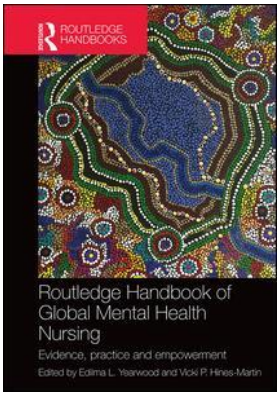

Routledge Handbook of Global Mental Health Nursing Evidence, practice and empowerment

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Overview of Mental Health in Low-, Middle- and High-Income Global Communities

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PART I

Historical and contemporary mental health nursing

1

OVERVIEW OF MENTAL HEALTH IN LOW-, MIDDLE- AND HIGH-INCOME GLOBAL COMMUNITIES

Edilma L. Yearwood and Spencer R. Case

Arthur Kleinman asserted that a significant barrier to global mental health is moral in that individuals with mental illness exist within poor environmental conditions and that governments, as stewards of its citizenry, have failed to protect them (2009).

Introduction

Global mental health is an emerging science and the scientists and clinicians engaged in this work are aggressively working to bring this neglected issue to the forefront. Their actions are motivated by the knowledge that the extent of poor mental health is widespread with catastrophic public health impact, and that significant challenges to well-being exist for individuals, families and communities particularly those living in poorly resourced environments. More than 450 million people globally suffer from mental health challenges with 1 in 4 individuals affected by a mental illness (WHO, 2010a); however, two thirds of those in need of mental health treatment never receive it (WHO, 2001a). Mental illness constitutes roughly 13 percent of the global burden of disease, outpacing cardiovascular disease and cancer (WHO, 2001a) with depression expected to be the second highest cause of disease burden in middle-income countries by 2030 (WHO, 2010a). Suicide is ranked as the third leading cause of death in 15- to 44-year-olds and the second cause of death in 10- to 24-year-olds (WHO, 2014), a statistic that translates into 800,000 to one million deaths annually.

Globally, more than 40 percent of countries have no mental health policy (WHO, 2001a) and additionally, one-third of countries allocate less than 1 percent of their health budgets to mental health. There are fewer available mental health beds to address existing needs, with ranges of 5–50 beds per 100,000 population depending on low-, middle-, or high-income country status (WHO, 2014). Globally, nurses are the most prevalent health care professionals and constitute the largest group working in mental health (Morris, Lora, McBain, & Saxena, 2011). However, we argue that nurses are not being fully utilized as resources in mental health promotion and prevention efforts across all countries.

The assertion made in 2005 that, "there can be no health without mental health," (WHO, 2005, p. 11) endorsed and supported by the World Health Organization (WHO), appears to have been a timely catalyst for an increased focus on obtaining prevalence data on mental, neurological and substance use disorders globally, and for bringing about widespread discussion of mental health and prevention of *mental ill health*. However, variability exists across countries at multiple levels when looking at drivers known to promote or impede mental health or well-being. At the macro system level, areas that are the responsibility of governments include ensuring healthy economic conditions, developing and enforcing humanistic policies, valuing comprehensive well-being of its citizenry and promoting knowledge by making education accessible for all. These factors provide a basic underlying framework for health, including mental health. Building on these, safeguarding human rights as a fundamental underpinning of well-being, early case finding, ensuring availability of treatment resources (human, materials and services), stigma elimination, supportive cultural attitudes, consumer awareness, mental health literacy and mental health promotion strategies are critical ingredients to further support mental health. The process of global mental health awareness and promotion, research, and developing evidence-based treatment strategies to fit specific resource-able and culturally distinct contexts is developmentally in its infancy across different global communities. New models of treatment must be developed, including intentional integration of mental health care in primary care, task sharing through the use of traditional healers and non-specialist workers in low resourced environments, and expanded use of technology to begin to meet the vast mental health needs that exist and that cannot be managed with the existing number of trained mental health care providers who primarily reside in cities or more populated regions within countries. Without healthy human contributors to societal development, the specific community, state, region or country remains at a disadvantage, fails to flourish and lags behind comparable entities across multiple measures of overall health, including mental health.

Non-communicable disease burden, of which mental health is a component, increased from 36 percent to 49 percent in low- and middle-income countries from 1990–2010. During the same time frame, non-communicable disease burden in high-income countries saw only a 4 percent increase (Charlson *et al.*, 2015). Cause specific deaths (one underlying cause) resulted in 775,000 deaths attributable to Alzheimer's and other dementias, alcohol abuse and epilepsy. Excess deaths (due to multiple factors) accounted for over 8 million deaths and were associated with alcohol use disorder, schizophrenia, Alzheimer's and other dementias and opioid misuse. Other mental disorders such as bipolar, major depression, autism, and intellectual disability resulted in 4.5 million deaths (Charlson *et al.*, 2015).

This chapter will provide the framework for understanding the emergent field of global mental health as will be described throughout this text, define common terminology, discuss incidence and prevalence of major neuropsychiatric disorders, describe characteristics of low-, middle-, and high-income countries, illustrate consequences of unmet mental health needs and identify individuals and organizations leading the global mental health movement.

The purpose of this textbook is to provide a nursing perspective on the global mental health crisis, describe prevention, mental health promotion and evidence-based treatments, and present several in country exemplars with individuals and groups experiencing mental and behavioral health challenges. Nurses, as the largest health care profession globally can make significant contributions to improving mental health across all income communities and the profession can play a more significant role in the movement for global mental health and the evolution of global mental health science.

