THE RETURN ON THE INDIVIDUAL:
TIME TO INVEST IN MENTAL HEALTH

IT'S **#TIMETOINVEST** IN MENTAL HEALTH

ABOUT SPEAK YOUR MIND AND THE ROI REPORT

Speak Your Mind is a nationally-driven, globally united mental health campaign, powered by United for Global Mental Health. The ROI report was conceived at a global meeting of mental health campaigners in 2019 and further developed through the year.

Speak your Mind website **here**.

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EXECUTIVE SUMMARY

THE RETURN FOR SOCIETY

The investment we afford those around us, those we don't necessarily know or see, shapes our world. Yet the structures we operate within compel us too often to ask, 'what do we get in return for our investment?' and we answer in dollars and cents. Traditionally the return on investing in improving mental health is measured in money but this does not tell the whole story, the argument is incomplete.

The Return on the Individual turns the traditional approach on its head, putting the individual at the centre of the case for the world needs to dramatically increase investment in mental health and highlighting the benefits that can't easily be quantified in currency. Investing in good mental health brings a huge return: it includes the financial return - it is well established that for every US$1 invested into improving common mental health conditions US$4 are returned - but also includes the returns to individual lives and their communities, businesses, economies, and society at large. Further, mental health and wellbeing has its own value. Improvement in mental health and wellbeing is a return in itself for the individual that far exceeds any return that we can count in financial terms.

For some the vast scale of poor mental health across the world may be hard to imagine. Some numbers can seem so large they can be hard to believe, and the individual person affected gets lost. However, most of us will have witnessed poor mental health and the impact it has on the individuals and their families in our own lives.

We may also have witnessed how support to these individuals can dramatically improve their mental health. Such support can be given in a myriad of ways including through health services, schools, the workplace or the community. In this report, the stories of individual people including **Timiebi**, **Graeme, Josephine, Sodikin** and **Cecilia** present the case for investment in mental health that is stronger than standalone statistics and instead demonstrates the return on the individual as a whole.

TIMIEBI

GRAEME

JOSEPHINE

SODIKIN

CECILIA

THE SCALE OF THE CHALLENGE

The numbers of people with common mental health conditions are truly enormous - dwarfing the rates of many common physical health conditions that receive far greater investment:

- There are **264 million** people suffering from anxiety, and **322 million** from depression conditions worldwide;
- An estimated further **50 million** people are living with dementia, with this number projected to triple by **2050**;
- Those with severe mental health conditions have a **10-25 year** life expectancy reduction.
- One of the most extreme manifestations of poor mental health is suicide which claims the lives of close to **800,000** people every year – with many more attempting to take their own lives;
- Half of all mental health conditions start by **age 14**, and three quarters by their **mid-20s**;
- Tragically, suicide is the second leading cause of death for young people aged **15-29 years**.
- Yet less than **2 per cent** of national health budgets globally are spent on mental health.

For those people who want to seek treatment, care or support, there are far too many barriers. These include stigma and discrimination, a lack of resources, and too few trained health workers, teachers, peer support workers and other carers. In low and middle-income countries, between 76 and 85 per cent of people with mental disorders receive no treatment; in high-income countries, this percentage is between 35 and 50. For some, not seeking conventional treatment or support is a positive choice and they find other ways to manage or improve their mental health through informal networks. But far too many do not seek treatment because of stigma or because they cannot access or afford it.

THE SCALE OF THE RETURN FOR THE INDIVIDUAL

If the world increases spending to the recommended levels, not by tomorrow, but by a steady and consistent increase from now until 2030, the impact could be huge. In this report we reveal new research that estimates the health impacts following an increase in public mental health investment until 2030 for five mental health conditions: major depression, anxiety disorders, psychosis, bipolar disorder and epilepsy.

The new research shows the number of cases of anxiety, depression and epilepsy alone can be decreased by nearly 60 million between now and 2030. What is more, we see that not only a slowing in the rate of anxiety, depression and epilepsy case increase, but the beginning of an overall reduction in cases across the world.

Maybe the starkest demonstration of what adequate mental health investment could achieve is the number of lives that could be spared with adequately funded mental health systems. For example, nearly 200,000 deaths could be avoided in the three mental health conditions of depression, psychosis and epilepsy alone.

THE RETURN FOR THE ECONOMY

Mental health and economic performance are closely interlinked. It is estimated that as **many as 20 percent of the world's working population has some form of mental health condition at any given time.**

With an estimated 12 billion productive days lost each year due to depression and anxiety alone, poor mental health costs the world economy approximately US$2.5 trillion per year in reduced economic productivity and direct cost of care. This cost is projected to rise to US$6 trillion by 2030 alongside increased social costs.

Whilst the underlying causes of poor mental health are complex and multifaceted, the workplace represents an effective location (or platform) for addressing mental health issues through workplace policies and interventions – interventions that can yield substantial financial benefits for employers and represent a sound return on investment.

The majority of large companies now recognise the connection between mental wellbeing, productivity and company performance. Leading companies are not only prioritising their employees' mental health but also using their public platform to encourage others to follow. However, these companies are not simply altruistic, they are successful businesses. Companies that invest in employee mental health have four times the staff retention of companies who do not effectively manage employee wellbeing. **Overall companies on average receive a $5 return for every $1 invested in employee mental health and wellbeing.**

Today more and more people are working at least part time from home. In some countries that trend has been greatly accelerated in the short term by the response of governments and businesses to the COVID-19 pandemic. This has led to an increase in conversations about employee mental health among employers across all sectors as they work to maintain and strengthen employee morale and productivity in times of uncertainty.

Moreover, reports predicting a huge impact on the global economy from COVID-19 is causing further concern - for governments, companies and individuals. Mental ill health typically rises during economic recession. Therefore, mental as well as physical resilience in the face of uncertainty is critically important. Individuals, business and society as a whole need to ensure sufficient investment in addressing mental health now and in the future as we all face uncertain times.

THE RETURN FOR SOCIETY

Mental health is a public good and is interwoven into society. **By promoting good mental health, we promote the ability of everyone to fully participate in society, whether in their social networks, workplaces, schools, communities or families.** The potential impact of good or poor mental health on society is enormous and not yet fully understood. In this report we look at the societal impact of mental health on three specific areas:

- **Physical health:** The link between mental health and physical health is well established - people with poor mental health have significantly worse physical health. Improved mental health can lead to reduced tobacco, alcohol and substance abuse, reduced vulnerability to infectious diseases such as HIV and Tuberculosis (TB), and reduced obesity and chronic health conditions. Around half of people with TB have depression – this makes them ten times more likely to stop treatment, leaving them at higher risk of death and of contributing to increased drug resistance.
- **The family unit:** Poor mental health affects entire families. The mental wellbeing of parents and carers influences the outcomes of the children they are responsible for: from reduced birth rates to educational attainment. Globally, 10-20 per cent of children and adolescents experience mental disorders, while 15-23 per cent of children live with a parent with a mental illness, predisposing them to having poor mental health themselves
- **Social cohesion:** Evidence is building that mental illness is a barrier to social connections - good mental health allows better connections through meeting the needs of the individual. The responsibility to improve social connectedness extends beyond the individual to the local community (local health services and voluntary groups) and broader society (government, NGOs, the media).

The return on investing in mental health and wellbeing goes well beyond the financial gains. There are significant returns for both the individual affected and wider society. This report brings together the investment arguments that go beyond simply dollars and cents, turning 'return on investment' on its head, and redefining it as the 'return on the individual'. The case is clear for revolutionary investment in mental health worldwide. But for this investment to be successful, the individual must be placed at its heart

CHAPTER ONE: THE RETURN ON THE INDIVIDUAL

THE RETURN ON THE INDIVIDUAL

THE SCALE OF THE CHALLENGE

An estimated 970 million people around the world had a mental health or substance use condition in 2017 (the most recent year of data) – around 13% of the global population. [1]And the numbers are rising. While the scale of poor mental health may be shocking, most of us have some experience of it. Mental disorders can affect anyone, whatever their age and wherever they live. And our mental health can vary throughout our lives. For some, conditions are relatively mild and last for a limited time. For others, they are more serious and last a lifetime. [2]Behind the data are real people affected by poor mental health directly and many more affected indirectly – family, friends, colleagues and others.

Depression and anxiety are **two** of the most common mental disorders, prevalent across demographics. Estimates from 2017 show **284 million** people are living with anxiety and **265 million** with depression. [3]An estimated **50 million** people are living with dementia, and this number is projected to **triple by 2050** – with **10 million** new cases each year. [4]In more severe cases, conditions such as these can lead to suicide, which claims the lives of close to **800,000** people every year[5] and is attempted by many more.

The burden of mental disorders is on the rise. Some numbers can seem so large they can be hard to imagine and the individual person affected gets lost. Here, the voices of some of those individuals accompany the evidence of the staggering scale of the problem and the 'return' for their lives when others invest in their mental health.

TIMIEBI'S STORY

Due to factors such as stigma and discrimination, the enormity of this crisis is often hidden, leaving the burden with those affected. This was true for Timiebi in Nigeria. She started experiencing poor mental health when she was 12 years old but didn't realise at the time.

When she was at university, falling behind with her studies, she went to see a counsellor and was diagnosed with depression. It was a pivotal moment for Timiebi. At first, she didn't believe the diagnosis and thought...

"I'm Nigerian. We're strong and resilient. This isn't something that Nigerians have."

After experiencing a panic attack, Timiebi started to accept her mental health was suffering. Struggling to write her dissertation and finding it difficult to understand what was happening to her, she moved back home. She reached out to Mentally Aware Nigeria6, which was able to help her understand her condition and find mental health support services.

Timiebi thought nobody in Nigeria accessed services like these apart from severely ill and dangerous people. She was given a ticket for her appointment – number 140.

This made her realise many people were struggling with their mental health and how normal it is to reach out for help. It made her feel less alone.

By investing in Timiebi's mental health, Mentally Aware Nigeria helped her find ways to deal with her condition, improving her life. She said...

"For my future, I see me embracing more aspects of my life and my mental health, continuing to talk about it everywhere I go."

Her willingness to share her first-hand experience of poor mental health may now help many more people. The support people need varies greatly. Some choose to live with mental health conditions without treatment or support. But everyone has the right to good physical and mental health and wellbeing. In many countries, this right is not honoured in practice or even recognised.

[1] Institute for Health Metrics and Evaluation. Findings from the Global Burden of Disease study 2017. Seattle, WA: IHME; 2018.
[2] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553-1598.
[3] World Health Organization. Depression and other common mental disorders: global health estimates. Geneva: WHO; 2017. License: CC BY-NC-SA 3.D IGO Available from **here.**
[4] World Health Organization. Dementia [online]. WHO; 2019 Available from: who int/news-room/fact-sheets/detail/dementia.
[5] World Health Organization. Depression and other common mental disorders: global health estimates. Geneva: WHO; 2017. License: CC BY-NC-SA 3.D IGO. Available from: **here.**
[6] Mentally Aware Nigeria Initiative [online]. Lagos: MANI; 2018. Available from **here.**

LOST POTENTIAL

Mental disorders make up a large proportion of the global burden of disease. [7]This is a calculation of ill health and death due to diseases, injuries and risk factors for all regions of the world, measured in disability-adjusted life years (DALYs), the years of healthy, productive life lost to illness, through early death or disability. [8]Figure 1 shows the rising burden of mental health and substance use conditions, Alzheimer's disease and other dementias, and suicide, across country categories. Depression is ranked by the World Health Organization (WHO) as the single largest contributor to global disability (7.5% of all years lived with disability in 2015) and anxiety is ranked 6th (3.4%).[10]

The loss of potential behind these figures is huge. Many people living with these conditions are unable to work. They lose the financial and personal benefits a job offers and are unable to contribute to their local and national economies.

