



## ***Mental health among displaced people and refugees: Making the case for action at the World Bank Group***

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**Washington, D.C.**

**December 8, 2016**

# *Mental health among displaced people and refugees: Making the case for action at the World Bank Group*

*“Every day, millions of men, women and children around the world are burdened by mental illness. Yet mental health too often remains in the shadows, as a result of stigma and a lack of understanding, resources and services.*

*Two decades ago, we faced a similar situation with HIV and AIDS. People affected by AIDS faced severe stigma and there was a widespread failure of policymakers to acknowledge or address the growing number of people dying in the world – especially in Africa – from the lack of access to affordable treatment. It was unjust, it was wrong, and it was unleashing a health and development catastrophe. So a group of us decided to raise our voices and bring HIV and AIDS out of the shadows and we demanded action.*

*Today, we are here to bring mental health into the spotlight and squarely on the global development agenda where it belongs.”*

*Jim Yong Kim, President, World Bank Group*

*High Level Opening Panel*

*“Out of the Shadows: Making Mental Health a Global Development Priority”*

*Flagship Event at 2016 IMF/WBG Spring Meetings*

*Washington D.C., April 13-14, 2016*

## *1. The Challenge*

The current crisis of forced displacement is posing serious humanitarian and development challenges across the world which the World Bank and the international community-at-large cannot ignore given their scale and complexity. As documented in a recent World Bank report,<sup>1</sup> about 65 million people – one percent of the world’s population – live in forced displacement and extreme poverty. **As differing from economic migrants who move in search of better opportunities and those affected by natural disasters, the forcibly displaced, both refugees and asylum-seekers (about 24 million people), and internally displaced persons (about 41 million people), are fleeing conflict and violence.** These are the highest numbers since World War II.

Host countries often already have limited resources and the refugee influx can quickly overwhelm existing capacities including health, social, housing and educational systems and services. Inflows

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<sup>1</sup> “World Bank. 2016. Forcibly Displaced: Toward a Development Approach Supporting Refugees, the Internally Displaced, and Their Hosts. Washington, DC: World Bank. © World Bank.  
<https://openknowledge.worldbank.org/handle/10986/25016> License: CC BY 3.0 IGO.”

of displaced people can also cause social and economic challenges and disruptions to host communities. **However refugees can also bring skills, expertise and labor that can benefit communities in the longer term.**

As advocated in the report, reducing vulnerabilities of the forcibly displaced during a crisis and helping rebuild their lives and contributing to their communities in the medium term, while mitigating the impact on governments and host communities, can be supported by the international community. It requires adequate effort and effective collective action to support economic activity, job creation, and social cohesion, as well as to strengthen and expand health and education services, and housing and environmental services.

## **2. Mental Disorders: A Global “Invisible Burden”**

Mental, neurological and substance use disorders (MNS), often an “invisible” or “hidden” problem, contribute to a significant proportion of disease burden, and an increasing obstacle to development in countries around the world.<sup>2 3</sup> MNS disorders, which are a heterogeneous range of disorders that owe their origin to a complex array of genetic, biological, psychological, and social factors, often run a chronic course, are highly disabling, and are associated with significant premature mortality.<sup>4</sup> MNS disorders have their onset across the life course and include epilepsy, anxiety disorders, autism, and intellectual disability in childhood; migraine, depression, psychotic disorders (schizophrenia and bipolar disorders), illicit drug use, and alcohol use disorders in adolescence and young adulthood; and dementia late in life.

According to a recent report<sup>5</sup>, there was a 41 percent increase in absolute disability-adjusted life years (DALYs) caused by MNS disorders between 1990 and 2010, from 182 million to 258 million DALYs (the proportion of global disease burden increased from 7.3 to 10.4 percent). With the exception of substance use disorders, which increased because of changes in prevalence over time, this increase was largely caused by population growth and aging. The report also indicates that MNS disorders were in 2010 the leading cause of years lived with disability (YLDs) in the world. In 2010, DALYs for MNS disorders were highest during early to mid-adulthood, explaining 18.6 percent of total DALYs for individuals aged 15 to 49 years, compared with 10.4 percent for all ages combined. Within the 15 to 49 years age group, mental and substance use disorders were the leading contributor to the total burden caused by MNS disorders. For neurological disorders,

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<sup>2</sup>Marquez, P.V. (2015). “Shining a light on mental illness: An “invisible disability”?” The World Bank Blogs, December 2, 2015. Available at <http://blogs.worldbank.org/health/shining-light-mental-illness-invisible-disability>; Evans, T, Marquez, P.V., and Saxena, S. (2015). “The zero hour for mental health.” The World Bank Blogs, May 4, 2015. Available at <http://blogs.worldbank.org/health/zero-hour-mental-health>.

<sup>3</sup> Mnookin S., et al. Out of the shadows: making mental health a global development priority report. Geneva: World Bank Group and World Health Organization, 2016. Available at: <http://documents.worldbank.org/curated/en/270131468187759113/Out-of-the-shadows-making-mental-health-a-global-development-priority>.

<sup>4</sup> Patel V, Chisholm D, Parikh R, Charlson FJ, Degenhardt L, Dua T, et al. “Addressing the burden of mental, neurological, and substance use disorders: key messages from Disease Control Priorities, 3rd edition”. The Lancet. Published online 8 October 2015.

<sup>5</sup> “Patel, Vikram; Chisholm, Dan; Dua, Tarun; Laxminarayan, Ramanan; Medina-Mora, Maria Elena. 2016. Disease Control Priorities, Third Edition : Volume 4. Mental, Neurological, and Substance Use Disorders. Disease Control Priorities;. Washington, DC: World Bank. © World Bank. <https://openknowledge.worldbank.org/handle/10986/23832> License: CC BY 3.0 IGO.”

DALYs were highest in the elderly. Overall, males accounted for 48.1% and females for 51.9% of DALYs for MNS disorders. The relative proportion of DALYs for MNS disorders to overall disease burden was estimated to be 1.6 times higher in HICs (15.5% of total DALYs) than in LMICs (9.4% of total DALYs), largely because of the relatively higher burden of other health conditions, such as infectious and perinatal diseases, in LMICs. However, because of the larger population of LMICs, the report noted that absolute DALYs for MNS disorders are higher in LMICs compared with HICs.

