Submission to the International Development Committee Inquiry on Disability and Development on Psychosocial Disabilities

EXECUTIVE SUMMARY

This submission, representing non-governmental organizations, academic institutions and service user organizations, calls upon the UK Government to harness the potential that addressing psychosocial disabilities can have to maximize positive global development outcomes.

Mental Health is essential to achieving sustainable development. It is a crosscutting issue that stretches across all aspects of health and human development. Good mental health is central to overall health and well-being. Life expectancy for those with serious mental illness is 15-20 years less than for those with good mental health, and mental ill health accounts for a huge proportion of years lived with disability. Disability associated with mental ill health is not yet a global priority, despite WHO statistics showing that approximately half a billion people worldwide are disabled as a consequence of experiencing an episode of mental illness.

Our three main recommendations, drawn from a global consensus of the Movement for Global Mental Health, are to:

- Promote protection of human rights and prevent discrimination against people with mental illness and psychosocial disability
- Bridge the massive mental health treatment gap and improve access to health and social care
- Explicitly integrate attention to mental health into development initiatives

This submission explores how practical interventions can support recovery that will allow what has been a neglected community to participate fully in common development objectives.
1 INTRODUCTION

1.1 Disability associated with mental ill health has for too long been a low priority in development. Psychosocial disabilities\(^1\) are increasingly recognized as resulting not only in individual social exclusion, but being an important factor frustrating the aspirations of families, communities and emerging economies. According to the World Report on Disability, 1 billion people worldwide experience a disabling condition. Of these, 60% of the causation is strongly linked to mental, neurological and substance abuse conditions. The economic cost of these conditions was estimated to the $2.5 trillion in 2010.

“1 in 4 people will experience an episode of mental illness in their lifetime”

1.2 The World Health Organization (WHO) estimates that 1 in 4 people will experience an episode of mental illness in their lifetime, and that approximately 600 million people worldwide are disabled as a consequence. Most (85%) of these people are in low and middle income countries. Psychosocial disability is one of the most pressing development issues of our time but risks being left behind in disability, human rights and development discourse. Poverty and hunger, conflict and trauma, poor access to health and social care, and social inequity are significant risk factors, increasing vulnerability to persons with psychosocial disabilities in low and middle income country contexts. Despite such challenges, communities under stress often show a remarkable resilience. The most effective work in global mental health aims to reinforce this resilience and find solutions that reinforce local coping strategies and resources with scientifically proven interventions.

2 THE FINANCIAL COSTS AND BENEFITS OF AN INCREASED EMPHASIS ON DISABILITY

2.1 HUMAN RIGHTS ABUSES

2.1.1 Psychosocial disability emphasizes the central importance of social attitudes and discrimination in the experience of people labeled with mental illness. Socially unacceptable behavior is frequently punished with exclusion and, all too commonly, frank human rights abuse. There is documented evidence from all regions of the world that people with psychosocial disabilities experience some of the most severe human rights violations of any group of people.

2.1.2 This includes being tied to beds or kept in isolation in psychiatric institutions, being incarcerated in prisons, being chained and caged in small cells in the community, and being physically abused by ‘traditional’ healing practices. Estimates form the Ministries of Health in Indonesia for example, indicate that over 18,000 people are currently being physically restrained because of their mental health

\(^1\) Psychosocial disability is the preferred term used in the UN Convention on the Rights of Persons with Disabilities (CRPD) and defines people who are affected by a variety of mental health issues. Psychosocial disability does not represent any particular condition or category of mental disorder or illness, but is defined by the impact on a person’s life of the interaction of a mental condition and the way that society treats that person as a consequence.
condition. This has been called a failure of humanity and is a global emergency that requires immediate and sustained action.

2.1.3 As a consequence, the aim of improving access to human rights and dignity is as much about changing the environment in which people live as addressing any impairment they may have. Allowing people to access the things they value most (such as livelihood, a family life and participation in community decision-making), requires a change in attitudes, and a challenge to the stigma that people with psychosocial disabilities face. This focus on human rights and stigma reduction is the main message of organizations of people with psychosocial disabilities from the global south, as well as being central to the growing Movement for Global Mental Health.

