

# Addressing the Problem of Severe Underinvestment in Mental Health and Well-Being from a Human Rights Perspective

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## Abstract

Throughout the world, mental health remains a neglected priority, low on the agenda of policy makers and funders at the national and international levels. While this is shifting somewhat, there remains a considerable need to address the underprioritization of mental health and well-being, perhaps even more so in the wake of the COVID-19 pandemic. However, given the history of mental health interventions—which have overemphasized the biomedical model and have thus resulted in coercion, denial of life in the community, and unnecessary pathologization of human experience—there is also a need to ensure that increased funding does not simply replicate these mistakes. This is particularly true in the current landscape, where efforts to “scale up” mental health and to reduce “treatment gaps” are gaining momentum and where post-pandemic responses are still being formulated. As the potential for global mechanisms for funding mental health increases, national and international funders should look to practices that are rights affirming and contextually relevant. In this paper, I explore the current landscape of mental health financing, in terms of both national resource allocation and development assistance. I then outline the momentum in global mental health that is likely to materialize through increased funding, before considering ways in which that funding might be utilized in a manner that promotes human rights.

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## Introduction

Around the world, financial investment by national governments, international development organizations, and United Nations (UN) agencies in mental health and psychosocial support is extremely inadequate to meet demand. Laura Asher and Mary De Silva, for example, suggest that “the dire shortage of mental health specialists, coupled with chronic underinvestment in mental health services by both governments and international donors, are key reasons for poor access to care.”<sup>1</sup>

Far from being a developing country problem, underinvestment in mental health is a global phenomenon, despite the apparent significant need for people to access mental health and psychosocial support services and often despite legislative and policy mandates for parity between physical and mental health. Moreover, the quality and efficacy of services funded is a fundamental question that needs further reflection. This is particularly true when one considers the need for interventions to focus on the fundamental rights of people with mental health conditions because this is an area where myriad rights violations have been recorded.<sup>2</sup>

Applying a human rights lens to global mental health means recognizing that the glaring neglect of mental health as a policy and resourcing priority is unacceptable, but it also requires critically examining the manner in which efforts to address that neglect are undertaken. The replication of systems that have thus far been responsible for the oppression and abuse of people with mental health challenges can, however, be problematic. According to numerous scholars and practitioners, traditional biomedical approaches rely heavily on coercion and a disease framing, and addressing this overemphasis on a purely biomedical view of etiology requires a shift in established mental health systems as well as efforts to build new systems.<sup>3</sup> Therefore, in normative terms, increased funding for mental health must be aligned with fundamental human rights principles as determined by international instruments, most notably the UN Convention on the Rights of Persons with Disabilities (CRPD), which has been ratified by 181 countries and which protects and promotes the rights of people with

disabilities, including psychosocial disabilities. Another such instrument is the International Covenant on Economic, Social and Cultural Rights (ICESCR), which has been ratified by 170 states and which requires states to protect and promote the right to health, with a dedication of the “maximum available resources” to do so.<sup>4</sup> It is important to note that these instruments obligate states to implement policies and programs that are in keeping with principles such as dignity, autonomy, and life in the community.<sup>5</sup> This means that the rollout of rights-oriented programming for mental health and well-being need not necessarily be predicated on the assumption of the availability of financing; instead, financing ought to be determined by the needs and obligations arising out of the CRPD and other rights instruments.

With these factors in mind, this paper seeks to reflect on the current landscape with regard to financing for mental health, both in relation to domestic health spending and in relation to development assistance for mental health (DAMH). In addition, I examine the nature of services provided when resources are available, and what their human rights implications might be. I then consider current global efforts to promote mental health, seeking to illustrate the crucial moment that policy makers, service users, and advocates find ourselves in, including in light of the COVID-19 pandemic. In doing so, I argue that a significant contribution can be made by adopting a rights-oriented, well-being-focused approach to mental health financing as efforts to “scale up” mental health gain momentum.

## The current landscape of mental health financing

Research related to mental health financing is extremely limited and rarely clear. The World Health Organization (WHO) notes that just 40 countries were able to report on their domestic budget for mental health in 2014.<sup>6</sup> This number rose to 80 countries in 2017, representing something of an improvement but nonetheless constituting less than half of WHO member states.<sup>7</sup> Even where budgets are available, these are often not disaggregated

beyond a distinction between hospital-based and community-based services.

With regard to international aid for mental health, a 2016 report by the Overseas Development Institute “highlights how little information there is on what donors are spending on mental health globally, [and] what types of activities are funded.”<sup>8</sup> This is illustrative of the significant challenge that exists in putting together a complete picture of the funding landscape for mental health.

There is another inherent problem in any analysis relating to development assistance for health (DAH) research, as highlighted by Jessica Mackenzie and Christie Kesner.<sup>9</sup> Larger projects might have a mental health component but are often dealing with a larger range of health concerns (including HIV/AIDS and gender-based violence). In such cases, it is rare that mental health interventions are separate line items, making it impossible to accurately state what proportion of funds goes to these services. This raises the risk of over-reporting and should be borne in mind when considering the figures presented.

Recognizing the constraints mentioned above, I utilized already-published data from the academic literature and institutional reports such as those of WHO, the Overseas Development Institute, the South African Human Rights Commission, and Lion’s Head Partners. Similarly, to track global DAMH, I utilized the Creditor Reporting System of the Organization for Economic Cooperation and Development and the Development Assistance for Health Database of the Institute for Health Metrics and Evaluation.<sup>10</sup>

The results of this secondary data analysis are expanded on below. It should be noted, however, that changes to flows of aid and domestic health spending are expected in the wake of the COVID-19 pandemic. Therefore, these results provide a useful baseline for “what has been” as the world begins to reconsider “what should be.”