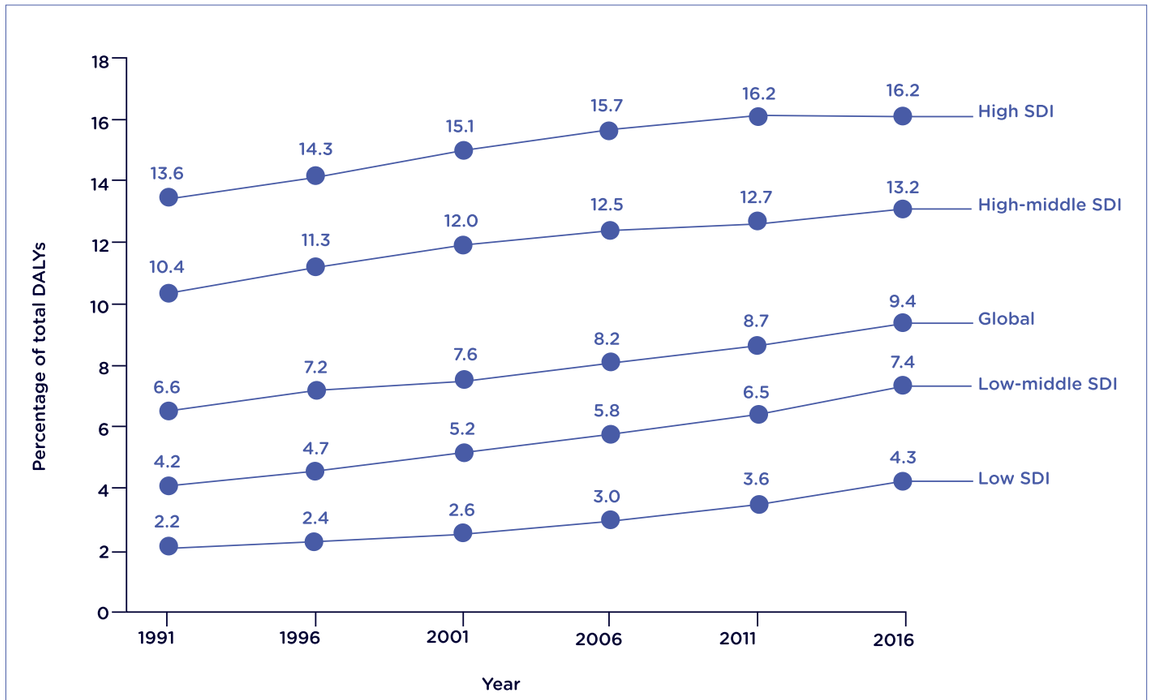

FIGURE 1: Disability-adjusted life years due to mental health and substance use conditions, Alzheimer's disease and other dementias, and suicide, across country categories (Socio-Demographic Index – SDI)[9]

[7] World Health Organization. Burden of disease: what is it and why is it important for safer food? WHO [cited 2019 Dec 19]. Available from **here.**
[8] World Health Organization. Metrics: Disability-Adjusted Life Year (DALY) [online]. WHO [cited 2019 Oct 28]. Available from **here.**
[9] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553-1598.
[10] World Health Organization. Depression and other common mental disorders: global health estimates. Geneva: WHO; 2017. License: CC BY-NC-SA 3.D IGO. Available from **here.**

YOUTH MENTAL HEALTH

Our mental health can vary throughout our lives, but children and younger people are at particularly high risk of developing disorders. The global burden of mental disorders is highest in younger age groups (Figure 2), especially in the mid to late 20s.

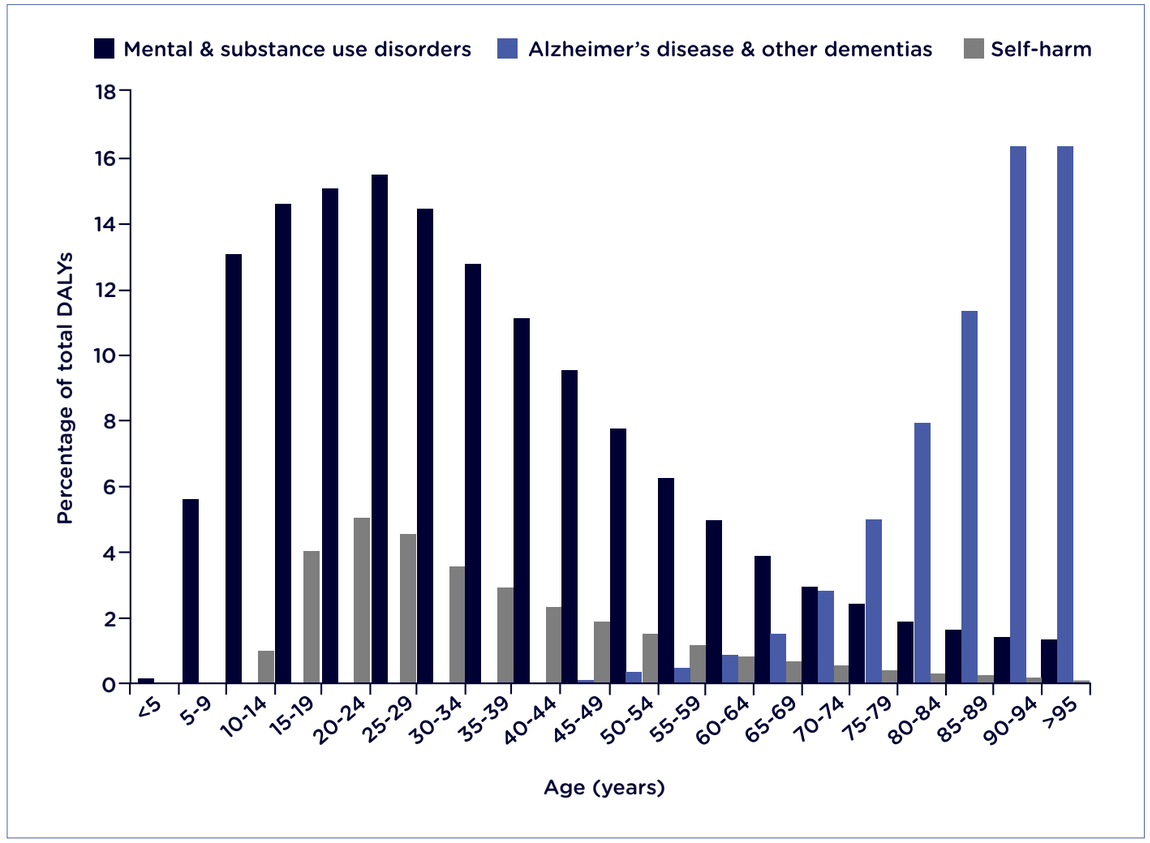

FIGURE 2: DALYs by mental health and brain health conditions as a percentage of DALYs for all physical and mental health conditions.[12]

Half of all mental health conditions start by age 14, and three quarters start by the mid-20s.[11] Suicide is the second leading cause of death for young people aged 15 to 29.

Investment in children's' mental health brings a substantial return and tends to align with country development beyond economic growth. For example, country rankings based on the ratio of child and adolescent psychiatrists for 100,000 children aged 14 or younger largely mirrors the country rankings of the Human Capital Index (HDI).[13]

Stuart and Annette in Australia lost their 15-year-old daughter, Mary, to suicide. Mary had an eating disorder, which began when she was 12 and continued until the day she died. When she became very unwell, she was admitted to her local hospital for two months. Stuart and Anette feel Mary didn't get the support she needed to recover and overcome her mental ill health. Their lives have changed forever.

[11] Kessler RC, Amminger GP, Aguilar-Gaxiola S, Alonso J, Lee S, Ustun TB. Age of onset of mental disorders: a review of recent literature. Curr Opin Psychiatry. 2007;20(4):359-364.
[12] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553-1598.
[13] Sourander A, Chudal R, Skokauskas N, Malallah Al-Ansari A, Brunstein Klomek A, Pornnoppadol C, et al. Unmet needs of child and adolescent psychiatrists among Asian and European countries: does the Human Development Index (HDI) count? Eur Child Adolesc Psychiatry. 2017;27:5-8.

MENTAL ILL HEALTH IN LATER LIFE

As we age, changes in our physical and mental health can place a burden on us, our families and our wider communities, with often complex requirements for health and social care, and other services. Across the world, people's mental health deteriorates as they age as most people also undergo a decline in their cognitive abilities. Some develop more serious conditions like dementia, a syndrome in which there is a decline in memory, thinking, behaviour and ability to carry out daily tasks. **The estimated proportion of people aged 60 and over with dementia at any time is between 5 and 8 per cent.**[14]

Investing in measures to reduce the incidence of dementia is important to the individuals affected and society. To date, there is no cure for dementia or treatment to alter its progressive course, but many potential new treatments are being investigated. WHO and other organisations have issued guidance on preventing dementia, including ensuring people have good physical health and combating risk factors such as depression and social isolation.[15]

THE GAPS IN TREATMENT QUANTITY AND QUALITY

For those people who seek treatment or support with their mental health, there are far too many barriers in their way – stigma and discrimination, a lack of resources, and a lack of trained health workers, teachers, peer support workers and carers. The result is a big treatment gap.

In countries with the largest populations, including China (home to a third of the global population) and India, **80 per cent of people with mental health or substance use conditions do not seek treatment.**[16] **In low and middle-income countries (LMICs), between 76 and 85 per cent of people with mental disorders receive no treatment, and in high-income countries (HICs), this percentage is between 35 and 50.**[17] **In the USA, a study found 82 per cent of older people said it was important to have their thinking or memory regularly checked, but only 16 per cent said they received regular cognitive assessments.**[18]

For some, not seeking conventional treatment or support is a positive choice and they find other ways to manage or improve their mental health through informal networks such as friends, family of religious leaders. But many do not seek treatment because of stigma, a lack of funds, or a lack of appropriate services.

When people do seek treatment, services can be of poor quality or even harmful, due to a lack of investment and outdated practices. **1 in 5 people with depression reported receiving minimally adequate treatment, and in LMICs this figure is 1 in 27.**[19] **Studies analysing data from HICs, including Australia, Canada, England and the USA, have shown that despite the increased availability of treatment, the prevalence of mental disorders has not decreased.**[20] This underlines how wider societal factors need to be addressed as well as providing high-quality health services.

Mental health services are overwhelmed by the issues that contribute to the treatment gap, and a lack of human resources means those seeking treatment do not receive adequate care. In 2014, mental health workers accounted for only 1 per cent of the global health workforce. 45 per cent of the world's population lived in a country with fewer than one psychiatrist per 100,000 people.[21] Numbers of trained counsellors and peer support workers [22] are not available globally, but based on evidence from countries such as the UK, it is likely they are highly inadequate to address the needs of people of all ages. The workforce is a key building block of any health system; these systems simply fail if not well resourced. To address this failure in nearly all countries, governments need a comprehensive approach.[23]

The WHO Mental Health Atlas reports the median number of mental health workers globally is 9 per 100,000 people, with a wide variation (from below 1 in LMICs to 72 in HICs). In Africa, there is not even 1 mental health worker (0.9) per 100,000 people.[24] The WHO Mental Health Atlas reports stigma among health workers towards those with mental ill health is also high, which further impacts on people seeking support.