The 2015 Global Burden of Disease (GBD) studies also confirm the large contribution of mental and substance use disorders to global disability: depressive disorders and anxiety disorders are among the leading 10 causes of global years lived with disability (YLDs) for both sexes combined ((ranked 4<sup>th</sup> and 8<sup>th</sup>, respectively) <sup>6</sup>, and among the leading 30 causes of global disability adjusted life years (DALYs) for both sexes combined (ranked 15<sup>th</sup> and 28<sup>th</sup>, respectively).<sup>7 8</sup> Suicide, which is frequently caused by mental disorders, also exacts an enormous toll on society: In India, it has overtaken complications from pregnancy and childbirth as the leading cause of death among women aged 15 to 49.<sup>9</sup>

**There is also a comorbidity and a notable link between mental disorders and costly, chronic medical conditions**, including cancer, cardiovascular disease, diabetes, HIV, and obesity, as well as a host of risky behaviors.<sup>10</sup> Worsened by low levels of investment and effective treatment coverage, mental disorders have serious economic consequences and may limit the potential impact or effectiveness of development assistance. Those with mental disorders are more likely to engage in unhealthy lifestyle behaviors such as smoking, alcohol use, poor nutrition and lack of physical activity. Mental disorders greatly increase the risk of a person developing another chronic disease,<sup>11</sup> and are associated with reduced health care seeking and less compliance with medical regimens. At the same time those suffering from chronic diseases are also more likely to develop mental health problems. Therefore, it is clear that mental disorders are closely linked with physical

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<sup>6</sup> GBD 2015 Disease and Injury Incidence and Prevalence Collaborators. (2016). "Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries, 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015." *Lancet* 388: 1545–602.

<sup>7</sup> GBD 2015 DALYs and HALE Collaborators. "Global, regional, and national disability-adjusted life-years (DALYs) for 315 diseases and injuries and healthy life expectancy (HALE), 1990–2015: a systematic analysis for the Global Burden of Disease Study 2015". *Lancet* 388: 1603–58.

<sup>8</sup> The 2015 GBD Study uses the disability adjusted life-year (DALY), combining years of life lost (YLLs) due to mortality and years lived with disability (YLDs) in a single metric. One DALY can be thought of as one lost year of healthy life.

<sup>9</sup> Patel, V., et al. (2012). "Suicide mortality in India: a nationally representative survey." *Lancet* 2012; 379:2343-51.

<sup>10</sup> See for example, Sorel, E. (2016). "Depression and Comorbidity in Primary Care in China, India, Iran, Romania". *International Medical Journal* Vol. 23, No. 2, pp. 118.

Iran, Romania

<sup>11</sup> Bloom, D.E., et al. (2011). Marquez, P. and J. Farrington (2013). "The challenge of non-communicable diseases and road traffic injuries in Sub-Saharan Africa: an overview." Washington DC: World Bank. Available at <http://documents.worldbank.org/curated/en/2013/06/17997739/challenge-non-communicablediseases-road-traffic-injuries-sub-saharan-africa-overview>.

health and affect both a significant portion of the population and disproportionate numbers of the vulnerable and the underserved.

As noted in the World Health Organization (WHO)'s "Mental Health Action Plan 2013-2020,"<sup>12</sup> homelessness and inappropriate incarceration are far more common for people with mental disorders than for the general population, and this tends to exacerbate their marginalization and vulnerability.

### ***3. The Economic and Social Impact of Mental Disorders***

**Not only do mental disorders represent a significant disease burden, it is also very costly to country economies.** The global cost of mental disorders was estimated to be approximately \$2.5 trillion in 2010; by 2030, that figure is projected to go up by 240 percent, to \$6 trillion.<sup>13</sup> In 2010, 54 percent of that burden was borne by low- and middle-income countries (LMICs); by 2030, the proportion is projected to reach 58 percent.

**Studies done in high-income countries have found that the costs associated with mental disorders total between 2.3 and 4.4 percent of gross domestic product (GDP).**<sup>14</sup> The overwhelming majority (roughly two-thirds) of those costs are indirect ones associated with the loss of productivity and income due to disability or death.

**Spending on mental health can be one the highest areas of health expenditure,** representing between 5% and 18% of total health expenditures for a selection of countries able to break down total spending (Germany, Hungary, Korea, the Netherlands and Slovenia). While these figures can point to high spending for mental health, it may still not be commensurate to the high prevalence and burden of disease represented by mental ill-health. The proportion of total public health expenditure allocated to mental health care is often very small. For example, mental disorders is responsible for 23% of England's total burden of disease, but receives 13% of National Health Service health expenditures.

**The indirect costs of mental health** – the economic consequences attributable to disease, illness, or injury resulting in lost resources, but which do not involve direct payments related to the disease – are particularly high. This includes the value of lost production due to unemployment, absences from work, presentism (the loss in productivity that occurs when employees come to work even when unwell and consequently function at less than full capacity) or premature mortality.

### ***4. Mental Health of Displaced Populations and Refugees***

**Traditionally the refugee experience is divided into three categories: preflight, flight, and resettlement.**<sup>15</sup> The **preflight phase** may include, for example, losses of family members,

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<sup>12</sup> WHO. (2013). Mental Health Action Plan 2013-2020. WHO, Geneva.

<sup>13</sup> Bloom DE, Cafiero E, Jané-Llopis E, et al. The global economic burden of noncommunicable diseases. Geneva: World Economic Forum, 2011.

<sup>14</sup> Hewlett, E. and Moran, V. (2014). Making Mental Health Count: The Social and Economic Costs of Neglecting Mental Health Care. OECD Health Policy Studies, OECD Publishing.

<sup>15</sup> Different studies cited at Refugee Health Technical Assistance Center (<http://refugeehealthta.org/physical-mental-health/mental-health/>): include: Birman, D, Beehler, S, Harris, E et al. 2008. "International family, adult, and

livelihoods, and belongings paired with possibly physical and emotional trauma to the individual or family, the witnessing of murder, and social upheaval. Adolescents may also have participated in violence, voluntarily or not, as child soldiers or militants. **Flight** involves an uncertain journey from the host country to the resettlement site and may involve arduous travel, refugee camps, and/or detention centers, often involving further losses and traumatic stressors. Children and adolescents are often separated from their families and at the mercy of others for care and protection. **The resettlement process** includes challenges such as the loss of culture, community, and language as well as the need to adapt to a new and foreign environment. Children often straddle the old and new cultures as they learn new languages and cultural norms more quickly than their elders. All of these experiences may play a role in the acquisition of, or protection from mental health conditions in each individual within a refugee population.