Low-, middle-, and high-income countries

On an annual basis the World Bank determines Gross National Income status of World Bank members and other countries with populations greater than 30,000. The three factors examined are country income level, region of the world in which the country is situated and country lending status.

Low-income countries are defined as countries with citizen incomes of $1035 or less annually. Examples of countries in this category include the Central African Republic, Democratic Republic of the Congo, Cambodia, Afghanistan, Ethiopia, Haiti, and Uganda.

Middle-income countries are countries in which citizens on average earn between $1036 and $12,615. Examples of countries in this category are Angola, Brazil, China, Columbia, Costa Rica, Cuba, Turkey, and the Dominican Republic.

High-income countries are countries in which citizens on average earn greater than $12,616 annually. Countries in this category include the United States, Canada, England, Australia, France, Germany, Belgium, and Argentina (World Bank, n.d.).

Mental health and mental illness

Mental health has been defined as, "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively, and is able to make a contribution to his or her community" (WHO, 2001b, p. 1). While mental health is achievable in individuals across the lifespan, it is increasingly clear that overall psychological wellness or mental well-being is dependent on factors frequently outside the control of the individual. These external factors termed social determinants of health (SDH) include environmental conditions that exist where people are born, live, work, and play; socio-economic status such as poverty; access to education and subsequent health literacy; race and gender; early childhood experiences associated with social advantages or disadvantages; availability of and access to resources including health care services; lack of or ineffective policies, and individuals and communities who have been disempowered (Braverman *et al.*, 2011; Friel & Marmot, 2011). In addition, biological risk for mental illness exists, rendering some more vulnerable as most psychiatric disorders have a genetic basis and frequently originate in childhood or adolescence. Recently there has been a push to replace the term mental health simply with well-being due to the stigma associated with the terminologies of mental health and mental illness. Both terms, mental health and well-being will be used in this textbook.

Mental illness, at times referred to as mental ill health, is a brain disease manifested when the individual experiences alteration in thinking, mood or behavior often accompanied by distress and/or impairment in functioning, disability or mortality (WHO, 2013). Addressing and ameliorating individual vulnerabilities across multiple areas must become the focus of effective interventions to avoid or mitigate mental ill health. The burdens associated with mental disorders include poor health literacy, poor quality of life, inability to achieve one's potential, isolation, and potential for shorter life expectancy. There are an estimated 450 million people worldwide living with a mental illness and of that number, approximately 50–85 percent who are in need of mental health services do not receive them (Demyttnaere *et al.*, 2004). In low-income countries less than 1 percent of health spending is allocated to mental health. In middle-income countries approximately 2.5 percent is spent on mental health, and in high-income countries, 5 percent of health care dollars are earmarked for mental health services (WHO, 2011).

Along with the sparse allocation of financial resources dedicated to mental health promotion and treatment, many countries are either missing written policies or plans, or have outdated

documentation outlining a vision for ensuring the mental health of its citizenry. In addition, accurate data collection on prevalence, monitoring of services and research on treatment effectiveness are missing, primarily in low- and middle-income countries. Variability across countries in the area of data collection methodology impacts the quality, accuracy and completeness of what truly exists and what is known. Without these data, it is difficult to make a compelling case for reallocation of funds even if they were available (WHO, 2013). Global mental health scientists are aggressively striving to rectify this situation.

Global Burden of Disease (GBD) represents epidemiological data reflecting risk factors, mortality, morbidity, health and injuries associated with disease burden. GBD incorporates prevalence and disability to arrive at an estimate of years lived with disability (YLDs). In addition it collects data on number of years that are lost to premature mortality (YLLs). The sum of both of these factors yields to disability-adjusted life years (DALYs). The 2010 GBD survey indicated that mental, neurological, and substance use disorders were the leading cause of YLDs, accounting for more than 10 percent of the global burden of disease (Whiteford *et al.*, 2013; Whiteford, Ferrari, Degenhardt, & Feigin, 2015). These chronic and non-communicable diseases more significantly impact low- and middle-income countries. Table 1.1 illustrates the WHO GBD for neuropsychiatric disorders and Table 1.2 provides a comparison between WHO and the Institute for Health Metrics and Evaluation (IHME) across neurologic, mental, behavioral, self-harm, and interpersonal violence dimensions.

Table 1.1 Global burden of disease: how the WHO Mental Health Atlas 2011 calculated the global burden of disease for mental ill health

WHO
Neuropsychiatric disorders (as reported in the WHO Mental Health Atlas 2011 Country Profiles)
The following disorders were used to calculate the global burden of disease (DALYs) for mental ill health in the WHO *Mental Health Atlas 2011* country profiles. (Note: the WHO does not use the term "neuropsychiatric disorders" in the most recent classifications for the GBD.)
Unipolar depressive disorders Bipolar affective disorder Schizophrenia Epilepsy Alcohol use disorders Alzheimer and other dementias Parkinson's disease Multiple sclerosis Drug use disorders Post-traumatic stress disorder Obsessive-compulsive disorder Panic disorder Insomnia (primary) Migraine
www.who.int/healthinfo/global_burden_disease/2004_report_update/en/ www.who.int/mental_health/evidence/atlas/profiles/en/

Table 1.2 Comparison between WHO and the Institute for Health Metrics and Evaluation (IHME) across neurologic, mental, behavioral, self-harm, and interpersonal violence dimensions