Filling the gap in treatment and support will take investment in mental health. The current investment model that favours high-cost in-patient care over low-cost (and more effective) community-based care must be reversed.[25,26] Those seeking support need to be seen as individuals, who may prefer to stay in their communities and be supported by family and friends, their schools or social services. An approach tailored to each patient is more likely to be successful. This is reflected in WHO's forthcoming recommendation on 'best buys' for mental health.[27]

THE TRUE COST OF EMERGENCIES

Our mental health and wellbeing are affected by the environment in which we live. **The determinants of health include a range of social and economic factors, including poverty, income inequality and exposure to humanitarian emergencies and conflict.**[28] People who experience a humanitarian emergency (such as conflicts, natural disasters or public health emergencies) are at increased risk of developing mental health disorders.[29,30] The UN estimates that in 2019 nearly 132 million people in 42 countries will need humanitarian assistance resulting from conflict or disaster, and nearly 69 million people worldwide have been forcibly displaced by violence and conflict, the highest number since World War II.[31] The latest WHO research suggests one in five of those affected are living with mental health issues, from mild depression or anxiety to psychosis, and one in ten are living with a moderate or severe mental disorder.[32] **Protracted conflicts in countries from Colombia to Yemen are leading to higher rates of mental ill health and stress, and contributing to higher rates of distress for people of all ages.**

[14] World Health Organization. Dementia [online]. WHO; 2019 Available from here.
[15] World Health Organization. Risk reduction of cognitive decline and dementia: WHO guidelines. Geneva: WHO; 2019. License: CC BY-NC-SA 3.0 IGO. Available from here.
[16] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553-1598.
[17] World Health Organization. Mental disorders fact sheet [online]. WHO; 2019 [cited 2019 Oct 28]. Available from here.
[18] Alzheimer's Association. Alzheimer's disease facts and figures. Alzheimer's Association; 2019. Available from here.
[19] Thornicroft G, Chatterji S, Evans-Lacko S, Gruber M, Sampson N, Aguilar-Gaxiola S, et al. Undertreatment of people with major depressive disorder in 21 countries. Br J Psychiatry. 2017;210(2):119-124.
[20] Jorm AF, Patten SB, Brugha TS, Mojtabai R. Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. World Psychiatry. 2017;16(1): 90–99. doi:10.1002/wps.20388.
[21] World Health Organization. Mental health atlas 2014. Geneva: WHO; 2015. Available from here.
[22] Value of Peer Support Work – systematic reviews have indicated that compared to professionals, Peer Support Workers achieve similar outcomes in mental health service users, and are even better than professionals at reducing inpatient service use, enhanced engagement with care, and resulted in a variety of recovery-related outcomes (empowerment, behavioural activation, hopefulness for recovery).
Resources: Pitt V, Lowe D, Hill S, Prictor M, Hetrick S, Berends L. Consumer-providers of care for adult clients of statutory mental health services. Cochrane Database Syst Rev. 2013;(3):CD004807.; Puschner B. Peer support and global mental health. Epidemiol Psychiatr Sci. 2018;27(5):413-414.
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[24] World Health Organization. Mental health atlas 2017. Geneva: WHO; 2018. Available from here.
[25] Thornicroft G, Alem A, Atunes Dos Santos R, Barley E, Drake RE, Gregorio G, et al. WPA guidance on steps, obstacles and mistakes to avoid in the implementation of community mental health care. World psychiatry. 2010;9(2):67–77.
[26] Thornicroft G, Tansella M. The balanced care model: the case for both hospital- and community-based mental healthcare. Br J Psychiatry. 2013;202(4):246–248.
[27] World Health Organization. Mental health: governance [online]. WHO; 2019 Available from here.
[28] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553-1598.
[29] Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: A systematic review and meta-analysis. Lancet. 2019;394:240–248.
[30] Tol WA, Barbui C, Galappatti A, Silove D, Betancourt TS, Souza R, et al. Mental health and psychological support in humanitarian settings: linking practice and research. Lancet. 2011;378(9802):1581–1591.
[31] van Ommeren M. Mental health conditions in conflict situations are much more widespread than we thought: but there's a lot we can do to support people [online]. World Health Organization; 2019 Available from here.
[32] Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H, Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. Lancet. 2019;394:240–248.

JOSEPHINE'S STORY

Similarly, epidemics and other public health emergencies can change the environment around us and affect our mental health. The 2014 Ebola outbreak in Liberia changed Josephine Karwah's life forever. She was diagnosed with Ebola and went to an Ebola Treatment Unit (ETU) operated by Médecins Sans Frontières, where she first received treatment and mental health counselling.

Returning to her community, Josephine entered a world that was not the same as before Ebola. The stigma surrounding the disease, including baseless myths about contracting the disease, permeated her community, making her return to normal life impossible. At this time, she was introduced to the Carter Center, which was working to transform the mental health system in the country. The Carter Center helped Josephine through counselling and access to services. She is now living what she refers to as 'normal' life in the community and is studying Biology.

Countries like Liberia that have weakened health systems due to years of political instability and lack of investment cannot handle the increased burden when a public health emergency hits. They must be supported to rebuild and maintain public health systems to ensure better care for people like Josephine in the future.

The current COVID-19 pandemic is a public health emergency of enormous significance. Each public health emergency differs and therefore the effects on mental health within populations differ too. There has undoubtedly been a negative effect on mental health due to the COVID-19 pandemic and some evidence of this is already emerging. However, the true extent and impact are yet to be fully analysed and understood. At time of this report's publication we recommend referring to the latest WHO materials addressing the mental health needs of different sections of the population.[33]

Further information on the changing situation and updates on mental health materials can be accessed through the WHO. Recently the advice provided by WHO in conjunction with the IFRC recommends a, "Whole of Society" approach. This involves promotion of self-care strategies; reassuring people it is normal to experience fear and anxiety and identifying ways people can support others; and providing clear, concise and accurate information about COVID-19, including how to access help if one becomes unwell.

THE RIGHT TO MENTAL HEALTH

Mental health is a global public good and a fundamental human right for all. Mental health policies, laws and interventions for treatment, prevention and promotion should be compliant with international and regional human rights instruments and frameworks. These include the Convention on the Rights of Persons with Disabilities (CRPD), which promotes, protects and ensures the rights and fundamental freedoms of all people with disabilities.[34]

Unfortunately, this is far from the reality, as demonstrated by the work of Human Rights Watch, Human Rights in Mental Health, FGIP and others, and documented by the work of the UN Special Rapporteur on the right to physical and mental health.[35] **Despite the international legal frameworks, and even national legislation and policies in some countries, many people with mental disorders are denied their human rights – including the rights to education, employment, citizenship, legal capacity and access to healthcare.[36]**

People living with mental disorders can be detained in mental health services against their will by involuntary, forced, coerced admission, or admission without consent. Those detained against their will may also be forced to have treatment. They may lose their rights to own property or make legal contracts. WHO reports...

> **People with dementia are frequently denied the basic rights and freedoms available to others. In many countries, physical and chemical restraints are used extensively in care homes for older people and acute-care settings, even when regulations are in place to uphold the rights of people to freedom and choice.[37]**

Forced treatments, shackling and other human rights abuses continue to be prevalent across the globe, making people with mental health conditions particularly vulnerable and marginalised.

SODIKIN'S STORY

When Sodikin in Indonesia first started experiencing mental health challenges, his family didn't know how to support him. He would get angry and smash things. First, his family took him to a faith healer, then a mental hospital a day and a half walk from their home. They were given medicine to help his condition, which worked for a little while, but when he needed his prescription repeated, nobody could provide it. After being sent back and forth between the local healthcare centre and hospital, his family gave up. That's when the shackling began.

Sodikin spent more than eight years in shackles in a tiny hut outside of his family home, until an NGO came to rescue him. He had to be carried out of the hut because his muscles had wasted away so much he couldn't walk. He stayed at a shelter for seven months while he healed. Sodikin is now the main breadwinner in his family and works in a clothing factory. When someone's human rights are violated in this way, there is often no opportunity to complain or seek justice for the violations.

[33] WHO, Mental health and psychosocial considerations during the COVID-19 outbreak, WHO. Available from **here.**
[34] Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553-1598.
[35] United Nations Human Rights Office of the High Commissioner. Mr. Dainius Puras: Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of health [online]. OHCHR; Available from **here.**
[36] Ibid.
[37] World Health Organization. Dementia [online]. WHO; 2019 Available from **here.**

FUNDING MENTAL HEALTH CARE

The Sustainable Development Goals (SDGs) aim to bring about a better future for all. SDG3 [38] explicitly mentions good health and wellbeing. This, together with widespread agreement on WHO's Mental Health Action Plan 2013–20 has focussed attention on how to fund the prevention and support of mental illnesses,[39] primarily from national sources.

Estimates for the shortfall in funding for mental health range from US$1.88 per person in low-income countries to US$2.62–3.70 per person (US$6,600–9,330 million in total) in lower-middle-income countries.[40] In 2004, the National Sample Survey Organisation in India found the equivalent of US$280 million was spent on getting treatment for psychiatric disorders, 90 per cent of which was borrowed from a variety of sources, including household savings.[41]

Universal health coverage (UHC) aims to provide access to health services for all, without people suffering financial hardship. It provides a mechanism through which mental health services in the broadest sense could be resourced. WHO recommends using UHC to ensure neither prevention or treatment of mental illness are left behind. [42] Countries are currently being encouraged to develop their own plans to deliver UHC for all by 2030. This is a vitally important moment to ensure mental health is integrated into national health budgets and plans for the foreseeable future.

Extended cost-effectiveness analyses have been developed that account for the broader benefits of mental health interventions in a UHC context. These can be used to evaluate the benefits of and targets for investment at national or local levels. [43] For example, for mental, neurological and substance abuse disorders, an investment of US$1.21 per capita in Ethiopia and US$1.37 in India equated to 1,500 and 3,000 healthy life-years per 1 million people respectively.[44]

The complexity, challenges and scale of the world's mental health crisis are huge. But the voice of the individual should not be lost. People with mental disorders must be central to decision making about their own care and support. They are best placed to determine which outcomes are most important to them. A functioning rights-based mental health support system, through the community, public services or workplace, not only brings social and economic returns but would transform people's lives in ways that cannot be quantified.

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[39] World Health Organization. Mental health action plan 2013-2020. Geneva: WHO [cited 2019 Nov 11]; Available from **here.**
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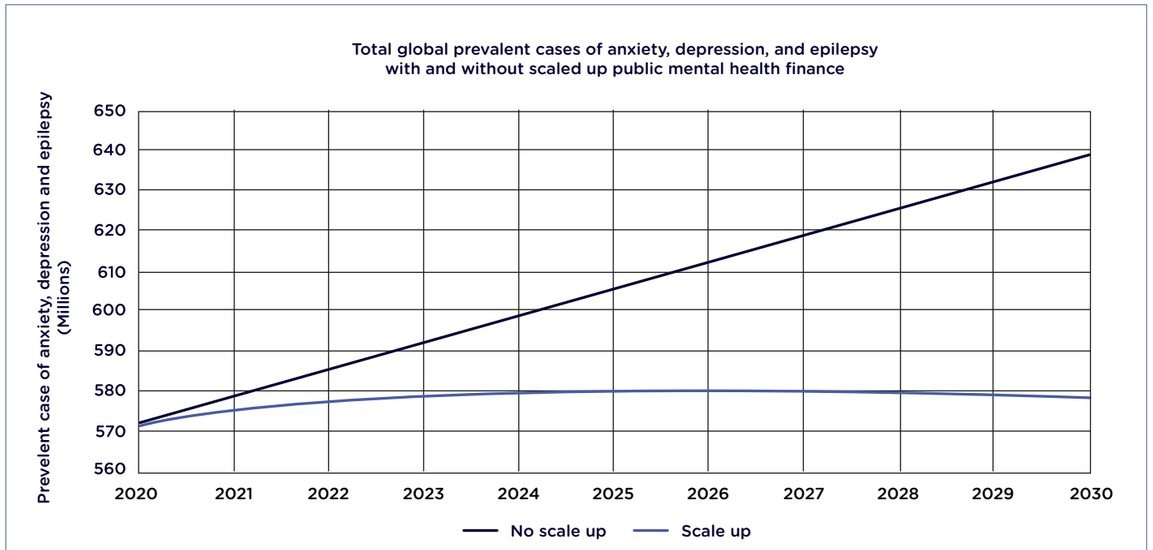
THE SCALE OF THE RETURN FOR THE INDIVIDUAL

What would the world look like if mental health systems were adequately financed? If the world increases spending to the recommended levels, not by tomorrow, but by a steady and consistent increase from now until 2030, the impact could be huge.

New research commissioned by UnitedGMH and conducted by Deakin University in Australia estimates the health impacts following an increase in public mental health investment until 2030 for five mental health conditions: major depression, anxiety disorders, psychosis, bipolar disorder and epilepsy using WHO's One Health Tool (OHT).

The research explores the impact of a consistent increase in public expenditure for these five conditions up to recommended levels in 2030. The full methodology with limitations can be found here. The full research findings with forecasted economic returns will be subsequently published.