## Domestic funding for mental health

Domestic funding for mental health by governments is low despite many calls for parity between

physical and mental health services.<sup>11</sup> In 2013, WHO noted that, globally, the average percentage of national health spending devoted to mental health was about 0.5%.<sup>12</sup> Some high-income countries devoted more spending, but this amounted to only about 5% of total health budgets on average.<sup>13</sup> In pure monetary terms, WHO reported in 2017 that there was a strong association between higher per capita gross domestic product (GDP) and per capita expenditure on mental health. However, it also noted that with regard to mental health spending as a percentage of the total health budget, there was not a strong association with GDP per capita.<sup>14</sup> This suggests that some low- and middle-income countries dedicate a larger proportion of their health budget to mental health than some high-income countries. In terms of individual out-of-pocket expenditures, WHO reported that in 17% of countries, people pay entirely or mostly out of pocket for access to mental health services.<sup>15</sup>

Average annual health expenditure around the world amounts to US\$141 per person, while the median government spending on mental health per capita in 2017 was US\$2.50.<sup>16</sup> Despite the fact that some low- and middle-income countries might spend more on mental health than some high-income countries, overall the gap between high-income and low-income regions is stark, with countries in Europe dedicating US\$21 per capita while those in Africa dedicate just US\$0.10 per person per annum.<sup>17</sup> This disparity represents a significant challenge in its own right, because estimates suggest that simply raising the annual per capita expenditure in low-income countries to US\$1 annually would require an investment of some US\$30 billion globally.<sup>18</sup> Yet in light of the fact that the majority of signatories to the CRPD are low- and middle-income countries, the obligation to provide appropriate care and support services for those affected suggests that financing ought to be determined by service needs as opposed to the corollary and status quo of access and quality being determined by available resources.<sup>19</sup> As noted by the UN Economic and Social Council, a “lack of resources cannot justify inaction or indefinite postponement of measures to implement those

rights.<sup>20</sup> The council further notes that international cooperation and funding are key and necessary mechanisms to ensure equitable and sufficient service provision. This suggests that adequate financing for appropriate, quality services is both a national concern and an international one.

### Interventions and approaches funded

In high-income countries, 43% of all spending on mental health is dedicated to hospital-related infrastructure, maintenance, and service provision.<sup>21</sup> In low-income countries, this figure is 80%. Even where budgets for community-based services are allocated, these tend to be medical in nature, referring to the delivery of psychotropic medication in primary health care settings. Addressing mental health needs from this perspective does not fully account for the social, political, legal, and economic determinants of well-being (see below for further detail), and risks undermining human rights principles. Box 1 provides insight into some of the complexities of domestic mental health financing, including issues of devolution of financing decisions to local governments.

These case studies illustrate the point that mere allocation of funds is not sufficient for the provision of mental health and psychosocial support services. The nature of the services provided and the governance of those services are equally important considerations. The emphasis on well-being in New Zealand's budget is encouraging, although it is clear that there remain some obstacles to a fully rights-based approach, while the South African case illustrates the need for more than simply allocation or reallocation of funding to attain a rights-oriented model. I will return to these topics after exploring the landscape of international development assistance as a source of financing for mental health.

### Development assistance for mental health

According to the Institute for Health Metrics and Evaluation's DAH database, total spending by bilateral donors, UN agencies, and philanthropies

on mental health amounted to roughly US\$162 million in 2018.<sup>22</sup> As demonstrated by Figure 1, this represents a substantial increase in spending from previous years, assuming that all data are accurate and complete. Even so, the total amount of global DAH in 2018 was US\$38.9 billion, demonstrating that funding for mental health represents just 0.4% of total DAH.<sup>23</sup> This, too, is illustrative of the substantial lack of prioritization of mental health as a global health concern.

A few countries stand out with regard to their spending on DAMH. The United States is the largest bilateral donor, followed by the United Kingdom and Germany.<sup>24</sup> In recent years, Canada has been viewed as a champion of global mental health, with Grand Challenges Canada reportedly spending US\$42 million in 31 countries between 2011 and 2017.<sup>25</sup> However, the data from the Institute for Health Metrics and Evaluation for 2018 do not reflect significant spending. This may be because mental health is no longer a priority, or it may be because of any number of concerns with regard to classifying funds as DAMH. In any event, the governments of Canada, United Kingdom, and Australia have collectively founded the Alliance of Champions for Mental Health.<sup>26</sup>

Notwithstanding the funding from bilateral donors, the single largest source of DAMH is from private foundations, corporations, and campaigns. The Institute for Health Metrics and Evaluation estimates that total flows of financial investment into mental health services from all private sources amounted to US\$65.7 million in 2018.<sup>27</sup> Organizations such as the Wellcome Trust, Comic Relief UK, CBM International, Fondation d'Harcourt, the National Lottery Community Fund, the Novo Foundation, the Disability Rights Fund, the Catholic Overseas Development Agency, the Leonard Cheshire Disability Trust, and the Mariwala Health Initiative are funders of mental health and psychosocial services and research in developing countries (though their sizes and geographic scopes differ considerably).<sup>28</sup> Corporate sponsors of mental health-related services include Johnson and Johnson and Sanofi.<sup>29</sup> It is worth noting, however, that commentators and scholars have cautioned

that investment in mental health by pharmaceutical companies can be a source of substantial bias in terms of research outputs and even policy decisions, because of potentially profit-driven motives aimed at increasing market sizes for consumers of psychotropic medications.<sup>30</sup> Investment in develop-

ing countries by pharmaceutical corporations may therefore present many of the same challenges that have thus far been identified in developed-country settings, where policymaking related to mental health has, through strong and sustained lobbying, been heavily influenced by a biomedical model that