Organization: IHME	*Organization: WHO*
Classification: "neurological disorders"	*Classification: "neurologic conditions"*
Alzheimer's disease and other dementias	Alzheimer's disease and other dementias
Parkinson's disease	Parkinson's disease
Epilepsy	Epilepsy
Multiple sclerosis	Multiple sclerosis
Migraine	Migraine
Tension-type headache	Non-migraine headache
Other neurological disorders	Other neurological conditions
http://viz.healthmetricsandevaluation.org/gbd-compare/#	www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index1.html
IHME	*WHO*
"Mental and behavioral disorders"	*"Mental and behavioral disorders"*
Schizophrenia	Unipolar depressive disorders
Alcohol use disorders	Bipolar disorder
Drug use disorders	Schizophrenia
Opioid use disorders	Alcohol use disorders
Cocaine use disorders	Drug use disorders
Amphetamine use disorders	Anxiety disorders
Cannabis use disorders	Eating disorders
Other drug use disorders	Pervasive developmental disorders
Unipolar depressive disorders	Childhood behavioral disorders
Major depressive disorder	Idiopathic intellectual disability
Dysthymia	Other mental and behavioral disorders
Bipolar affective disorder	
Anxiety disorders	
Eating disorders	
Pervasive development disorders	
Autism	
Asperger's syndrome	
Childhood behavioral disorders	
Attention-deficit hyperactivity disorder	
Conduct disorder	
Idiopathic intellectual disability	
Other mental and behavioral disorders	
http://viz.healthmetricsandevaluation.org/gbd-compare/#	www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index1.html
IHME	*WHO*
"Self-harm and interpersonal violence" *Note: the IHME does not use the term "suicide"*	*"Intentional injuries"* *Note: the WHO does not use the term "suicide"*
Self-harm	Self-harm
Interpersonal violence	Interpersonal violence
Assault by firearm	Collective violence and legal intervention
Assault by sharp object	
Assault	
http://viz.healthmetricsandevaluation.org/gbd-compare/#	www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index1.html

General information on calculating the burden of disease for mental ill health (unrelated to the WHO *Mental Health Atlas 2011*)

There are two global health authorities that calculate the global burden of disease (GBD) for mental ill health, the Institute for Health Metrics and Evaluation (IHME) and the World Health Organization (WHO). The IHME and the WHO calculate the GBD for mental ill health by classifying conditions according to type, and both organizations classify conditions differently. The GBD can be reported according to Disability Adjusted-Life Years (DALYs) where one DALY equates to 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. DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences.
>
> *(World Health Organization, n.d.)*

Overview of mental health challenges

Mental, neurological/neurodevelopmental and substance use disorders all present challenges to individuals, families, and communities, impacting global burden of disease, economies, and overall health across multiple environments. Low- and middle-income countries are particularly challenged to adequately assess prevalence, develop and implement evidence-based treatments, have adequate human and treatment resources, and to provide long-term supports to maintain mental health. Each of these categories is briefly described below and will be explored in greater length throughout this book.

Mental health disorders

Mental health disorders are a set of symptoms associated with a DSM-5 or ICD-10 diagnosis in which there is significant disturbance in an individual's cognition, emotion regulation, or behavior that impacts functioning. Mental disorders are caused by genetic, social, and environmental factors. They are usually chronic and contribute to disease burden due to early onset, prevalence, impairment, persistence, and associated co-morbidities. Mental disorders contribute to distress in social, learning, occupational, relational, or other important activities. Examples of mental disorders include mood dysregulations such as major depression and bipolar disorder, schizophrenia, anxiety disorders such as post-traumatic stress, generalized anxiety, obsessive-compulsive, panic, and somatization disorders (APA, 2013; Collins, Patel, & Joestl, 2011; Hyman, Chisholm, Kessler, Patel, & Whiteford, 2006; Whiteford *et al.*, 2015).

Neurological/neurodevelopmental disorders

Neurological/neurodevelopmental disorders are disorders of the brain, spinal cord, or nerves that impact memory, learning, mood, movement, and one or more of our senses. The etiology of these disorders are varied and include genetics, poor nervous system development, degenerative

diseases, injury, seizures, infections, tumors, or poor blood flow (NINDS, n.d.). Disorders in this category include Alzheimer's and other dementias, epilepsy or seizure disorders, autism, learning and intellectual disabilities, attention deficit disorder, Parkinson's disease, and acute ischemic strokes (Chandra *et al.*, 2006; NINDS, n.d.).

Substance use disorders

Alcohol, tobacco, and illicit drug use is a significant public health crisis across the lifespan and across all income countries globally. Substance use should be examined looking at volume and frequency of consumption, dependence and tolerance, impaired control, consequences to health, safety, quality of life, relationships, and productivity (Rehm, Chisholm, Room, & Lopez, 2006). Substances include alcohol, opiates such as heroin, opium and analgesics, stimulants such as cocaine and methamphetamines, inhalants and hallucinogens, among others.

WHO Mental Health Gap Action Programme (mhGAP) developed evidence-based management and scaling up guidelines for use when intervening with mental, neurological, substance use and child and adolescent disorders along with clinical practice recommendations applicable to low- and middle-income communities (Dua *et al.*, 2011; mhGAP, 2008). In addition, the Institute of Medicine supported development of core care competencies for non-specialist health workers in low- and middle-income countries. The competencies focused on the major mental, neurological and substance use disorders causing the greatest burden such as depression, psychosis, seizure, and alcohol use disorders (Collins, Musisi, Frehywot, & Patel, 2015). The competencies identified provider skills and characteristics to effectively manage the disorders, screening strategies, knowledge of what is assessed during screening, knowing when to refer to providers with additional training, and awareness of basic care needed (Collins *et al.*, 2015).

