a priority area among the Sustainable Development Goals (SDGs) has heightened the need to address mental health concerns globally. Certainly, the impact of the COVID-19 pandemic has highlighted the importance of paying special attention to mental health, not least because one of the main symptoms associated with the disease is depression. In Africa, evidence indicates that mental health has been largely neglected as a health concern and noting that less than 1% of national health budgetary allocations are apportioned to mental health infrastructure and resources, which is significantly less than the minimum percentage health budget spend for mental health that the World Health Organization (WHO) recommends which is 5%. [20] Between the years 2000 and 2015 the number of years lost to disability as a result of mental and substance use disorders increased by 52% in Africa with 17·9 million years reportedly lost to disa-

bility as a result of mental health problems. [21-22]. As the disease burden has increased, resources and infrastructure to adequately address mental illness have either stagnated or declined, pointing to systematic neglect of mental health in Africa. In the context of COVID-19 pandemic, human rights protection and mental health needs have not been adequately integrated into the pandemic emergency response policies and management. [23] Various reports have highlighted widespread undermining of mental health and violations of individual civil liberties and fundamental human rights including mobility rights, access to accurate information, access to proper protection for health workers, right to education, and discrimination against including individuals living with mental and neurological disorders [24]

Optimal mental health is a fundamental human right. The intersection between mental health and human rights (and, in turn, development) is acknowledged most recently through the Sustainable Development Goal Three [25].

The legally binding basis is however expressed in Article 12 of the International Covenant on Economic, Social and Cultural Rights, which protects "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." [26].This provision is mirrored in the African Charter on Human and Peoples Rights' Article 16 and various other UN human rights instruments that contain the right to health provision. Additionally, the UN Convention on the Rights of Persons with Disabilities (CRPD) imposes obligations on State Parties to address both physical and mental disabilities (Article 25). [27]

Several UN resolutions and reports on the right to health affirm mental health as a basic 'human right'. Moreover, the WHO Mental Health Action Plan (MHAP) provides policy imperatives to facilitate efforts of State Parties to address mental health. [28] One of its underpinning principles is human rights and it states that "mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the CRPD and other international and regional human rights instruments." [29]

Therefore, a human rights framework for mental health exists. Certainly, the need to adopt a holistic, human rights-based approach to mental health is required and is affirmed by WHO's recent guidance on community mental health care. [30] The challenge is that the shift to addressing mental health as a human rights concern has been slow [31]

Lived Experience Narrative - Sandra Ferreira (South Africa)

Having had the experience on more than one occasion of being gagged and restrained feels like the perfect irony and metaphor of human rights violations within my mental health journey. Admittedly, I realise that when someone is in a state of psychosis and irrationality that it is a difficult situation to manage and that there is no 'one size fits all' solution. However, looking back at my experiences, what I can say is that 'muting' or disqualifying me as a human being had no positive effects on my recovery or understanding of my rights or condition. If anything, it angered me and agitated my state further. What

is happening to me? I do not understand why I am here. Quite simply… I was scared. Unfortunately, these are not questions that are easily answered in the current models of treatment. Medication is often the first port of call, but treatment should be practised as multi-dimensional and person-centred from the start. Over the years, I have taken the time to learn as much about my condition, medication and my rights through reading, research and through my physical experiences. I however continued to experience a response where my voice, my being, was boxed into a category and my knowledge was disregarded. Without a doubt, compassion, empathy, understanding, education and relatability should be core values and foundations of treatment. All humankind is equal and should be treated as such. Recovery is not linear but human rights and dignity should be a priority.

5. Multi-dimensional Determinants of Mental Health

Mental health is an integral and essential component of the health of African societies. It is more than just the absence of mental disorders or disabilities. Mental health is a state of well-being in which an individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and can contribute to his or her community. [32] In Africa, optimal mental health and well-being are fundamental to interpersonal and family relationships, emotions, social life and livelihoods.

Mental health and well-being in Africa are largely determined by biological factors (e.g. physical health, genetic vulnerabilities, disabilities, temperament); psychological factors (e.g. trauma, self-esteem, coping skills); and social factors (e.g. interpersonal skills, family relations and circumstances, peers, substance use). In Africa persistent socio-economic pressures (e.g. poverty, level of education) have been identified as among the key social determinants of poor mental health among individuals and communities. [33] Other known determinants of mental health in Africa include protracted conflict and violence, gender discrimination, social exclusion, stressful work conditions, and human rights violations. All of the aforementioned factors are deeply rooted in persistent poverty and income inequality that are the realities of most communities on the African continent. [34]

The provision of mental health services in Africa is a developmental and human rights issue that requires urgent redress. Africans with mental disorders are faced with multiple levels of discrimination at structural, economic and social levels with limited access to appropriate mental health services. Context-specific interventions will fulfil the constitutional obligations and imperatives of nation-States in Africa, as well as significantly reduce the burden of mental and neurological disorders in Africa. [35]

Lived Experience Narrative – Tivania Moodley (South Africa)

As a suicide attempt survivor, my lived experience with depression emanated from years of a lack of self-worth, living a lie, having to conform to society's expectations of me, exacerbated by harsh life experiences such as rape and intimate partner violence. I could not express my truth, and suffocated in silence, eventually considering suicide as an option. I survived my suicide attempt, and since spent many years trying to understand the correlation between mental health and gender-based violence and I have come to understand keenly the relationship between acts of violence and men's mental health. I firmly believe, that when we address mental health in men and boys, we inadvertently save girls and women against gender-based violence.

Lived Experience Narrative – Marcos Tabule Alex (South Sudan)

I am a 42-year-old person living with disabilities. In 1992 during my intermediate class of senior two, I experienced an Antinov aerial bomb in my school where I lost twelve of my colleagues in the incident. I was a top performer in my class and with this incident, I became less able to concentrate, started withdrawing from my colleagues, feeling body fatigue, and headaches were the order of my day and sometimes I had less appetite for food. I was referred to an organisation known as HealthNet TPO who provided me with anti-psychotic drugs that enabled me to regain my life...

Since then I have worked with HealthNet TPO to help people who have witnessed similar situations. This was my first job in a humanitarian organisation and my role as Community Mental Health and Psychosocial Officer was to identify people who have witnessed and experienced Mental Health and Psychosocial issues and refer them to access services. As a Mental Health and Psychosocial Support Practitioner, I have a dream that we ***Leave No one with Mental Health and Psychosocial problems behind.***

6. Refugee Mental Health in Africa

Africa currently hosts an estimated 37 per cent of the world's 19·7 million refugee population, (36) calling for an urgent need for the early and ongoing provision of mental health services in refugee communities in Africa that extends beyond the period of displacement to resettlement in a host country, particularly for refugee women and girls. In Africa, the term refugee applies to "every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to-seek refuge in another place outside his country of origin or nationality". [37] Refugees are one of the most vulnerable populations in the world. Their vulnerability stems from their experiences of forced migration, including exposure to traumatic events such as war and conflict, loss or separation from family, arduous journeys to safety and

exposure to violence including sexual violence, abuse and exploitation. These experiences make them highly susceptible to mental disorders that persist for many years after displacement. [38]

While key policy documents related to refugee mental health have been developed, the mental health needs of refugees have not been addressed in a systematic, and coordinated manner in Africa despite epidemiological evidence pointing to the need for targeted intervention. [39] A multi-country study that analysed refugee health records in 90 refugee camps indicates a very low uptake of mental health services among refugees despite a high prevalence of post-traumatic stress disorder (PTSD), anxiety and depression[40]. Gender differences in mental health-seeking behaviour have also been reported among refugees, with female refugees more likely than males to report emotional disorders, medically unexplained somatic complaints and other psychological complaints. [41]

Lived Experience Narrative - Tendai Chisirimunhu Kathemba (South Africa)

South Africa has been the country I sought protection as a refugee. I left my home and birth country Zimbabwe at the height of social, political, and economic turmoil. Losing a brother and witnessing politically motivated violence towards me (as a youth back then), crushed my hope and I realised I no longer had a life and future living in Zimbabwe, so I fled to South Africa.

Living as a refugee in South Africa was one of the most difficult challenges I encountered in my life. I have struggled with depression and anxiety but had to be 'strong'. The system is stacked against you from day one and you must fight hard. I had a huge cognitive dissonance being African and realising for the first time the hostility and contempt a migrant or refugee faces daily in South Africa, yet Africa is my home.

You are labelled and stigmatised as a 'refugee', and this can be quite disorienting when you know your worth and value as well as contributions to society.

As much as I have had a tough time living in SA as a refugee, in a twisted way it has become my home away from home. I have been exposed and had opportunities that I believe that my country would still not and cannot offer me or the young people growing up there. I have established friendships that have become family and have plugged myself (albeit sometimes forcefully) within communities, actively participating and have been warmly embraced and treated with kindness by many South Africans. This is the narrative I mostly chose to carry in my head so I can remain 'sane' and because it is true. The bad has come with a lot of good.

7. Access to Mental Health Care in Africa

Africa is one of the regions in the world with the lowest mental health public expenditure rates, with an estimated per capita expenditure of less than US$ 10 cents. it is not surprising that the proportion of Africans who receive treatment for mental health problems continues to be extremely low compared to other regions of the world [42; 43]. According to Sankoh, Sevalie and Weston (2018), Africa can only account for an estimated 1·4 mental health workers per 100 000 population, compared with a global average of 9·0 mental health worker per 100 000 and the rate of visits to mental health outpatient facilities per year is 14 per 100 000 in Africa compared to the global annual rate of 1051 visits per 100 000 population [44].

Notwithstanding relatively poor access to mental health services, the COVID-19 pandemic is also reportedly halting crucial mental health services in Africa. According to WHO (2021) "critical funding gaps are halting and disrupting crucial mental health services in Africa, as demand for these services rise amid the COVID-19 pandemic". In the context of the COVID-19 pandemic in Africa, there is an urgent call for increased funding for mental health services. The WHO Regional Director stated that "COVID-19 is adding to a long-simmering mental health care crisis in Africa" [45]

In Africa "we also need more action to provide better mental health information and education, to boost and expand services, and to enhance social and financial protection for people with mental disorders, including laws to ensure human rights for everyone." [46]

Lived Experience Narrative – Marie Angele Abanga (Cameroon)

Mental health has for several years been considered a taboo subject in my country, because anything to do with the mind is mysterious or spiritual. It, therefore, hasn't mattered enough for conversations about mental health to be normalized.

While I struggled with my mental health in my teenage years, I was largely ignored, blamed and even punished for being selfish, reckless and a 'good-for-nothing child'. There was and still is little information about mental health care services available for people struggling with their mental health, and this meant people like myself dealt with a lot of stigma – in my case self-stigma and some from my family who thought I was reckless or seeking attention.

I struggled with my mental health and self-medicated in my own way until I attempted suicide and had a lightbulb moment; had I died it would have been my loss, not societies. I decided to leave my abusive marriage that was the source of tremendous trauma and settled abroad, where I went to see a psychiatrist and a psychotherapist– services I would never have been easily accessible in my country.

8. COVID-19 and Mental Health

The COVID-19 pandemic has had an unprecedented and rampant impact on societies across the world, leaving health, social and mental health devastation in its tracks.

The global health pandemic has impacted on the mental health of millions of people across all nations. This virus not only impacts on health outcomes but its negative symbiotic relationship with mental health compromises millions infected and affected.

The United Nations (2020) stated that "Although the COVID-19 crisis is, in the first instance, a physical health crisis, it has the seeds of a major mental health crisis as well if action is not taken. Good mental health is critical to the functioning of society at the best of times. It must be front and centre of every country's response to and recovery from the COVID-19 pandemic. The mental health and wellbeing of whole societies have been severely impacted by this crisis and are a priority to be addressed urgently." [47]

COVID -19 lockdown measures came at a heavy social and economic cost to many countries but its impact was specifically evident in under-resourced and poverty-stricken communities across the world including Africa where pre-existing inequalities were already alarming. The total number of COVID-19 infections on the continent have remained lower than expected compared to Europe. South Africa remains the epicentre of the pandemic in Africa with the highest infection and death rates. The vaccine programmes across Africa were slow to start and continues to lag behind developed nations while affordability also pose challenges.

"Disadvantaged groups will suffer disproportionately from the adverse effects of COVID-19. Low-income earners performing jobs in precarious, informal sectors of the economy without unemployment insurance, limited access to healthcare, and no back-up savings, are especially at risk." [48]. He added that "The COVID-19 pandemic may not only present a temporary shock, but have lasting implications for poverty rates in South Africa through its effects on people's health, education, and employment prospects, as well as potential knock-on effects from increasing rates of crime and domestic abuse.

Despite this bleak situation, "High-income countries have reserved more than half of the world's coronavirus disease (COVID-19) vaccine doses despite representing just 14% of the world's population, according to an analysis of publicly available data on premarket purchase agreements." [49]

"The successful, equitable implementation of COVID-19 vaccination programmes requires unprecedented global coordination and a sustained commitment of resources—financial, logistical, and technical—from high-income countries." [50]

Most of Africa continues to battle with their purchasing disadvantage and demand-and-supply challenges. The global vaccine access inequalities have a direct impact on Africa's ability to reduce infection rates and deaths. Yet we know no one is safe unless everyone has access to vaccines. Population immunity on the continent will without a doubt reduce the devastating mental health as well as social consequences of mental health.

Lived Experience Narrative - Wariimi Karingi (Kenya)

The COVID-19 pandemic has had adverse effects on the global economy and disrupted social interactions. It has caused a considerable degree of fear and worry. I am not an exception to this, and the fact that I am living with depression and anxiety disorder has been extremely hard.

From the onset of the pandemic, I have experienced numerous relapses due to the 'new normal'. I had a morbid fear of the virus. My anxiety levels skyrocketed because of the thought of losing family members, friends, and my own life. I was initially afraid of speaking up because at the time everyone was experiencing the same challenges, both those with lived experience and without lived experience; we were all trying to survive.

After about four months, I eventually opened up to my psychiatrist who recommended we increase the dosage of my anti-anxiety drugs and have therapy sessions weekly for a couple of months. My health has greatly improved over the past few months. I still have my fears, however; thanks to the correct treatment, I have been able to cope better without my life getting disrupted.

9. Mental Health Intervention – Innovative Practice

Despite the challenges in mental health service provision and specifically the lack of resources, many NGOs have designed and developed innovative practices to ensure greater access to mental health services at a community level.

The Zimbabwean Friendship Bench Project, a mental health innovation provided by lay "grandmother counsellors" also known as "gogos", has provided mental health problem-solving interventions on village or park benches outside primary health care (PHC) clinics to over 27 000 individuals with common mental disorders. These are offered mostly to individuals who would ordinarily not seek assistance. This low-cost intervention has been highly successful.