#### Box 1. Case studies for domestic mental health budgeting

##### New Zealand

In 2019, New Zealand made headlines by adopting the world's first "well-being budget," with one of its key priorities being to "take mental health seriously."<sup>\*</sup> This budget contained US\$1.2 billion for mental health services over the next five years. This is indeed a significant commitment, but in real terms represents a contribution of just 0.006% of GDP annually.<sup>†</sup> The well-being budget is of interest also because of its approach to holistic support for communities, paying attention to social protection and poverty reduction. It therefore seeks to address not only the biological determinants of well-being but also the social and economic determinants, an approach that has been shown to be increasingly necessary to undo the overmedicalization of mental health.<sup>‡</sup> The approach to mental health is somewhat progressive in that it supports mental health from various cultural perspectives, engaging with traditional Maori practitioners as well as medical practitioners. In addition, there is an emphasis on the prevention of serious or acute distress, seeking to support people at all points on the spectrum of symptoms in community health settings.<sup>§</sup> Nonetheless, the budget also seems to focus heavily on locating mental health services in clinics and substance abuse recovery facilities, and dedicates funds to the construction of new such facilities. It also emphasizes the role of clinicians over other non-medical interventions.<sup>\*\*</sup>

##### South Africa

The tragic deaths of 140 people during a maladministered process of deinstitutionalization in 2016 in South Africa (now commonly referred to as the "Esidemeni tragedy," named after the facility from which patients were discharged) brought to light more systemic concerns regarding the treatment of people with mental health conditions.<sup>††</sup> Widespread neglect of mental health services has since been uncovered. Despite the adoption of the National Mental Health Policy Framework in 2013, which requires parity between mental health and physical health services, spending on mental health services is estimated by the National Treasury to be roughly 2.6% of the national health budget.<sup>‡‡</sup> However, according to the National Department of Health, accurate data regarding resource allocation for mental health is difficult to obtain, as each province decides on its own allocations from the provincial health budget. Of South Africa's nine provinces, just two have fully costed and budgeted mental health plans.<sup>§§</sup> The South African Human Rights Commission has reported that none of the provinces is able to provide a detailed budget for mental health services and just one province is able to estimate funding for mental health services in primary health settings (primarily providing outpatient medical interventions), amounting to 19% of the total mental health budget.<sup>\*\*\*</sup> The largest allocation of resources is reserved for psychiatric institutions, which the National Treasury estimates at 5 billion rands, or 2.2% of the national health budget.<sup>†††</sup> Efforts to reform the national mental health system have been largely at a standstill since the Esidemeni tragedy unfolded, but South Africa is embarking on an ambitious universal health coverage project—the National Health Insurance—due to be completed in 2026.<sup>‡‡‡</sup> Mental health services are included in the National Health Insurance, but the allocation of resources and the actual quality and content of services remain unclear.

\* Government of New Zealand, The wellbeing budget (Wellington: Government of New Zealand, 2019). Available at <https://www.budget.govt.nz/budget/pdfs/wellbeing-budget/b19-wellbeing-budget.pdf>.

† Ibid.

‡ D. Puras, The role of the determinants of health in advancing the right to mental health, UN Doc. A/HRC/41/34 (2019).

§ Government of New Zealand, The wellbeing budget.

\*\* Ibid.

†† "Life Esidemeni case goes back to court," *Maverick Citizen* (September 19, 2019). Available at <https://www.dailymaverick.co.za/article/2019-09-19-life-esidemeni-case-goes-back-to-court>.

‡‡ South African Human Rights Commission, Report of the national hearing on the status of mental health care, March 2019 (Johannesburg: South African Human Rights Commission, 2019). Available at <https://www.sahrc.org.za/home/21/files/SAHRC%20Mental%20Health%20Report%20Final%2025032019.pdf>.

§§ Ibid.

\*\*\* Ibid.

††† Ibid.

‡‡‡ Personal communication with former official from the South African Department of Health, September 14, 2019.

favors the pharmaceutical industry.<sup>31</sup>

According to the Organization for Economic Cooperation and Development, the largest recipients of DAMH are in the Middle East and Africa. Countries where humanitarian emergencies are underway receive the largest amounts of funding, while other recipients reflect more “protracted” challenges. Figure 2 provides an overview of where DAMH funding flows are most commonly directed.