Table 1.3 provides an additional portrait of multiple factors impacting mental health in various countries and provides a visual comparison. The table includes among other factors, GBD, population literacy, presence or absence of mental health policies, resources (psychiatrists, mental health nurses, inpatient and community treatment facilities, and suicide rates).

An upper middle-class country exemplar

China, with a population of 1.3 billion people, reportedly has over 100 million people with mental health challenges (Tse, Ran, Huang, & Zhu, 2013), but accurate data is difficult to obtain. With this volume of individuals and families in need of treatment, the current 4 percent of health budget allocated for mental health along with the lack of inpatient resources created a crisis, which resulted in critical changes. The health budget targeting mental health has recently been doubled, resulting in mental health surveillance and work plans to target surveillance data, and additionally, the first National Mental Health Law has been passed. The law supports voluntary treatment, prevention and rehabilitation, expands the role of non-governmental organizations (NGOs) in providing services, promotes scientific research and international collaboration, puts in place social services to support individuals and families in need and provides resources to finance services (Phillips *et al.*, 2013; Zhou & Xiao, 2015).

Ultimately, unmet mental health needs have serious consequences. Table 1.4 provides a brief list of these effects on individuals. These consequences will be discussed throughout this textbook, reiterating the urgency for an intentional and comprehensive approach to eliminating challenges associated with achieving mental health and well-being.

Table 1.3 Mental health landscape: mental health aspects by country according to population and gross national income per capita

GNI per capita grouping (US$)	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*
***Country** (population in millions)* *World Bank Region*	*% GBD MIH*	*TE on health as % of GDP*	*TE on MH as % of HB*	*% Literate*	*LE at birth*	*MH policy*	*Psych./ 100k*	*MH nurse/ 100k*	*Psych. hosp.*	*Comm. res.*	*MH OP Fac.*	*Suicides/ 100k*
Low-income: GNI per capita of $1,035 or less.												
*Bangladesh (156.6)												
South Asia	*11.2*	*3.41*	*0.44*	*M: 73* *F: 76*	M: 69 F: 71	Yes	0.07	0.20	1	11	60	UN
*Ethiopia (89.2)												
Sub-Saharan Africa	*5.8*	*4.26*	*UN*	*M: 62* *F: 39*	M: 61 F: 64	No	0.04	0.59	1	1	57	UN
*Congo, Dem. Rep. (71.1)												
Sub-Saharan Africa	*4.7*	*2.04*	*UN*	*M: 69* *F: 62*	M: 48 F: 51	Yes	0.066	0.236	6	0	1	UN
Lower-middle-income: GNI per capita of $1,036 to $4,085.												
India (1,276.5)												
South Asia	*11.6*	*4.16*	*0.06*	*M: 88* *F: 74*	M: 65 F: 68	No	0.301	0.166	43	UN	4000	M: 12.2 F: 9.1
Indonesia (248.5)												
East Asia and Pacific	*10.7*	*2.36*	*UN*	*M: 97* *F: 96*	M: 68 F: 72	Yes	0.01	UN	48	UN	UN	UN
Pakistan (190.7)												
South Asia	*11.9*	*2.62*	*UN*	*M: 79* *F: 59*	M: 65 F: 67	Yes	0.185	7.384	5	0	3729	UN
Upper-middle-income: GNI per capita of $4,086 to $12,615.												
China (1,357.4)												
East Asia and Pacific	*17.6*	*4.55*	*UN*	*M: 99* *F: 99*	M: 73 F: 77	Yes	1.53	2.65	780	UN	UN	M: 13.85 F: 12.29

Brazil (195.5)												
Latin America and the Caribbean	*20.3*	*9.05*	*2.38*	*M: 97* *F: 99*	M: 71 F: 78	Yes	3.07	1.6	208	564	860	M: 7.3 F: 1.9
Mexico (117.6)												
Latin America and the Caribbean	*19.4*	*6.47*	*0.65*	*M: 98* *F: 98*	M: 75 F: 79	Yes	1.57	2.62	46	UN	28	M: 6.8 F: 1.3
****Cuba** (11.3)												
Latin America and the Caribbean	*25.2*	*11.28*	*UN*	*M: 100* *F: 100*	M: 76 F: 80	Yes	10.85	29.6	24	UN	402	M: 19.6 F: 4.9
High-income (non-OECD): GNI per capita of $12,616 or more.												
Russian Federation (143.5)												
Europe and Central Asia	*15.6*	*5.44*	*UN*	*M: 100* *F: 100*	M: 64 F: 76	Yes	11.61	46.26	360	11	4173	M: 53.9 F: 9.5
Saudi Arabia (30.1)												
Middle East and North Africa	*14*	*4.97*	*3.89*	*M: 98* *F: 96*	M: 73 F: 75	Yes	2.91	13.41	20	2	94	UN
United Arab Emirates (9.3)												
Middle East and North Africa	*19.9*	*2.81*	*UN*	*M: 94* *F: 97*	M: 76 F: 78	No	0.3	2.12	1	0	3	UN

Sources:
2012 World Bank GNI per capita Country Classifications: http://data.worldbank.org/news/2015-country-classifications
Organization for Economic and Co-operation and Development, About the OECD: www.oecd.org/about/
Population Reference Bureau: 2013 World Population Data Sheet: www.prb.org/pdf13/2013-population-data-sheett_eng.pdf
UN least developed country list: http://unctad.org/en/pages/aldc/Least%20Developed%20Countries/UN-list-of-Least-Developed-Countries.aspx
WHO Mental Health Atlas 2011: www.who.int/mental_health/publications/mental_health_atlas_2011/en/
WHO Mental Health Atlas 2011 Country Profiles: www.who.int/mental_health/evidence/atlas/profiles/en/#U

Notes:
2015 World Bank GNI per capita grouping (US$)
UN = information unavailable
*Country meets 2013 UN criteria for least developed country
**Cuba is notable in terms of health resources

Table indicators by column:
GNI per capita grouping (US$): Countries represent the three largest countries (2013 populations) per 2012 World Bank income group. The high-income grouping only includes non-OECD countries.