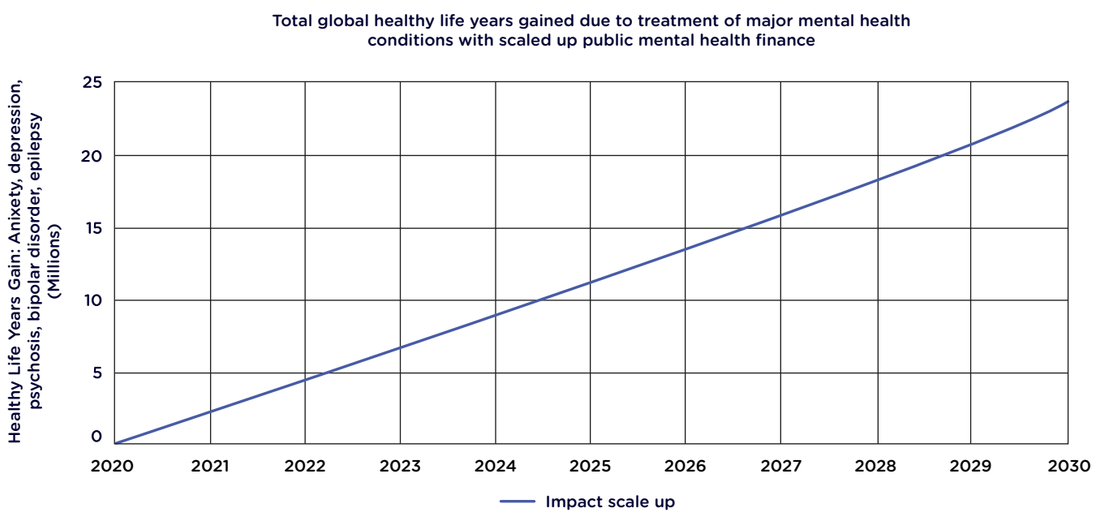
The research looks at this increase as a global total (and by grouping countries as per their World Bank income category to be subsequently published). The treatment coverage increase in line with this expenditure increase was modelled using the OHT and the health impacts of this given by prevalent cases averted, health life years gained and deaths avoided.



The new research shows the number of cases of anxiety, depression and epilepsy alone can be decreased by nearly 60 million between now and 2030. What is more, we see a bend in the curve, one that not only slows the rate of anxiety, depression and epilepsy case increase, but the beginning of an overall reduction in cases across the world. Each case decreased is a Timiebi or Graeme who may not experience mental ill health or for whom their recovery will be far quicker.

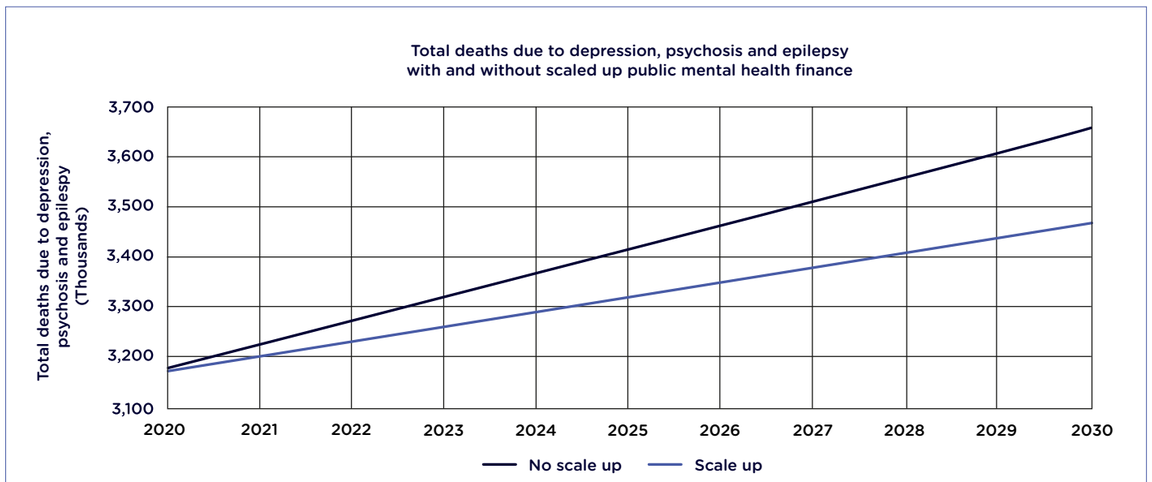
The results also show a sustained increase of healthy life years gained – the additional number of years of life that a person lives without disability as a result of receiving a treatment – for those with anxiety, depression, psychosis, bipolar disorder or epilepsy.

The research shows an increase of nearly 25 million healthy life years over the next decade when adequate government spending on mental health is achieved. These are years that someone like Sodikin or Cecilia can continue to live at home, work to help support their family and contribute to their community.



Maybe the starkest demonstration of what adequate mental health investment could achieve is the number of lives that could be spared with adequately funded mental health systems.

For example, nearly 200,000 deaths could be avoided in the three mental health conditions of depression, psychosis and epilepsy alone.



The complexity, challenges and scale of the world's mental health crisis are huge. But investment can make a real difference and prioritising mental health is essential. Behind every number and statistic is a real person: the voice of the individual should not be lost. People with mental disorders must be central to decision making about their own care and support. They are best placed to determine which outcomes are most important to them. A functioning and adequately resourced rights-based mental health support system, through the community, public services or workplace, not only brings social and economic returns but would transform people's lives in ways that cannot be quantified.

CHAPTER TWO: THE RETURN FOR THE ECONOMY

THE RETURN ON THE ECONOMY

Investment in mental health is increasingly an essential priority for societies. In terms of the breadth of the potential economic impact, no other area of health matches it.[45] Poor mental health limits people's opportunity to work and earn an income. This fall in productivity reduces consumption and results in significant output losses for the economy. Over time, poor mental health also carries significant costs for our national health systems,[46] which are facing challenges from growing, diversifying and ageing populations, rising prevalence of chronic illnesses, and the use of expensive technologies. Poor mental health also has broader economic costs to society.

Despite this high burden and associated costs, globally, mental health remains severely underfunded, receiving a fraction of the funding allocated to other areas of health.[47] This is especially true in LMICs where both the quantity and quality of treatment is inadequate, disproportionately affecting some of the world's most vulnerable people. **Funding for mental health typically accounts for between 1 and 4 per cent of a country's health spending,[48] with funding often fragmented rather than focused on coherent systemic change or universal service provision. This results in a large imbalance between the need for, and the quality and availability of, effective mental health services.** But this is not just a health sector issue, and any meaningful change will require stakeholders to work collaboratively across sectors (for example, education, employment and the judicial system) to solve what is a major inter-sectoral and broader development challenge.

With depression predicted to become the leading cause of poor health in HICs by 2030,[49] increased attention needs to be paid to the promotion of mental health and wellbeing and to prevention and early intervention in related conditions. **Growing evidence shows mental health can deliver an overwhelmingly positive return on investment (ROI) for both businesses and the wider economy.[50]** When people are physically and mentally healthy, they can work and live productive lives, allowing employers to make more profit and whole economies to develop for the benefit of all.

Former President of the World Bank, Jim Yong Kim, went as far as to argue this is not just a compelling case but something the global economy cannot afford not to do.[51]

THE COST OF POOR MENTAL HEALTH

The economic burden of poor mental health is substantial and increasing. But it remains widely overlooked compared with other, higher profile health agendas. It is estimated that up to 20 per cent of the world's working population has some form of mental health condition at any given time.[52,53] Health performance and economic performance are interlinked. Poverty adversely affects life expectancy, mainly through infant malnourishment and death. **Tackling health conditions, such as early death, disease and disability, depends not just on standards of living, but on the performance of the health systems and economies they depend on**. In turn, a healthy workforce is essential for maintaining economic competitiveness. Mental health disorders can, therefore, have a profound impact on the economy.[54]

Countries with weak physical and mental health systems find it harder to achieve sustained growth. Evidence confirms that a 10 per cent improvement in life expectancy at birth can lead to a rise in economic growth of 0.3 to 0.4 per cent a year. Whilst countries have invested heavily in physical health in order to reduce morbidity and mortality – including improvements in sanitation and immunisation coverage – investment in mental health has remained extremely low. **Poor mental health costs the world economy approximately US$2.5 trillion per year in reduced economic productivity and physical ill health.[55] This cost is projected to rise to US$6 trillion by 2030 alongside increased social costs. LMICs are expected to bear 35 per cent of this cost.[56]** As a result of this global increase, mental illness will account for more than half the economic burden of disease over the next two decades, higher than cancer, diabetes and chronic respiratory disease combined.[57]

CECILIA'S STORY

Behind every economic statistic are people with their own stories. Cecilia in Ghana started experiencing challenges to her mental health in 2016, three months after she got married. She didn't understand what was happening. She would walk long distances without knowing where she was going. People would go out to find her and bring her home. She kept waking up with bruises on her body, with no idea how she got them. She said...

> **"I felt like the whole world was coming down on me and I thought, 'I don't even want to live anymore.' I tried taking my life."**

Cecilia went to an herbalist and was on medication for two months. She felt calmer initially, but she had a relapse a few weeks later. Her husband realised her situation was much more serious than they had thought. He took her to the hospital, where she was diagnosed with acute psychosis. She was given new medication that stabilised her and was able to return to work as a teacher.

However, Cecilia experienced another relapse at school. The school was not aware of her mental health diagnosis and when they found out, she was asked to leave her job of five years. She did not receive the month's salary she was owed. When she was at home, she had another relapse, was admitted to hospital and diagnosed as bipolar.

This time, she was part of a self-help group and received support to start a business. Through the group, she got in touch with BasicNeeds-Ghana, United for Global Mental Health and Time to Change Global, which have helped Cecilia feel confident talking about her mental health.

As well as the psychological and often physically debilitating nature of severe mental health conditions, the inability to work can put huge stress on the individual and have wider economic impacts. **In Cecilia's case, investment in her mental health has enabled her to support her family and contribute to her local economy.**

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[57] Ibid.

HEALTHCARE COSTS

The healthcare costs of treating people with mental health conditions are a major challenge for health systems around the world. WHO estimates 25 per cent of patients using a health service globally suffer from at least one mental health disorder, despite most being undiagnosed.[58] The close correlation between mental and physical health is a key reason for the high healthcare costs of mental health disorders.[59,60,61] For example, a UK-based study found the costs of treating people with diabetes and depression occurring together are almost double those to treat diabetes alone,[62] due to the increased challenges of self-managing care. Across LMICs, mental health disorders increase healthcare spending for households, with mental health-affected households consistently reporting higher total health expenditure than non-mental health-affected households.[63] Mental health and wellbeing have far-reaching implications for broader healthcare spending.

In some cases, there is disaggregated data on the cost of a specific condition or syndrome. For example, in 2015, the total global societal cost of dementia was estimated to be US$818 billion, equivalent to 1.1 per cent of global gross domestic product (GDP). The total cost as a proportion of GDP varied from 0.2 per cent in LMICs to 1.4 per cent in HICs. It is estimated the total global cost of dementia will double by 2030 to US$2 trillion.[63]

In HICs, such as Canada and the USA, mental health conditions, along with heart conditions and trauma, consistently rank among the highest categories of healthcare spending when accounting for out-of-pocket, private and government spending.[65,66] In 2013, annual spending on mental health in the USA was US$201 billion, largely consisting of the high cost of inpatient care, out of a total health spend of US$2.9 trillion. However, inpatient institutions treat only a small minority of those living with a mental health condition. While across EU countries, the direct health spending costs of treating mental health are estimated to be 1.3 per cent[67] of GDP (US$209 billion), there are still large resource gaps. If the treatment costs of mental health disorders were fully funded relative to their burden in these countries, healthcare spending would represent a much greater challenge to even the most developed economies.

Serious mental illness remains a major public health challenge. Yet, across the globe, annual mental health spending remains, on average, US$2.50 per person per annum.[68] In LMICs, the high cost of treating mental health disorders represents a significant challenge. With only around 2 per[69] cent of annual health budgets allocated to mental health, a general lack of health insurance and a high proportion of out-of-pocket expenditure (OOPE), much of the financial burden falls on households. This is extensive, with studies from Ethiopia, India, Nepal and Nigeria showing spending money on mental health treatment significantly increases the likelihood of a household outspending its resources, which can lead to debt and poverty.[70] OOPE is inequitable and can expose whole populations to catastrophic healthcare costs that block development and perpetuate the poverty and illness trap.