**Mental disorders can be triggered by extreme adversity, such as massive displacement.** Conflict exposes displaced populations and refugees to violence and high levels of stress,<sup>16</sup> causing dramatic rises in mental illness that can continue for decades after armed conflict has ceased, as documented in different studies.<sup>17</sup> Armed conflict and violence disrupt social support structures and expose civilian populations to high levels of stress. Consistent with the findings of earlier Global Burden of Disease (GBD) studies, GBD 2015<sup>18</sup> confirmed the large contribution of mental and substance use disorders to global disability, and a positive association between conflict and depression and anxiety disorders.

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child enhancement services (FACES): a community-based comprehensive services model for refugee children in resettlement." *Am J Orthopsychiatry* 78(1): 121-32. 4; Carswell, K, Blackburn, P, Barker, C. 2011. "The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers." *Int J Soc Psychiatry* 57: 1007; Lustig, S, Kia-Keating, M, Kight, W et al. 2004. "Review of child and adolescent refugee mental health." *J Am Acad Child Adolesc Psychiatry*; 43(1): 24-36; 4. Murray, K, Davidson, G, Schweitzer, R. 2010. "Review of refugee mental health interventions following resettlement: best practices and recommendations. *Am J Orthopsychiatry* 80(4): 576-85.

<sup>16</sup> Mnookin S., et al. (2016) above, and Sorel, E.R., et al. (2005) "Populations' Mental Health in Post Conflict Contexts." *Advances in Psychiatry Second Volume* (2005): 163.

<sup>17</sup> Mnookin S., et al.(2016), and Bolton, P., et al. (2002): "Prevalence of depression in rural Rwanda based on symptom and functional criteria." *The Journal of Nervous and Mental Disease* 190, no. 9:631-637; Chung, R. and M. Kagawa-Singer (1993). "Predictors of psychological distress among Southeast Asian refugees." *Social Science & Medicine* 36, no. 5: 631-639; De Jong, J., et al. (2001). "Lifetime events and posttraumatic stress disorder in 4 post conflict settings." *JAMA* 286, no. 5:555-562; De Jong, J., et al. (2003) "Common mental disorders in post conflict settings." *Lancet* 361, no. 9375:2128-2130; Dubois, V., et al. (2004). "Household survey of psychiatric morbidity in Cambodia." *International Journal of Social Psychiatry* 50, no. 2: 174-185; Karam, E.G., et al. (2008). "Lifetime prevalence of mental disorders in Lebanon: first onset, treatment, and exposure to war." *PLOS Medicine* 5, no. 4:e61; Mollica, R.F., et al. (1997) "Effects of war trauma on Cambodian refugee adolescents' functional health and mental health status." *Journal of the American Academy of Child & Adolescent Psychiatry* 36, no. 8:1098-1106; Mollica, R.F., et al. (2004). "Mental health in complex emergencies." *Lancet* 364, no. 9450:2058-2067; Pham, P.N, et al. (2004). "Trauma and PTSD symptoms in Rwanda: implications for attitudes toward justice and reconciliation." *JAMA* 292, no. 5: 602-612; Silove, D., et al. (2008) "Estimating clinically relevant mental disorders in a rural and an urban setting in post-conflict Timor Leste." *Archives of General Psychiatry* 65, no. 10:1205-1212.

<sup>18</sup>GBD 2015 Disease and Injury Incidence and Prevalence Collaborators. 2016. "Global, regional, and national incidence, prevalence, and years lived with disability for 310 diseases and injuries,1990–2015: a systematic analysis for the Global Burden of Disease Study 2015." *Lancet* 388: 1545–602.

While most of those exposed to emergencies suffer some form of psychological distress, **accumulated evidence<sup>19</sup> shows that the prevalence common mental disorders such as depression, anxiety, and post-traumatic stress disorders (PTSD), increase from a baseline of 10% to 15-20% among crisis-affected populations while severe mental disorders, such as psychosis or debilitating depression and anxiety can increase from 1-2% to 3-4%.** Such mental health problems have especially severe consequences in humanitarian settings where they affect the ability of affected populations to function and survive.

**The more common mental health diagnoses associated with refugee populations are emotional disorders, such as depressive and anxiety disorders, including post-traumatic stress disorder (PTSD), generalized anxiety, panic attacks, adjustment disorder, and somatization.**<sup>20</sup> The incidence of disorders varies with different populations and their experiences. Different studies have shown rates of PTSD and major depression in settled refugees to range from 10-40% and 5-15%, respectively. Children and adolescents often have higher prevalence with various investigations revealing rates of PTSD from 50-90% and major depression from 6-40%. Risk factors for the development of mental health problems include the number of traumas, delayed asylum application process, detention, and the loss of culture and support systems. On the other hand, protective factors include a supportive environment where affected populations can access basic needs, maintain or form new social connections and relationships and are supported in pursuing educational and economic opportunities.

If not effectively addressed, the long-term mental health and psychosocial well-being of the displaced population and refugees may be affected. Many Cambodians, for example, continue to suffer mental disorder and poor health almost four decades after the Khmer Rouge-led genocide of the late 1970s.<sup>21</sup>

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<sup>19</sup> WHO & UNHCR. 2012. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO ([http://www.who.int/mental\\_health/resources/toolkit\\_mh\\_emergencies/en/](http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/)); WHO & UNHCR. 2015. mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO ([http://www.who.int/mental\\_health/publications/mhgap\\_hig/en/](http://www.who.int/mental_health/publications/mhgap_hig/en/)); WHO, UNICEF, UNFPA, UNHCR, & UN Action. MHPSS for conflict-related sexual violence: 10 myths. WHO: Geneva ([http://www.who.int/reproductivehealth/publications/violence/rhr12\\_17/en/](http://www.who.int/reproductivehealth/publications/violence/rhr12_17/en/)).