1 ***% GBD MIH*:** % of the global burden of disease (GBD), measured in disability-adjusted life year (DALYs) due to mental ill health (neuropsychiatric disorders).
2 ***TE on Health as % of GDP*:** Total government expenditure on health as a percentage of GDP.
3 ***TE on MH as % of HB*:** Total government expenditure on mental health as a % of the health budget.
4 ***% Literate*:** Literacy rate (%) for males and females.
5 **LE at Birth:** Life expectancy at birth (years).
6 **MH policy:** Mental health policy in existence, yes or no.
7 **Psych. /100k:** Psychiatrists per 100,000 people.
8 **MH nurse /100k:** Mental health nurses per 100,000 people.
9 **Psych. hosp.:** Total number of psychiatric hospitals in the country.
10 **Comm. res.:** Total number of community residential facilities in the country.
11 **MH OP fac.**: Total number of mental health outpatient facilities.
12 **Suicides/100k:** Suicide rate per 100,000 people, males and females.

2012 World Bank analytical income groups (World Bank Atlas Method) (US$): Countries classified according to 2012 gross national income (GNI) per capita. Low-income countries are those with a GNI per capita of $1,035; lower middle-income countries are those with a GNI per capita of more than $1,036 but less than $4,085; upper middle-income countries are those with a GNI per capita of more than $4,086 but less than $12,615; high-income countries are those with a GNI per capita of $12,616 or more. **Note:** Income classifications are set each year on July 1.
(http://data.worldbank.org/news/2015-country-classifications)

What is the OECD: The Organization for Economic and Co-operation and Development (OECD) is a group of 34 economically advanced, and democratically and market oriented countries that "promote policies to improve economic and social wellbeing around the world." High-income non-OECD countries are represented in the table because although average GNI per capita may be over $12,616, other development indicators such as health and education may be less substantial when compared to OECD member countries.
(www.oecd.org/about/)

Table limitations:
- The table only represents data for countries with the largest populations according to GNI grouping.
- OECD countries are not included.
- Missing data ("UN") from the WHO Mental Health Atlas 2011 country profiles.
- The WHO Mental Health Atlas 2011 country profile reports data from multiple sources, some of which may not be the most recent.
- The WHO Mental Health Atlas 2011 survey terminologies may have been interpreted differently across countries.
- Column 1: The WHO Mental Health Atlas 2011 GBD calculations for "neuropsychiatric disorders" include: unipolar depressive disorders; bipolar affective disorder; schizophrenia; epilepsy; alcohol use disorders; Alzheimer's disease and other dementias; Parkinson's disease; multiple sclerosis; drug use disorders; post-traumatic stress disorder; obsessive-compulsive disorder; panic disorder; insomnia (primary); migraine. Therefore, multiple mental and behavioral disorders may not included in the WHO GBD calculation (WHO (2008), The Global Burden of Disease: 2004 Update). www.who.int/healthinfo/global_burden_disease/2004_report_update/en/ Geneva: WHO.)

Table 1.4 Consequences of unmet mental health needs

Chronicity of symptoms
Decreased productivity (GBD; DALYs)
Exacerbation of symptoms
Isolation
Loss (relationships, work, status, self-esteem)
Poor economic status
Poor quality of life
Poor self-concept
Suffering
Victim of stigma

Global mental health advocates

Numerous organizations have begun to include concepts associated with advancing mental health in their mission, have developed goals to achieve improvement in psychological well-being of individuals, and have identified strategies to improve conditions that contribute to overall community well-being. These organizations include the United Nations (UN), the World Health Organization (WHO), regional WHO offices (in the Americas, Africa, Eastern Mediterranean, Europe, South-East Asia, and Western Pacific), the National Institute of Mental Health (NIMH), Non-Governmental Organizations (NGOs), the World Bank, Human Rights organizations, religious institutions and the London School of Hygiene and Tropical Diseases. While these steps are crucial and laudable, the overwhelming needs and low resource status of some countries makes this work daunting.

The Millennium Development Goals (MDGs) developed by the UN in 2000 identified goals that were complementary to the social determinants of health but did not specifically identify or include mental health or psychological well-being as a goal. Work on achieving the MDGs spanned the period 2000 to 2015. The UN is now in the process of replacing MDGs with Sustainable Development Goals (SDGs). The goals of the original MDGs were to: 1) eradicate extreme poverty and hunger; 2) achieve universal primary education; 3) promote gender equality and empower women; 4) reduce child mortality; 5) improve maternal health; 6) combat HIV/AIDS, Malaria and other diseases; 7) ensure environment sustainability, and 8) develop global partnerships for development (UN-WHO Policy Analysis, 2010). More recently the Movement for Global Mental Health asked the UN to include three components in the new SDG's that relate to social determinants of health. These include:

1. Promote protection of human rights and prevent discrimination against people with mental illness and psychosocial disability.
2. Bridge the massive mental health treatment gap and improve access to health and social care.
3. Integrate attention to mental health into development initiatives.