2.2 A GROWING BURDEN OF DISEASE

2.2.1 Recent systematic analyses comparing disability attributable to different impairments show that mental and behavioral problems account for 7.4% of the global burden of disease measured using Disability Adjusted Life Years (DALYs). Neurological conditions including dementia and epilepsy account for 3% of DALYs. Mental and behavioral problems command an even greater share of Years Lived with Disability (YLD): nearly one-quarter of the global total. This is the biggest single cause, more than cardiovascular diseases and cancer combined (Figure 1).

<table>
<thead>
<tr>
<th>Top 5 contributors to the health burden (DALYs and YLDs) for 2010.</th>
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<tr>
<td><strong>Cardiovascular and circulatory diseases</strong></td>
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<td><strong>Diarrhea, lower respiratory infections, meningitis and...</strong></td>
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<td><strong>Neonatal disorders</strong></td>
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<td><strong>Cancers</strong></td>
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<td><strong>Mental health problems</strong></td>
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Figure 1 | Top 5 contributors to the health burden (DALYs and YLDs) for 2010.

2.2.2 Mental illnesses cause such a large burden of disease both in the person experiencing the impairment and the social exclusion and human rights violations that result. 50% of mental health problems start in childhood, and many conditions have a relapsing and remitting course which can last for many years, particularly if untreated. As well as long-lasting impairment from these conditions

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2 The Movement for Global Mental Health is a network made up of service users, practitioners, academics, the development community and other stakeholders, which has a common aim of advocating for protection of human rights and campaigning for improved access to appropriate mental health care. http://www.globalmentalhealth.org/

3 One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.
(morbidity), a high excess mortality is being increasingly recognized. In high income countries men with mental health problems die 20 years and women 15 years earlier than people without mental health problems. In low income countries this gap is likely to be much wider.

"Men with mental health problems die 20 years, and women 15 years, earlier than people without mental health problems"

2.2.3 This life expectancy gap is due partly to high rates of suicide (nearly one million people globally take their own lives every year), but also because people with psychosocial disabilities lead poorer, more disadvantaged lives, experience more physical health problems, and are often excluded from services accessible to others resulting in severe disabilities. This mortality gap must be recognized as a human rights issue.

2.3 CHRONIC UNDER INVESTMENT IN SERVICES AND RESULTING TREATMENT GAP

2.3.1 Globally, there is chronic under-investment in psychosocial disabilities, and a huge mismatch between investment by governments and the relative burden of psychosocial disabilities (Figure 2). Low income countries spend about 0.5% of their health budgets (which are in themselves very low) on psychosocial disabilities, despite them causing 25.5% of the YLDs. Investment in relevant work in the social and education sectors is equally low.

2.3.2 This under-investment in mental health services has resulted in a huge treatment gap. In low income countries, less than 20% of people who would benefit from services are able to access them. In some countries, and for more severe disorders such as schizophrenia, the treatment gap is as wide as 98%. Treatment choices are therefore frequently limited to traditional or religious treatments which are often ineffective. Such settings have often been used to simply contain people who families cannot cope with, and can be abusive, with chaining and forced treatment common. Where services do exist, they are often based in large cities, far from people who may need them. This lack of access to treatment breaches a fundamental right to accessing health care.
3 THE STRENGTH OF THE EVIDENCE BASE ON ‘WHAT WORKS’

3.1 The large treatment gap is particularly critical as the evidence overwhelmingly shows that prompt treatment improves health outcomes, social integration and economic outcomes for individuals. Improving access to treatment, combined with improving human rights, is the key call to action to improve the quality of life of person with psychosocial disabilities.

3.2 A growing body of research, much of which deliberately prioritizes operational and implementation issues, has also resulted in strong evidence of (cost) effective interventions suited even to the poorest settings with weak infrastructure. This evidence has recently been compiled into 6 actions for global policy makers in the World Innovations Summit for Health (WISH) Mental Health Report.⁴ Linked to this, information on over 60 successful innovations to improve psychosocial disabilities globally has been compiled by the Mental Health Innovation Network and is available online.⁵

3.3 We know what works – the challenge now is to implement these evidence-based services to scale while meeting the essential standard of local contextual appropriateness. It is not morally defensible to remain idle in the face of enormous abuse of the right to access treatment and gross human rights abuses when we now have the evidence of what works.