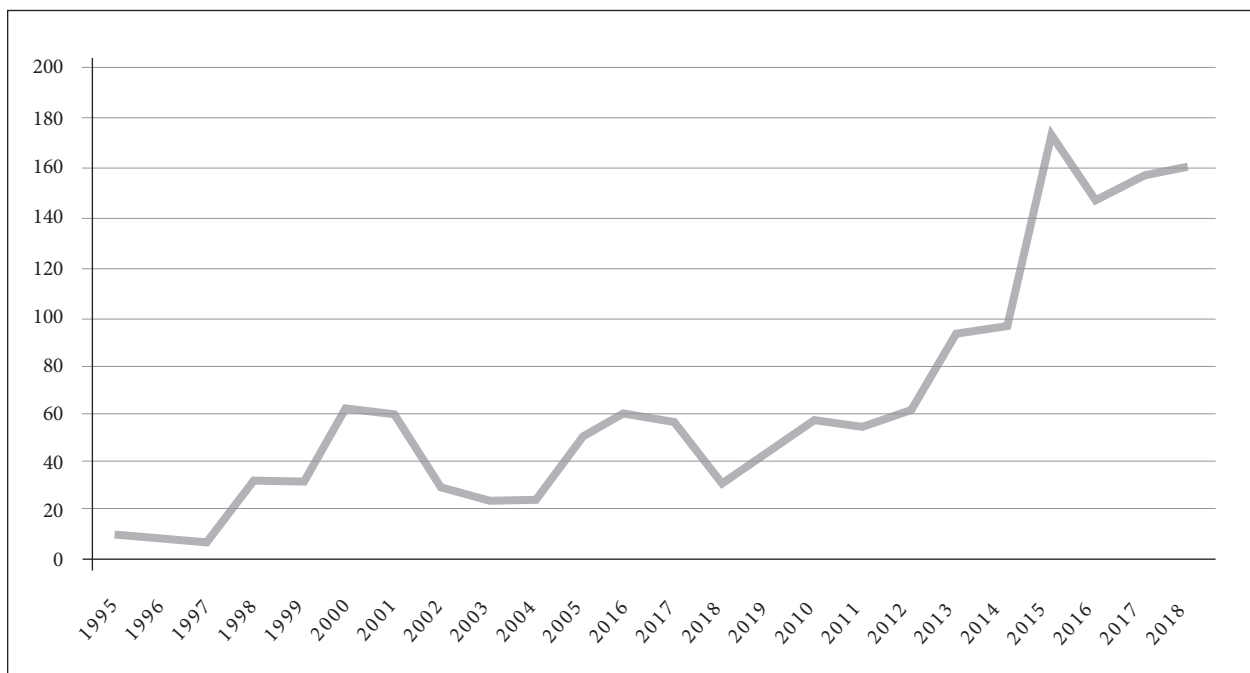
While there is limited and somewhat dubious data regarding flows of DAMH, to date, no report or database accurately captures the nature

of mental health funding or the interventions supported, leaving open the question of what the already-meager resources devoted to mental health and psychosocial support are actually promoting. Further research is urgently needed to examine the trends in this field not only with regard to aid flows but also with regard to the content of that aid.

### Current trends in global mental health

The lack of a sufficient response to mental health concerns around the world is perhaps best demon-

FIGURE 1. Total development assistance for mental health from all sources (in millions of US\$)



Source: Institute for Health Metrics and Evaluation

TABLE 1. Largest funders for mental health interventions globally (2018)

Australia	\$51,106
Bill and Melinda Gates Foundation	\$1.4 million
Canada	\$852,160
France	\$3.6 million
Germany	\$9.5 million
Other	\$29 million
United Nations	\$9.4 million
Private foundations and corporate donors	\$65.7 million
United Kingdom	\$13.1 million
United States	\$19.6 million

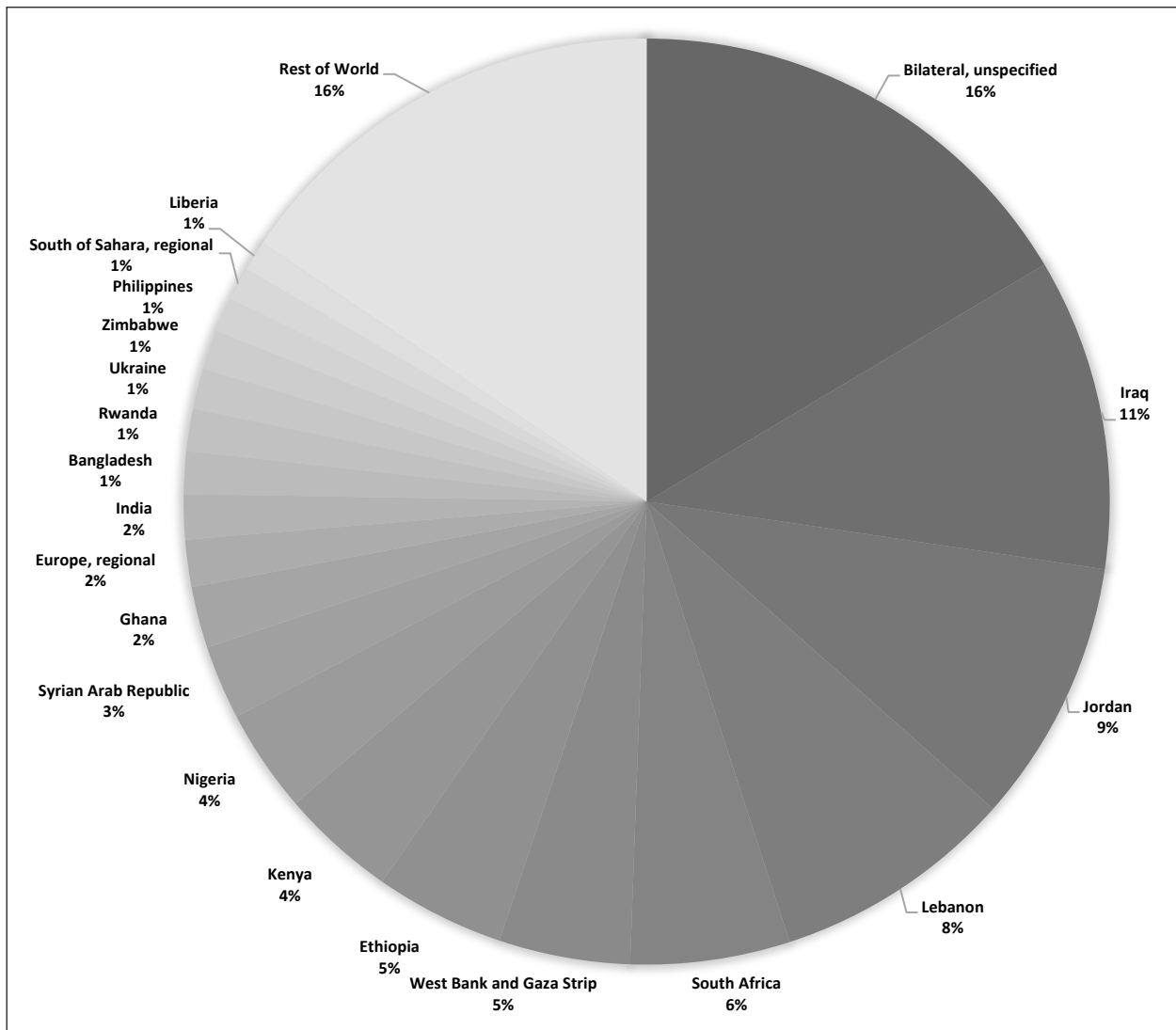
Source: Institute for Health Metrics and Evaluation