(Eaton, Kakuma, Wright, & Minas, 2014)

The SDGs will be constructed with broad input from ministers of health, health care professionals, consumers and advocacy groups from around the world and are expected to be aligned with identified goals of participating low-, middle-, and high-income countries. The broad

guiding principles driving goal development for this next round of global health goals include human rights, treatment gaps, equality, and sustainability.

As the mental health crisis continues and expands into all age groups and across borders, it is important to identify seminal works, movements, and organizations that are intentionally working to improve mental health for all. The focus has been on acquiring accurate prevalence data, developing community-involved interventions, training lay individuals from the community and culture to deliver interventions and support those with mental and behavioral challenges, working to decrease stigma, and providing research-informed education to promote mental health literacy in both professional and lay communities. The following is a partial resource list illustrative of this work.

Seminal documents, organizations and advocacy groups in the field of mental health promotion

1 *mhGAP*: The Mental Health Gap Action Programme of the World Health Organization works to promote government and stakeholder action to scale up services and interventions to provide care for those challenged by mental, neurological, and substance use disorders. mhGAP developed the *Mental Health GAP Evidence-Based Treatment Intervention Guidelines for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings* (WHO, 2010b) and the *mhGAP Humanitarian Intervention Guide* (WHO, 2015).

2 *WHO*: The World Health Organization was established in 1948 by the United Nations and identified as the leading authority worldwide to direct and coordinate the health of all nations within the United Nations. The mission of WHO "in the area of mental health is to reduce the burden of mental disorders and to promote the mental health of the population worldwide" (WHO, 2011). To accomplish its mission, the WHO promotes leadership, research, health standards, importance of using evidence to inform actions and treatments, disease surveillance and response, technical support, education, and monitoring of health conditions. It provides a significant body of work on its website on a variety of health and mental health related topics. WHO has been at the forefront in responsiveness to both communicable and non-communicable diseases, health systems, health promotion and preparedness.

3 *Mental Health Atlas*: The *Mental Health Atlas* series is a publication of the WHO that was started in 2001. Subsequent versions of the document were in 2005, 2011 and most recently, 2014. The goal of the Atlas series is to "collect, compile and disseminate relevant information on mental health resources available within countries" (WHO, 2011). This evidence-based document chronicles global trends in the field to support advocacy and action to support an increase in resources, direct research activities, and ultimately catalyze a positive change in conditions.

4 *The Lancet Series*: *The Lancet Mental Health* Series of 2007 and 2011 was a groundbreaking set of scholarly papers that brought together researchers and scientists from around the world who engaged in methodical and comprehensive descriptions of initial and updated mental health conditions in low-, middle-, and high-income countries. The authors of many of the papers continue to conduct research and disseminate updated data on a variety of mental health issues. The series can be accessed at: www.thelancet.com/series/global-mental-health and www.thelancet.com/series/global-mental-health-2011.

5 *Human Rights Advocacy*: Human Rights Advocacy groups work to advocate for victims of human rights violations. Globally most countries have ratified international treaties endorsing human rights and humanitarian laws.

6 *Movement for Global Mental Health*: The Movement for Global Mental Health (MGMH) is a network of individuals and organizations, whose goal is to improve services for people with mental and psychosocial disabilities worldwide. MGMH prioritizes their work in low- and middle-income countries with a focus on scientific evidence and human rights protection. Additional information can be obtained at www.globalmentalhealth.org.

7 *Grand Challenges Canada*: The Grand Challenges Canada was established in 2010 to support Bold Ideas and Big Impact global research. The research must identify a barrier that if removed would help solve a significant problem in a developing country. Global mental health is one of the portfolios funded. Additional information can be obtained at www.grandchallenges.ca/grand-challenges/global-mental-health.

8 *National Institute of Mental Health (NIMH) (USA)*: NIMH strives to promote understanding and treatment of mental illnesses by engaging in and advancing basic and clinical research aimed at prevention, recovery and cure. NIMH is the largest organization in the world that endeavors to comprehend brain science and human experiences that contribute to behaviors. The 2016 NIMH operating budget is $31.3 billion dollars. Additional information can be obtained at www.nimh.nih.gov.

9 *Substance Abuse and Mental Health Services Administration (SAMHSA) (USA)*: SAMHSA was established in 1992 to advance behavioral health and decrease the impact of substance abuse and mental illness in communities within the United States.

The 2016 budget of 3.7 billion dollars will target goals of building strong communities, strengthen crisis systems, increase the behavioral health workforce, develop strategies to combat prescription drug and opioid abuse and support behavioral health needs in tribal communities. Additional data can be obtained at www.samhsa.gov.

10 *Pan American Health Organization (PAHO)*: Founded in 1902, PAHO is an international public health agency and Regional Office for the Americas of the World Health Organization that provides technical support and fosters partnerships in countries in the Americas, Canada and the Caribbean. Their Non-Communicable Diseases and Mental Health branch focuses on prevention and control of non-communicable diseases, identifying and mitigating risk factors for mental, neurological, and substance abuse disorders that are culture specific. It raises public awareness, supports capacity building, and promotes policies, programs and services to enhance mental health. Additional information about PAHO can be obtained at www.paho.org.

11 *Center for Global Mental Health* (www.centreforglobalmentalhealth.org) *at the London School of Hygiene and Tropical Medicine* (www.lshtm.ac.uk): A renowned center that focuses on public and global health research, scholarship and education with a goal of translating knowledge to practice and policy.