<sup>20</sup> Different studies cited at Refugee Health Technical Assistance Center (<http://refugeehealthta.org/physical-mental-health/mental-health/>): include: Birman, D, Beehler, S, Harris, E et al. 2008. "International family, adult, and child enhancement services (FACES): a community-based comprehensive services model for refugee children in resettlement." *Am J Orthopsychiatry* 78(1): 121-32. 4; Carswell, K, Blackburn, P, Barker, C. 2011. "The relationship between trauma, post-migration problems and the psychological well-being of refugees and asylum seekers." *Int J Soc Psychiatry* 57: 1007; Lustig, S, Kia-Keating, M, Kight, W et al. 2004. "Review of child and adolescent refugee mental health." *J Am Acad Child Adolesc Psychiatry*; 43(1): 24-36; 4. Murray, K, Davidson, G, Schweitzer, R. 2010. "Review of refugee mental health interventions following resettlement: best practices and recommendations. *Am J Orthopsychiatry* 80(4): 576-85.

<sup>21</sup> Mollica, R.F., et al. (2014) "The enduring mental health impact of mass violence: A community comparison study of Cambodian civilians living in Cambodia and Thailand." *International Journal of Social Psychiatry* 60, no. 1:6-20.

## ***5. How to address mental health needs in conflict-and post-conflict-related situations?***

**Mental health is an integral part of health, but has received inadequate attention by health care planners and also by society in general across the world.** Despite its enormous social burden, mental disorders continue to be driven into the shadows by stigma, prejudice, fear of disclosing an affliction because a job may be lost, social standing ruined, or simply because health and social support services are not available or are out of reach for the afflicted and their families. A vast majority of low and middle income countries allocate less than 1% of their health budgets for mental health.

Mental disorders tend to be more acute and often unattended in conflict-and-post-conflict situations where vast segments of the population have lived through long periods of armed conflict and ethnic confrontations.<sup>22</sup> Many have been the subject of harassment, sexual abuse and rape, incarceration, and torture.

**Most countries are ill-equipped to deal with this “invisible” and often-ignored challenge – which is amplified by the growing conflict and the refugee crisis in the Middle East and other parts of the world.** Communities living in these contexts require a range of psychosocial support and mental health services. Refugees and displaced population often face significant barriers in accessing quality mental health services including lack of knowledge about available services, lack of transport to services which are often centralized in major cities, language and cultural barriers between refugees and service providers as well as limited follow up supports.

Addressing mental health needs is critical in times of crises, and recovery, in addition to sustainable development. It is important to note, however, that useful examples exist of how disaster and emergency contexts have successfully been used to make substantial and sustainable improvements in mental health systems in low- and middle-income countries.<sup>23</sup>

Humanitarian program designers need to be conscious that displaced people not only had experienced traumatic events, but also have lost much of their assets and risk the further depletion of human and social capital. People may have experienced witnessing the killing of loved ones, family separation, abandonment of children and the elderly, and being subjected to torture, rape, and other forms of violence that can leave deep and prolonged mental scars.

**Unlike physical wounds and losses, conditions such as depression, anxiety (such as post-traumatic stress disorder), and traumatic brain injuries, which affect mood, thoughts, and behavior, are often “invisible” to the eye or simply persist unrecognized, unacknowledged, or ignored in humanitarian and development assistance programs, undermining efforts to help rebuild and sustain the lives of displaced populations.** There is the need to be conscious

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<sup>22</sup> Marquez, P.V. (2014). “Mental Health: Time for a Broader Agenda.” The World Bank Blogs, April 22, 2014. Available at <http://blogs.worldbank.org/health/mental-health-time-broader-agenda>.

<sup>23</sup> Epping-Jordan JE, Ommeren MV, Nayef Ashour H, Maramis A, Marini A, Mohanraj A, Noori A, Rizwan H, Saeed K, Silove D, Suveendran T, Urbina L, Ventevogel P, Saxena S. Beyond the crisis: building back better mental health care in 10 emergency-affected areas using a longer-term perspective. *International Journal of Mental Health Systems* (2015) 9:15



of continued hardships and challenges faced by refugees in host communities which affect their mental health and well-being. Ongoing stressors such as lack of access to employment, disruption of educational aspirations, bullying for children at schools as well as social isolation and uncertainty can increase the risk for mental illness. Some studies have shown for example, that daily stressors in the current environment were more predictive of developing mental health problems than past trauma for conflict affected populations.<sup>24</sup>

## 6. Collaborative, multisectoral approaches

As highlighted in WHO's Mental Health Gap Action Plan (mhGAP),<sup>25</sup> which aims to scale up mental health services in low-income and middle-income countries, and in the summary report and commentary prepared after the 2016 WBG/WHO event,<sup>26 27</sup> evidence-based interventions have been effective in promoting, protecting, and restoring mental health, well beyond the institutionalization approaches of the past.

Taken together, mental health and psychosocial interventions and programs can improve economic, social and human development, and strengthen health systems. Properly implemented, these interventions represent “best buys” for any society, with significant returns in terms of health and economic gains. Some of these are within the health sector (e.g., treatment with medicines or psychological interventions) and others outside it (e.g., psychological interventions through social services, providing timely humanitarian assistance to refugees). An increased focus on mental health and psychosocial program implementation is consistent with their inclusion in Sustainable Development Goal 3<sup>28</sup> to ensuring healthy lives and promoting well-being for all ages, and in Priority 4 of the 2015 Sendai Framework, which identifies mental health as an essential aspect of disaster risk reduction.<sup>29</sup>

**A collaborative response is required to tackle mental health as a development challenge.** Such a response would involve multidisciplinary approaches that integrate health services at the community level,<sup>30</sup> in schools, and in the workplace to explicitly address the mental health and psychosocial needs of displaced people and host communities, including alcohol and other drug

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<sup>24</sup> There are several studies by Ken Miller on this, e.g. Miller, K. E., Omidian, P., Rasmussen, A., Yaqubi, A., Daudzai, H., Nasiri, M., Bakhtyari, M.B., Quraishi, N., Usmanikhil, S., & Sultani, Z. (2008). Daily stressors, war experiences, and mental health in Afghanistan. *Transcultural Psychiatry*, 45, 611-639.

<sup>25</sup> WHO. mhGAP (Mental Health Gap Action Programme) Intervention Guide. Geneva: World Health Organization, 2010.

<sup>26</sup>World Bank Group, WHO. Report of Proceedings of Event “Out of the Shadows: Making Mental Health a Global Development Priority.” Washington, DC: World Bank Group, 2016. Available at:

<http://www.worldbank.org/en/topic/health/brief/mental-health>.