strated by the fact that large-scale health surveys such as the Global Burden of Disease list mental health conditions as some of the most prevalent “diseases” worldwide.<sup>32</sup> According to estimates, mental “disorders” will affect one in four people in their lifetime, and depression is considered the single-largest cause of disability in the world.<sup>33</sup>

There are inherent challenges with regard to the language and framing of mental health in instruments such as the Global Burden of Disease that proffer a “disease” model of mental health, that rely heavily on diagnostic criteria that are increasingly considered inadequate, and that view mental health

challenges as monolithic in terms of their effects on individuals (see further exploration of this subject below).<sup>34</sup> Notwithstanding these concerns, they do offer insight into the sheer lack of proportion between public health responses to physical health challenges and public health responses to mental health conditions, as well as the glaring unmet need for spending to promote mental health. The COVID-19 pandemic has also served to further highlight the substantial need for resourcing for mental health, as the public health crisis, social isolation, and economic hardship pose significant challenges for individual and community well-being.

FIGURE 2. Destinations for development assistance for mental health (2017)



Source: Organization for Economic Cooperation and Development Creditor Reporting System Database.

Efforts to counter the mental health “treatment gap” have been gaining momentum. In 2015, the UN adopted the 2030 Agenda for Sustainable Development, more commonly known as the Sustainable Development Goals, marking the first time that a major global development instrument included the promotion of mental health and well-being as an objective.<sup>35</sup> Commentators have also referred to the goal relating to the strengthening and prevention and treatment of substance abuse as a mental health-related goal, suggesting that the nexus between mental health and development had finally been acknowledged at an unprecedented level and scale.<sup>36</sup>

In 2016, the World Bank and WHO organized a conference entitled “Out of the Shadows: Making Mental Health a Global Development Priority,” which noted the need for improved financing for mental health to support efforts to close the “treatment gap.”<sup>37</sup> Similarly, the World Bank has noted the substantial developmental and economic costs of the “mental health burden,” highlighting the need to help states recognize the human capital-related costs of unattended mental health conditions.<sup>38</sup>

Substantive engagement around global mental health has also taken the form of a Lancet Commission on Mental Health and Sustainable Development, whose report was launched in 2018 at the First Global Ministerial Mental Health Summit.<sup>39</sup> Both of these initiatives have called for increased attention to mental health in global policy and financing spaces and have recognized the substantial need for states, particularly those where there is a lack of clinical treatment options, to address vast “treatment gaps.” As part of states’ commitments to the SDGs, monitoring will be undertaken under the auspices of Countdown Global Mental Health 2030. The initiative will focus on three domains for monitoring and accountability, namely mental health determinants, mental health system and service components, and mental health outcomes and risk protection.<sup>40</sup>

It is clear that momentum is building in the field of mental health, an important development given the abject exclusion of mental health care

and psychosocial support in health budgets and in international instruments. Indeed, the inclusion of language relating to mental health in the UN Political Declaration on Universal Health Coverage is seen as a major victory for many who have advocated strongly for mental health to not be ignored in discussions on universal health coverage.<sup>41</sup> Similarly, there is increasing recognition of the mental health implications of the COVID-19 pandemic, which suggests that more attention could—and should—be paid to mental health in future. As with current funding, however, the nature of interventions funded is an equally fundamental question as the level of resourcing available. This is the subject turned to next.

### Applying a human rights lens to global mental health and well-being and resource allocation

As noted, the largest proportion of financing for mental health in domestic health budgets is often devoted to supporting psychiatric institutions. Community-based mental health services are usually poorly funded, and the lack of coordination and governance means that non-financial resources and infrastructure are not forthcoming. Non-clinical interventions and interventions not rooted in the biomedical paradigm are still not the norm, meaning that the community-based services which are funded are focused on access to clinical treatment without focusing on the numerous non-biological determinants of mental health. With regard to DAMH, data relating to the content of what is funded are very limited, so it is virtually impossible to state accurately what is or is not supported.

Increasingly, evidence is emerging of approaches to mental health that are community oriented and not over-reliant on the biomedical disease model. These approaches have demonstrated utility in multiple contexts with varying cultural precepts and variable resource availability. Efforts to support people with lived experience of mental health challenges that align with human rights principles often incorporate peer support because



there is substantial benefit in engaging with peers with similar experiences, in developing communities that allow for connection and support, and in building self-efficacy rather than relying on the intervention of a clinician.<sup>42</sup> Similarly, rights-based approaches incorporate efforts to prevent coercion and to respect the right to legal capacity, focusing on supported decision-making and utilizing various measures such as the open dialogue approach, the circle of support model, and interlocutors such as the “personal ombudsman” or the “guarantor of personal autonomy.”<sup>43</sup> Their viability and efficacy is increasingly recognized, and their applicability in contexts as diverse as India, Sweden, and Costa Rica is indicative of their utility. Box 2 examines some models of mental health interventions that are respectful of human rights and that have demonstrated efficacy.