4 ADEQUACY OF CURRENT POLICY COMMITMENTS

4.1 Practical steps to improve psychosocial disabilities globally include the WHO Mental Health Gap Action Programme (mhGAP) which aims to provide evidence-based resources for governments and civil society to scale up services for mental, neurological and substance use disorders, especially in low and middle income countries. Unfortunately, more commitment is needed by governments and other international donors to budget adequately for prevention, treatment and care for psychosocial disabilities, though awareness is increasing about the issue.

4.2 A major milestone was achieved in May 2013 when the World Health Assembly of the WHO unanimously adopted a Global Mental Health Action Plan (2013-2018) for the first time. In addition, the WHO has started to address the related issues of human rights. Their QualityRights program aims to provide resources for monitoring mental health care facilities and supporting processes for improving the care they provide.

5 EFFECTIVENESS OF DFID’S APPROACH TO REHABILITATION AND SERVICE PROVISION

5.1 Despite the growing recognition of the essential need to address psychosocial disabilities in development, global development budgets remain woefully inadequate. The UK Government, through DFID, is one of the few governments who have invested in understanding more about scaling up services for mental health in low resources settings. Since 2005, DFID have funded two Research Partnership

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⁴ http://www.wish-qatar.org/app/media/381
⁵ http://mhinnovation.net/innovation/
Consortiums. The Mental Health and Poverty Project explored the relationship between poverty and mental health in four African countries. Since 2011, DfID have committed to funding £6 million over 6 years for the PRogramme for Improving Mental health care (PRIME). PRIME is groundbreaking as it is the first project to design, implement, scale up and evaluate mental health services in collaboration with Ministries of Health in five countries in Asia and Africa.

5.2 As DfID has taken a lead in commissioning appropriate research in this field, it is well placed to translate this into scaled programmes. While there are few examples at present, the strength of evidence, and systematic way that DfID has approached this, is a good foundation on which to build.

6 INTEGRATION OF DISABILITY ISSUES WITHIN DFID’S SECTOR PROGRAMMES

6.1 Mental health is unique in its relevance to many other aspects of health and development. As well as being critical to success in addressing poverty and economic development, there are strong links to almost all the other Millennium Development Goals. Psychosocial disabilities are the most common Non-Communicable Diseases (NCD) by disease burden, as well as playing an important role in successful interventions for the other NCDs. In a similar way, there are key mental health aspects of programmes addressing HIV/AIDS (depression, medication compliance), maternal and child health (post-natal depression, early child stimulation) and Neglected Tropical Diseases (stigma, depression).

6.2 Mental health status is associated in multiple ways with each of the nine thematic areas for emerging post-MDG priorities, and can therefore be considered as a fully cross-cutting issue. For instance, in relation to education, educational stressors are risk factors for college students, while an important route for access to mental health care for young people is via educational organizations.

7 THE ROLE OF PERSONS WITH PSYCHOSOCIAL DISABILITIES

7.1 The growing momentum of evidence, advocacy networks and investment is reflected in the increasingly strong policy and legislative framework for psychosocial disability. The CRPD has psychosocial disabilities as a core mandate, proving a strong mechanism for holding signatory countries to account. This monitoring function is explicitly stated in the CRPD (Article 33(2)) as a key way that persons with psychosocial disabilities and the organizations can participate.

7.2 The stigma associated with psychosocial disabilities has been such that their voice has been poorly represented even among the disability movement, let alone in the health and development sector. This is changing fast, with increasing numbers of countries having organizations of persons with psychosocial disabilities, and in some cases continental umbrella bodies, such as the Pan African Network of Persons with Psychosocial Disabilities. This will allow greater participation in not only CRPD processes (e.g. parallel reports), but at all levels of service development and planning that affect their interests. Global development organizations and governments need to commit to this principle.

http://www.prime.uct.ac.za/
8 UK’S ROLE IN ENSURING POST-2015 DEVELOPMENT GOALS CONSIDER DISABILITY ISSUES

8.1 Given the cross-cutting nature of mental health and psychosocial disability, the most powerful way that the UK Government and DfID can have an impact is to consider mental health within the full range of policies and programmes. Demonstrating appropriate consideration of mental health issues in external communication would send a powerful message to partners.