12 *WHO MiND: Mental Health IN Development*: This is a WHO Quality Rights online tool of national and international resources used to end discrimination and violations against those with mental and behavioral disabilities. Additional information can be obtained at ww.who.int/mental_health/policy/contact/en/.

13. WHO AIMS: This is an assessment tool to determine the overall quality of mental health systems. The tool focuses on six domains containing 156 items. Additional information about AIMS can be found at www.who.int/mental_health/WHO-AIMS/en.

14. WHO comprehensive mental health action plan (2013–2020) as shown in Table 1.5.

Conclusion

For the past 15 years there has been an intentional and dynamic focus on bringing an accurate picture of global mental health needs to the forefront and to the attention of those in positions

Table 1.5 WHO comprehensive mental health action plan (2013–2020)

Obective 1: To strengthen effective leadership and governance for mental health	**Target 1.1:** 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments (by the year 2020)	88 countries, equivalent to 56% of those countries who responded, or 45% of all WHO Member States. Value is based on a self-rating checklist (see Section 2.1 of report)
	Target 1.2: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020)	65 countries, equivalent to 42% of those countries who responded, or 34% of all WHO Member States. Value is based on a self-rating checklist (see Section 2.2 of report)
Objective 2: To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	**Target 2:** Service coverage for severe mental disorders will have increased by 20% (by the year 2020)	Not computable from Atlas 2014 data, but expected to be less than 25%, based on treatment gap and service uptake studies
Objective 3: To implement strategies for promotion and prevention in mental health	**Target 3.1:** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020)	80 countries, equivalent to 48% of those countries who responded, or 41% of all WHO Member States. Value is based on a self-completed inventory of current programmes (see Section 4 of report)
	Target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020)	11.4 per 100,000 population. Value is based on age-standardized global estimate (see WHO report on suicide, 2014)
Objective 4: To strengthen information systems, evidence and research for mental health	**Target 4:** 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020)	64 countries, equivalent to 42% of those countries who responded, or 33% of all WHO Member States. Value is based on a self-rated ability to regularly compile mental health specific data that covers at least the public sector (see Section 1 of report)

Source: Reprinted from *Mental Health Atlas 2014 with permission from the World Health Organization*.

to make necessary changes in the plight of those affected by mental ill health. These efforts are in response to a real crisis wherein only one out of four individuals globally is receiving treatment for their mental health needs. Stigma, poor knowledge of the etiology of mental, neurologic and substance use disorders, and an exclusive and long-standing focus on physical illnesses and communicable diseases have placed contributions to mental ill health at the bottom of the list

of health-related priorities. However, it is increasingly clear that overall health or well-being is intertwined with both one's physical and mental health. Unfortunately, significant disparities exist across low-, middle-, and high-income countries in the areas of mental health literacy, treatment resources (human, facilities, and medications), accuracy of prevalence data, access, stigma, and engagement in research, to inform culturally congruent mental health treatment interventions.

At the forefront of the global mental health movement are the World Health Organization, researchers from the UK, Australia, the United States and Canada, non-governmental organizations and the World Bank, among others. Concerted efforts have been under way to disseminate information in multiple venues in order to call attention to the crisis surrounding a significant increase in global mental ill health and the companion threats to individual well-being.

Globally, as stated earlier, nurses are recognized as constituting the largest number of health care providers in all countries, and represent an untapped resource in the movement to impact positive changes in mental health. In addition to supporting and showcasing the aforementioned trailblazers in the global mental health movement, this textbook will acquaint the reader with data, primarily from mental health nurses, about successful strategies engaged in with this population; endorse evidence-based interventions for use in low-, middle-, and high-income environments, and offer new ways of thinking and intervening with individuals challenged by their emotional and mental health vulnerabilities. Many of the mental health nurse scientists who contributed to this textbook support a strong focus on prevention, mental health promotion, mental health literacy, integration of mental health into primary care, and working aggressively with communities to decrease stigma, while providing culturally sensitive mental health care with individuals and groups within diverse communities. This textbook is a unique contribution to the nursing literature in that it offers nurses and other health care providers real-life and relevant experiences from the field about mental health across different countries, shares the voices of nurses working in different environments as they strive to promote mental health, and presents innovative strategies to assist with navigation of policy, practice, research, and advocacy roles. This textbook can serve as a tool kit when working with consumers, other mental health professionals, and those outside of the health care field who are engaged in developing a greater understanding of mental health, mental ill health, and the process of mental health promotion.

References

American Psychiatric Association (APA). (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). Arlington, VA: Author.

Braveman, P., Egerter, S., & Williams, D. (2011). The social determinants of health: Coming of age. *Annual Review of Public Health*, *32*, 381–398.

Chandra, V., Pandav, R., Laxminarayan, R., Tanner, C., Manyam, B., Rajkumar, S., Silberberg, D., Brayne, C., Chow, J., Herman, S., Hourihan, F., Kasner, S., Morillo, L., Ogunniyi, A., Theodore, W., & Zhang, Z. (2006). Neurological disorders. In *WHO Disease Control Priorities Related to Mental, Neurological, Developmental and Substance Abuse Disorders* (pp. 21–37). Geneva: WHO.

Charlson, F.J., Baxter, A.J., Dua, T., Degenhardt, L., Whiteford, H., & Vos, T. (2015). Excess mortality from mental, neurological and substance use disorders in the global burden of disease study 2010. *Epidemiology and Psychiatric Sciences*, *24*(2), 121–140.