Evidence on the value of Peer Support Work (PSW) has indicated that peer support workers achieve similar outcomes and are even better than professional services at reducing inpatient service use and enhanced engagement with care, and resulted in a variety of recovery-related outcomes (empowerment, behavioural activation, hopefulness for recovery). Despite the evidence of the benefits (from mostly high-income settings), PSW as a formal service in the African Region has not yet been fully recognised and incorporated into mental health systems. PSW can add value in community-based settings where a continuum of care sets the foundation for recovery, whilst it aligns with human rights and person-centred approaches and ensures that the person is at the centre of decision-making and decides what their specific and unique needs are in terms of facilitating recovery and overall wellbeing.

Lived Experience Narrative – Dixoni Emmanuel (Tanzania)

Going to school was difficult for me; it was too noisy and boisterous. I tried hard to avoid attention and became 'invisible'. In secondary school, I was bullied for a while. I then started to do sports and was pretty good at it. Yet, I found it difficult to move out into the world and I did not know what was happening to me. My college years were difficult but I survived; though I felt small and inferior, I had a big ego like any young man. For years, I was very unwell. One week down, then high for a while, anxious for a few days, then not sleeping. My emotions were 'all over the place' as the phrase goes. My soul was in pain.

What has turned my life around, has been a combination of medication, psychotherapy and peer support.

GROW, the self-help peer group that I am involved in, means a lot to me, I made friends and get ongoing support.

In an unparalleled, never-before-seen strategy, South Africa's COVID-19 State of Disaster regulations identified psycho-social support and interventions as essential while dealing with the devastating consequences of the pandemic. Even though mental health COVID-19 provincial plans were often fragmented, pockets of best practices were identified. Mental health non-profit organisations who pre-empted the lockdown were better prepared and able to reorganise their services while others experienced the lockdown as a barrier and limitation to provide accessible mental health care during the emergency and extended lockdown periods.

Cape Mental Health (CMH) was one such organisation that maximised the lockdown advance notice to design its remote mental health service. The oldest community-based non-profit organisation in South Africa with a proud history spanning 107 years, CMH is committed to providing comprehensive, proactive and enabling mental health services to persons with intellectual disability and those with mental illnesses in the Western Cape Province. The organisation has a track record of mental health service excellence in poor, under-resourced and densely populated communities. The Western Cape Province, in which it operates, is currently the epicentre of the third wave of the pandemic in South Africa, a country that remains the epicentre with the largest infection and death rates seen on the African continent.

The pandemic created the opportunity for CMH to shift, reinvent, reorganise and adapt the way the organisation provides mental health care from facility to home, and face-to-face counselling to virtual interventions and, most importantly, to retain contact, reduce isolation and continue virtual interactions with beneficiaries and all who required mental health support. In the planning stage of this model, the organisation recognised that approximately 98% of their beneficiaries had cellular phones that became a vital tool for migrating the mental health service remotely.

Despite the lockdown restrictions, the organisation was able to keep its 'doors open' by maintaining and building relationships and communicating with those in need about the services using remote

technology such as cellular phone applications, virtual IT technology, Skype, telephonic counselling and assessments, social media engagement, as well as video-conferencing where possible.

The entire switchboard and telephony system of the organisation migrated to a cellular phone. All telephone calls to any of the organisation's programmes were automatically diverted to one cellular phone operated by the receptionist at her home to relay all messages. Data management to render the service was centralised within our Administration Department.

A comprehensive basket of mental health services was offered during the lockdown period to ensure regular contact with service users and their families or caregivers to lessen their isolation, nurture their mental health and offer messages of hope. For example, online counselling services, mental health support, COVID-19 crisis and case management, were provided by a dedicated team of social workers through their preferred means of communication (cellular phone applications, SMS messages, telephone calls or e-mails) to service-users with emotional adjustment problems, psychosocial disability/mental illness, intellectual disability and anyone requiring support during this time.

Activities were shared remotely across all Special Education and Care Centres for children with severe and profound intellectual disability, and youth and adults with moderate and mild intellectual disability and those with severe and profound intellectual disability at Training Workshops Unlimited. The intervention at the Special Education and Care Centres was identified as a best practice mental health innovation during the COVID-19 pandemic by the Mental Health Innovations Network. [51]

10. Financial Investment in Mental Health

Under-resourced and inadequate mental health services have a devastating impact on the lives of many people in Africa.

Eaton et al. noted that Africa, in particular, struggles to meet a number of the key parameters. [52] In many sub-Saharan countries, less than 1% of already small health budgets is spent on mental health, and much of this is used wastefully on institutional care. However, we see a similar picture at an international level, where about the same 1% of Official Development Assistance for health is spent on mental health [53]. In South Africa the vast majority of mental health expenditure was spent on inpatient and outpatient mental health services - approximately 86% of these costs were attributed to inpatient services, while the remaining 14% were attributed to outpatient care. They found that the mental health budget allocations varied significantly across provinces. These findings highlight the significant lack of investment in community-based mental health investment despite the long history of deinstitutionalization and devolvement of primary health level and community mental health. [54] Patel et al. noted that mental disorders are on the rise in every country in the world and will cost the global economy $16 trillion by 2030 if no substantial commitment is made to reverse this situation. [55]

The estimated costs of scaling up treatment, primarily psychosocial counselling and antidepressant medication, amounted to US$ 147 billion. Yet the returns far outweigh the costs.

The WHO reported that national governments spend on average 2% of their health budgets on mental health, ranging from less than 1% in low-income countries to 5% in high-income countries. [56] The President of the World Bank Group, Jim Yong Kim, stated that "Despite hundreds of millions of people around the world living with mental disorders, mental health has remained in the shadows." [57] According to the WHO, for every US$ 1 put into scaled up treatment for common mental disorders, there is a return of US$ 4 in improved health and productivity. This is a strong motivation and justification for investing in mental health that has remained the Cinderella of health services on the continent. [58]

The inadequate response to invest and increase access to mental health has resulted in gross failure to ensure that all global citizens can live fully integrated lives. The United Nations Policy Brief: COVID-19 and the Need for Action on Mental Health states that "this historic underinvestment in mental health needs to be redressed without delay to reduce immense suffering among hundreds of millions of people and mitigate long-term social and economic costs to society." [59]

The value of investment needed over the period 2016–2030 for scaling up treatment, primarily psychosocial counselling and antidepressant medication, amounted to US$ 147 billion. (60) Mental health is an investment and not an expense and should be prioritised now more than ever across all African nations.

11. Proposed Regional and Sub-regional Specific Actions

The recommended region and sub-regional actions to address the inequalities are as follows:

- Regional and sub-regional structures using their oversight function to ensure that all countries on the continent have mental health policies and legislation with clearly identified targets for implementation and ring-fenced budgets; these national mental health policies that are multi-sectoral involve education, labour, justice, transport, environment, housing, social welfare and civil society sectors
- Promoting a "Recovery-oriented Mental Health System" in which each essential service is analysed with respect to its capacity to ameliorate people's impairment, dysfunction, disability, and disadvantage.
- Promoting and protecting the centrality of community-based care in the national response to mental health.
- Addressing the mental health of refugees; African nations should promote a climate that respects and protects basic civil, political, socio-economic and cultural rights fundamental to mental health promotion.
- Integrating trained Peer Support Workers into the mental health workforce.

- Integrating people with lived experience into higher education and curricula of health and mental health-related professional training.
- Ensuring meaningful and authentic engagement with people with lived experience in policy and practice.
- Forming partnerships with existing lived experience organisations to ensure lived experience engagement/consultation is included from the outset in decision-making processes.
- Establishing empowerment programmes for persons with lived experience, and ensuring access to information about mental health, mental health conditions and human rights.
- Aligning mental health services with the recovery model – where services integrate the medical, social and human rights models.
- The region working in unison using the existing platforms: viz. the Africa Union and regional policy subdivisions like the East Africa Community, IGAD, ECOWAS, among others, and always having mental health on the various regional congregations' agenda.

12. Proposed Country-Specific Actions

Countries have a responsibility to ensure equality and care for the most vulnerable. The following are proposed actions that governments can take to address the inequities:

- The development and implementation of mental health policies and legislation within a human rights framework with clearly identified targets for implementation and ring-fenced budgets; these national mental health policies should have a multi-sectoral focus, involving education, health, labour, justice, transport, environment, housing, social welfare and civil society sectors
- Multi-disciplinary Ministerial Advisory Committees that include people with lived experience should be established in every country.
- An integrated Community-based Mental Health Care Model that increases access to mental health services within communities and villages in rural areas that are provided by users of mental health services, other non-specialists, mental health workers and professionals should be implemented; these interventions are person-centred, readily accessible and cost-effective.
- Interventions that shift their focus from largely bio-medical to bio-psycho-social and culture-sensitive interventions.
- Lived Experience Councils or Advisory Committees established to help guide policy reform and to inform implementation, monitoring and evaluation of service delivery so as to ensure alignment with local and international human rights instruments and best practices.
- Existing lived experience organisations to receive additional support and to established these organisations where they do not exist – to ensure that the lived experience community is included in decision-making processes pertaining to policy and practice.
- Countries directing more funds to the mental health sector and using an integrated community-based approach in the implementation of mental health services; responding to a high need for community education awareness programmes to reduce the stigma attached to consumers of mental health services in the region; enhancing capacity building of mental health professionals using the MhGAP approach.

13. Proposed actions for individual citizens

Mental health is everyone's business. It is therefore imperative that everyone every individual contributes the following manner to create an equal society for persons with lived experience in the following manner:

Individuals could benefit from:

- Being informed about mental health conditions, how to identify when someone is experiencing an emotional crisis, and how to support and help such a person access appropriate services (where required or expressed by the person seeking help).
- Being part of the solution to destigmatise mental health and mental health conditions by engaging in conversations around mental health and mental health conditions without judgement.
- Being mindful of using language and terminology that is not stigmatising or discriminatory when talking about mental health and persons living with mental health conditions.
- Encouraging citizens to embrace community ownership of grassroots-based mental health programmes; faith-based institutions being more inclusive and focusing on universal health care with a mental health lens.
- Being willing to volunteer and support the work of NGOs in providing mental health interventions.
- Becoming mental health ambassadors and advocating for the human rights of all with lived experience.
- Gatekeepers in suicide prevention at community level.

14. Conclusion

Decades of poor investment and resourcing in mental health services have disadvantaged many people, thereby limiting access to mental health services in Africa. This legacy has continued preventing a significant proportion of people with lived experience from accessing mental health care within their communities despite affordable person-centred recovery-orientated interventions. Fragmentation in the service delivery and lack of political will to ensure a better dispensation for people with mental illness have been largely responsible for the neglect in policy and legislative frameworks to protect the most vulnerable of our society.

Many awareness campaigns have made clarion calls for greater equality in mental health care to ensure social justice and bring about redress but sadly have fallen short in real mental health actions. The theme of this World Mental Health Day 2021, "Mental Health in an Unequal World: *Together we can make a difference*", places the responsibility to address stigma, discrimination, investment in mental health and address social determinants of mental health at our doorstep, making it everyone's business. Silence endorses injustices and makes us complicit when no advocacy and action is realised. The calls for real action and prioritisation of mental health particularly during the COVID-19 pandemic can no longer be ignored. In this position statement we call for regional, country-specific and individual actions aimed at addressing the scourge of non-delivery in mental

health care.

Mental health can no longer continue to operate in an unequal world in which people's rights are disregarded. Every stakeholder needs to be involved in addressing mental health inequalities and the multi-dimensional determinants of mental disorders to promote human rights and social justice for every African. Arundell et al. recommended that "to reduce the disadvantage associated with these inequalities, meaningful and effective strategies need to be developed." (61). The COVID-19 pandemic has placed mental health at the forefront of the health emergency - it is everyone's responsibility to ensure social justice for all living daily with mental health needs. Every effort to reverse the social and health injustices and suffering needs to be prioritised. Africa needs to advance its strategies to ensure that equality, equity and justice prevail for those with mental health needs.

Of all forms of inequality, injustice in health is the most shocking and inhumane…
Dr Martin Luther King, Jr.

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Informed consent forms have officially been signed and given by all lived experience narrative contributors.

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Introduction Mental Health in an Unequal World- the case of Latin America and the Caribbean

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Summary

Latin America and the Caribbean is one of the most unequal regions in the world. It is sometimes divided into the subregions of South America, Central America and the Latin Caribbean and the non-Latin Caribbean and they all share in the marked inequality in the region. There are longstanding health, social, economic and racial/ethnic inequalities and it is also the most violent region in the world with disproportionately high rates of crime and violence (8% of the world's population but 33% of its murders) (Muggah et al, 2018; Moncada & Franco, 2021). These inequalities are seen between and within countries in the region (Mascayano et al, 2021). Wealth and income inequality especially is one of the more significant issues in this region that impacts every aspect of life. In a 2020 report from the InterAmerican Development Bank (Moreno, IADB, 2020), it was noted that the richest tenth of the population in this region captures twenty- two times the wealth of the lowest tenth. This disparity affects moreso women, those of African descent and indigenous peoples. These inequalities begin at birth and widen during childhood and adolescence having profound impacts on growth and development through inequalities in education, opportunity and access to health care among other social ills. The more disadvantaged are also more likely to be hindered by climate change, natural disasters and social upheaval inclusive of exposure to and experiencing violent crime and poor nutrition. It is no wonder that these disparities have been highlighted during the ongoing Covid 19 pandemic with the poor bearing the brunt of both the health effects and the effects of the mitigation lockdown strategies to combat it (Busso & Messina, IADB,2020). The report noted that high levels of inequality undermine the commitment to the common good and result in discouragement, distrust and cynicism which further disrupt social bonds and lead

to fragmentation and lack of community building. Institutions are also weakened by this distrust. These features of life in this part of the world make mental health promotion and mental illness prevention and treatment urgent societal and developmental issues. Improving access to mental health care and the strategic initiatives to tackle the socioeconomic, gender and ethnic inequalities remain constantly intersecting priorities.

Introduction

Mental health care is one of the main areas where the inequality that is inherent in the region of Latin America and the Caribbean manifests itself. In Disability Adjusted Life Years (DALYs) in the region, a comparison of 1990 and 2017 to review the most common diseases impacting on this metric, revealed self harm and violence increase from eighth to fourth, mental disorders from tenth to sixth and neurological disorders from twelfth to seventh (Berlinski et al, IADB, 2020). This suggests that the consequences of compromised mental and neurological health are becoming an increasingly significant burden on these societies. The other major shift has been the increased prevalence of the chronic non - communicable diseases. All of these - from diabetes to hypertension to obesity and cancer have bidirectional relationships with mental health. The current Covid 19 pandemic has highlighted and exacerbated these inequalities so the timing is right for a focus on how best to address the disparities in mental health care (Mascayano et al, 2021). The disparities that arise out of social inequality also affect North America where African Americans and some Hispanic populations have higher rates of mortality and morbidity for many illnesses and are less likely to access mental health care (Carratala & Maxwell, 2020). The burden of morbidity and mortality in every area of health is therefore greater for these groups. In societies already configured in ways that reinforce the inequalities that exist through unequal access to educational and employment opportunities, the effects of the disparities are worsening over time. Health disparities in Latin America are thought to be a consequence of disparities in living conditions so that the poor and disadvantaged are disadvantaged in this area also (Davila-Cervantes & Agudelo-Botero, 2019). These disparities are generally derived from income inequality and this has been found to be associated with poorer mental health at the subnational level and social, economic and public health policies should be developed to address this in a coordinated manner (Tibber et al, 2021).