<sup>27</sup> Kleinman, A., Lockwood Estrin, G., Usmani, S., Chisholm, D., Marquez, P.V., Evans, T.G., and Saxena, S. Time for mental health to come out of the shadows. *Lancet* 2016; 387: 2274-2275. Available at: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(16\)30655-9/abstract](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)30655-9/abstract) .

<sup>28</sup> United Nations. Sustainable Development Goals, Goal 3. Available at: <http://www.un.org/sustainabledevelopment/health/>

<sup>29</sup> Sendai Framework for Disaster Risk Reduction 2015-2030. United Nations Office for Disaster Risk Reduction (UNISDR). 2015. Available at: <http://www.unisdr.org/we/inform/publications/43291>

<sup>30</sup> American Psychiatric Association (APA). (2016). “Position Statement on Integrated Care.” Approved by the Board of Trustees, July 2016. Approved by the Assembly, May 2016.

use problems. It would also include innovative social protection and employment schemes that facilitate the reintegration of affected persons into social and economic activities, such as done under Canada's RISE Asset Development, which provides seed capital and lends at low-interest rates to people with a history of mental health and addiction challenges.<sup>31</sup>

### *7. Essential mental health interventions at the community level*

**Effective scaled-up responses to improve the mental health and psychosocial wellbeing of conflict-affected populations require careful adaptation to specific contexts of multi-layered systems of services and supports (e.g., provision of basic needs and essential services such as food, shelter, water, sanitation, and basic health care; action to strengthen community and family supports; emotional and practical support through individual, family or group interventions; and community-based primary care health systems).**

Most common forms of mental disorders, such as anxiety and depression, are prevalent, disabling, and respond to a range of treatments that are safe and effective. Yet, owing to stigma and inadequate funding, these disorders are not being treated in most primary care and community settings. The **Interagency Standing Committee**<sup>32</sup> has provided guidance on tiered action in emergency settings, including for camp coordination and management, that is human rights-based and takes a “do no harm” approach. This allows a focus on affected individuals as a whole, addressing both their physical and mental health needs, while reducing the risk of stigma and discrimination among families and communities. This is important since mental disorders are highly co-morbid with other priority conditions (e.g., maternal and child health conditions, HIV/AIDS, and non-communicable diseases such as cancer and diabetes).

To inform the design of context-specific interventions in emergency settings, the mapping of the problem is of paramount importance, including gathering information on mental health as part of current governmental policies and plans assessment of mental health and psychosocial information about the affected population (e.g. access and utilization of MH services, cultural specific understanding of mental health problems and help seeking behaviors), covering both those with disorders induced by the crisis, and those with preexisting disorders.<sup>33</sup> Such assessments can also clarify what is the current availability of mental health services in affected settings.

New kinds of tools are offering program implementers additional guidance on how to consider the complex articulation of systems of care in contexts with especially limited resources and

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<sup>31</sup> See Rise Asset Development: <http://www.riseassetdevelopment.com/>.

<sup>32</sup> Interagency Standing Committee. Mental Health and Psychosocial Support in Emergency Settings: What Should Camp Coordination and Camp Management Actors Know?. 2014. This and other documents accessed at: <https://interagencystandingcommittee.org/product-categories/mental-health-and-psychosocial-support>

<sup>33</sup> See WHO & UNHCR. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings. Geneva: WHO, 2012. ([http://www.who.int/mental\\_health/resources/toolkit\\_mh\\_emergencies/en/](http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/)); WHO & UNHCR. mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO, 2015. ([http://www.who.int/mental\\_health/publications/mhgap\\_hig/en/](http://www.who.int/mental_health/publications/mhgap_hig/en/)); WHO, UNICEF, UNFPA, UNHCR, & UN Action. MHPSS for conflict-related sexual violence: 10 myths. WHO: Geneva ([http://www.who.int/reproductivehealth/publications/violence/rhr12\\_17/en/](http://www.who.int/reproductivehealth/publications/violence/rhr12_17/en/)).

potentially competing priorities. A continuum of action spanning service delivery science, quality improvement methods, implementation science and “mixed” qualitative and quantitative methods, and formal randomized controlled trials and anthropological research, are all contributing to our knowledge of what works in context. Implementing organizations such as Partners In Health (PIH), International Medical Corps (IMC) or World Vision are actively adapting this kind of knowledge to practice “on the ground,” in post-disaster and emergency settings.

As illustrated in the matrix below, PIH experience in countries such as Haiti, Rwanda, Peru, and Liberia,<sup>34 35</sup> shows that many effective, evidence-based interventions can be implemented at the community and facility levels to deal with anxiety and depression-- two of the most common forms of mental disorders--along with psychosis. Adapting knowledge from WHO’s mhGAP and existing evidence, PIH has worked to develop a **mental health service delivery planning matrix to achieve universal health coverage**. This matrix includes a **care delivery “value chain”**, adapted from the business literature, or a “Total Health For All”<sup>36</sup> approach that integrates primary care, mental health and public health, to support understanding of how various activities entailed in delivering care fit together as part of a care delivery process. Implemented at community and facility levels, these interventions can be grouped into an essential package of services that includes: **promotion and prevention, including stigma reduction interventions, case finding** (e.g., psychological assessment, diagnosis), **treatment** (e.g., counselling, psychosocial interventions such as cognitive behavioral therapy, and treatment with essential medicines such as antidepressant and antipsychotic medications), and **follow-up** (e.g., monitoring of symptoms); and reintegration (e.g., social and economic interventions). Core, cross-cutting components of the system includes sustained supervision in clinical, programmatic and academic spheres for local implementation teams, as well as a focus on patient safety, quality of care, outcomes measurement (monitoring and evaluation), and the use of data to drive performance improvement.

There are examples from refugee countries as well. For example, **International Medical Corps (IMCs)** has successfully scaled up mental health services as part of primary health care in response to the Syria crisis in various countries, including Jordan, Syria, Iraq, Lebanon and Turkey. IMCs approach includes using **WHO’s mhGAP Intervention Guidelines** for training general health care staff, utilizing community health workers for community outreach and follow-up, having psychosocial workers attached to clinics to address multiple needs of affected populations and for

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<sup>34</sup> Marquez, P.V., and Walker, M. (2016). “Mental health services in situations of conflict, fragility and violence: What to do?.” The World Bank Blogs, November 1, 2016. Available at

<http://blogs.worldbank.org/health/mental-health-services-situations-conflict-fragility-and-violence-what-do>

<sup>35</sup> See Partners in Health Mental Health site: <http://www.pih.org/priority-programs/mental-health>. Also, PIH MENTAL HEALTH STRATEGIC PLAN 2016-21. The Imperative for Access and Quality. September, 2016.