Recent efforts to close “treatment gaps” and to “scale up” access to treatment suggest that there is not sufficient emphasis on approaches to mental health and well-being dedicated to addressing the social, economic, political, and legal determinants of mental health.<sup>44</sup> Scholars are increasingly interested in a framing of “mental health and well-being” as opposed to mental health alone. This broader conception focuses not only on the “health” component of mental health but also on the numerous ways in which health interacts with other forms of well-being, such as economic, social, and cultural well-being.<sup>45</sup>

This conception remains somewhat underutilized, but it highlights the notion that mental health is intrinsically linked to numerous other factors at the individual and at community levels. Interventions that ascribe to such a framing are therefore concerned with recognizing these linkages and promoting all of these forms of well-being as matters of social justice. As noted by the UN Special Rapporteur on the right to health, mental health interventions should be geared primarily toward removing barriers to well-being.<sup>46</sup> Support for the realization of civil, political, economic, social, and cultural rights may thus be thought of as mental health interventions. This may require measures and initiatives that have not traditionally been seen as mental health programming, such as

actions focused on income generation, education and vocational training, legal support, and stigma reduction in family and community systems. Holistic approaches to well-being that recognize the person’s psychosocial health as a product of their interaction with their environment are thus prioritized over narrow biomedical thinking. This is highlighted by the current COVID-19 pandemic, wherein the public health challenges posed by the virus are mirrored by social isolation brought about by physical distancing and financial hardship brought about by economic inactivity. The mental health implications of these myriad concerns are not likely to be addressed through exclusively biomedical interventions and will instead require a more holistic focus on well-being.

The well-being approach suggests that a similar framing of mental health and well-being in budgets for national and international financing can also incorporate such a conception in their own allocations. Necessarily, what this calls for is a reorientation of policy to provide holistic and cross-cutting supports. This might be difficult for funders and policy makers to conceive of, as it suggests a far more substantial outlay of resources. However, it is possible that the opposite is true in that a well-being focus incorporates various social protection and social upliftment mechanisms in a way that is holistic rather than fragmented and bureaucratically challenging. Moreover, when weighed against the cost of investing in other methods with limited utility and often lacking in clinical validity, these investments in whole-person approaches may very well be more cost-effective.<sup>47</sup> Regardless of cost, states, bilateral funders, and others will need to recognize the human rights obligations that arise out of instruments such as the CRPD and ICESCR and appreciate that the mere provision of services, when those services do not promote social justice, does not constitute meeting those obligations. Box 3 highlights some organizational approaches to mental health and well-being that proffer a more holistic understanding of the relationship between mental well-being and economic, social, cultural, and political well-being.

## Increased attention being paid to financing mental health

As numerous new initiatives are taking shape to galvanize action to improve access to mental health

services globally, there have also been increasing efforts aimed at ensuring the financial viability of those efforts. A study commissioned by the Global Campaign for Mental Health published in June 2018 highlights numerous potential options for the devel-

### Box 2. Models of effective mental health interventions that are non-coercive and supportive of human rights

#### Circle of Care\*

In the city of Pune in India, the Babu Trust focuses a significant portion of its mental health interventions on the promotion of inclusion. Recognizing that stigma, discrimination, and social exclusion are important contributors to distress, and that opportunities for connection and community interaction are important, the circle of care model eschews the need for biomedical intervention and has substantial benefits not only for individuals but also for broader communities.

#### Open Dialogue<sup>†</sup>

Open Dialogue refers to a model that has been adapted in multiple contexts. The model originated in Western Lapland in Finland and then continued to develop elsewhere. Working with families and social networks, as much as possible in their own homes, open dialogue teams engage with people in crisis situations to provide support and stimulate dialogue regarding treatment options. As a result of the success of this model, it now constitutes the “normal” mental health approach in Western Lapland and receives direct funding from the national government. The region now has the best documented mental health outcomes in the Western world.<sup>‡</sup>

#### Friendship Bench<sup>§</sup>

Developed in Zimbabwe with the initial purpose of bridging the “treatment gap,” the friendship bench has gained international acclaim as a model that relies on peer supporters and lay workers to provide informal and easily accessible support to people experiencing mental health challenges. Anyone needing support can utilize the bench, located in their community. Friendship benches have been shown to be both effective and scalable, and their utility has led to replication in developed-country contexts such as the United States and Canada.<sup>\*\*</sup>

#### Soteria<sup>††</sup>

Soteria houses were first developed in California in the United States. The model uses the principles of recovery, safety, and community to reduce distress and to build social networks within mental health residential facilities. Restraints are not used, even during periods of “acute psychosis,” and antipsychotic medication is rarely utilized. The Soteria model has been shown to have equal or better outcomes than traditional biomedically oriented approaches to schizophrenia spectrum conditions.<sup>‡‡</sup>

#### Hearing Voices Networks<sup>§§</sup>

Hearing voices networks are peer support mechanisms that eschew biomedical interventions in favor of experiential and peer-oriented processes aimed at recovery, while also recognizing the value of what are typically referred to as “hallucinations.” With numerous networks in more than 20 countries, this approach has shown to have positive clinical outcomes.<sup>\*\*\*</sup>

\* B. V. Davar, “Social inclusion of persons with psychosocial disabilities: Babu Trust experiences” (paper presented at the Department of Psychology, University of Allahabad, Seminar on Social Exclusion and Mental Health, September 21–22, 2014). Available at [https://www.academia.edu/8404515/Social\\_Inclusion\\_of\\_persons\\_with\\_psychosocial\\_disabilities\\_Babu\\_Trust\\_Experiences](https://www.academia.edu/8404515/Social_Inclusion_of_persons_with_psychosocial_disabilities_Babu_Trust_Experiences).

† Open Dialogue, Open Dialogue: An international community. Available at <http://open-dialogue.net>.

‡ R. Whitaker, *Anatomy of an epidemic* (New York: Crown Publishing Group, 2010).