In many low-income settings, the high costs of treatment have made the treatment gap for mental health disorders bigger. For community-oriented psychosocial interventions, the targeted treatment standard for mental health disorders, the gap is essentially 100 per cent in some LICs.[71] **Poverty brings with it heightened stress, social exclusion, malnutrition, violence and trauma, all of which contribute to mental illness. It's a vicious cycle. People living with mental illness experience widespread stigma and discrimination, suffer violence and abuse, and find it harder to get work, get an education and contribute to their family and community.[72]**

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Mental disorders, such as depression and anxiety, and substance use disorders add up to an enormous global disease burden that leads to premature mortality, physical ill health and poor quality of life. People with mental disorders have higher exposure to, and prevalence of, key risk factors such as unhealthy diets, smoking, insufficient physical activity and harmful use of alcohol. While the cost of treating mental health disorders is high, spending on mental health is disproportionately low. This is projected to create further challenges. With the global funding and treatment gap, as well as the prolonged burden of mental health conditions, the healthcare costs of mental health disorders are expected to increase.

UNEMPLOYMENT AND WELFARE COSTS

The Organisation for Economic Co-operation and Development (OECD) reported in 2012 'unemployment itself is very detrimental to mental health'. It also noted, 'people with mental disorders who find a job see significant improvements in mental health. This is in line with clinical findings according to which employment can be an important element in recovery, improving also non-vocational outcomes.' The high rates of unemployment of people with mental disorders lead to a significant cost to society.

The OECD noted the employment rate of people with chronic mental health disorders (CMDs) is around 60 to 70 per cent, or 10 to 15 percentage points lower than for people with no mental disorder. There is a high share of long-term unemployment (as a percentage of total unemployment) for people with CMDs, leading to a high risk of them being discouraged to find work or withdrawing from the labour market.

People with CMDs do not face higher rates of long-term unemployment but will often lose their job again quickly. In countries with high levels of unemployment, those with CMDs can find themselves driven out of labour markets. The same report noted between a third and a half of all new disability welfare support claims are for reasons of mental ill health. Among young adults, that proportion goes up to 70 per cent.[73] This creates a loss of skills and expertise in the workforce, with both economic and health costs to individuals and society.

PRODUCTIVITY COSTS

Health system costs represent only a small proportion of the total adverse economic impact of poor mental health.[74] Higher costs are incurred by reduced participation and productivity in the workforce, which results in lost contributions to economic output.[75,76] Companies have not always been prepared to deal with this largely 'invisible' and often-ignored challenge. Despite their enormous social burden, mental disorders continue to be in the shadows because of stigma and prejudice, fear someone may lose their job or social standing, or because health and social support services are not available or out of reach. **Based on a study of the world's 36 largest countries, it is estimated 12 billion productive days are lost each year due to depression and anxiety, at a cost of US$925 billion.[77]**

Work-related mental ill health is responsible for more lost days than any other work-related illness, costing both employer and employee.[78] While the overall average workplace absence per employee has declined over the past decade, total absence due to mental health conditions has risen.[79]

The UK's ONS Labour Force Survey reported an increase of 2.5 per cent in the total days lost to mental health conditions between 2009 and 2016.[80] The World Mental Health Survey found individuals experience 4 to 15 more days out of role per year as a result of depression and 8 to 24 days because of generalised anxiety.[81] Absence from work can have even greater implications in LMICs, where the unanticipated costs of illness and reduced ability to work can affect entire households, particularly when the productivity of the main household income earner is reduced. [82]The income of households affected by mental health disorders is consistently lower than households without them.[83] In these cases, mental health disorders can perpetuate a cycle of poverty, recognised as the medical poverty trap.[84]

An additional productivity cost results from presenteeism, which occurs when those suffering from poor mental health attend work but operate at reduced productivity.[85] Approximately 12 per cent of employees in Japan and the USA report not telling their employer about a mental health disorder due to fear of losing their job, particularly in the context of an uncertain economic climate.[86] Evidence is increasingly showing the costs of presenteeism far outweigh those of absenteeism, with estimates varying between 1.9[87] and 10[88] times the cost of absence from work. It is estimated that presenteeism costs the UK economy between £27 billion and £29 billion per year.[89]

The economic cost is even greater in Brazil, where presenteeism due to depression is estimated to cost the economy US$63 billion annually, or 3.4 per cent of GDP. In South Africa, the cost of presenteeism due to depression is estimated to be US$14.8 billion, significantly higher than the estimated cost of absenteeism of US$2.2 billion, which together are equivalent to 4.6 per cent of GDP.[90]

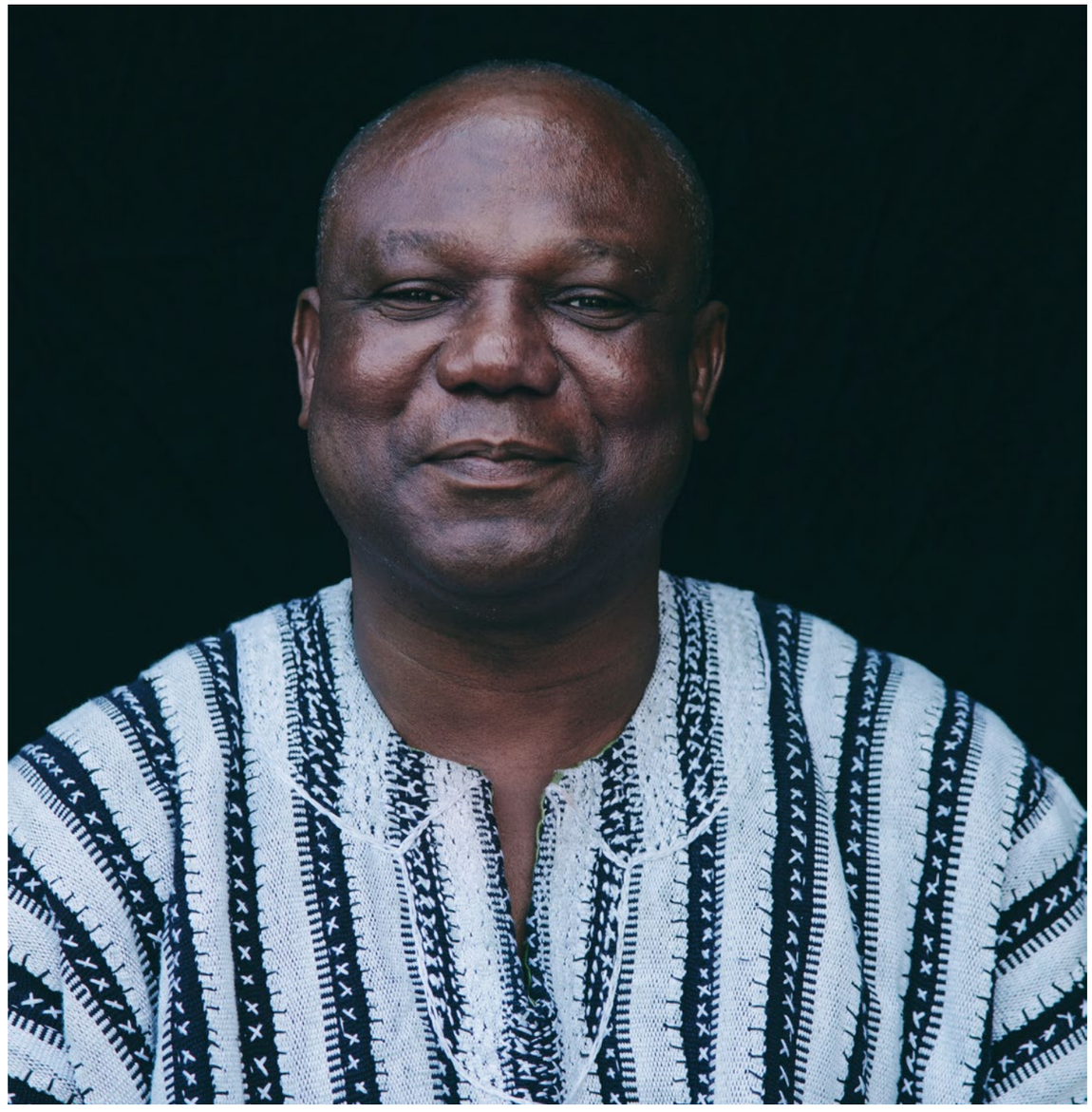
A third productivity cost arises from the turnover of staff due to mental health-related reasons. Studies of people's reasons for leaving work in HICs have found that mental health accounts for between 5 and 7 per cent[91] of staff turnover within businesses, costing £8.6bn alone within the UK.[92] Motivations cited include the need for a better work-life balance and workplace stress. Due to the high costs associated with replacing staff, which is estimated to be the equivalent of a year's salary,[93] 70 per cent of employers report staff turnover as harming business performance.[94]

Country-level analyses have shown the resulting economic cost of mental health issues to national and global economies. One global analysis of 26 LMICs found the total productivity losses to be US$461 billion per year, while the cost in ten HICs amounts to US$464 billion.[95] In Jamaica, between 2015 and 2030, lost economic output is predicted to be US$2.8 billion.[96]

In Canada, mental health disorders are conservatively estimated to cost the Canadian economy US$50 billion each year,[97] the equivalent of 2.5 per cent[98] of the country's GDP. Productivity losses due to mental health can also be exacerbated by other factors, such as exposure to war, violence and natural disasters.

In Lebanon, in addition to 1.5 million Syrian refugees, an estimated 70 per cent of the Lebanese population has been exposed to one or more war event, increasing the likely prevalence of mental health disorders and consequential productivity losses.

It is estimated that mental health disorders cost the Lebanese economy 9.4 million working days each year, resulting in an annual loss in economic output of US$354 million.



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LOST OPPORTUNITY COSTS

Slowly but surely, companies are taking responsibility on pressing global issues. This is not just altruism. They see it as a way to ensure their long-term sustainability and access new growth opportunities, remain competitive and mitigate the costs and risks of an interconnected, rapidly changing world.

A significant proportion of the economic burden of poor mental health is borne by employers.[99] There is increasing recognition of these costs and the wider impact of mental health on businesses. Conversely, there is also the acknowledgement of the impact that workplaces can have on an individual's mental wellbeing.[100] Considering this, there is a strong case for businesses to promote mental health and wellbeing and implement policies and programmes to help tackle this global crisis.

IMPACT OF THE WORKPLACE ON MENTAL HEALTH

Leading companies no longer see investments in their people as peripheral. These investments have become a core element of business strategies that seek to create long-term stakeholder value and mitigate risks. **While the underlying causes of poor mental health are complex, changes to the workplace have the potential to improve people's mental wellbeing, relatively simply and at low cost.** [101] Likewise, a poor work environment can either exacerbate a pre-existing condition or cause someone's mental health to deteriorate.

Globally, workplace stress is one of the most reported work-related health problems. Defined as a physical and emotional response, it can occur if the capacities, resources or needs of an individual do not match what is expected of them.
The most vulnerable people include those starting jobs and those in the early stages of their career. **Research has shown workers in specific professions, such as doctors and nurses, are particularly at risk of workplace-related mental health issues.** This is the case across both HICs and LMICs, with one study in Norway showing a high prevalence of attempted suicide among ambulance personnel[102] and another in the conflict-affected setting of Yemen showing high levels of 'burnout' among doctors.[103] For these high-risk professionals, the work environment can have a significant impact on their mental wellbeing and ability to be productive.

Conversely, workplaces can be a place of stigma towards those with mental health. Health workers themselves can be a source of stigma without the necessary training on mental ill health and how to address it. Moreover, despite employment being beneficial for people with Major Depressive Disorder (MDD), a study of 35 middle and high-come countries found that 62.5% of the research participants (all of whom had a MDD) had anticipated and/or experienced discrimination in the work setting. Almost 60% of respondents had stopped themselves from applying for work, education or training because of anticipated discrimination.[104]

Loss of employment has also been associated with a reduction in mental wellbeing.[105] People who lose their job are twice as likely to display depressive symptoms as those who remain in employment. [106]The recent global economic downturn has been linked with an increase in the rate of suicide.[107] Both employment status and the quality of employment can affect people's mental wellbeing, with wide-ranging effects for businesses and whole economies.

IMPACT OF MENTAL HEALTH ON THE WORKPLACE

Mental health is one of the key issues facing businesses today. With a large proportion of adults in employment, the workplace represents an opportunity to address mental health issues. By developing and implementing workplace interventions, businesses can support people to improve their mental health. Such interventions can yield substantial benefits for employers and represent a sound return on investment.[108] Beyond managing mental health conditions, research has consistently shown promoting good mental health in the workplace brings economic benefits for individuals, businesses and the economy.[109]
The workplace can be a space for issues to be identified and addressed, and, where required, for people to be linked to a formal healthcare system for treatment.