8.2 It is impossible to seriously address psychosocial disability without considering both human rights and health in tandem. As we approach a new phase of global consensus on development priorities, health is increasingly seen as an essential component of overall sustainable development, and as a positive outcome of successful achievement of human rights, social, and environmental targets. Similarly, mental health (and better social inclusion for persons with psychosocial disabilities) has an extremely strong case as being essential for sustainable human development, with mental wellbeing increasing as a result of such development.

8.3 The UK Government needs to build on its recognition of the importance of happiness and wellbeing by recognizing that enabling access to mental health care has the best evidence of impact in this area. Addressing psychosocial disability is an essential step in addressing key development issues such as social inclusion and equity, universal health coverage, a holistic and life-course approach to health, access to justice and human rights, and sustainable economic development. Members of the Movement for Global Mental Health contributed to a common position statement related to the post-2015 development agenda. They have three calls for action which we would echo (Figure 3).

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<tr>
<th>Main calls of the Movement for Global Mental Health post-2015 position statement</th>
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| 1. **Promote protection of human rights and prevent discrimination against people with mental illness and psychosocial disability**  
  - Promote implementation of the UN Convention on the Rights of Persons with Disabilities, strengthen human rights protections and prevent discrimination.  
  - Enable people with mental illness and psychosocial disability to make decisions about their own welfare, and to participate fully in processes affecting them.  
  - Ensure equal access for people with mental illness and psychosocial disability to health, education, livelihood and other development projects, to ensure that people who are among the most vulnerable are not left behind. |
| 2. **Bridge the massive mental health treatment gap and improve access to health and social care**  
  - Support the full implementation of the WHO Comprehensive Mental Health Action Plan.  
  - Integrate mental health treatment and psychosocial support services into Non-Communicable Disease services.  
  - Ensure parity with physical illnesses in access to treatment and care.  
  - Ensure full access for people with mental illness and psychosocial disability to universal health coverage. |
| 3. **Explicitly integrate attention to mental health into development initiatives**  
  - Ensure sustained attention to the most vulnerable groups, including people with mental illness and psychosocial disability, in development activities in the fields of health, education, economic development and human rights.  
  - Integrate measures of mental wellbeing in monitoring and evaluation of development effectiveness. |
9 SUMMARY

9.1 This submission reiterates these priorities and calls upon the UK Government to ensure interventions addressing psychosocial disabilities are recognized as being essential, and an opportunity to maximize positive global development outcomes.

10 KEY SUPPORTING DOCUMENTS


11 SUBMITTING ORGANIZATIONS

**NEPAL MENTAL HEALTH FOUNDATION (NMHF)**

NMHF is a leading psychosocial disability rights organization in Nepal established and led by people who have been affected by psychosocial disability issues. It is gradually evolving as a policy centered organization specializing on the UN Conventions on the Rights of Persons with Disabilities (CRPD) and cross-cutting disability issues.

It was registered with the Government of Nepal in 2008 as an NGO and has been actively working to engage politicians, bureaucrats, media, Disable People Organizations, and civil society to promote disability rights through promoting disability-inclusive social policies and rights based public awareness.

**CENTRE FOR GLOBAL MENTAL HEALTH**

The Centre for Global Mental Health (CGMH) is a collaboration between the London School of Hygiene and Tropical Medicine (LSHTM) and King’s Health Partners.

The vision of the Centre is to foster research and capacity building in policy, prevention, treatment and care with the ultimate objective of closing the treatment gap for people living with mental, neurological and substance use disorders. The Centre, alongside WHO, is one of the main drivers of the Mental Health Innovation Network, a collaborative platform for those working on Global

**CBM- THE OVERSEAS DISABILITY CHARITY**

CBM is an international Christian disability and development organization, committed to improving the quality of life of persons with disabilities and at risk of disabilities in the poorest countries of the world. CBM’s vision is an inclusive world in which all person with disabilities enjoy their human rights and achieve their full potential.