An acknowledgment that these gross inequalities in the social system are reflected in the health system can be measured and quantified through the ease of access to care, availability of appropriate treatments and relevant health promotion and prevention efforts. It is also reflected in the way health systems are managed and governed with institutional systems that are inclined to restrict and inhibit diversity and equity of access. There has been a renewed interest in the health effects of inequality. The association of these inequalities with race remains one of the greatest health problems in the world. This is especially pointed with regard to mental health and studies in the United States have repeatedly shown this (Williams et al, 2019). Even in Columbia, ethnic- racial inequity has been identified as a structural component of inequities in access to health services and contributed to the disadvantages for those so affected in the population (Viafara- Lopez et al, 2021).

Mental Health Systems in the Region

Dealing specifically with mental health, the World Health Organisation has developed 10 overall recommendations for mental health care (WHO-AIMS, 2013)

1. Treatment in primary care of mental disorders
2. Availability of psychotropic drugs
3. Develop national policies, programmes and legislation
4. Development of human resources
5. Public education
6. Give care in the community
7. Monitor community mental health
8. Involve communities, families and consumers
9. Links with other sectors
10. Support more research

These recommendations are further grouped into six domains in the assessment instrument for mental health care systems (AIMS) through which the issues related to inequality and mental health can be discussed. The domains are 1. Policy and legislative framework. 2. Mental health services. 3. Mental health in primary care. 4. Human Resources in mental health care. 5. Public education and links with other sectors. 6. Monitoring and research. The following is a review of the last published report on mental health in Latin America and the Caribbean published by the Pan American Health Organisation (PAHO) in conjunction with the World Health Organisation (WHO) in 2013 (WHO-AIMS, 2013). All statistics quoted come from the text of the report.

Domain 1 – Policy and Legislative Framework

While most countries in the region now have mental health policies and plans the degree to which these have been implemented vary widely and in turn affect how equitably the services available to the mentally ill can be accessed. Human rights, community- based care, legislation governing the treatment of the mentally ill are in various stages of evolution throughout the region and the financing of mental health services tends to be in the range of 1-3% of the national budget on average in the region. This combined with the absence of social security benefits, difficulties with housing and employment all contribute to the lived inequality of those disadvantaged by the socioeconomic and other societal inequalities. In this way, protection of the most vulnerable is unattainable. The inability to afford medication and low minimum wage levels mean that those at the lower end of the social spectrum are subject to the likelihood of unaffordable medicines especially as the public sector services are not consistently accessible or consistently stock all of the necessary medication. Many countries in the region do not have updated legislative frameworks for mental health and this indeed is an urgent priority to provide protection for those who are already disadvantaged

by their lack of economic and social status.

Domain 2 – Mental Health Services

Most of the services are based on tradition and history based on the systems developed by the former European colonisers in the region and generally function around a centralized mental hospital/s with outpatient services in the community. Many of the hospitals serve a residential function as well as an acute care function and there are an average of 12 beds /100000 population in the region. Day care facilities are lacking as are forensic units though generally the non - Latin Caribbean have the most evolved services. Many of the countries have free public sector services but these function at varying levels of efficacy and effectiveness. Private care is also available in most countries but since these must be individually funded, they are only accessible to those with available economic resources. It generally creates a two-tiered system where the public services are available to the poorer classes and the private services to those better off financially. This reinforces the inequality in the society and mean that those who use the public sector are less likely to challenge for their rights if these rights are being abused. Another gaping absence is services for children and adolescents particularly in the non latin Caribbean where only 7.5% of the service allocation is for this age group compared to 21% and 23% for Central and Latin America (WHO-AIMS, 2013). The elderly and those with co-morbid chronic non-communicable illnesses are also underserved. There are few dedicated services for these populations and their care is subsumed in to the general services on an as needed or as requested basis.

Domain 3 – Mental Health in Primary Care

The provision of mental health care in primary care has been identified as a means of addressing the gaps in treatment that leave many mental disorders unrecognized and therefore undiagnosed and untreated. Having the facility to treat mental health problems at this level also decreases the burden on the more specialized services and also contributes to reduced stigma. However, the uptake from this approach has been fairly limited in the region, as training in mental health and the absence of practice guidelines have hampered primary care health professionals from engaging in this process more comprehensively. This may in turn lead them to seek help from more traditional sources such as healers, people who claim to deal in the supernatural or churches and other religious practice. Belief systems regarding the cause of mental illness while pervasively embrace the supernatural and the spiritual also influence the decreased engagement with services that are thought to be oriented toward physical health. This further underserves the population who are likely to be those who are already disadvantaged and diminishes the quality of the mental health care that they may be able to access. Cuba is an exception to this situation and here members of the Comprehensive Family Health Care teams regularly interact with mental health and social work professionals to offer an integrated model of care.

Domain 4 – Human Resources in Mental Health Care

In the region, there is wide variation in the availability of mental health professionals – 6-79 per 100,000 in Central America and the Latin Caribbean; 4 – 173 in South America and 9.6-182 in the non -Latin Caribbean. The number of psychiatrists also varies with South America and the non-Latin Caribbean being as much as twice that available in Central America. Apart from the non-Latin Caribbean, the availability of nurses working in mental health is relatively low. Another problem is that the psychiatrists tend to be concentrated in urban areas making mental health care in the rural areas much less accessible. In addition, the psychiatrists and some of the other mental health professionals share their time between the private and the public sector making them less available to meet social need. They are also then compromised in advocating for improvements to public health care services or indeed to develop new ones that are adapting to the needs of the population. Training in mental health related disciplines is available throughout the region but the availability of mental health professionals in allied disciplines such as Psychology , Occupational Therapy and the creative therapies such as Music and Art Therapy remains less than optimum. Social work is perhaps the one discipline where the numbers reflect the needs of the population and compare favorably to the developed world. Because of these limitations and the demands placed on limited human resources, burnout among these mental health professionals is common and again in the absence of mental health plans and policies, their services are utilized in private practice and the benefits are denied to the masses particularly those who are socially displaced and indigent. User and family associations are also mostly non-existent and their absence means that the needs of those most disadvantaged may not be identified and addressed particularly with regard to human rights and the improvement of services.

Domain 5 Public Education and Links to Other Sectors

There has been a growing appreciation and implementation of education and awareness campaigns for mental health which target various sectors in the society. Most of the countries in the region have coordinating bodies that manage these campaigns. The absence of user and family groups and perhaps stigma against the mentally ill, is reflected in the consistent lack across the region of legislative or systematic mechanisms to facilitate housing, employment and non-discriminatory practices for people living with mental illness. Formal interdisciplinary links with other sectors for example the legal and judicial system mean that services do not always meet the holistic needs of the population being served. This is particularly seen in South America, where in only half the countries of this subregion 1-20% of prisons offer services for the mentally ill. Interestingly in the non- Latin Caribbean most of the prisons have some form of mental health service in the larger islands. Still, the links with the judicial and law enforcement systems are not so developed as there are few training provisions for these officers involved in discharging these services in mental health. Similarly links with the education sector are patchy as are those with social services and services for populations such as the homeless and the street dwellers.

There are usually established links within the health sector however there may also be gaps when

individuals need multiple inputs such as those provided by primary care and substance abuse services or indeed more specialized medical or surgical services

Domain 6 – Monitoring and Research

Provision of data and information systems reporting on the utilization of the mental health services is inconsistent, information systems in most of the countries do not have the tools or technology to report effectively on the utilization of mental health services. Most countries report on the number of beds being occupied, the length of stay and the range of diagnoses of the admissions but very little is reported on the kinds of admissions – involuntary compared to voluntary and the patterns of utilization. This means that an understanding of the epidemiology of mental illness over time is not easy to engage. This hinders an appreciation of the effectiveness of the services and the direction in which they should adapt to suit the particular needs of their population. It also serves to disguise possible human rights violations and/or treatment biases particularly in already disenfranchised groups (Almanzar et al, 2015). Information generally flows to the Ministries of Health to justify funding and allocations of staff but there is little critical analysis.

Research is also limited particularly in mental health though there is now greater attention being paid to this area. In most of the region, only 10-15% of the health papers published do report on or include some aspect of mental health. A possible reason for this is the lack of funding for research in general except in the larger countries of the region such as Brazil, Argentina and Mexico. A lot of funding comes from the pharmaceutical industry which would be interested in developing their agenda rather than meeting the developmental needs of the country. In addition, dissemination of information derived from research tends to have limited impact because there is limited exposure to the population through public engagement.

The WHO-AIMS report concluded that while there was cause for optimism and some major advances had occurred over the previous decade (2001-2010), a lot needed to be done to address the many disparities within and between countries. Mental health legislation, more equitable financing, decentralizing mental health care, greater integration with primary care services, greater intersectoral links, protection of human rights of those with mental illness and improvements in information systems and research activity are all required to address the deficits identified.

Discussion/Conclusion

Inequities in access to mental health care, social vulnerability, and an absence of social inclusion all influence the generation of mental health distress and the capacity to seek and receive appropriate help for this distress (Blucacz et al, 2020). The treatment gap in mental health is a major concern in the region and a high proportion of adults, children and indigenous people remain untreated and therefore unable to fully engage in productive optimum lives (Kohn et al, 2018). This has implications for human and social development in the region and must be addressed as an

area of special concern. The marked difference in access to services in rural compared to urban communities, the lack of mental health in patient beds and specific services remain obstacles to ensure equity of mental health care in this region.

The Jamaican model of treating mentally ill patients in a general hospital setting on beds in the medical ward (Abel et al, 2011) has been one strategy to overcome this rural-urban divide by reducing the need for dedicated psychiatric beds in a specific location.

Other difficulties in the region include insufficient services, poor integration of related services, fragile crisis management and inconsistent family and social support because of inherent limitations in psychosocial resources and lack of strong structural networks for crisis management (Sampaio & Bispo Jnr, 2021).

In the Americas, there are specific geo-political issues such as migrant refugees, crime and violence, mental health support during this ongoing Covid 19 pandemic, drug use and treatment and rehabilitation of those socially displaced and mentally ill warrant great attention. Migration and unregulated movement of populations seeking a better life or escaping from conflicts or persecution remains a feature and this also creates inequities as these groups have additional mental health needs related to managing trauma for example that are rarely met. The recent crisis in Venezuela and the many citizens of Central and South America who attempt to enter other countries in the Americas illegally bears witness to this (Derr, 2016 ; Mougenot et al, 2021).

Mental health services in Latin America and the Caribbean have improved over the 21st century. One of the major inhibiting factors is insufficient funding which is a consequence of the parlous and vulnerable economic state of many countries in this region. Lack of consensus, and inadequate and perhaps inappropriate training among the human resources, the lack of family and user association advocacy and a relatively dormant political will all contribute to the slower development of mental health services in this region. Renewed interest in human rights, the development of research capacity, the psychological impact of natural disasters and now the covid 19 pandemic and the greater opportunities for international cooperation may also influence the positive growth of these services. (Caldas de Almeida, 2013). One of the major drivers of mental health services reform was the 49th Directing Council of PAHO/WHO which approved the Strategy and Plan of Action on Mental Health in the region of the Americas (Rodriguez, 2010). This plan mandated the Ministries of Health of the region to engage in sectoral reform and provided technical assistance to achieve the goals. Although insufficient funding was a limiting factor, the awareness of the growing burden of diseases attributable to psychiatric and neurological problems and also a growing treatment gap where the majority of those afflicted with these problems were not accessing services prompted these initiatives which have borne some fruit.

Challenges/Objectives

1. To remove the stigma associated with mental health and treatment.
2. To ensure equitable mental health delivery and access among all socio- demographic groups.

3. To minimize disability and improve linkages with other sectors to ensure improved social services for those with mental health problems and other underserved populations eg prisoners
4. To increase funding for mental health
5. To improve prevention and mental health promotion efforts
6. To improve mental health delivery in maternal health.
7. To integrate primary care services with mental health services.
8. To have improved liaison services between mental health and other medical services eg maternal health and child health.
9. To improve research activity and ensure appropriate dissemination.
10. To improve advocacy through facilitation of user groups and caregiver support strategies

Closing Comments

Public health, and primary care must be intimately involved in the expansion and development of mental health services to reach more people and reduce the number of unrecognized mental health problems. Improved access to educational opportunity is also another pivotal factor as is maternal and child health care. Child and adolescent mental health services in the region lag far behind other more developed countries. At the other end of the age spectrum, the region's demographic shift is also well underway and is already demanding a greater range of geriatric mental health services for the growing elderly population (WHO-AIMS, 2013). Again, here the inequalities of the region will determine the effectiveness of these responses within populations.

The incorporation and alignment of faith based services with mental health services may be helpful in addressing mental health literacy and antistigma interventions as beliefs related to supernatural causation of mental illness and prayer and faith as a means to overcome psychological distress are common in the region (Caplan, 2019). More general efforts to improve mental health literacy, thereby diminishing the stigma of mental illness and encouraging and facilitating help seeking are urgent priorities

Workplace wellness and mental health, improved disaster management plans incorporating mental health emergencies that are inevitable a part of these disasters is needed. Specific services for populations like the incarcerated, substance use disorder programs, mitigating the roles of pollution and climate change are all components of the strategies to combat the likely mental health needs of the region in the coming decades and address the inequalities that now exist in the region that are amplified by the socioeconomic inequalities. Devising preventive and early access facilities for intimate partner and interpersonal violence are also priorities as these disproportionately affect the region's disadvantaged. Training of mental health professionals in all areas from psychiatry to nursing to the various physical occupational and creative therapies would all help to decrease inequality and mental health support and treatment.

Intersectoral academic and service linkages with maternal and paediatric health services will serve to anticipate some of the problems that begin in childhood but only express themselves in adolescence and young adulthood including those of poor nutrition and bullying. Multisectoral

approaches marrying economics, education, social services and mental health alongside the provision of services to address issues such as housing, employment and discrimination. Working with Making the links between the social problems such as interpersonal violence and social inequality with mental health problems is also needed given the regions unfortunate tag as the most dangerous in the world. Finally, recognition that inequality has a direct and powerful effect on mental health and contributes to many of the region's problems and requires political and social will to be overcome if the region's development is not to be permanently stunted. Equity of access to mental health services is one of the ways in which the social inequalities that affect the region can be addressed.