Leading companies are not only prioritising their employees' mental health but also using their public platform to encourage others to follow. Initiatives such as the Time To Change Employers Pledge[110] and The Mental Health at Work Commitment[111] are supported by global giants such as PepsiCo., **L**loyds Banking Group, and Unilever. These progressive companies are working closely with civil society and in some cases public health systems to combat mental health stigma in the workplace and show leadership.

However, these companies are not simply altruistic, they are successful businesses, and recognise the connection between good mental health, productivity and company performance.[112] One private-sector study showed companies that do not manage employee wellbeing effectively are four times less likely to retain staff over a year.[113] A positive work environment can also reduce the likelihood of interpersonal conflicts, reducing staff complaints.

A systematic review of workplace mental health interventions shows that ROI ranges between 0.4:1 to 11:1, with an average of 5.2:1.[118] The highest ROIs are attained through broad, organisation-wide initiatives, focused on culture and awareness raising.[119,120,121] In the UK, the Department of Health and Social Care has demonstrated promoting mental health in a company with 1,000 employees could reduce annual productivity losses by 30 per cent. Similarly, British Telecom reported implementing a company-wide mental wellbeing strategy resulted in a 30 per cent[122] reduction in mental health-related absence.[123]

In Canada, one review analysing companies that had implemented mental health initiatives found the median yearly ROI was CA$1.62, and companies whose programmes had been in place for three or more years had a median yearly ROI of CA$2.18.[124] This data demonstrates achieving a positive ROI for a company can take three or more years. However, organisations investing in workplace mental health programmes are mitigating the rising costs of inaction.[125]
Research consistently shows the earlier interventions can be made the more significant the potential benefits are likely to be. Alleviating workplace stress and actively improving wellbeing reduces absenteeism, presenteeism and staff turnover, and contributes to an overall increase in productivity. Meanwhile, businesses that fail to promote mental wellbeing not only incur immediate productivity losses but are likely to see greater and more costly mental health-related issues long term.[126]

Broadly, there are two focus levels for workplace mental health interventions:

- The first targets the organisational level - promoting awareness and management capabilities.
- The second focuses on the individual level[114] - providing support through, for example, flexible working arrangements and psychological counselling.[115,116]

The WHO suggests that interventions should take a 3-pronged approach:

- Protect mental health by reducing work-related risk factors.
- Promote mental health by developing the positive aspects of work and the strengths of employees.
- Address mental health problems regardless of cause.[117]

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GRAEME'S STORY

Whilst 'tone from the top' is critical to ensuring a positive mental health culture within a company, employees at all levels of organisations are driving internal change and companies that support this are seeing the positive results. This was the case for Graeme in the UK. When Graeme was 13 years old, he was climbing a tree when a branch gave way. He fell and broke his back. He spent ten months in hospital, and it was years before he had full movement again. He was told he would need a walking stick by age 40, which led to his depression.

For a long time, Graeme felt like depression controlled his life. He experienced two mental breakdowns. One was particularly traumatic. He collapsed in a supermarket and couldn't move. This led to him spending two months at home, unable to step outside, let alone work.

Fortunately, Graeme overcame his mental ill health and today works and leads a fulfilling life. He uses his experience to teach mindfulness, which he describes as his calling. In his workplace, HSBC, he arranged to get 20 on-site mental health first aiders. Through this, he has been able to make a difference to the lives of others, the achievement he is most proud of.

He said...

“HSBC has empowered me to take the mindfulness course that helped me to help others. Companies stepping up to help people when they face a mental health challenge can mean the world to someone. When you get to a point where you feel like ‘maybe this is too much for me’, programmes are in place to help you get through that.”

RETURN ON INVESTMENT FOR MENTAL HEALTH

The Lancet Commission on Investing in Health developed an investment framework to bring about dramatic health gains by 2035. The commission demonstrated the cost-effectiveness of mental health and wellbeing interventions and that these can and should take account of the economic value of employees being able to work productively as well as the intrinsic value of improved health. This approach attributes two thirds of the derived value of investing in health to the instrumental components, including the economic and labour force benefits, and one third to the intrinsic benefits of being healthy. This approach attributed a value of 0.5 times per person income.[127]

This approach was adopted in a global ROI study of 36 countries, grouped by income level, which set out the financial value of the economic and health benefits of scaling up the treatment of depression and anxiety.[128] **The study found a linear increase in treatment coverage between 2016 and 2030 could generate an estimated US$230 billion in productivity gains and US$310 billion in the value of extra healthy life years.** While the ROI for all income groups is overwhelmingly positive, providing a clear rationale for investment, there are slight variations between income groups, with LICs expected to accrue US$3.3 worth of benefits for every US$1 spent, compared with HICs where for every US$1 spent, US$4 is expected in return.

In addition to the global ROI studies, some national-level analyses have shown the specific benefits that a country can expect to accrue from scaling up investment in mental health services. In line with the global analyses, these have shown some variation across income regarding the expected ROI and the most effective interventions. The size and type of investment vary across groups of countries, with HICs typically more able to mobilise resources and engage the private sector in workplace-based initiatives. Considering the drive for UHC in the context of the SDGs, investments in LMICs typically focus on integrating mental health services into primary and community-based healthcare.[129]

There may also be an additional need in LMICs to conduct epidemiological studies to better understand the prevalence and drivers of mental health disorders to develop effective interventions. While the global investment case for supporting mental health interventions is strong, these should be developed, and resources allocated, in response to the specific contextual needs of each country.

One study in Jamaica, an upper-middle-income country, showed scaling up treatment for depression, anxiety and psychosis between 2015 and 2030, at a cost of over US$115 million, could deliver total benefits of over US$434 million for the Jamaican economy. This consists of both economic productivity gains and the financial value of wider social benefits.

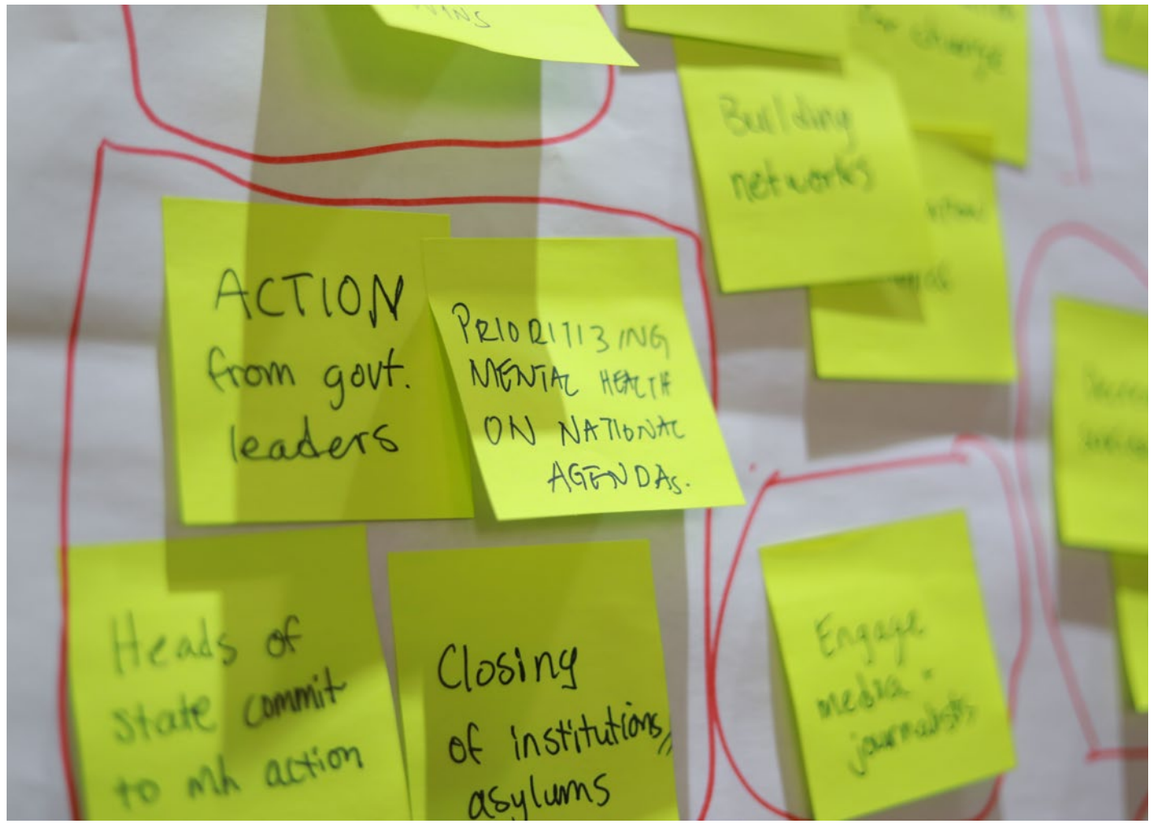
As of 2018, the coverage of basic psychosocial treatment for mental health disorders in Jamaica was 15 per cent. Targeted investments seek to increase coverage to 50 per cent, primarily through the integration of mental health services into primary care and increasing the training of healthcare professionals. The study estimates the clinical treatment of anxiety will produce an ROI of 5.5:1, while the treatment of depression will produce an ROI of 5.2:1.

In Australia, a cost-benefit analysis has assessed the investment case for supporting individuals with mental health disorders. The study focused on helping individuals with a mental health disorder to gain and maintain employment, as well as supporting wellbeing in the workforce, minimising preventable hospitalisation for mental health disorders, and investing in promotion, prevention and early detection interventions. It is estimated that an investment of approximately US$4.4 billion, would generate economic returns of between US$8.2 and 12.7 billion.[130] Most of this would be generated through savings to employers as a result of workplace interventions, likely to be around US$4.5 billion. The study emphasises the significant advantages of targeted early interventions, which generate the highest cost savings.

A third study in Lebanon has analysed the potential returns of scaling up investment in mental health services. The ongoing conflict in neighbouring Syria has had a profound effect on Lebanon’s people and economy, exposing the fragility of Lebanon’s healthcare system. As in all war-affected countries, exposure to conflict can significantly increase an individual’s risk of developing a mental health disorder. WHO estimates that of those who have experienced conflict in the past ten years, 1 in 11 people (9 per cent) will have a moderate or severe mental health disorder, increasing the likely prevalence of mental health disorders in Lebanon.

The ROI study shows even a small annual investment of US$2 million per year over four years could restore more than 13,000 healthy life years and avert over 20,000 mental health cases. The value of these health returns would be US$13.5 million per annum. In terms of productivity, a modest 5 per cent increase in making people able to work through treatment could add US$1.7 million to the Lebanese economy, delivering a total of US$6.62 in financial value for every US$1 spent. As in other countries, there is a strong public health and business case for investing in mental health services in Lebanon.

The studies to date show mental health is not just a health issue. It is also a development issue and, increasingly, an economic issue. Significant losses are incurred as a result of poor mental health and wellbeing globally. ROI studies have demonstrated the potential gains from addressing mental ill health. There are clear rationale and a strong investment case for governments and businesses to promote mental wellbeing. However, along with increased funding, there is a need for evidence-based policies and services, developed in line with human rights frameworks and respecting cultural contexts. This would help both the public and private sector understand the impact of mental wellbeing and support people to realise their right to physical and mental health.



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CHAPTER THREE: THE RETURN FOR SOCIETY

THE RETURN FOR SOCIETY

Our mental health varies throughout our lives as our circumstances and experiences change. All of us will be affected by poor mental health at some point, if not ourselves, through our relationships with family, friends and colleagues. Mental health conditions do not just affect the person who has them. They have an impact on whole communities.

Poor mental health is a global challenge that disproportionately affects the most vulnerable members of society– people living in poverty, young people, older people, women and girls, and refugees. A lack of attention to mental ill health will hold back the achievement of the SDGs, due to the negative impact of mental health on physical health and a range of areas beyond health, including our economies.[131]
By promoting mental health, we help people fully participate in their families, workplaces and communities – for the benefit of all.

Mental health is a public good worthy of attention and investment. Receiving sick pay for mental health conditions allows people to recover without falling into financial hardship and placing a burden on public services. Ensuring a new mother is supported through her postnatal depression helps minimise the knock-on effects on her spouse or baby, improving early childhood development with life-long impacts. Integrating mental health support into responses to HIV, TB and tobacco use strengthens these efforts, bringing broader health benefits.