<sup>36</sup> Sorel, E. (2015). “TOTAL HEALTH FOR ALL IN THE 21ST CENTURY: INTEGRATING PRIMARY CARE, MENTAL HEALTH AND PUBLIC HEALTH” in WORLD FEDERATION FOR MENTAL HEALTH. “DIGNITY IN MENTAL HEALTH.” World Mental Health Day, The 10th of October 2015.

delivering scalable psychosocial interventions, as well as establishing networks and referral pathways between different service providers.<sup>37</sup>

## Mental Health Value Chain



**Anti-stigma campaigns can be powerful tools in confronting barriers to support for people with mental disorders.** Stigma and discrimination in relation to mental illnesses have been described as having worse consequences than the conditions themselves.<sup>38</sup> Stigma associated with mental disorders can result in social isolation, low self-esteem, and limited opportunities in areas such as employment, education and housing. Stigma can also hinder patients seeking help, thereby increasing the treatment gap for mental disorders.<sup>39</sup> What is more, stigma associated with mental disorders also influences how these disorders are prioritized and contribute to discriminator

<sup>37</sup> See IMCs. 2015. "The Syria Crisis. Addressing Mental Health Needs and Gaps in the Context of the Syrian Crisis." <http://internationalmedicalcorps.org/document.doc?id=526>. Also see: <http://reliefweb.int/report/syrian-arab-republic/syria-crisis-addressing-regional-mental-health-needs-and-gaps-context>.

<sup>38</sup> Thornicrofts, G., et al. (2016). "Evidence for effective interventions to reduce mental-health-related stigma and discrimination." *Lancet* 387: 10023, p1123–1132.

<sup>39</sup> Quinn, N., et al. (2013). "Nature and impact of European anti-stigma depression programmes." *Health Promotion International*: das076.

attitudes of clinicians toward people with mental illnesses<sup>40</sup>, with adverse consequences on the quality of mental health services delivered.<sup>41</sup> Anti-stigma campaigns as well as peer to peer support models which actively involve those recovering from mental health problems in helping others and taking on visible and active roles in their communities can help break down stigma and raise awareness. A recent global review<sup>42</sup> provides evidence that social contact is the most effective type of intervention to improve stigma-related knowledge and attitudes in the short term. However, the evidence for longer-term benefit of such social contact to reduce stigma is weak. The main findings in that review are: (1) at the population level there is a fairly consistent pattern of short-term benefits for positive attitude change, and some lesser evidence for knowledge improvement; (2) for people with mental illness, some group-level anti-stigma interventions show promise and merit further assessment; (3) for specific target groups, such as students, social-contact-based interventions usually achieve short-term (but less clearly long-term) attitudinal improvements, and less often produce knowledge gains; (4) this is a heterogeneous field of study with few strong study designs with large sample sizes; (5) research from low-income and middle-income countries is conspicuous by its relative absence; (6) caution needs to be exercised in not overgeneralizing lessons from one target group to another; (7) there is a clear need for studies with longer-term follow-up to assess whether initial gains are sustained or attenuated, and whether booster doses of the intervention are needed to maintain progress; (8) few studies in any part of the world have focused on either the service user's perspective of stigma and discrimination or on the behavior domain of behavioral change, either by people with or without mental illness in the complex processes of stigmatization. In view of the magnitude of challenges that result from mental health stigma and discrimination, the review suggests that there is a need for a concerted effort to fund methodologically strong research that will provide robust evidence to support decisions on investment in interventions to reduce stigma.

**Current evidence-based treatments for moderate to severe depression and anxiety disorders include structured, time-limited psychological treatments and antidepressant medications.**

Numerous randomized trials support the efficacy of **psychological treatments, especially in the form of brief treatments based on cognitive, behavioral, and inter-personal mechanisms.** For example, a recent study<sup>43</sup> that assessed the effectiveness of a brief multicomponent intervention incorporating behavioral strategies delivered by lay health workers to adults functionally impaired by symptoms of psychological distress in a conflict-affected setting, found that a lay worker-administered intervention consisting of 5 weekly 90-minute individual sessions that included empirically supported strategies of problem solving, behavioral activation, strengthening social support, and stress management, compared to enhanced usual care interventions, may be a

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<sup>40</sup> Sartorius, N. (2007). "Stigma and mental health." *Lancet* 370, no. 9590:810-811.

<sup>41</sup> *Ibid.*; Sartorius, N., (2002). "Iatrogenic stigma of mental illness." *British Medical Journal* 324, no. 7352:1470-1471; Magliano, L., et al. (2004). "Perception of patients' unpredictability and beliefs on the causes and consequences of schizophrenia." *Social Psychiatry and Psychiatric Epidemiology* 39, no. 5:410-416; Magliano, L., et al. (2011). "The influence of causal explanations and diagnostic labeling on medical students' views of schizophrenia." *Academic Medicine* 86, no. 9:1155-1162.

<sup>42</sup> Thornicrofts, G., et al. (2016). "Evidence for effective interventions to reduce mental-health-related stigma and discrimination." *Lancet* 387: 10023, p1123-1132.

<sup>43</sup> Rahman, A., et al. (2016). Effect of a Multicomponent Behavioral Intervention in Adults Impaired by Psychological Distress in a Conflict-Affected Area of Pakistan. A Randomized Clinical Trial. *JAMA*. doi:10.1001/jama.2016.17165. *JAMA*. doi:10.1001/jama.2016.17165. Published online November 12, 2016.

practical approach for treating adults with psychological distress in conflict-affected areas. Indeed, the application of this intervention resulted in clinically significant reductions in anxiety and depressive symptoms at 3 months.

“Task-sharing” models by which non-specialist providers deliver care, adapted from the global movement to scale up care for HIV/AIDS over the past two decades, are offering hope for the spread and scale of mental health services, for high- as well as low-income countries where they are being tested. There is also a growing body of evidence<sup>44</sup> demonstrating that non-specialist workers in primary care and community settings can deliver mental health care with great effectiveness to a variety of populations (see below graph on task allocation<sup>45</sup>).