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Pediatric Racial/Ethnic Mental Health Disparities in North America

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Purpose of this Position Statement

- To highlight the significance of racial/ethnic disparities in pediatric mental health in North America, particularly the United States
- To outline the various types and levels of racial/ethnic disparities in clinical care, as well as systemic disparities related to structural racism and discrimination in the mental health and health system
- To outline recommendations for addressing racial/ethic disparities that encompass provider, health and social service systems, and population level interventions and reforms

Introduction

North America, particularly the United States, has undergone a major growth of non-European populations over the past 50 years. This has been both a result of demographic changes (aging of the European origin populations and relative grrater growth of African American, Latinix, Asian origin, and American Indian populations) and significant immigration from Latin America, Southeast and East Asia, the Middle East, and Africa. As a result, by last year (2020) the majority of children and youth in the U.S. are from non-European backgrounds (this will be the case for the overall population by 2045). These populations face higher rates of psychosocial disparities such as poverty, lack of education, and barriers to health and mental health services, as well as dealing with multiple stressors such as traumatic stress, community violence exposure, immigration stresses, and acculgturation stress from pressure to assimilate to mainstream American culture. These are placing greater stressors on these populations than on their European-origin cohorts, and starting to result in increasing rates of mental health morbidity, such as suicidality, stress related disorders,

school disciplinary actions, and rates of incarceration and placement in state custody. At the same time, the children's mental health service system in the U.S. is a largely fragmented system geared to middle class Caucasian norms of family independence and self-sufficiency. In spite of some efforts, this system lacks the necessary skills and capacity to address the special cultural and psychosocial needs of these growing populations. This mental health system has inherent structural racism and discrimination as a result where Black Indigenous and Populations of Color (BIPOC) lack access to care and experience lack of effective services and outcomes, adversely affecting their quality of life and potentially adversely affecting the overall mental health of the nation. (Ref here)

The challenges and the need

The increasing need for and utilization of child mental health services in the United States has spurred their rapid growth. Recent studies suggest that approximately 20 percent of children and adolescents have a diagnosable mental, emotional, or behavioral disorder, with 5 percent having serious mental illness and emotional disturbance and over US $ 247 billion being spent annually on children's mental health services (Perou et al, 2013). Several morbidities have been associated with childhood emotional disturbance and mental illness, including suicide, homicide, substance abuse, child abuse, teenage pregnancy, school dropout, youth crime, and associated institutionalization and incarceration. However, less than 1 percent of children in the United States receive mental health treatment in hospital or residential settings, with another 5 percent receiving treatment in outpatient or community-based settings; greater than two-thirds of children in need still receive insufficient or no mental health services whatsoever. There is evidence that the recent COVID-19 pandemic has significantly increased levels of mental health need and rates of morbidities as well as rates of mental health utilization among children and youth, aggravating these gaps in services even more (FAIR Health, 2021).

BIPOC children and families have been traditionally served by public community-based mental health and human services agencies. Children from these populations experience higher levels of stressors, such as poverty, discrimination, immigration, acculturation stress, and exposure to violence and trauma, and they are likely to have higher levels of need for services. It has become clearer that these populations suffer from major disparities in access to care as well access to quality and effective care, particularly African American and Latinix youth. A growing awareness and recent reckoning with the long-term impact of racism and discrimination in the United States racism has pointed to inherent structural racism in societal institutions, including mental health, health, education, and social services, which are now recognized as resulting in such disparities and the lack of cultural competence of such services. The cost of effectively serving BIPOC children and adolescents is in stark contrast to the much higher cost of psychosocial morbidities of racial/ ethnic disparities, including lost human potential and the costs of welfare dependency and institutionalization. The United States continues to have the highest youth incarceration rates in the world, the highest levels of out-of-home or community residential placement for youth, and a high rate of children in state custody (Alegria, et al. 2015; Youth.gov, 2021), both disproportionate-

ly impacting youth of color. Due to lack of funding for effective community-based mental health services, a health and human service agencies (schools, social welfare agencies, child protective agencies, juvenile justice, and public health) have shouldered the increasing burden of psychosocial morbidity experienced by these children and youth. These agencies typically address pieces of the service system puzzle, with little to no coordination with other agencies serving the same youth resulting in increasing care fragmentation. (Abram et al, 2015; Alegria et al, 2015).

These trends have increased pressures on public child mental health and social service agencies to demonstrate improved clinical and cost-effectiveness, increasingly turning to managed care approaches to finance and organize mental health and social services. Most children covered by Medicaid (the public insurance system in the US) are under managed care plans, including for behavioral health services. Most managed care approaches were developed with private sector populations in mind, relying on a priori benefit restrictions based on actuarial data on middle-class populations with adequate social supports, who are traditionally lower users of services. When applied to public child mental health services, these approaches deprive children at high risk of effective intervention and preventive services. They also contribute to fragmentation of care and burden shifting to other child-serving agencies and systems, significantly increasing morbidity and acute need. Some state Medicaid programs have successfully implemented community-systems-of-care approaches and integrated them with managed care methods through its home and community based behavioral health services waivers (Medicaid and CHIP Payment and Access Commission. Report to Congress on Medicaid and CHIP, 2021), but so far, no state in the United States has been successful at statewide implementation of system of care in spite of an extensive number of systems of care pilots (U.S. Department of Health and Human Services, 2015).

Services research literature with underserved minority youth has been sparse, and initially was focused on documenting racial differences in services provided. African American children tend to remain in foster care for longer periods of time and to have more foster care placements than white children. Studies have shown culturally diverse children to be underrepresented in mental health institutions and overrepresented in child welfare and juvenile justice settings and placements compared to nonminority youth, even when they are equally psychiatrically impaired. Ethnic and racial differences in the diagnoses of culturally diverse adolescents have been identified by some investigators, including overdiagnosis of conduct disorder and psychoses and underdiagnosis of affective, personality, and substance abuse disorders. Significantly lower rates for overall services utilization persist over a number of years, and specifically for the treatment of depression among African Americans and Latinos have been documented (Alegria et al, 2015). Significant amongst them, the SAMHSA Comprehensive Community Mental Health Services for Children and their Families initiative has demonstrated not only significantly improved access by BIPOC children and families, but also equivalent outcomes that are correlated to cultural competence program measures.

Proposed region specific actions

This position statement is written in the context of a well recognized global crisis in children's mental health, highlighted by the COVID pandemic. Therefore, it is important to note that most nations fall short in addressing these important and growing needs (Benton, Boyd, and Njoroge, 2021).

The main recommendations outlined below in the country section are more specific to the United States. However, the proposals and models are also a goog fit for thhe children's mental health needs experienced by the rest of North America, particularly Mexico and Canada.

Mexico has significant racial/ethnic disparities that parallel regional disparities due to its dearth of chidlren's mental health services but also their concentration in urban centers and academic institutions. Mexico lacks a community-based children's mental health infrastrcutre that reaches down to smaller towns and rural areas, where the majority of its indigenous populations resides. , which is a very young popoulation. Only 200 psychiatrists are licensed to see children, so there is not only an extreme shortage of child/ adolesdcnet psychiatrists, but also similar shortages of other mental health disciplines.

Sixty percent of Mexicans have national health insurance, so 40 % are uninsured. A combination of state and federal funding supports the country's 32 states in administering their health care systems. States also differ substantially in their health investment since they differ substantially in their tax base and other resources as well as the degree of social need. Child and adolescent mental health services in Mexico are delivered through an underfunded, and uncoordinated network of institutional providers (many psychiatric hospitals) isolated from the larger health care system. Some localities have consulting psychiatrists and psychologists serving schools as a means of providing some access to services. The natioinal child welfare system, Desarrollo Integral de la Familia (DIF), under the federal Secretariat of Health, has some family preservation service that at times can be mobilized for chidlren with behavioral and mental health problems. (Espinola-Nadurille et al, 2010; Sistema Nacional para el Desarrollo Integral de la Familia (DIF), 2021).

The Canadian system is socialized and organized at the levelof provinces with prpovincial and federal funding. The Canadian system is organized around primary care, with specialty care provided by referral to specialist and specialty centers Canada has significantly greater access to childen's menta health services and much higher numbers of mental health professinoals, with some ties to schools and other local institutions but largely based in clinics and hospitals. Canada still faces a shortage of intensive community-based services for children and families and lack of coordination across child serving agencies. The challenge for Canada is that provinces outside of Ontario and Quebec face many of the similar issues as in the U.S. due to their more Euro-centric orientation in spite of growing Native and non European immigrant populations. Mexico has challenges around implementation of many of these recommendations given their relatively resource poor environment and less developed mental helth system. (Mental Health Commission of Canada, 2021).

Both Mexico and Canada could benefit from a more systematicinter-agency approach to children's behavioral health services that alsoexpanded community-based services in local communities.

Given their significant diversity due to its high percentate of indigenous and growing immigrant populations, both nations can also benefit from culturally competent approaches. Though Canada has recentl focued more attention to the needs of First Nation populations, Mexico's mental health system could benefit from a more comprehensive culturally competent approach that leveraged non-professional indigenous lay mental health workers and cultural healers to provide an outreach basic behafiiral workforce. In fact, in the U.S. a model for this approach, the Promotas de Salud model, is used along the US-Mexico border for publis health and behaviiral health promotion (Grames, 2006).

Proposed country specific actions

A. Implementation of cultural competence mental health training for all US mental health providers, both at the pre-practice training level and tied to their on-going licensure maintenance

Cultural competence is an integral element of community-based systems of care. It implies that practitioners in systems of care develop the necessary attitudes, skill, and knowledge base to serve minority and culturally diverse children and families in their communities, as well as having service systems that develop policies and practices to remove barriers for access to services and make these more responsive to the needs and values of diverse communities. Studies have also shown higher engagement in treatment by minority youth and families if the clinician is of a similar ethnic/ racial background, though the impact on outcomes is less significant (Cabral and Smith, 2011). These findings have led to a focus to address disparities through recruitment of greater number of BIPOC providers into the mental health professions. Though such efforts are very much needed, less attention has been paid to the effectiveness of cultural competence training of mainstream providers to equip them to better serve BIPOC children and families, as well as well as training on the implementation of many evidence-based psychotherapy and community treatment programs that are effective in serving BIPOC children and families (Pumariega et al, 2013).

The community-based systems-of-care approach is congruent with the cultural values of ethnic minority populations, which emphasize strong extended family involvement in the life and upbringing of children and the use of natural community resources first in dealing with the emotional and physical problems of family members. These factors have been shown to be protective from some of the morbidities associated with emotional disturbance, such as substance abuse and suicidality. National guidelines for cultural competence for managed Medicaid services have been published by the CMHS, and the Practice Parameter adopted by the American Academy of Child and Adolescent Psychiatry (AACAP) operationalizes elements of cultural competence at both the clinical and systems levels. Building on this work, more recent efforts by various professional organizations and researchers on children's mental health has focused on the impact of structural racism on racial/ ethnic disparities, such as the rising prevalence of psychiatric morbidities such as suicide in BIPOC children and the barriers to access to effective mental health and social services (Four Racial Ethnic Panels, 1999; Pumariega et al, 2013; Alegria et al, 2015).

B. Statewide and nationwide systematic implementation of the community systems of care model as the overall structure for children's mental health services

Over the last 35 years, the community-based system of care model and principles have been developed in response to similar problems with fragmentation of care and lack of appropriate access in child mental health, particularly for children and families with multiple problems and needs. These principles are based on a flexible and individualized approach to service delivery for the child and family within the home and community as an alternative to treatment in out-of-home settings, while attending to family and systems issues that impact such care. The key principles include: access to a comprehensive array of services, treatment individualized to the child's needs, treatment in the least restrictive environment possible, full utilization of family and community resources, full participation of families and youth as partners in services planning and delivery, interagency coordination, the use of case management for services coordination, no ejection or rejection from services due to lack of "treatability" or "cooperation" with interventions, early identification and intervention, smooth transition of youth into the adult service system, effective advocacy efforts, and non-discriminating, culturally sensitive services (Winters and Pumariega, 2007).

Family-driven care is a cornerstone of the system-of-care model and has had a significant influence on national policy for both child and adult mental health. The child and family drive the clinical planning process through determining the goals and desired outcomes of services, selecting the composition of the interagency service planning team, evaluating the effectiveness of services, and having a meaningful role in all decisions, including those that impact funding of services. The interagency planning team typically has representatives from all the agencies and sectors involved with the child, and the team process facilitates interagency and interdisciplinary collaboration. The complementary contributions of various team members function synergistically in identifying system and community resources to promote better outcomes (Stroul and Freedman, 1986; Winters and Pumariega, 2007).

For children with complex problems involved in multiple child-serving agencies, assessment and treatment planning are primarily accomplished through interdisciplinary clinical teams. These teams bring together different clinical and support resources to address the child's needs to supporting him/ her and their family in their community environment. Teams use the wraparound process, a specific model of a child- and family-driven team planning process that has been empirically tested within systems of care. Wraparound is a definable, integrated planning process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a set of positive outcomes. The wraparound process builds on the strengths of the child and family, is community-based (using a balance of formal and informal supports), is outcome-driven, and provides unconditional care. Use of a strength-based orientation and discussion of needs rather than problems promote more active engagement by families in service planning activities. Interventions designed to reinforce strengths of the child and family may include nontraditional therapies such as specific skills training or mentored work experiences that remediate or offset deficits. These interventions generally are not included in traditional categorical

funding and may require flexible funds that are not assigned to specific service types. Care management is key for the wraparound process so that different services and different interventions can be well coordinated and integrated for greatest effectiveness, and not duplicated (Winters and Pumariega, 2007).

Family participation is also facilitated through the parallel development of child and family teams (CFT's). CFT's are composed primarily of nonprofessional members led by the consumer family, usually a parent. In cases of older youth as consumers, the youth may serve as team leader. Empowering youth and families to assume a central role in outlining treatment goals and planning requires the involvement of specially trained individuals who can guide such families to develop such goals. CFT's collaborate with interdisciplinary teams and professionals in agencies providing services. The CFT creates an overall care plan, including a crisis plan. The clinical team then negotiates their role in the crisis and care plans. This negotiation further educates families about how their child's needs could be addressed through treatment and enables professionals to learn about the realities faced by the family (Winters and Pumariega, 2007).

More recently, services quality, cost-effectiveness, and outcomes and integration of evidence-based practices have received greater emphasis within community-based systems of care programs. An example of such emphasis has been the multisite national evaluation of the Comprehensive Mental Health Services Program for Children and Their Families. This program, which has funded over 170 local and regional systems of care programs, has had national evaluations with methodology measuring symptom, functionality, and strength change over baseline ratings at the start of the programs and matched control evaluations The most recent report to Congress (U.S. Department of Health and Human Services, 2015) on the evaluation of this program as well as previous reports outlined significant improvement in internalizing and externalizing symptoms and child/family function using objective measures, increased stability of living situation with reduced caregiver strain, improved educational function, reduced hospitalizations, reduced law enforcement contacts, and reduced cost of care in other service sectors such as education, juvenile justice, child welfare, and general health, and more recently cost reductions in mental health costs. Other results from the program evaluation have demonstrated correlations of clinical and functional outcomes to program site fidelity to system of care principles, including cultural competence domain measures (Stephens, Holden, and Hernandez, 2004). Additionally, these programs have demonstrated equivalent access and outcomes for BIPOC children, youth, and their families (U.S. Department of Health and Human Services, 2015).