Poor mental health has a ripple effect on people's physical health, family and social relationships. It is not only bad for the individual in question but negatively affects their family and society at large. Good mental health is determined by a broad range of social determinants, including personal and social factors. But it can be addressed with holistic, integrated approaches.

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THE IMPACT OF POOR MENTAL HEALTH ON PHYSICAL HEALTH AND MORTALITY

The link between mental health and physical health is well established. People with poor mental health have significantly worse physical health.[132] In HICs, the gap in deaths between those with poor mental health and the rest of the population is widening. Current estimates put this gap between 13 and 30 years, demonstrating the need to address the physical health problems of those with poor mental health.[133,134] Globally, those with severe mental health conditions have a 10-25 year life expectancy reduction.[135]

Rates of tobacco, drug and alcohol use are higher among people with poor mental health. These people are also more likely to be obese and less likely to be physically active compared with the general population.[136] However, it is not inevitable that people with mental health conditions should have to contend with physical health challenges. A wide range of opportunities to invest in both their mental and physical health are available.

INVESTING IN PREVENTION

Physical Activity & Obesity

There is a two-way relationship between physical activity and good mental health. People who are more physically active cope better with stress, and good mental health allows people to engage in more physical activity.[137] Physical activity can be used as a 'prescription' for depression, with moderate effects on mood.[138] Exercise can reduce anxiety for people with chronic physical illnesses[139] and reduce hallucinations in patients with schizophrenia, a psychotic disorder.[140] People with serious mental illnesses are twice as likely to be obese,[141] due to medication side effects and the fact these disorders make self-care more challenging. Furthermore, increasing physical activity is one way to reduce the risk of dementia.[142]

Weight loss measures such as dietary changes and exercise plans have proven moderately effective for those with poor mental health over short periods.[143] Combined with one-to-one and group advice sessions, they can help people living with severe mental illnesses lose a significant amount of weight and keep it off for 18 months.[144] Motivation is key to weight loss. Encouragingly, even long-term psychiatric-care residents are keen to develop and participate in personalised weight-loss programmes.[145]

Overall, investing in helping people be physically active and eat healthily represents an opportunity.

Alcohol, Drug & Tobacco Use

The coexistence of mental illness and alcohol or drug misuse – with each exacerbating the other – is called dual diagnosis. This is a common situation. Close to half the patients seen through psychiatric services use drugs or alcohol in harmful ways. And more than three quarters of patients accessing drug or alcohol services report mental health problems.[146] **People with a dual diagnosis find it more challenging to engage with treatment, whether medication or talking therapy, and, as a result, have poorer outcomes than those with a single diagnosis.[147]**

Tobacco kills up to half its users and many more exposed to secondary smoke, such as children, leaving no doubt that smoking should be eradicated to protect health. People with poor mental health are two to three times more likely to be smokers.[148] Yet, despite heavier use, greater dependence and lower quit rates, smokers with mental illnesses are often motivated to stop smoking.[149] Treatments that work for people with good mental health can be effective for those with poor mental health too.[150] However, the delivery of these interventions is likely to require a bespoke approach. Studies are underway to explore this.[151]

As effective as medication and talking therapies are in helping people quit alcohol, drug and tobacco use, creative combinations of the two, tailored to the individual, may be needed.[152] There is good evidence that integrating treatment for mental ill health and substance misuse is more effective than treating each separately. Integration in this context extends to social services, housing support, employment support and the criminal justice system, rather than being restricted to healthcare alone.[153]

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INVESTING IN MENTAL HEALTH TO IMPROVE PHYSICAL HEALTH

One in three people with a long-term physical health condition also have poor mental health,[154] and there is increasing agreement that addressing mental health and psychological wellbeing improves physical health too.

Tuberculosis

People with severe mental illness are several times more likely to die from TB, HIV/AIDS or other infectious diseases.[155] Around half of people with TB are estimated to have depression.[156] TB is a curable disease, with early help-seeking, attending follow-up appointments and completing treatment programmes important factors for success.[157] Poor mental health can disrupt this patient journey. Those with depression are ten times more likely to stop treatment, leaving them at higher risk of death, disability and poorer quality of life. [158] Untreated depression is associated with the spread of TB and increased drug resistance.[159]

Patient outcomes can be improved by providing psychological support [160] and WHO-recommended integrated approaches, which include psychological interventions, psychiatric medications and structured education for patients living with both TB and depression diagnoses. [161] International experts are advocating an integrated approach to be adopted by national governments and international aid agencies.

HIV

The links between poor mental health and HIV merit the attention of those working to improve health globally. HIV is four times more prevalent in people with poor mental health compared with those with good mental health.[162] **People with poor mental health may take more risks in their sexual behaviour and substance misuse and subsequently develop HIV.[163]** Once a diagnosis is made, people with HIV are at higher risk of psychological distress, financial burden and stigma.[164] Ongoing high-risk sexual behaviour and limited adherence to treatment and follow-up lead to more chance of onward transmission, poor clinical outcomes and higher societal costs.[165,166]

Investing in psychological therapy and psychiatric medications is effective at addressing mood disorders, improving adherence to treatment, decreasing risky behaviour and empowering people across age groups.[167,168] Once again, integrated services are recommended, as they increase the positive impact of HIV programmes.

These have proven acceptable to patients, healthcare providers and managers.[169,170] The Joint United Nations Programme on HIV/AIDS (UNAIDS) and The President's Emergency Plan For AIDS Relief (PEPFAR) have already updated their policies accordingly, and the Global Fund is now considering a similar approach to leverage

the substantial funds raised.

IMPACT ON FAMILIES

Poor mental health affects entire families. Children's mental health has an impact on them for the rest of their life. And the mental wellbeing of parents and carers influences the outcomes of the children they are responsible for.

IMPACT OF PARENTAL MENTAL ILLNESS ON CHILDREN

Children's interactions with the world are mediated through their main caregivers. These experiences form the basis of their physical, social and cognitive development. As a result, disruptions to a child's engagement with their environment can have lasting negative consequences for their health as they grow up.

Most of the research examining the impact of parental mental ill health on children has focussed on mother and child interactions, but data about fathers is also emerging. **Global estimates suggest that as many as one in five mothers experience mental health problems during pregnancy and/or the first year after childbirth.[171] This is also a challenging time for fathers. One in ten men experience postnatal depression.[172]**

Poor mental health among parents affects their children too. Globally, 10 to 20 per cent of children and adolescents experience mental disorders.[173] 15 to 23 per cent of children live with a parent with a mental illness, predisposing them to have one themselves. And the numbers are rising.[174] In the UK, one in four children will have experienced maternal mental illness by the time they reach the age of 16 [175] and in Australia, approximately one in five children have a parent with a non-substance abuse mental illness.[176]

The potential consequences of parental mental ill health are summarised in Figure 3 [177] These are the result of complex interactions between the type of condition, severity, genetics, environment and social support structures. Parenting alone cannot be held to account for these outcomes.

However, data from several studies builds the case for a causal relationship between parental mental illness and adverse childhood outcomes.

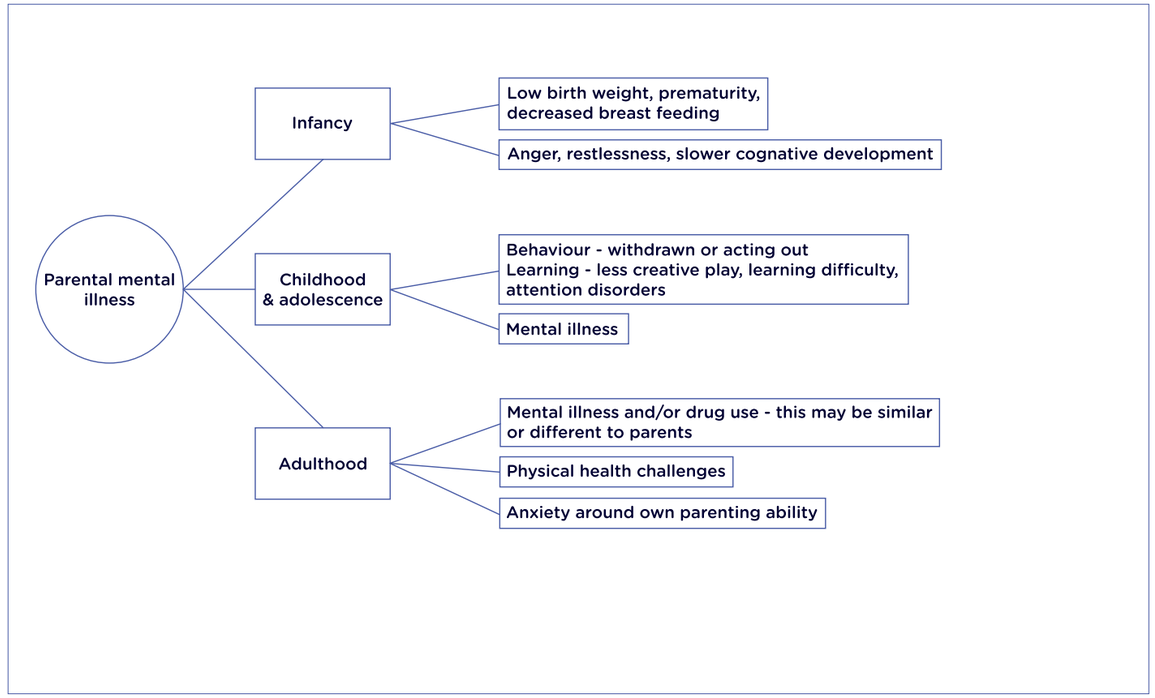

FIGURE 3: Consequences of parental mental illness

Parental mental illness creates a complex range of experiences for children. In more than 20 studies from different countries, assessing a range of ages, children describe managing their behaviour to achieve harmony at home. They report a need to conceal the problem – due to stigma or bullying – and cope by seeking information and support. They frequently feel guilty and blame themselves.

Adverse outcomes in children, although common, are not inevitable. A Welsh study followed up with the adolescent children of parents with recurrent depression for four years. One in five young people remained in good mental health throughout that time, both in terms of mood and behaviour. Protective factors included positive emotions expressed by the parent with depression, support from a co-parent, good social relationships, self-efficacy and frequent exercise. As the number of protective factors increased, so did resilience.[178]

There is strong evidence in LMICs that perinatal mental health conditions are linked to various harmful outcomes in children, with most evidence pointing to lower birth weight in babies of women depressed during pregnancy and/or after childbirth.[179] Other outcomes for children born to mothers with depression include higher rates of child diarrhoeal and respiratory diseases, stunting, increased hospital admissions, lower completion of recommended immunisation schedules, and social and emotional difficulties.[180] Further studies have shown maternal depression and stress can lead to mothers stopping breastfeeding early, which has further negative effects.[181]

In a study from Cambridge in the UK, children were assessed over 16 years. Children of mothers with postnatal depression were five times more likely to experience depression themselves. The risk was increased where there was prolonged maternal depression, poor support for the mother or marital conflict.[182] In other studies, poverty, maternal education and social class were found to influence the effect of exposure to parental mental illness.[183]

COSTS OF PARENTAL MENTAL ILLNESS

A common-sense approach suggests treating parental mental health problems would improve child health outcomes. However, there are complex relationships between mental health, parenting and physical health. Many professional bodies recommend a holistic approach that addresses not only the mental illness but also support for co-parents and children.[184]

Given the evidence gaps and range of potential consequences that could occur at different times of life, economic analyses including children are challenging. Two examples exist, both centred around maternal mental illness.

Looking at maternal perinatal depression, psychosis and other conditions, and accounting for a wide range of adverse childhood outcomes, a UK-based evaluation estimated a total cost of £8.1 billion per year since birth. 72 per cent of these costs related to the child.[185] A USA model reported that maternal depression and anxiety had a societal cost of US$14.2 billion for 2017, with 40 per cent of the cost due to adverse childhood outcomes.[186]

As mental health care has moved towards an outpatient model, there is an increased need for support in the community. Caregivers play a central role in the recovery and wellbeing of those affected by mental illness,[187] so investing in meeting their needs is an important component of holistic support.