§ Friendship Bench, Creating safe spaces to talk. Available at <https://www.friendshipbenchzimbabwe.org>.

\*\* T. Rosenberg, “Depressed? Here’s a bench. Talk to me,” *New York Times* (July 22, 2019). Available at <https://www.nytimes.com/2019/07/22/opinion/depressed-heres-a-bench-talk-to-me.html>; Strategic Group, Riaz Mamdani unveils first public Friendship Bench in Canada. Available at <https://www.strategicgroup.ca/news/riaz-mamdani-unveils-first-public-friendship-bench-in-canada>.

†† T. Calton, M. Ferriter, N. Huband, and H. Spandler, “A systematic review of the Soteria paradigm for the treatment of people diagnosed with schizophrenia,” *Schizophrenia Bulletin* 31/4 (2008), pp. 181–192.

‡‡ Ibid.

§§ Intervoice, The International Hearing Voices Network. Available at <https://www.intervoiconline.org>.

\*\*\* J. Dillon and G. A. Hornstein, “Hearing voices peer support groups: A powerful alternative for people in distress,” *Psychosis* 5/3 (2013), pp. 286–295.

opment of funding mechanisms for mental health.<sup>48</sup> These include “innovative funding” mechanisms derived from multiple sources, along with an international financing facility, an international capital account, and a global mental health giving pledge.

Similarly, a 2019 article published in *Lancet Psychiatry* calls for a “partnership for transforming mental health globally,” stating that

*the Sustainable Development Goals and the Universal Health Coverage agenda provide new impetus for the global mental health field ... Established networks, such as the Movement for Global Mental Health and the Mental Health Innovation Network, and emerging efforts such as the Global Campaign for Mental Health offer the foundations of a partnership and indicate that the time is ripe for establishing a multipolar*

*and inclusive partnership to address the challenge of financing a global scale-up of mental health services<sup>49</sup>*

The article explores several options for the development of a global funding mechanism for mental health, including a public-private partnership model akin to the Global Fund to Fight AIDS, Tuberculosis and Malaria and a mechanism located in the World Bank, modeled on the Global Financing Facility. These discussions are indicative of a growing momentum around the need for a global entity that will direct funding toward mental health services.

An emphasis on well-being in a broader sense (that is, apart from a purely health orientation) is somewhat absent in these discussions, suggesting

### Box 3. Organizational approaches to mental health and well-being that support human rights

#### Basic Needs\*

Basic Needs combines health, socioeconomic, and community-oriented solutions to support people with mental health challenges. The organization's goal is to combine effective and affordable mental health services with livelihoods approaches in order to address some of the root causes of distress, namely social exclusion, poverty, and lack of access to opportunities. To date, Basic Needs has supported over 600,000 people with mental health challenges in low- and middle-income countries in Africa and Asia.

#### The Banyan†

The Banyan is a psychosocial support organization located in three states in India. It provides emergency and acute medical, psychiatric, psychological, and social care through street-based services, hospital settings, shelter-based services, community-based outpatient care, and inclusive long-term care options for persons with high-support needs. The Banyan's community-based work includes interventions to address the determinants of distress, including social exclusion, poverty, and homelessness. The organization conducts training, peer support, and outreach activities in addition to clinical interventions.

#### Kamili Mental Health Organization‡

Kamili provides free community-based mental health services across Kenya. In addition to providing clinical services, the organization conducts educational and awareness-raising activities. Kamili also engages with service users to support microenterprises and micro-loans in an effort to reduce the contribution of economic hardship to mental distress.

#### La Collina Social Cooperative§

La Collina Social Cooperative is part of the Italian social protection system, whose development followed the dismantling of the county's institution-based mental health infrastructure in the 1970s. The cooperative system focuses on community integration through employment and the development of social enterprise. Based in Trieste, La Collina Social Cooperative employs people with lived experience of mental health challenges to work in various industries, such as hospitality, tourism, and business administration. By addressing barriers to social inclusion and promoting self-efficacy, this model has been shown to lead to significantly improved outcomes.

\* Basic Needs, What we do. Available at <http://www.basicneeds.org/what-we-do/>.

† Banyan, About us. Available at <https://thebanyan.org/aboutus>.

‡ Kamili Organization, About us. Available at <https://www.kamilimentalhealth.org/copy-of-about-us>.

§ La Collina Social Cooperative, Social inclusion. Available at <https://www.lacollina.org/presentazione-inserimento-lavorativo.html>.

that any envisaged mechanism might not pay sufficient attention to the numerous determinants of mental health and well-being. For advocates of a well-being approach, this represents a significant opportunity to engage with the conception and framing of mental health and well-being as a social justice consideration and as a product of social, economic, cultural, and political factors.

Additionally, it is important to note that global health financing has been the subject of criticism on human rights grounds in the past, suggesting that any form of consolidated funding mechanism for mental health will need to consider these critiques, or indeed, consider whether such a mechanism is desirable at all. One such criticism has centered on the absence of the participation of affected individuals and communities—particularly those in the Global South—in decision-making spaces.<sup>50</sup> Participatory decision-making in the planning of health funding mechanisms, and the mainstreaming of mental health and well-being into existing mechanisms, can be a useful tool to recognize the cross-cutting nature of mental health and well-being and the importance of a plurality of approaches to address underfunding and underprioritization. Multiple funding mechanisms and institutional frameworks have the potential to support such plurality, but these can be bureaucratically burdensome, so the harmonization of such mechanisms and locally driven governance and oversight measures can enhance effectiveness.