There are several major groups of antidepressants in common use today, including tricyclic antidepressants and selective serotonin reuptake inhibitors (SSRIs).<sup>46</sup> Studies have found strong evidence for the efficacy of antidepressant pharmacotherapy and no evidence of an advantage for any specific drug over another. Antidepressants generally, and SSRIs in particular, have well-documented efficacy in the treatment of anxiety disorders, trauma-related disorders like PTSD, and other disorders related to depression. Similarly evidence for psychosocial and psychopharmacological interventions for psychosis is adequate.

#### ***8. Treatment settings and integration with health and social systems***

Displaced people and refugee populations are confronted with extraordinary stresses and challenges to their physical and psychological health. Whether mobile or in a camp setting, they can easily fall through the cracks of assistance mechanisms. For this reason the articulation of coherent mental health and psychosocial services within government infrastructures, as well as in the development and NGO sector, can provide a critical safety net in significantly improving the health and well-being of displaced people and refugees.

The provision of mental health and psychosocial support services at the community level cannot be seen as a vertical or free-standing intervention offered in a health facility. Rather, it needs to be part of broad integrated platforms—population, community, health, social and educational services—that provide basic services and security, promote community and family support through participatory approaches, and strengthen coping mechanisms not only to improve people’s daily functioning and wellbeing, and protect the most vulnerable (e.g., women and children,

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<sup>44</sup> The healthy activity program lay counsellor delivered treatment for severe depression in India. Systematic development and randomised evaluation. / Chowdhary, Neerja; Anand, Arpita; Dimidjian, Sona; Shinde, Sachin; Weobong, Benedict; Balaji, Madhumitha; Hollon, Steven D.; Rahman, Atif; Wilson, G. Terence; Verdelli, Helena; Araya, Ricardo; King, Michael; Jordans, Mark J D; Fairburn, Christopher; Kirkwood, Betty; Patel, Vikram. In: British Journal of Psychiatry, Vol. 208, No. 4, 01.04.2016, p. 381-388.

<sup>45</sup> PIH. Mental Health Planning Matrix to Achieve UHC, on the basis of personal communication with Giuseppe Raviola, MD, MPH, Director, Mental Health, Partners In Health, October 21, 2016.

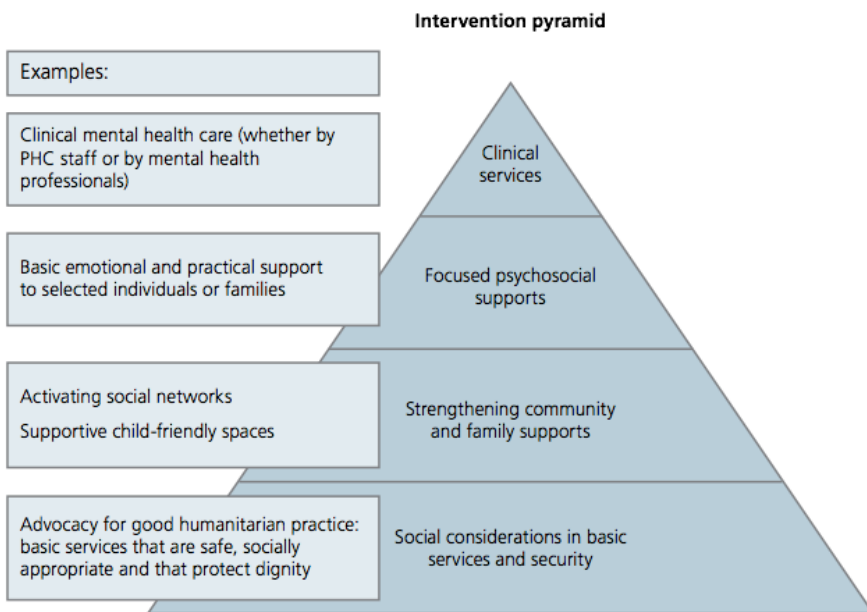
<sup>46</sup> Mnookin S., et al. Out of the shadows: making mental health a global development priority report. Geneva: World Bank Group and World Health Organization, 2016. Available at: <http://documents.worldbank.org/curated/en/270131468187759113/Out-of-the-shadows-making-mental-health-a-global-development-priority>

adolescents, elderly, and those with severe mental disorder) from further adversity, but also to empower the affected people to take charge of their lives as valuable members of society.

Mental health planners and policy makers need to ensure, through public awareness and community engagement, care delivery systems that are sensitive to local social, economic, and cultural contexts; this will ensure that mental health care is appropriately sought out and utilized.

The **Inter-Agency Standing Committee (IASC)**'s intervention pyramid for mental health and psychosocial support presented below illustrates task responsibility by levels of care.

### *Intervention pyramid for mental health and psychosocial support in emergencies*<sup>47</sup>



Efforts at collaborative, integrated care – an evidence-based approach to care for chronic illness applied in primary care settings – should guide the effective use of resources for delivery of quality mental health care. Such efforts emphasizes systematic identification of patients, self-care, and active care management by clinical providers, blended with other medical, mental health, and community supports.<sup>48</sup>

<sup>47</sup> Inter-Agency Standing Committee (IASC). 2007. IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC. ([http://www.who.int/mental\\_health/emergencies/9781424334445/en/](http://www.who.int/mental_health/emergencies/9781424334445/en/)).

<sup>48</sup> Druss, B., and E. Reisinger (2011). Mental disorders and medical comorbidity. The Synthesis Project: Research Synthesis Report No. 21; Katon, W., et al. (2006). "Cost- effectiveness and net benefit of enhanced treatment of depression for older adults with diabetes and depression." *Diabetes Care* 29, no. 2, 265–270; O'Neil, A., et al. (2015). "A shared framework for the common mental disorders and Non-Communicable Disease: key considerations for disease prevention and control." *BioMed Central Psychiatry* 15; Patel, V., et al. (2013). "Grand challenges: integrating mental health services into priority health care platforms." *PLOS Med* 10, no. 5: e1001448; Jamison, D. (in press). "Disease Control Priorities, 3rd edition: improving health and reducing poverty." *Lancet*.