Despite this significant Federal investment in the Communities of Care program (by now over one billion dollars) and their significant outcomes, there has been few efforts at bringing the program up to scale for statewide or national implementation, especially through the Medicaid public insurance program. This program would address not only the need of BIPOC children and families, but also all children and families, and would be more cost effective than the current fragmented approach. This is the main second recommendation within this position statement, which could be enacted at first through Federal legislation granting financial incentives for state system reform to interested states, but eventually making Medicaid funding contingent on a system of care framework and model for all regions of each state.

The ideal application of the system of care model at a state-wide level would have basic medical, developmental, and behavioral health services coordinated through a collaboration of school-based mental health programs and Pediatric Medical Homes. School-based mental health programs have been a cornerstone of most of the programs under the Comprehensive Mental Health Services Program for Children and Their Families. Schools are the ideal setting for the "base" for a comprehensive mental health system of care program given the significant time that children spend in school, the access to evaluation of children's functionality, how behavioural/ mental health disorders adversely impact academic and social function evident in schools, access to the observations of multiple observers (teachers, counsellors, staff) and high level of family engagement to schools. Many schools already provide a certain level of mental health services, but in this proposed structure all ambulatory services (including even middle intensity services such as partial programs or intensive community teams) would be based out of schools (Stephan et al, 2007).

The Pediatric Medical Home is another important cornerstone for this system. These share many principles and elements with the community-based mental health systems model (Arsanow, et al, 2017). Adjunctive entities that have recently surfaced nationally and are closely tied to pediatric medical homes are Pediatric Behavioral Health Collaborative Programs. These provide the supports that are often necessary for pediatric primary care providers to address entry level behavioral health (and often developmental) services, including consultation (telephonic or televideo) with child and adolescent psychiatrists, psychologists, and licensed social workers, assistance with care coordination services to assist families in accessing community resources, ongoing training and skill building support, and technical assistance for practices to integrate behavioral health services within the practice's care processes. This collaboration can also identify children and youth with complex needs who require a more interdisciplinary coordinated care approach. (Pumariega, 2017; Arsanow et al, 2015; Grimes et al, 2018).

For children, youth, and families who have more complex mental health needs, more intensive care could be coordinated at the local level using interdisciplinary teams and child and family teams which would interface with school-based mental health programs and Pediatric Medical Homes, in conjunction with Pediatric Behavioral Health Collaborative Programs. These could pursue comprehensive assessment and treatment planning, bring in the necessary medical and behavioral specialists/ disciplines from their respective sectors (private, public, academic, non-profit, etc.) to negotiate service/ treatment plans across school, home, and community with families and affected persons, implement such plans, address arbitrary barriers to access to care and care coordination (for example, between private/academic and public providers, across schools and mental health providers, and blended funding sources for different types and levels of services. Such interdisciplinary teams would be significantly more clinically effective and cost effective. State entities that currently provide limited support and referral services could provide the oversight, structure, and case management support, and serve a convening function for such teams, with incentives from enhanced funding for team participation (as opposed to solo treatment in silos) and empower such teams by streamlining eligibility and access procedures. More uniform standards around the qualifications of service providers and application of evidence-based interventions to fidelity by such care coordinating entities could also greatly enhance such approaches. The primary care provider within the Pediatric Medical Home and the pediatric behavioral health collaborative program

would continue to be central and engaged within these teams.

Proposed actions for individual citizens

Individual citizens can take up more active advocacy for children's mental health services, particularly for BIPOC children and families, and for children's system of care reform in general. This will require public education campaigns that inform citizens on the impact of racial/ ethnic mental health disparities on communities and the ineffectiveness of the currently fragmentad chidlren's mental health system. Individual citizen advocates, outsode of the professional ranks, coudl influence legilators (first at the Federal level and later at the state level) on holding hearing and investigations on systematic children's mental health services reform and reasons wy a auccfessul model has not been taken to larger scale. This might also reqjuire efforts at stigma reduction so the parents of affeccted children can speak out and give input to legislators on how the current system fails their children.

Implementing change

Strategies that could be used to advocate these change steps include public stigma reduction campaigns, advocacy organizations approaching friendly Federal legislators about investigations and hearings as proposed above, and to address BIPOC communites ad enlist them in joining advoacy efforts. The two main advocachy organizations that could be motivated to take on this effort are the Federation of Families for Chidlren's Mental Health and the National Alliance for the Mentally Ill. The Federation was actualy very involved in the advocacy for the initiation and sustainability of the Federal Communities of Care program. National advocacy organizations for BIPOC populations such as the NAACAP, Urban League, League of Latin American Voters (LULAC) and Federal legislative caucuses such as the Congressinlal Black Caucus and the Congreressional Hispanic Caucus would be natural allies. Professinla organizations such as the American Academy of Child and Adolescent Psychiatry, the American Psychological and Psychiatric Associations, and others are also key in advocating for this change. The outcome of these advocacy efforts could be a system of care that is culturaly responsive, anti-racist, clinically effective, and cost accountable.

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Urgent action needed to scale-up mental health services in an unequal world

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Equity is at the heart of the 2030 Agenda for Sustainable Development, with a particular aim to "promote physical and mental health and well-being, and to extend life expectancy for all, by achieving universal health coverage and access to quality health care [so] no one [is] left behind" (WHO SDGs, paragraph 26 of the 2030 Agenda)[1]. However, action on achieving both universal health care and promotion of mental health and well-being remains patchy and uneven in the Eastern Mediterranean Region (EMRO) of WHO and globally.

The burden of mental disorders continues to grow with a significant impact on nation states, developmental and security trajectories and their ability to deliver on their commitments to promote and protect the rights of their citizens. This includes impacting on their right to enjoy the highest attainable standards of health, and to achieve their true potential as individuals contributing to their families and communities.

The EMRO has the highest rates of mental disorders among the WHO regions. This is primarily accounted for by prevailing protracted humanitarian emergencies in several countries in the region, which on one hand increases the need and demand for mental health services, while on the other results in attrition of the capacities of health and social care systems to deliver the needed care. The mental health care systems continue to suffer from neglect and apathy with the inadequate allocation of human, structural, institutional, and financial resources. The situation is further compounded by the stigma, discrimination, and human rights abuses to which people with mental disorders are exposed (United Nations, 2020)[2].

This Position Statement aims to outline the risks and challenges relating to mental health in an unequal world; providing practical and inclusive recommendations designed to correct the apathy and neglect of the past decades to support bringing mental health into the mainstream of public health.

Background

The Eastern Mediterranean Region stretches from Morocco in the West to Pakistan in the East and consists of 21 WHO Member States and the Occupied Palestinian territories (West Bank and Gaza Strip). It is home to 731 million people characterized by marked disparities between and within countries, complex, protracted humanitarian emergencies, and a growing youth population with large-scale internal displacement and migration. While some countries have experienced growth and development, others have witnessed extreme adversity with subsequent deterioration in health parameters in general and mental health in particular. Furthermore, the social, religious, and cultural norms are also amongst the important determinants of mental health in the Region. While contributing to the high levels of social cohesion and support for people with mental health problems, they also contribute to some damaging beliefs and practices that lead to stigmatization of and discrimination against people with mental health disorders. All these issues can have serious consequences on accessibility, availability, affordability, and acceptability of health and social care services for persons with mental health disorders.

Introduction

Mental, neurological, and substance use disorders (MNS) affect 1 in 10 persons around the world at any given time (Mental Health Atlas, 2017)[3]. The Lancet Commission on Global Mental Health (2018) reported a rise in mental disorders in every country in the world over the last three decades, which is expected to cost the global economy $16 trillion by 2030. The economic cost is attributed to lost productivity due to mental illness based on an estimated 12 billion working days predicted to be lost every year. The report showed that poor mental health not only has an impact on the individual level but also on the social, cultural, and economic level that could result in inequality in matters such as education, income, nutrition, housing, and social support (Policy Brief, 2018)[4].

In the past couple of decades, Eastern mediterranen Region countries have experienced rapid social, political, and economic change that has resulted in widespread civil unrest and violence and exposed the majority of the population to stress. These factors have especially adversely impacted vulnerable groups such as women, children, the elderly, migrants, and persons with MNS disorders (Eaton et al., 2020)[5]. This has contributed to the gradual rise in the rates of MNS disorders in countries of the Eastern Mediterranean Region, from 7% in 2000 to 9.8% in 2019 (WHO, 2021)[6].

The rise in rates of MNS disorders has not been matched with a commensurate increase in the traditionally low allocations for mental health in countries of the Region. This translates into a paucity of the mental health workforce, with 7.5 mental health professionals per 100 000 people on average for the Region (compared with the world average of 24·3 per 100 000) and 5.2 inpatient beds per 100 000 people in short-stay facilities; as well as a lack of treatment options and services (Eaton et al., 2020). This not only reduces availability and access to treatment but also results in an unfair distribution of resources as mental health services become concentrated in capital cities and available for those who could afford them, leading to the yawning treatment gap. Among the vulnerable population groups, children, women, older adults, refugees, people with disabilities, and those in institutions such as prisoners are particularly adversely affected. (IASC, 2020)[7]. For the purpose of this document, we are focusing on four of these vulnerable groups: women, children, older adults and refugees.

Given that 75% of mental disorders occur before the age of 25, the lack of investment in young people's mental health further exacerbates the burden on the individual and communities due to loss in productivity (Eaton et al., 2020).

With the onset of the global COVID-19 pandemic, countries of the Eastern Mediterranean Region like elsewhere have seen an intensification of mental health crises fueled by a widespread sense of uncertainty, financial stress, social isolation and bereavement. The resulting increase in rates of mental illness is exacerbated by decreased access to treatment, alongside the challenges of particular health consequences of COVID-19 (Dong & Bouey, 2020; Torales et al., 2020; Eaton et al., 2020)[8, 9, 5].

The COVID-19 pandemic will have significant long-term consequences that need to be tackled by governments, communities and individuals. However, it has also brought to the fore the urgency

to have mental health at the front and center of the policies that address poverty, access to health, employment, and inequities in education (Eaton et al., 2020).

The challenges and the need

More than two-thirds of the world's total Refugees (17.5 million) (including Palestinians) are from the Region, of which almost 67.0% (11.7 million) remain in the Region (UNESCWA, 2019)[10].

Despite the high burden of mental, neurological, and substance use disorders, support for mental health and well-being remains one of the most neglected areas of public health. This is evidenced by the low level of public investment made in mental health, with a median spending of 3% of the health budget on mental health. It is important to contextualize that the EMRO is a low investor in health care compared to other regions.

Most countries spent under 5% of GDP on health care and all countries spend below the world average for expenditure on health care. Additionally, despite the fact that currently 59% of the EMR countries have a national policy/plan for mental health in line with international human rights instruments (IHRI), only 7 (32%) of the EMR countries have implemented this (50% of high-income countries versus only 17% of countries in fragile and conflict settings).

The situation is compounded by inefficiencies in the allocation of these meagre resources, which is reflected in the relative paucity of community-based services and patchy integration of mental health components in primary health care settings with limited service coverage (only 5 regional countries reported that they meet the criteria for integration of mental health in primary health care) (Table 1).

Table 1: Mental health component integrated into primary health care (Mental Health Atlas, 2020)

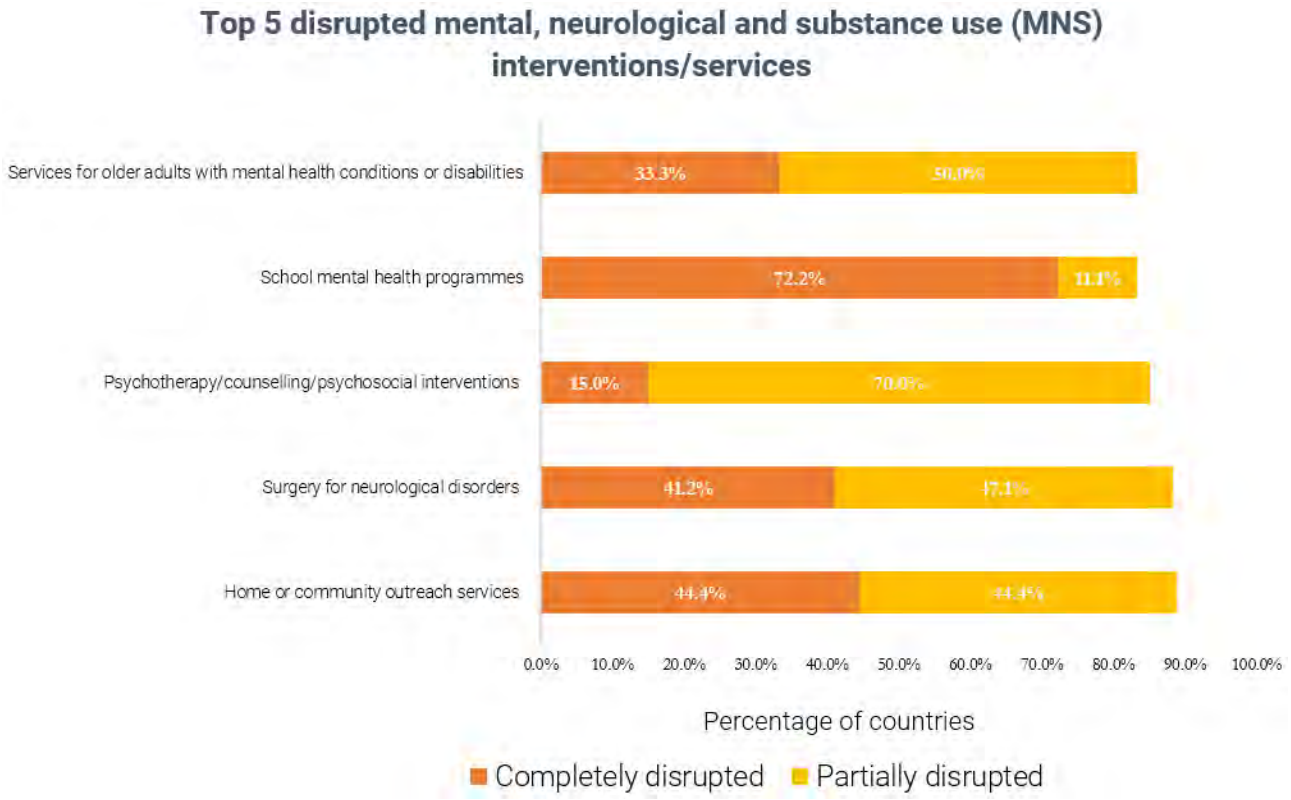
	Guide-lines	Phar-ma-col-ogy	Psy-cho-so-cial	Training	Su-per-vi-sion	Total Score	Score 4 or 5
Eastern Mediterranean Region (N=22)	86%	29%	11%	82%	71%	2.8	**23%**
Rest of the World (N=172)	62%	33%	19%	75%	70%	3.0	**26%**
EMRO Country Group 1 (N=6)	100%	23%	9%	100%	68%	3.5	**50%**
EMRO Country Group 2 (N=10)	100%	25%	11%	90%	70%	2.9	**20%**
EMRO Country Group 3 (N=5)	60%	0%	0%	60%	60%	1.8	**0%**

The issue of scant human resources available for mental health is compounded by the fact that the majority of professionals are deployed in large institutions mostly located in major urban centers and therefore accessible to only a fraction of the population who need them. The result is high

treatment gaps for mental, neurological and substance use disorders differentially affecting the most vulnerable groups of the population.