Where new mechanisms are instituted, it is also necessary to consider some of the critiques of the “rights approaches” of existing global funding mechanisms in the health field that have over-emphasized the input of large civil society bodies over that of smaller organizations which more directly represent communities.<sup>51</sup> Similarly, tokenistic approaches that merely utilize civil society organizations as implementers of projects without recognizing their value as custodians of accountability have also been critiqued.<sup>52</sup> Donor conditionality that is removed from local context and therefore lacks an understanding of social, cultural, and political factors is an additional challenge, and one that can be mitigated through increased

flexibility and direct transfers.<sup>53</sup> This then requires some reflection as to whether such direct bilateral funding ought to be the preferred approach, and the perspectives of advocates and people with lived experience of mental health challenges can add substantial value to such deliberations.

It should be noted that while there is strong momentum around the development of a financing facility for mental health, the obligations arising out of the CRPD and ICESCR recognize that states have a responsibility to maximize their own ability to cater to the needs of their inhabitants. Therefore, global impetus can also be galvanized to support states to do so, through measures such as progressive taxation, debt restructuring and cancellation, and technical assistance.<sup>54</sup> These mechanisms lend themselves to similar critiques regarding stakeholder participation, local knowledge prioritization, and civil society governance and accountability mechanisms.<sup>55</sup> Addressing these concerns is vital if financing is to be human rights focused.

The strong impetus around mental health in numerous global spaces is indeed quite promising and may well represent a considerable shift from the neglect that has plagued mental health systems around the world for so long. Even so, there are some important questions relating to whether rhetoric is actually matched by financial commitment, particularly as the public health agenda is dominated by the COVID-19 pandemic. Additionally, this moment is illustrative of the fact that an approach to mental health that does not take into account social, economic, and political factors is likely to recapitulate many of the criticisms that have been leveled at mental health systems in the past and is likely to undermine efforts to address the numerous challenges that individuals and communities are facing. Pandemic response funding should recognize the significance of mental health and well-being and avoid redirecting mental health funding to other priorities. This would be counterproductive for societal well-being and contrary to the obligation to promote and protect the right to the highest attainable standard of physical and mental health.

## Conclusion

The underprioritization of mental health and well-being is a global problem that spans domestic investment and international development assistance. This is compounded by a significant lack of accurate data on spending and resource allocation. What little data there is suggests that spending on mental health continues to emphasize institution-based services, despite guidance from bodies, including WHO, that speaks to the need for community-based services, and despite the assertion of the right to life in the community in the CRPD. National budgeting for mental health is complex and requires accurate data capturing and the implementation of existing calls for parity. Moreover, it requires a reorientation from a framing of mental health as a purely public health concern to one that recognizes the ways in which well-being is affected by access to livelihoods, freedom from discrimination, belonging in a community, and numerous other factors. This offers the potential to utilize resources more holistically and to make decisions that do not see health as separate from, for example, social protection or education. Increased oversight of national-level resource allocation should be a fixture in all countries, and the involvement of people with lived experience in decision-making is an essential addition.

Similar concerns abound with regard to DAMH. At present, there is very little governance or oversight of international funding for mental health and well-being, and the perspectives of people with lived experience of mental health challenges seem to be absent in decision-making settings.<sup>56</sup> Likewise, additional data regarding DAMH would be useful, particularly in relation to the nature of the efforts funded. Research and advocacy around DAMH funding flows can substantially alter the way in which investments in mental health and well-being are made, and efforts to engage with the subject of holistic models of financing that are contextually relevant and participatory in nature can be of substantial value. These considerations should take into account the numerous critiques of international health financing mechanisms, many of which have created hierarchies of participation,

have institutionalized conditionality, and have at times resulted in ineffective and inefficient delivery.

While it is encouraging to see the shifts evident in global decision-making spaces with regard to investment in mental health, this also presents substantial dangers if coercive and stigmatizing practices are to be “scaled up” in an effort to close “treatment gaps” without any emphasis on the numerous social, economic, political, legal, and cultural determinants of mental distress and mental well-being. This is particularly worrying as indications of profit-motivated interests determining mental health policy are increasingly being uncovered. However, as demonstrated above, there are numerous interventions and models of support that do not simply replicate institution-based and coercive practices, that do not recapitulate Western-oriented or Global North-developed practices in the Global South, and that do not promote a narrow biomedical framing of mental health. Supporting these models can significantly alter the way that all social support services are delivered, but it can do more than that. It can also reverse the stigmatization of people with lived experience of mental health challenges by shifting the disease framing that contributes to their marginalization.<sup>57</sup> Rights-based approaches—which engage with the social, economic, cultural, and political determinants of mental health and well-being—are both effective and necessary, and a strong evidence base is developing to demonstrate their utility and their applicability. Arguably, these approaches are rendered even more relevant and necessary in the current context, in which the COVID-19 pandemic is having a substantial impact not only on physical and biological well-being but also on social and economic well-being.

This moment represents a truly singular opportunity for advocates and policy makers. The momentum that is building around mental health can be an unparalleled catalyst for change. In addressing the barriers to mental health and well-being, a focus on social, economic, political and legal factors can be substantially helpful. The recognition of the mental health implications of the COVID-19 pandemic demonstrates a need for

investment in holistic approaches to well-being if these implications are to be effectively addressed, and it requires that financing for mental health and well-being not be rendered “secondary” to other funding needs if the right to the highest attainable standard of physical and mental health is to be realized. In keeping with the principle of participation as enshrined in the CRPD, the voices of those affected must be centralized in policymaking and resource allocation decisions. Addressing the various biological, social, economic, cultural, and political determinants of mental health and well-being admittedly requires substantial investment, beyond even the increases that are already being seen. Even so, it is clear that there is both an obligation and a need for increased attention and increased funding for the promotion and protection of mental health. Perhaps more pointedly, there is an urgent need for attention and resourcing for the promotion and protection of well-being.

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