A large international survey of HICs looking at people caring for those with severe mental illness highlighted some important findings:[188]

- Most carers are family members and have been carrying out care duties for nine years.
- Being a carer can be a positive or negative experience.
- Four out of five caregivers feel unable to cope.
- One in three caregivers feel depressed.
- One in three caregivers feel their physical health has worsened.
- One in three caregivers feel lonely and isolated.
- Six out of ten caregivers feel unrecognised by the healthcare system.
- Eight out of ten caregivers want more help, in the form of information, emotional support, respite care and financial support.

These broad themes are echoed in other studies from around the world.[189]

In some settings, caring duties have disadvantaged carers economically.[190] In the USA, more than 15 million people provide unpaid care for people with Alzheimer's or other dementias. This adds up to an estimated 18.5 billion hours, with a value of US$234 billion.[191] Again, intuition would suggest improving an individual's mental health would improve their carer's quality of life. But evidence for this is lacking.

A range of interventions exists to support carers, summarised below.[192]

Interventions to reduce carers' psychological distress:

- Training and education programmes
- Information technology-based support
- Involvement in formal planning of support
- Educational and emotional support
- Spiritual and religious support
- Strategies to manage disturbed or unusual behaviour
- Informal social-support systems
- Talking therapies, including family-based therapies

The effectiveness of these interventions depends on social and cultural conditions and carers' existing knowledge and personality traits. As with support for children, it is important to address the full range of needs, whether related to mental and physical health or wider factors, such as employment or relationships with others in society.

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SOCIAL SUPPORT AND NETWORKS FOR MENTAL HEALTH

Just as the mental health of children and parents has an impact on families, so too does the mental health of individuals impact on society. The influence of social relationships on health and wellbeing is well recognised.[193] Several overlapping terms are used to discuss these relationships, including social cohesion, social capital and social networks. The idea is also explored through the lens of loneliness, defined as 'a subjective unpleasant feeling arising from a mismatch between a person's desired level of meaningful social relationships, and what they perceive they have'.[194] There are structural components (roles, social structures and opportunities to interact) and cognitive or relational components (the quality of relationships, shared norms and trust)[195] to social relationships. This range of concepts and definitions poses a challenge to research. increase the positive impact of HIV programmes.

Poor social connections can be considered both a risk factor for and a consequence of poor mental health. People with weak social connections are more likely to develop mental health illnesses[196] while those who join social groups are less likely to have depression.[197] **Broadly speaking, individual social connectedness is more protective than community connectedness, and cognitive social connectedness is more protective than structural connectedness. Individuals with good quality relationships are consistently seen to have better mental health.[198]**

Clinically, social isolation is recognised as a symptom of depression and a precursor for other mental health diagnoses. Treating depression results in a small improvement in social connectedness[199] and social functioning is proposed as a marker for successful treatment of depression.[200] It is likely that a two-way relationship exists between mental health and social connectedness.

Social connections are as much about the people around those with mental health problems as they are about the individuals directly affected. Social stigma leads to negative stereotypes of those with mental illnesses. It is associated with discrimination and results in people with good mental health avoiding those affected by mental illness. In a survey in England, nine out of ten mental health service users reported experiencing discrimination.[201] This creates barriers to accessing services, maintaining social contacts and developing new connections.

There have been attempts to intervene to improve the social connectedness of those with, or at risk of developing, a mental illness. These have taken the shape of community engagement, small group activities, individual talking therapy, and multi-pronged approaches. They have been shown to improve social connectedness.[202] And improving social connectedness appears to lead to small improvements in mental health outcomes in some studies. However, the longer-term effects and the best approaches remain unclear.[203]

Individuals form the building blocks of social groups such as families, and social groups form the building blocks of society. Well-integrated societies have less crime, lower mortality and better physical and mental health.[204] To feel connected, individuals need:

- Social and economic empowerment
- Civic clubs
- Physical activity
- The ability to volunteer
- Stable families
- Religious or spiritual involvement[205]

Evidence is building that mental illness is a barrier to social connections. A common-sense approach would suggest that good mental health would allow better connections through meeting the needs above. However, the responsibility to improve social connectedness extends beyond the individual to the local community (local health services and voluntary groups) and broader society (governments, NGOs, the media).[206]

PUTTING MENTAL HEALTH AT THE HEART OF PUBLIC POLICY

Improvements in mental health and the consequential positive effects on society will not come through isolated or standalone activities but through integrated public policies with mental health at their heart. It is vital to look at how these policies could be measured and funded.

MEASURING MENTAL HEALTH & WELLBEING

Globally, it is acknowledged that we need to go beyond economic measures to assess the wellbeing of a population. Wellbeing is a positive concept that includes both subjective satisfaction with life and meaningful functioning. Good mental health is related to both.[207]

Tools to measure individual wellbeing help to shift the focus from measuring ill health to measuring good health. The Warwick-Edinburgh Mental Well-being Scale (WEMWBS), for example, has captured changes in wellbeing over time and differences between individuals.[208] Such tools are important for public health and mental health interventions where broader wellbeing rather than disease-specific outcomes are sought. They are particularly useful to assess those who do not have good mental health but do not reach the threshold for mental illness. There are calls to create a Wellbeing Adjusted Life Year as an alternative to the Quality Adjusted Life Year (QALY) to help distribute resources.[209]

Wellbeing measures can also contribute to national data. Perhaps the earliest example of a composite index that explicitly includes wellbeing is the Gross National Happiness Index coined by the King of Bhutan in 1972. National indices that include wellbeing now exist in many OECD countries and are useful to:

- Provide individual and national measures of wellbeing
- Improve knowledge of the drivers of wellbeing
- Aid in the understanding of decision making and the subsequent impact on cost-benefit analysis[210]

In 2018, the Lancet Commission on Global Mental Health and Sustainable Development outlined a set of indicators to monitor mental health progress within the context of the SDGs. Indicator domains included mental health systems, services and health outcomes; economic, social and environmental determinants; risk protection; and non-health outcomes (social and economic). The commission further recommended the use of these indicators to establish a comprehensive monitoring and accountability mechanism for mental health. In response, the Countdown Global Mental Health 2030 was launched and featured at the Goalkeepers event organised by the Bill and Melinda Gates Foundation in September 2019.

Implemented by a coalition of Harvard University, WHO, The Global Mental Health Peer Network, The Lancet and United for Global Mental Health, Countdown Global Mental Health 2030 will develop and implement an ambitious global monitoring and accountability framework for mental health, in keeping with the political commitments made within the SDGs and WHO Comprehensive Mental Health Action Plan.[211] The Countdown will go beyond traditional health indicators and monitor social and economic risk factors, determinants and outcomes to truly measure mental health and wellbeing progress.

INTEGRATED CARE

The evidence presented above, together with WHO and national recommendations, highlights the importance of integrating physical health, mental health, psychological and wider services to address all aspects of mental health support and prevention.[212] The principle of integrated care is not new. It reflects the aim 'to improve patient experience and achieve greater efficiency and value from health delivery systems' in other words put the individual at the centre of care.[213]

Although the evidence base is still being developed, integration reflects varying degrees of coordination and may improve efficiency in several ways, through:

- Targeting support and resources
- Preventing duplication of treatment or assessment
- Closing bottlenecks and gaps in care pathways
- Ensuring support decisions take account of capacity and resource needs
- Ensuring support is undertaken by the right professionals, including social care services[214]

Within the health sector, the UK's National Health Service has started to trial fewer rigid boundaries between primary care, hospitals, and community and mental health services by bringing budgets together into new local systems of support.[215] These initiatives aim to provide liaison mental health services in acute hospital settings; incorporate perinatal mental health care; provide psychological therapy for people with long-term physical health conditions; and improve physical health assessment and follow-up for people with severe mental health illness. Ideally, these models of support would connect and interact with services beyond the health service to extend to social care, housing, education, NGOs and employers.[216]

Investing in mental health can produce returns for society that are possible to quantify, such as improvements in physical health and child development. A more holistic view of how to measure mental health is emerging. However, other impacts are hard to measure but help to hold together the fabric of society. The return on investing in mental health throughout communities is greater social connectedness and cohesion, bringing all the benefits and societal progress that accompany harmonious and open communities.

WELLBEING ECONOMIES

Calls to rethink economic models have grown louder, as tools for measurement and policy action have developed the concept of 'wellbeing economies'. At their core, wellbeing economies refocus government spending to deliver human, social and ecological wellbeing rather than wealth alone. Multi-factor metrics are used to evaluate and compare policies and there is increasing cooperation across different parts of government. This changes the definition of success at the national level, resulting in improved policy making, which brings good mental health for the whole population to the fore. Scotland, Iceland and now the EU are exploring mechanisms to take a wellbeing economy approach to resource allocation and prioritisation.[217]

New Zealand is the first country to formally adopt a WELCOME BUDGET (May 2019). This centres on conceptually redefining government spending as investment in people, what they do, where they do it, and how they feel. The country's five priorities are:[218]

- Taking mental health seriously
- Improving child wellbeing
- Supporting the aspirations of Maori and Pasifika peoples
- Building a productive nation
- Transforming the economy

Operationally, the government will set out each year how these priorities will guide spending. Potential impacts on wellbeing will be used to assess bids from government departments and will be incorporated into performance reporting. With regards to taking mental health seriously, using this approach has resulted in record levels of funding for the development of mental health services, covering not only treatment but prevention too.[219] Although it is too early to evaluate the impact of wellbeing approaches across entire budgets, there are lessons about the validity and value this offers at a sector level, as discussed below through examples from social protection and education.

SOCIAL PROTECTION

There are two critical pathways to including wellbeing in policies and processes: the removal of negative factors and the promotion of positive factors. Social protection aims to promote wellbeing through the reduction of poverty and economic vulnerability.[220]
This is particularly important for those with mental illnesses who face challenges with unemployment or underemployment. In a robust analysis, it was shown that even small increases in unemployment benefit resulted in improved wellbeing and that health co-payments showed a negative relationship with wellbeing.[221] Applying the wellbeing lens to policies demonstrates positive effects beyond an increase in wealth.

EDUCATION

The promotion of positive factors in the pathway to wellbeing can be seen in education that 'fosters traditional academic skills and skills for happiness and wellbeing'.[222] **This includes resilience and the ability to form positive relationships, shifting focus away from academic achievements alone.** Children from kindergarten through to high school who receive positive education or social and emotional learning programmes have improved social and emotional skills, attitudes, behaviour and academic performance.[223,224] The benefits of education in adult life reflect the duration and quality of education. Highly educated people have longer life expectancies, better social connectedness and improved wellbeing.[225]

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CONCLUSION

CONCLUSION

The return on investing in mental health and wellbeing goes beyond the economic. There are significant returns for both the individual affected and wider society.

The case is clear for a revolution in mental health investment globally. Now is the time for each of us to act to make it a reality.

Recommendations for businesses, governments and individuals to help deliver good mental health for all:

For Individuals

- Reducing stigma starts with talking about mental health and encouraging others to as well. Learn more from organisations such as the Global Mental Health Peer Network.
- Learn more about how to optimise your own mental health and physical health. Use the information provided by organisations such as WHO (**who.int**).
- Join those advocating greater political and financial support for mental health. Go to **unitedgmh.org/blue-print-group**.
- Campaign for greater action on mental health. Go to **gospeakyourmind.org**.

For Governments

Invest in the mental health of your citizens:

- Uphold the commitments made to deliver the UN Sustainable Development Goals by 2030 and Universal Health Coverage.
- Deliver the commitments made in the WHO Comprehensive Mental Health Action Plan 2013–2020 and advocate for an ambitious plan for 2021–2030 to accelerate action.
- Place persons with mental health conditions at the centre of policy and practice – involve them in the design, development, implementation, monitoring and evaluation of services
- Deliver on other relevant action plans, for example, the WHO Global Action Plan on the Public Health Response to Dementia 2017–2025.
- Ensure that the youth mental health is adequately invested in and interventions are developed with youth engagement.
- Ensure the rights of all citizens to good physical and mental health free from coercion are upheld by implementing rights-based mental health legislation with the UN Convention on the Rights of Persons with Disabilities being the cornerstone.

For Businesses

Invest in the mental health of your workforce:

- Protect mental health by reducing work-related risk factors.
- Promote mental health by developing the positive aspects of work and the strengths of employees.
- Address mental health problems regardless of cause.

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