On top of the deficiency in several mental health professionals, specialised training for addressing the mental health needs of children, women, older adults and the institutionalized, such as prison inmates, is even more deficient.

Since March 2020, the COVID-19 pandemic has exacerbated the already fraught situation. A rapid assessment of the impact of COVID-19 carried out by WHO in June 2020 shows high levels of disruption of essential mental, neurological, and substance use services in countries of the Region (Figure 1). (WHO, 2020)[11]



However, the analysis also highlights the fact that emergencies often provide opportunities in that multiple innovative interventions and approaches were instituted to overcome service disruptions. The extraordinary situation helped galvanize many countries to provide mental health and psychosocial support (MHPSS) through establishing helplines for MHPSS (85%), resorting to telemedicine and teletherapy to replace in-person consultations (80%) and setting up self-help or digital psychological interventions (65%).

3.1 Vulnerable group: Women

The most prevalent mental health conditions, such as depression and anxiety disorders, are more common in women who suffer disproportionately at the prime of their lives. Perinatal mental health conditions, especially depression, are common around the world, yet likely to be missed with limitations in specialised resources in the Eastern Mediterranean Region. The effects on the un-born child and families are well documented in the literature.

In the first study to quantify the burden of mental disorders in the Region 1990-2019, the Global Burden of Diseases, Injuries, and Risk Factors Study (GBD), the Institute for Health Metrics and Evaluation (IHME) showed how women suffer a higher mental health burden across the Region. Women lost 3.3 million total DALYs to depression, compared to men's nearly 2.1 million DALYs, in 2019. Similarly, women in the Region lost more than 1.9 million DALYs due to anxiety, compared to 1.3 million DALYs in men. (GBD, 2021)[12]

3.2 Vulnerable group: Children

The Region is also home to a growing youth population with 50% of the population being under the age of 25 years. This is significant given that 75% of all mental conditions commence before the age of 25.

While specialized services for children and adolescents are gradually increasing in the Region,

these remain insufficient to meet the demand. Only 6 countries of the 22 in the Region have child and adolescent mental health beds and only 12 have some form of outpatient facilities for this group. Staff working in these facilities are considerably fewer than the global median. Limited efforts exist towards education and prevention of mental illness that target the younger population, specifically children and adolescents.

3.3 Vulnerable group: Older Adults

Overall, older adults are highly revered in the Region and they are typically looked after by members of their family within their household. However, older people are also susceptible to MNS disorders. Depression is the most common mental illness in this age group. In those with pre-existing mental illness, chronicity will have its toll on their cognition, functioning and physical health. Loneliness, perceived loss of role and frailty are all factors contributing to mental health disorders in this population. More education for healthcare professionals and research is needed to address the issue of paucity of service availability and data on the extent of the problem for this section of the population.

In 2020, a regional survey assessing the status of implementation of the global action plan on the public health response to dementia showed that the majority (71%) of EMR countries do not have a dementia-specific national policy, strategy, plan or framework. Community-based services providing health and social care for people with dementia existed in around two-thirds (65%) of countries in the EMR; these services were most prevalent in countries with high-income and abundant re-

sources (83.3%) (GDO, 2021)[13].

3.4 Vulnerable group: Refugees

Many countries in the Region are experiencing civil unrest, political turmoil and natural or man-made disasters. Ten of the 22 countries in the Region are designated as fragile and conflict-affected states and levels of conflict in the Region have increased since 2010. 419 million (57%) people lived in nine countries with graded emergencies (Afghanistan, Iraq, Libya, Pakistan, Palestine, Somalia, Sudan, Syria and Yemen). Internally displaced persons (IDPs) in the Region have been growing steadily during the past decades rising to 19.5 million (2020), 45.0% of the world's total number.

Protracted emergencies and vulnerabilities to natural disasters with their attendant destruction and disruption of socio-cultural, political and economic institutions and activities, can leave people – particularly the most vulnerable people – susceptible to poverty, destitution, violence, social exclusion, internal displacement and migration; all of which lead directly to poor and unequal mental health.

According to the WHO estimates, at least 1 in 5 people living in areas affected by conflict is likely to have a mental health disorder and these rates are likely to go up further in the long run (Charlson et al., 2019) [14]. The United Nations High Commissioner for Refugees (UNHCR), states that "Women and girls make up around 50% of any refugee — internally displaced or stateless — population and

those who are unaccompanied, pregnant, heads of household, disabled or elderly are especially vulnerable". The promotion of mental health and well-being was recognized as a health priority for the first time by world leaders through the Sustainable Development Goal 2, Target 3.4. Specifically, paragraphs four and 23 provide a strong basis for inclusion by calling upon nations to leave no one behind, including refugees, internally displaced persons, and migrants. (United Nations, 2015)[15]

The New York Declaration for Refugees and Migrants, adopted in 2016, commits to refugee children and outlines plans for working on those commitments. Points 26, 29 and 32 stress the importance of addressing the needs of refugee children who have been exposed to physical or psychological abuse and focusing on their psychosocial development. To this date, mental health professionals in countries receiving refugees are struggling to deal with the issues related to refugee and asylum-seeking children.

Capitalizing on Opportunities

The adoption of the Global Mental Health Action Plan 2013–2020 by the World Health Assembly represents a paradigm shift from institutional to an integrated, person-centered, community-based model of mental health care. In 2021 this Plan was endorsed for an extension until 2030 to ensure its alignment with the 2030 Agenda for Sustainable Development. This is in line with the provisions of the UN Convention on the Rights of Persons with Disabilities [16] which calls for active involvement of people with mental health problems in all policy dialogues, development of services and their delivery as well as all decisions about their own.

One of the watershed developments at the global level has been the inclusion of mental health-related targets and indicators as part of the health-related Sustainable Development Goals, which has broadened the remit from 'No health without mental health" articulated in the global action plan to "No sustainable development without mental health".

Universal health coverage is identified as the overarching target for the health goal of the UN 2030 Agenda for Sustainable Development, which has led to a reinvigoration of the "health for all" commitment first made during the Alma-Ata Declaration (1978). Thus, the inclusion of specific indicators related to mental well-being and substance use disorders provides an opportunity to integrate mental health across all populations, communities and health platforms. The Disease Control Priorities (third edition), Department of Global Health © 2018 also identifies the most cost-effective interventions to be included in the universal health coverage benefit packages, with the goal of influencing program design and resource allocation at country level to address the MNS disorders equitably.

The other key developments include the Sendai Framework for Disaster Risk Reduction 2015 – 2030, which outlines four priorities for action to prevent new and reduce existing disaster risks: (i) Understanding disaster risk; (ii) Strengthening disaster risk governance to manage disaster risk; (iii) Investing in disaster reduction for resilience and; (iv) Enhancing disaster preparedness for effective response, and to "Build Back Better" in recovery, rehabilitation and reconstruction. The Sendai Framework's fourth priority explicitly urges countries to provide for MHPSS services for all people in need to promote resilience and building back better. It highlights the need to empower "women and persons with disabilities to publicly lead and promote gender equitable and universally accessible response, recovery, rehabilitation and reconstruction approaches".[17] That has been backed up at the World Humanitarian Summit in 2016, where Member States, UN organizations, non-governmental organizations and other relevant actors committed to advancing the Agenda for Humanity centralizing the "Leaving No One Behind" approach.

Building on these developments, the Regional Framework for scaling up action on mental health was adopted in 2015 by the member states at the regional committee to align the regional agenda with the global Mental Health Agenda for improving the mental health and wellbeing of whole populations. The framework provides countries of the Region with a roadmap of specific, evidence-based strategic interventions and indicators to monitor progress. The measures included in the framework are high-impact, evidence-based, cost-effective, and affordable, and can be implemented by all countries irrespective of income. The framework consists of 13 strategic interventions for countries to implement and 19 progress indicators to monitor implementation (WHO, 2021) [18].

The framework, together with other documents, tools and technical packages, will help countries to bridge the treatment gap through not only increasing the resources for mental health care but, more importantly, utilizing the available human and material resources efficiently to deliver integrated, community-centered care in an equitable fashion.

Proposed region-specific actions

The last decade has witnessed some increase in investment in mental health and expansion of services, with a focus on community outreach programs. Such expansions are a major step towards service improvements, though they remain insufficient to meet the demands.

Mental health should be an essential component of universal health coverage benefit packages to ensure sustainable investment and prioritized financing.

Emergencies often result in increased focus and commitment for MHPSS which needs to be leveraged to ensure building back better of the mental health systems and services. This can be done by incorporating mental health and psychosocial support as an essential part of emergency preparedness, response and recovery plans.

Targeted health-related research remains an important area for development. While regional research output has increased five-fold in the decade from 2004–2013, however, the regional share of global research production remains small and progress is not distributed evenly with a few countries claiming a high share of publications (WHO, 2019)[19].

Proposed country-specific actions

Mental health should be reflected in the national development agendas and policies as well as health policies, where mental health should be formulated as a universal right and appropriately resourced for achieving the 2030 Agenda for Sustainable Development.

A concerted effort has to be made to integrate mental health across the national emergency preparedness, response and recovery plans to ensure the availability of multi-layered multi-dimensional MHPSS to the population(s) in need, including the most vulnerable population groups such as women, children and adolescents, older adults, persons with disabilities, migrants and refugees.

Mental health-related policies and legislations should be reviewed and reformed to be aligned with existing international human rights covenants/tools, such as the UN Convention on the Rights of Persons with Disabilities.

Strengthening workforce capacity must be undertaken across health, social and educational sectors for a collaborative multi-sectoral approach to promote mental health, prevent mental, neurological and substance use disorders, provide care and promote recovery.

Build mental healthcare capacity by expanding a qualified mental health and social care workforce to provide MHPSS interventions to the population in a timely manner using the emerging technologies to deliver evidence-informed interventions across the spectrum of care and needs.

Investing in strengthening programs for mental health promotion and prevention of mental dis-

orders, such as adopting a life-course approach with a special focus on early child development, parenting skills, life skills education for children and adolescents (Life Skills Education School Handbook, WHO 2020)[20]. Promoting maternal mental health, suicide prevention and workplace interventions are equally important, including support for health care workers and for caregivers of persons with dementia.

Promoting mental health literacy to counter stigma and discrimination is essential and requires national and community-based efforts to develop and implement targeted programs.

Urgent investment is needed to explore and develop the rational and prudent use of technology to build and deliver mental health psychosocial support services; building on the experience gained over the years in different settings, especially during the current COVID-19 pandemic, which has seen the rapid deployment of technology to support healthcare delivery.

Countries must strengthen their health information systems to generate real-time data by ensuring that mental health indicators are present in national health information systems. In addition, mental health indicators must be included in national systems to monitor key developmental and humanitarian targets.

More targeted investment is needed to generate and use new evidence to help guide policy and legislative review and the resulting development of services responsive to the needs of the population.

Empower mental health service users and carers through the involvement of people with lived experience in the design and monitoring of policies on a national level and service delivery in communities. Governments and policy makers should consider involving the individual in policy making, service delivery and mental health promotion/awareness activities, etc.

Allocate resources to encourage the gradual shift away from institutional to a more integrated community-based model of care delivery. This should include psychological interventions as a major tool to help people in need in less rich countries.

Inpatient mental health facilities should be designed in a manner that clearly separates between long-stay and short-stay wards to overcome the blockage of facilities by long-term patients.

Proposed actions for individuals

Develop personal skills: Health promotion supports personal and social development through providing information and education for health and enhancing life skills. It increases the options available to people to exercise more control over their own health and over their environments and to make choices conducive to health (source: WHO, 1986)[21].

Due to the continuing stigma of mental illness, engaging those with lived experience is often challenging. People with mental illness should be encouraged to participate in public mental health

initiatives while efforts are made to protect them from vulnerable exposure. In the Region, family plays a very important role in the management of people with mental illness and promotion of their recovery. Families therefore must also be actively engaged in planning to ensure successful outcomes. For instance, in comparison to Western mental health laws, in several countries in the Region the family's role in the mental health law is highly emphasised, acknowledging their crucial role/participation.

Implementing change

In order to implement change and provide equal opportunities for all citizens in the EMR region, the required interventions necessitate a whole of society and whole of government approach, with active engagement and ownership from all the stakeholders across the public, private sectors, civil society and academia. The priority interventions should ensure the inclusion of evidence-based mental health interventions in the UHC-BPs of the countries across population, community and health system platforms and delivery channels, to ensure all individuals have equal access to mental health services without discrimination. It is also important to set up a well-resourced mental health department within the Ministry of Health that coordinates and oversees implementations and monitors these policies using an equity and human rights lens

Special considerations should be made to protect vulnerable groups such as women, children, refugees, prison inmates, as well as people from different ethnic and cultural groups who are more likely to experience stigma and discrimination (IASC, 2020)[6]. Such groups might have difficulty accessing mental health services due to lack of support from the community and professionals. A key implementation concern should be around strengthening capacities for MHPSS service provision through the incorporation of the MHPSS component in emergency preparedness, response and recovery plans with specified resources.

Counselling and psychotherapy are becoming increasingly more popular and accepted across the globe for many people with certain mental health conditions and should be considered by the WHO and individual countries as cost-effective and efficient options for a broad range of mental health disorders.

The American Psychological Association state that many people prefer psychotherapy to pharmacological treatments because of medication side-effects and individual differences and people tend to be more adherent if the treatment modality is preferred (Deacon & Abramowitz, 2005; Paris, 2008; Patterson, 2008; Solomon et al., 2008; Vocks et al., 2010). Research suggests that there are very high economic costs associated with high rates of antidepressant termination and non-adherence (Tournier, et al., 2009), and psychotherapy is likely to be a more cost effective intervention in the long term (Cuijpers, et al., 2010; Hollon, et al., 2005; Pyne, et al., 2005)[23].