Collins, P., Patel, V., & Joestl, S. (2011). Grand challenges in global mental health. *Nature*, *475*, 27–30.

Collins, P. Musisi, S., Frehywot, S., & Patel, V. (2015). The core competencies for mental, neurological, and substance use disorder care in sub-Saharan Africa. *Global Health Action*, *8*: 26682.

Demyttenaere, K., Bruffaerts, R., Posada-Villa, J. Gasquet, I., Kovess, V., Lepine, J.P., Chatterji, S. (2004). Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *JAMA*, *291*(21), 2581–2590.

Dua, T., Barbui, C., Clark, N., Fleischmann, A., Poznyak, V., van Ommeren, M., Saxena, S. (2011). Evidence-based guidelines for mental, neurological, and substance use disorders in low-and middle-income countries: Summary of WHO recommendations. *PLoS Medicine*, *8*(11), e1001122.

Eaton, J., Kakuma, R., Wright, A., & Minas, H. (2014). A position statement on mental health in the post-2015 development agenda. *International Journal of Mental Health Systems*, 8, 28.

Friel, S. & Marmot, M. (2011). Action on the social determinants of health and health inequities goes global. *Annual Review of Public Health*, *32*, 225–236.

Hyman, S., Chisholm, D., Kessler, R., Patel, V., & Whiteford, H. (2006). Mental disorders. In *WHO Disease Control Priorities Related to Mental, Neurological, Developmental and Substance Abuse Disorders* (pp. 1–20). Geneva: WHO.

Kleinman, A. (2009). Global mental health: A failure of humanity. *The Lancet*, *374*(9690), 603–604.

Mental Health Gap Action Programme (mhGAP). (2008). *Scaling Up Care for Mental, Neurological, and Substance Use Disorders*. Geneva: WHO.

Morris, J., Lora, A., McBain, R., & Saxena, S. (2011). Global mental health resources and services: A WHO survey of 184 countries. *Public Health Reviews*, 34(2).

National Institute of Neurological Disorders and Stroke (NINDS). (n.d.). Available at www.ninds.nih.gov (accessed May 25, 2016).

Phillips, M., Chen, H., Diesfeld, K., Xie, B., Cheng, H., Mellsop, G., & Liu, X. (2013). China's new mental health law: Reframing involuntary treatment. *American Journal of Psychiatry*, *170*(6), 588–591.

Population Reference Bureau. (2013). 2013 World population data sheet. Available at www.prb.org/pdf13/2013-population-data-sheet_eng.pdf (accessed May 25, 2016).

Rehm, J., Chisholm, D., Room, R., & Lopez, A. (2006). Substance abuse disorders. In *WHO Disease Control Priorities Related to Mental, Neurological, Developmental and Substance Abuse Disorders* (pp. 57–100). Geneva: WHO.

Tse, S., Ran, M., Huang, Y., & Zhu, S. (2013). The urgency of now: Building a recovery-oriented, community mental health service in China. *Psychiatric Services*, *64*(7), 613–616.

UN-WHO Policy Analysis. (2010). Available at www.who.int/mental_health/policy/mhtargeting/mh_policyanalysis_who_undesa.pdf (accessed May 25, 2016).

Whiteford, H., Ferrari, A., Degenhardt, L., & Feigin, V. (2015). The global burden of mental, neurological and substance use disorders: An analysis from the global burden of disease study 2010. *PLoS ONE*, 10(2): e0116820.

Whiteford, H., Degenhardt, L., Rehm, J., Baxter, A., Ferrari, A., Erskine, H., Vos, T. (2013). Global burden of disease attributable to mental and substance use disorders: Findings from the Global Burden of Disease Study 2010. Available at http://dx.doi.org/10.1016/S0140–6736(13)61611–6 (accessed May 25, 2016).

World Bank. (n.d.). Country classifications. Available at data.worldbank.org/news/2015-country-classifications (accessed May 25, 2016).

World Health Organization (2015). Metrics: Disability-adjusted life year (DALY). Available at www.who.-int/healthinfo/global_burden_disease/metrics_daly/en/(accessed May 25, 2016).

World Health Organization Health Report. (2001a). Mental health: New understanding, new hope. Available at www.who.int/whr2001/media_centre/press_release/en/(accessed May 25, 2016).

World Health Organization. (2001b). *Strengthening Mental Health Promotion*. Geneva: WHO.

World Health Organization. (2005). Available at www.euro.who.int/__data/assets/pdf_file/0008/96452/E87301.pdf (accessed May 25, 2016).

World Health Organization. (2008). The global burden of disease-2004 update. Available at www.who.int/healthinfo/global_burden_disease/2004_report_update/en (accessed May 25, 2016).

World Health Organization. (2010a). *People with Mental Disabilities Cannot Be Forgotte*n. Geneva: WHO.

World Health Organization. (2010b). *Mental Health GAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings: Mental Health Gap Action Programme (mhGAP)*. Geneva: WHO.

World Health Organization. (2011). *Mental Health Atlas 2011*. Geneva: WHO.

World Health Organization. (2013*). Investing in Mental Health: Evidence for Action*. Geneva: WHO.

World Health Organization. (2014). *Mental Health Atlas 2014*. Geneva: WHO.

World Health Organization. (2015). *mhGAP Humanitarian Intervention Guide*. Geneva: WHO.

Zhou, W., & Xiao, S. (2015). Reporting on China's mental health surveillance. *American Journal of Psychiatry*, *172*(4), 314–315.