Key to promoting mental health and well-being is strengthening mental health literacy programmes to empower persons with mental health problems and combatting stigma and discrimination. This includes focusing on universal, targeted and indicated prevention programmes with special

reference to parenting skills, maternal mental health, school and workplace mental health, suicide prevention and life skills education with the active involvement of the persons and families with mental health problems.

Another key intervention is increasing and prioritizing the budget for scaling up integration of mental health in general health care especially in Primary health care. This intervention should be supported by capacity enhancement of general and family physicians and staff to provide evidence-informed mental health and psychosocial support interventions (WHO, 2016)[22] It also needs to be linked with establishing community-based mental health services, including establishing specialized mental health services in general hospitals for both outpatient and inpatient care (WHO, 2016)[18].

These interventions support establishing a stepped care model of service delivery ensuring continuity of care and increased service utilization. It will also help minimize the stigma attached to psychiatric facilities, where service users are more likely to accept services provided in 'neutral' environments, such as general hospitals and community settings (Eaton et al., 2020). This would involve reorienting the current service delivery models through allocating specified budgets for the development of such services.

Summary and Conclusion

Overall, there has been progress across the EMR, especially in areas related to policy and legislation. However, there is a need for countries in the EMR to commit afresh to deliver on existing commitments, articulated in the Regional Framework, for scaling up action of mental health. This is also crucial in realizing the World Health Organization's (WHO) ambitious 'triple billion target' (1 billion more people benefitting from UHC, 1 billion more people better protected from health emergencies and 1 billion more people enjoying better health and well-being).

As EMR countries emerge from the pandemic, the need to foster a commitment to build back economies and systems not just better but also fairer is hugely important. This is the time and ideal opportunity to work towards ensuring that a "mental health lens" is used by national governments, Ministries of Health, local governments, civil society, faith-based organizations and developmental agencies in their decision making processes using the best evidence-based interventions to create fairer and healthier societies. This will help to ensure the sustainable commitment of political, social, human and financial resources for developing mental health systems designed to deliver equitable, person-centered care in an inclusive, decentralized and integrated fashion.

While the pandemic has highlighted the profound challenges and hugely inequitable health impacts in every country in the Region, it has also identified significant potential for action. Putting mental health at the heart of policy action is an essential step forward towards equitable development and meeting the needs of citizens.

The opportunity to act is now, as COVID-19 has brought home to us the importance of mental

health as a resource and investment which is crucial for individuals to achieve their full potential, communities to be resilient in adversity, supporting its vulnerable members, countries to build back better and nations to fulfill their compact with their own citizens and help citizens of other nations so that no one is left behind.

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Socioeconomic Inequalities and mental health - proposed actions.

The European perspective.

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Introduction

We live in a world with unprecedented opulence for some and remarkable deprivation, destitution and oppression for others. .Health and health care across the world reflect this, with pronounced differences in the status of people's health, in the care they receive and the opportunities they have to lead healthy lives. This applies to all health, including mental health and is true not only across middle and low-income countries but also within relatively affluent societies such as across Europe.

Health inequalities and systematic differences in health between different groups of people are unfair and avoidable [2]. Much of these are created by structural and political processes that affect the everyday living conditions of individuals and populations (WHO) [3]. Health inequalities represent a very serious social injustice in modern societies.

Health inequalities in Europe

Inequalities in health and health care are patterned by a variety of socio-economic factors, income geography (for example, region or whether urban or rural) specific characteristics such as sex, ethnicity, disability or socially excluded groups (for example, people experiencing homelessness). There is a positive association between income inequality and mortality rates among countries within the Organisation for Economic Cooperation and Development (OECD) [4]. More generally, all health indices are strongly influenced by income inequality [5, 6]. Europe has some of the highest level of unequal distribution of income across the world, with countries like Russia, Lithuania, Bulgaria, Greece, Spain, Italy at the bottom of the list according to the classification using the Gini coefficient. Major differences in terms of health status and socio-economic categories can be observed not only between European countries but also within countries, demonstrating the strong link between socio-economic situation and health status [8, 9]. While life expectancy and mortality rates are better in Western European countries than in Eastern Europe stark social gradients in morbidity, mortality and life expectancy remain major challenges across all European countries [7].

Societal inequalities have the most adverse impact on the most vulnerable. There are many aspects of vulnerability, arising from various physical, social, economic, and environmental factors. Economic vulnerability, due to the impact of hazards on economic assets and processes (business interruption, secondary effects such as increased poverty and job loss), is strongly connected to social vulnerability, that is the potential impact of events on people who are poor, single parent households, pregnant or lactating women, people with disabilities, children, elderly etc.. Vulnerability is not just increased risk of exposure, but also reduced resistance (and related measures to prevent loss) and resilience. Effective coping mechanisms are needed for people, organizations and systems, using available skills and resources, to face and manage adverse conditions, emergencies or disasters [10].

Many of the social conditions that increase people's vulnerability to ill health tend to define social groups and target populations. These are not just sociological but also political concepts concerning human rights, as they are associated with inequities in accessing healthcare, services, treatments, welfare provisions, etc. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion [3]. Levels of inequality vary considerably even in countries with a similar level of per capita income. Health and social problems are worse in more unequal countries (Portugal, UK, Italy, Greece vs Scandinavian countries). Income inequality has risen around the world since 1980 although at different rates in different regions (for example, Europe 34% vs Middle East 61%). The burden of inequity impacts on the health status gap between the poorest and the richest income quintiles in 36 European countries. After controlling for age and gender, this gap is explained by 5 factors (years 2003-2016): (i) income security and social protection (35%) (ii) living conditions (29%) (iii) social and human capital (19%), (iv) health service (!0%) and (v) employment and working conditions (7%) [11].

Primary care is well placed to support health equity. Primary care services cover large populations and ensure direct contact with patients, often the GP is the first point of contact with the health service. Good examples are available in Europe, such as Partnership for Health Equity in Ireland (www.healthequity.ie) which was established to allow GPs, researchers, educators, health planners and policy makers to formally collaborate on a number of initiatives with the aim to improve the health of marginalised groups and those living in deprived areas [12]. Detailed data on social determinants of health can facilitate the identification of inequities in access to health care, for instance through a sociodemographic data collection tool used in a family medicine clinic [13]. The World WONCA Health Equity Special Interest Group (SIG) was set up bringing the essential experience, skills and perspective of interested GPs to address the differences in health that are unfair, unjust, unnecessary and avoidable [14]. The 2015 WONCA Europe Health Equity Workshop explored the barriers and facilitators for addressing the social determinants of health in primary care [12].

Mental health inequalities

As with physical health, mental health and wellbeing as well as mental health care are strongly influenced by socio-economic factors and individual characteristics such as gender, ethnicity, age. The world regions with high rates of common mental disorders also have high levels of inequality, as reported by the WHO [15]. Mental morbidity varies according to social conditions. In most rich countries (and across Europe) there are also significant variations in access, experience and outcomes of mental health care which are driven by social inequalities or differential vulnerabilities consequent upon economic, social and cultural factors. For example, African Americans are less likely to have access to mental health care and more likely to poorer quality mental health care than white Americans. Mental conditions are often misdiagnosed among different minority groups. In Europe, particularly in the UK, there is strong evidence of significant ethnic inequalities in mental health care experiences; black and minority ethnic communities have poorer access to services and worse clinical and social outcomes than the majority population. Recognition of mental health problems and diagnosis are strongly influenced by social status and in particular, belonging to a minority ethnic group.

One of the earliest and most enduring findings in psychiatric epidemiology is the strong link between social status (class) and increased risk of mental disorders [16]. Poverty (lack of socioeconomic resources) increases the risk of exposure to traumatic experiences and stress that increase the vulnerability to mental disorders. Unemployment can influence the development of common mental disorders, such as depression and anxiety. This link between poverty and mental health is bidirectional. Disparities in access to education and housing due to socioeconomic disadvantage, can increase the risk of mental illness while long term mental health problems can lead people into poverty due to discrimination in employment and reduced ability to work. Minority ethnic communities are exposed to a cumulative experience of microaggressions such as racism that compromise resilience and autonomy thus increasing their vulnerability to mental ill health. Gender inequality and gender disparities in mental health are strongly correlated [15]. Several studies indicate that women suffer mentally more than men particularly in societies with greater levels of gender ine-

quality and discrimination based on prejudice, creates barriers to accessing community resources and mental health care.

This 'social gradient' means that mental health problems are more common further down the social ladder. It is now widely accepted that inequalities in health, including mental health, arise because of inequalities in society – in the conditions in which people are born, grow, live, work and age. The social determinants of (mental) health act through a cumulative effect of disadvantage that is associated with increasing stress through the lifespan [17]. "These factors affect each individual differently, depending on the presence of buffers such as social support, financial resources and emotional resilience, but overall, it is harder to develop this resilience and have access to the right social support when in a position of disadvantage" [18].

Unequal access to mental healthcare is still a reality in Europe. Mental healthcare remains dependent on high out-of-pocket payments in most European countries, which leads to even greater health and social inequalities for people living with mental ill health. The report of the European Commission [19] also shows a lack of investment in preventive and mental health care in more than 10 European countries.

Up to 94% of all mental health care happens in Primary Care. As with physical health, major inequalities that impact on mental health are evident in access to primary care and in the recognition of mental health problems. Mental health literacy is identified as one of the key-factors in addressing this. The World Health Organization, as well as WONCA, have recognized this issue through specific worldwide initiatives, such as the mhGAP Programme for all non-specialized healthcare settings [20]. Mental health needs assessments do not incorporate discussion about inequalities in mental health. Frontline professionals tend to define inequalities as being linked to access to health services rather than social factors and are "often uncomfortable about discussing inequalities in mental health" [21].

In all western countries, most physical diseases, and severe, 'psychotic' psychiatric disorders are unequally distributed by social position [22]. People of lower socio-economic status are more affected by mental health problems including higher prevalence of 'common mental disorders' (mostly non-psychotic depression and anxiety, either separately or together). These conditions are associated with poor education, material disadvantage and unemployment [23].

Disadvantaged, vulnerable or marginalised groups are defined by the WHO as those who, 'due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society'. Examples might include unemployed people, refugees and others who are socially excluded. Stigma and related discrimination are often inherent to many of these inequalities, especially those related to mental health and socially excluded groups in general.

Experiencing prejudice and discrimination can also compound and hinder recovery from a mental health condition. This encompasses issues of knowledge (ignorance), attitude (prejudice) and behaviour (discrimination). As reported by the Mental Health Foundation [18], as many as nine out of ten people with mental health problems have experienced stigma or discrimination at one time of their life (at work, in education, from professionals or at home). This has a negative effect on

people in relation to employment, establishing new and retaining existing friendship, being able to join groups and take part in activities within the community, having the confidence to get out and about, being able to openly disclose mental health issues and speak up to professionals.

Ecological risk factors for mental ill health such as lack of adequate housing, reduced transport options, neighbourhood deprivation, adverse built or natural environment and living in an urban environment are commonly associated with social disadvantage and other social risk factors in most Western countries. Being homeless or at risk of homelessness is strongly associated with mental health problems. A 2014 study found that 80% of homeless people in England reported that they had mental health problems, with 45% having been diagnosed with a mental health problem. Also, poor-quality housing and housing that is unsafe and insecure, is a risk factor for mental health problems and may exacerbate existing mental health problems. On the contrary, transitioning from homelessness to housing, or experiencing housing improvements, has been shown to improve mental health [18].

These factors can contribute to social fragmentation and increased conflict within communities as well as neighbourhood problems, which in turn impact on health outcomes independently of socioeconomic status. Emerging evidence suggests that increase in social cohesion may reduce the negative effects of neighbourhood deprivation on mental health. Societal segregation can also have an adverse impact on mental health. For example, people with learning disabilities, experiencing segregated schools and activities, live a separate existence to the general community, and the consequent lack of community connections make them vulnerable to hate crime and discrimination, leading, in turn, to an increased risk of mental health problems. Urbanisation and urban living are risk factors for depression and anxiety as they are linked to socioeconomic deprivation, low social support, social segregation and environmental conditions such as air, water and noise pollution, as well as exposure to physical threats (accidents and violence) [18]. Lack of public spaces prevent community cohesion and increase isolation and loneliness. The report by the Mental Health Foundation shows the impact of the built environment across the life course, with school-age children's attitudes and behaviours affected by the quality of the built environment and local neighbourhoods. Poor physical condition in neighbourhoods adversely affecting schools. The lack of outdoor play space has been found to be a causative factor in increased mental health problems among children and young people [18]. Spending time in natural environments reduces levels of stress and/or improves attention fatigue and mood more than the built environment. By making green and blue spaces more available for people, levels could potentially decrease anxiety and distress, though this requires further research [18]. In the context of the global climate crisis, it is important to note that the natural environment can be both a positive and a negative influence on mental health, depending on the type of environment. Individual distress in the wake of a natural disaster due to climate change can increase the risk of mental health problems.

Health inequalities uncovered by the Covid pandemic

The Covid pandemic has exposed and exacerbated health inequalities between countries as well as within countries. According to Joseph Stigliz, Covid-19 is not an 'equal opportunity' virus [24]. The virus has had an unequal impact in all societies and countries. The poor, marginalised, physically ill and those with long term mental health problems and those in institutional care have been disproportionately affected by the pandemic. The post-pandemic world could experience even greater inequalities unless governments take action.

The European Region has been affected by the pandemic the most in the first phase. A WHO Europe survey of institutions has shown increasing violation of human rights in the first wave of the pandemic [25]. The Technical Advisory Group (TAG) on the Mental Health Impacts of COVID-19 in the WHO European Region, issued a set of recommendations on the 30 June 2021 [26]. The TAG agreed to frame the recommendations across three key areas of impact: 1)general population and communities 2)vulnerable groups and 3)public mental health services. It focused on vulnerable groups such as those who have less personal and social instruments and resources to cope with the pandemic and in particular its mental health consequences. The range of these 'vulnerable groups' is wide and cannot be defined by strict criteria, as it is evolving and open to further contributions. There are many aspects of vulnerability, arising from various physical, social, economic, and environmental factors. The concept of social vulnerability is the one that probably can better fit these issues. Social vulnerability refers to the potential negative effects on communities caused by external stresses on human health. The major threats to mental health are in relation to receiving care for the pandemic itself (prevention, PPI, appropriate care, vaccination), access to services they need (it is important to remind the WHO recognition that MHS are essential services) and the treatment gap, as well as the continuity of care, social gap / exclusion (physical body / social body), risk of self-isolation, stigma ("doubled" when people with mental disorders are also Covid positive or ill with Covid).

People with pre-existing mental health problems (in particular, those with severe mental illness) are most vulnerable to Covid and may lack access to proper information and medical care. Their human rights, safety, protection, and even their environment, are at risk. This group is also likely to be forgotten, neglected and exposed to additional suffering because of the shortage of mental health services operating within communities, e.g. restrictions that exacerbate the existing shortages in relation to rehabilitation interventions, socialization activities and day-care, job placement, social enterprise, personal support, home and educational assistance services, mainly carried out by NGOs.

Diagnosis by itself is a poor predictor of vulnerability. In identifying those at high risk, we need to consider a range of social factors and determinants of mental health and ill health as well as individual reactions based on personal narratives [27]. Those living in institutions, such as mental hospitals, nursing homes, halfway homes, social care homes, correctional facilities etc are particularly at risk. Residential institutions have become intrinsically more unsafe during the pandemic

and consequent restrictions and, as a result, provide less protection against contracting the virus, while worsening their mental health. The pandemic showed the health inequalities for people who live in care homes, not just the elderly, but also the group of patients with Learning disabilities and neurodevelopment disorders, like Autism Spectrum Disorders.

The poorest, people who are socially marginalized, living alone or confined to restricted spaces such as migrant and refugee populations, are at greater risk of the mental health consequences of the pandemic and connected restrictions. They need psychosocial support and health protection as well as a response to their primary needs. Homeless people living with mental illnesses are among the most vulnerable, lost in a social nothingness [27] as they have lost many of their natural support systems. Mental health services need to increase outreach support care for those who cannot access them. However, the restrictions consequent upon the pandemic appear to have led to the opposite, with a significant reduction in outreach support and activities. Improving outreach support should involve mobilising the available resources of communities, volunteers, neighbourhoods, associations and other community assets.

Families have now become the primary carers of their relatives, affected by Covid and those with severe mental illness, and one of the unintended consequences of this is the increase in caring responsibilities and burden for women. Women's experience is further worsened by higher rates of unemployment than men and the reported increase in domestic violence during the pandemic.

Actions to reduce health inequalities

Policy

- No EU member state has yet made a concerted effort to implement the most radical approach to TACKLING health inequalities, namely the reduction in the health gradient, whereby health is related to the position of social groups (and individuals within these groups) at every level within society. EU member states were advised to consider the potential advantages to society as a whole that might result from the adoption of this wider frame in 2005 [28] but this has not resulted in any significant policy changes in relation to health inequalities.

- Most of the interventions in tackling health inequalities focus on the immediate determinants of specific inequalities and are aimed at modifying lifestyles and behaviours in the more disadvantaged classes. It needs to be also recognised that more funding is required for academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities [29].

- The Commission on Social Determinants of Health [30] has declared that rising inequality is not inevitable, and policies and institutions are asked to play a decisive role, where intersectoral action and social participation / empowerment are key dimensions. State actions are recommended at (i) macro level: public policies to reduce exposure of disadvantage people to health-damaging factors (ii) meso level: community – to reduce vulnerabilities of disad-

vantaged people (iii) micro level: individual interaction – to reduce unequal consequences of illness in social, economic and health terms.

- The United Nations increased attention to all these factors in the Sustainable Development Goals (SDGs) [31]. It would be important to focus on the impact of policies designed to further equality, in order to address existing mental health disparities and achieve the highest possible level of health for all people.

- The European Union recently decided to foster and complement national plans via the largest-ever stimulus package of €1.8 Trillion to build a greener, more-digital and more-resilient post-COVID-19 Europe. The plan was called "Next generation EU". In some countries like Italy, part of this spending will be aimed to digital transition, green economy and at strengthening social cohesion by reducing social inequalities. This should create work opportunities, also through a welfare community with the involvement of social economy and social enterprises. It is unclear if there will be any dedicated investment directly to community mental health services, or to welfare services with an impact on the living conditions of people with mental health issues, at risk of marginalization and social exclusion.

- Within this context, WHO/Europe has urged a mental health coalition to support system reforms and COVID-19 recovery as a new flagship initiative. [32] WHO underlines that "mental health is a key public health concern in the WHO European Region – over 110 million people are living with some kind of mental health condition, accounting for over 10% of the population", and about 140 000 people die per year by suicide. Therefore "…a more concerted effort is required to secure better mental health for all, both through intensified country support and intercountry initiatives at regional and global levels."

- Some of the core components of the WHO mental health flagship will be: challenging stigma and discrimination by improving mental health awareness and literacy among not only the public but also service providers and decision-makers; enhancing access to person-centred, rights-based mental health care in communities. This will expedite progress towards universal health coverage for people with mental health conditions and make the case for a parity of esteem between mental and physical health.

- Since the pandemic has shone a light on the fragility of existing institution-based systems and the need for community-based support and care (delivered through digital means where necessary or applicable), "the mental health flagship will encourage efforts and investments to relocate care away from institutions and towards community services, including through the integration of mental health into primary health care and other priority programmes such as adolescent health and noncommunicable diseases" ref?.

- In the Athens Mental Health Summit Declaration (22-23 July 2021), the ministers of health and representatives of the Member States of the World Health Organization in the European Region have welcomed the proposal for a new European Framework for Action on Mental Health and supported the setting up of a Pan-European Mental Health Coalition. This confirmed the issue of vulnerability stating: "Population groups who have been identified as being at higher risk of

experiencing negative mental health impacts will require specific and targeted attention and support". Also "the pandemic has exacerbated pre-existing gaps in mental health care provision due to significant disruption to mental health services, coinciding with an increase in mental health needs and an overstretched health workforce". Ministers have recognized that "the COVID-19 pandemic has uniquely propelled mental health to the top of the policy agenda. We call for this to be a redefining moment in the history of mental health, with stigma and discrimination being tackled through integration of mental health into the mainstream health-care agenda". It calls "for mental health promotion and support to be at the heart of the post-COVID-19 recovery agenda to prevent the emergence of chronic mental health conditions as a result of the pandemic. We acknowledge the structural and environmental elements that contribute to poor mental health and well-being and seek to develop appropriate strategies to build resilient individuals and communities and improve our ability to protect the mental health and well-being of our populations in future crises and health emergencies" [33].

Service changes and welfare community

- A 'whole of society approach' to tackle the social problems thrown up by Covid-19 has been suggested. [34] This includes new forms of social connections, developed and enhanced as part of a collective effort. Such an approach will be equally relevant in tackling health inequalities more broadly.

- We need to avoid fragmentation of efforts by building alliances between public mental health-care, social services and the third sector. This will ensure an effective response to whole life needs, protecting not only health but also the human rights of people living in institutions, hospitals, prisons, shelters, nursing homes, group homes and other special facilities, and those experiencing social deprivation.

- Furthermore, in the community, there is an urgent need for policies to reduce the social disadvantage with an impact at the level of services. 'Social economy' includes cooperatives, mutual societies, non-profit associations, foundations and social enterprises, which operate a very broad number of commercial activities, provide a wide range of products and services across the European single market and generate millions of jobs. According to the EU Commission [35], there are 2 million social economy enterprises in Europe (10% of all businesses in the EU, more than 11 million people – about 6% of the EU's employees). Their members act in accordance with the principle of solidarity and mutuality and manage their enterprise on the basis of 'one man one vote' principle. They substantially contribute to economic, social and human development across and beyond Europe and supplement existing welfare regimes in many member states. They contribute to several key EU objectives, such as sustainable and inclusive growth, employment, social cohesion, social innovation, local and regional development and environmental protection, as well as individual well-being.

- In Italy, in recent years, mental health services of some regions, with the help of NGOs such as social cooperatives and voluntary associations, developed, differentiated strategies aimed

at multi-sectorality and empowerment. Based on the principles of social and health integration, these policies and programs provide for integrated social and health paths, basic social support, the right to independent living, training and job placement. One of the main organizational-strategic keys has been proved to be the construction of 'personal budgets', in which the suffering individual has an active role and a bargaining power. They provide the person with support in the exercise of fundamental rights and in access to social opportunities (home, education, training at work, health management, leisure activities), and for capacity-building paths in relationship with other services and institutions, towards a higher autonomy. In this way, social determinants can be directly addressed, both at the individual level and the socially vulnerable as a group.

- It is important to implement the emergency national plans dedicated to mental health, called for by the World Health Organization and reiterated by the World Federation for Mental Health [36] and prompted by the UN [37]. It has never been more urgent to step aside from individualistic notions and embrace the values and practices of sharing and solidarity, both civil and social. This will enhance our sense of being part of a community. Community mental health services, which have a long history of community networking and engagement, can act as exemplars and provide essential bridges to a post-covid, 'new normal', with collaboration and shared responsibilities for each other at its heart. This requires a rights based and person centred – but also whole community - approach.

- The OECD Mental Health Performance Network set from 2018 [38], recently confirmed [39] the following principles for the mental health sector: (i) focus on the individual, (ii) accessible, high-quality services, (iii) an integrated, multi-sectoral approach, (iv) prevention of mental illness and promotion of mental wellbeing, (v) strong leadership and good governance and (vi) future focused and innovative. These are in line with the WHO Action Plan cross-cutting principles and some of the most innovative good practice examples.

- The International Mental Health Collaborating Network (IMHCN) has identified a number of objectives especially related to the importance of Social Determinants of Mental Health: "This transformation requires a fundamental change in thinking about mental health through a comprehensive review of current services and practices. We need to act upon the clear evidence that social determinants play a fundamental part in the lives of people with mental health issues. The dominant clinical response today does not acknowledge or address the importance of social determinants in the current service model. The consequence of this is that life circumstances such as, poverty, inequalities, systemic racism, and discrimination are not systematically addressed. We must prioritise community service development through our Whole Person, Whole Life – Whole System strategic Approach.

Fundamental Change in Mental Health - Local and Global Action Plan.

The Covid - 19 pandemic has highlighted major health inequalities and the urgent need to act now"[40] 19 The Action Plan was developed by organisations representing people with lived experi-

ence, who use services, family members, mental health professionals, policy makers and researchers and it has been adopted by a Coalition of International Organisations:

- International Mental Health Collaborating Network
- World Federation for Mental Health
- World Association for Psychosocial Rehabilitation
- Mental Health Europe
- European Community based Mental Health Service Providers Network (EUCOMS)
- Global Alliance of Mental Illness Advocacy Networks (GAMIAN)
- Human Rights Monitoring Institute (HRMI)
- Italian Society of Psychiatric Epidemiology (SIEP)
- Transforming Australia's Mental Health Service System, Incorporated

- The Action Plan addresses the need for fundamental change in the approach to mental health that should prioritise improving mental health by focusing on social determinants and achieving equity in mental health care for all people, worldwide. These targets are for people and organisations to use locally within their communities and mental health services. Among the 12 Action points, it is important to note: *"4.3 There is a fundamental need to focus on understanding the importance of the social determinants of mental health in meeting the whole - life needs of people"*.

- The recommended action points are:

    - – To develop local strategic plans to tackle the social determinants of mental health through a community partnership that acknowledges international frameworks and goals.
    - - Mental health providers to prioritise these local strategic plans as they are of equal importance to the development of clinical services.
    - - To apply a co-production methodology: A democratic and inclusive process of development that encompasses all local stakeholders as equal partners to create a *Whole Life - Whole System* approach.
    - - To work with Non-Governmental Organisations and a range of different agencies (public and private) that provide significant services in our societies. We especially need to work with them to meet the whole life needs of people in the community.
    - - To increase and sustain the funding of community organisations that provide essential services not met by statutory organisations.
    - - To address inequalities, systemic racism and discrimination, ensuring that the needs and voices of oppressed, marginalised and vulnerable groups are prioritised, and this injustice is addressed through specific actions by applying equalities principles.

- The organisations included in this campaign have worldwide networks of thousands of members and this gives this campaign the potential to reach decision makers, activists, advocates and the public at a national and local level. The launch of this campaign will be coordinated by the coalition partners. "We see this Action Plan working simultaneously internationally, na-

tionally and locally. We believe that an action that is supported by international mental health leaders, national organisations and their local branches, mental health providers, service user groups and family associations have a much greater chance of being adopted and effective. We place great emphasis on identifying and celebrating good practice founded on human rights and values. There are many examples of good practice around the world that can be used to support our *Identified big issues* and what has already been achieved to address these [40]."

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SECTION E

Thanks

WFMH WORLD MENTAL HEALTH DAY 2021

Thanks

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I would like to thank everybody who has contributed to World Mental Health Day 2021 'Mental Health in an Unequal World: Together we can make a difference'.

I am very grateful to all the people who have contributed to this year's World Mental Health Day educational material, and to those people who provided peer reviews. We welcome partnership and are grateful to all our volunteers.

This year's educational material has been provided by people with lived experience, carers, health professionals from many specialities, governments and those who commission services. All our contributors have volunteered their time and expertise to provide this year's wonderful material – thank you. Each of their names will be published on the WFMH World Mental Health Day website. I am also grateful to the WFMH President Ingrid Daniels for her leadership.

The annual World Mental Health Day established in 1992 through the energies of Dick Hunter, and supported by the Carter Centre, has been actively supported by the WHO, United Nations and many individuals, institutions and professional colleges around the world with an interest in promoting mental health advocacy. I am very grateful to you all.

All our WFMH Secretary Generals and WFMH Past Presidents since 1992 have worked to ensure that this annual event on October 10th continues to grow with a clear message to ensure that mental health is a priority, and each of use receives the dignity of care that we are entitled to.

WFMH is also grateful to all the donors and volunteers who have ensured that WFMH has had the resources to continue its mental health advocacy work since it was established in 1948. Your contribution is very valuable and contributes to our continued success. We know that many of you will be organising a range of activities to celebrate World Mental Health Day and to highlight this year's theme. It is important to share our work because together, we can make a difference. Please let us know what you are doing as we may be able to showcase some of the work on the 2021 World Mental Health Day website.

My thanks to the WFMH 2019-2021 Executive, Regional Vice Presidents and Board of Directors for their support and to WFMH voting and non-voting organisational members and WFMH individual members for their support. I am also very grateful to the Technical Team that have supported the Office of the Secretary General for their untiring hard work.

Remember, wherever and whoever we are, together we can make a difference.

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WFMH World Congress London 2022

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It gives me great pleasure to invite you to come to our WFMH World Congress which takes place on:

28th June 2021 to 1st July 2022 at Central Hall Westminster, London, UK

Central Hall Wesminster, the venue of the 23rd WFMH Congress has a unique place in the history of WFMH because it was here that the first International Congress on Mental Health was held in August 1948 leading to the foundation of WFMH.

At that time the International Preparatory Commission for the congress concluded that:

'principles of mental health cannot be successfully furthered in any society unless there is progressive acceptance of the concept of world citizenship. World citizenship can be widely extended among all peoples through the application of principles of mental health.'

We know that the last two years have been very difficult across the world because of the pandemic, and we are pleased that the recovery has begun so that many of us will be able to come to London and meet face to face. This will also be a wonderful opportunity for us to prepare for the 75th Anniversary of WFMH which takes place in 2023.

If you would like to attend as a participant, presenter, sponsor or donor please let me know by e-mail on secretary.general@wfmh.global.

We very much hope to welcome you to London in 2022.

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