Given that anxiety and depression play large roles in the health of expectant and new mothers and their children, substantial investments in maternal and newborn health can render maternal care settings a viable and desirable platform for delivery of depression care, where early and effective intervention for maternal depression can be implemented. Regarding maternal deaths in childbirth, depressive symptoms in mothers are associated with preeclampsia, preterm birth, intrauterine growth retardation, and low birth weight in infants, with the prevalence and severity of antenatal anxiety and depression higher in low-and middle-income countries.<sup>49 50</sup> Interpersonal psychotherapy, however, is associated with a reduction in depressive symptomatology in pregnant women.<sup>51</sup> Also, mothers with high levels of psychological distress exclusively breastfeed for a shorter duration. Exclusive breastfeeding is considered the safest and most effective intervention to reduce infant morbidity and mortality by WHO, and cognitive behavioral counseling delivered in the postpartum period can reduce the risk of a mother stopping exclusive breastfeeding.<sup>52 53</sup>

In addition to its impact on overall physical health, mental disorders can exacerbate common co-occurring diseases, such as diabetes, hypertension, cardiovascular disease and cancer, communicable diseases such as HIV and TB, and major health challenges affecting mothers and children in the pre- and post-partum periods. Mental disorders are also a barrier to patient adherence to TB treatment, and WHO recommends therapeutic relationships and mutual goal-setting as interventions to improve TB treatment adherence by reducing psychological stress.<sup>54 55</sup>

There is significant evidence that integrated delivery of mental health and psychosocial support can be effective for these complex health problems. For example, psychiatric diagnoses are more common in HIV patient groups than other populations and are associated with poor ART adherence, but and psychological interventions for depressed HIV patients can lead to improved immune status, and antidepressant treatment is associated with improved antiretroviral medication

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<sup>49</sup> Verbeek T, et al. Anxiety and depression during pregnancy in Central America: a cross-sectional study among pregnant women in the developing country Nicaragua. *BMC Psychiatry*. 2015; 15(1): 292.

<sup>50</sup> Kim DR, et al. Elevated risk of adverse obstetric outcomes in pregnant women with depression. *Archives of Women's Mental Health*. 2013; 16 (6): 475-482.

<sup>51</sup> Spinelli MG, Endicott J. Controlled clinical trial of interpersonal psychotherapy versus parenting education program for depressed pregnant women. *American Journal of Psychiatry* 2003;160(3):555–62.

<sup>52</sup> Wachs TD, Black MM, Engle PL. Maternal Depression: A Global Threat to Children's Health. *Development, and Behavior and to Human Rights Child Development Perspectives*. 2009; 3(1): 51-59.

<sup>53</sup> Sikander S, et al. Cognitive-Behavioral Counseling for Exclusive Breastfeeding in Rural Pediatrics: A Cluster RCT. *Pediatrics*. 2015; 135 (2).

<sup>54</sup> Pachi A, Dionisios B, Moussas G, Tslebis A. Psychiatric Morbidity and other factors affecting Treatment Adherence in Pulmonary Tuberculosis Patients. *Tuberculosis Research and Treatment*. 2013; 2013.

<sup>55</sup> World Health Organization. Adherence to long-term therapies: evidence for action. 2003. <http://apps.who.int/medicinedocs/pdf/s4883e/s4883e.pdf>.



adherence.<sup>56 57 58</sup>

For example, psychiatric diagnoses are more common in HIV patient groups than other populations and are associated with poor ART adherence, but antidepressant treatment for depressed HIV patients is associated with an improvement in antiretroviral medication adherence, and psychological interventions can lead to improved immune status.<sup>59 60 61 62</sup>

The reality of “comorbidity” in affected populations implies the need to develop and implement mental health promotion, protection, illness prevention, screenings and interventions as part of integrated primary care, mental health and public health teams in an effective TOTAL Health model in collaboration with public, private and NGO partners.<sup>63</sup>

The collaborative care approach has proven effective in general population samples and vulnerable sub-populations in high-income countries, and increasingly in LMICs.<sup>64</sup> Evidence from low-income countries demonstrates the effectiveness of care delivery by community or lay health workers.

As shown in Box 1<sup>65</sup>, recent efforts in Syria provide an illustration of investments and activities required to build a mental health system to respond to the needs of the population during a crisis situation.

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<sup>56</sup> Gaynes, B.N., Pence, B.W., PhD, Eron J.J., Miller, W.C. Prevalence and comorbidity of psychiatric diagnoses based on reference standard in an HIV+ patient population. *Psychosomatic Medicine*. 2008; 70, 505–511

<sup>57</sup> Kumar V, Encinosa, W. Effects of Antidepressant Treatment on Antiretroviral Regimen Adherence among depressed HIV-infected patients. *Psychiatric Quarterly*. 2009; 80: 131-141.

<sup>58</sup> Carrico A, Antoni, M. Effects of Psychological Interventions on Neuroendocrine Hormone Regulation and Immune Status in HIV-Positive persons: A review of Randomized Controlled Trials. *Psychosomatic Medicine*. 2008; 70(5): 575-584.

<sup>59</sup> Gaynes, B.N., Pence, B.W., PhD, Eron J.J., Miller, W.C. Prevalence and comorbidity of psychiatric diagnoses based on reference standard in an HIV+ patient population. *Psychosomatic Medicine*. 2008; 70, 505–511

<sup>60</sup> Kumar V, Encinosa, W. Effects of Antidepressant Treatment on Antiretroviral Regimen Adherence among depressed HIV-infected patients. *Psychiatric Quarterly*. 2009; 80: 131-141.

<sup>61</sup> Carrico A, Antoni, M. Effects of Psychological Interventions on Neuroendocrine Hormone Regulation and Immune Status in HIV-Positive persons: A review of Randomized Controlled Trials. *Psychosomatic Medicine*. 2008; 70(5): 575-584.

<sup>62</sup> Based on PIHs In Health Four Zeros Strategic Plan, analysis and references compiled by Alexandra Rose, MSc GMH.

<sup>63</sup> Personal communication with Prof. Eliot Sorel, George Washington University School of Public Health, on December 7, 2016.

<sup>64</sup> UK Department of Health (2012). “IAPT three-year report: The first million patients.” Available at <http://www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf>; Layard, R., et al. (2007). “Cost-Benefit Analysis of Psychological Therapy.” *National Institute Economic Review* 202, no. 1:90-98; Ngo V., et al. (in press). “Grand challenges: integrating mental health care into the non-communicable disease agenda.” *PLOS Medicine*; Pemjean, A. (2010). “Mental health in primary healthcare in Chile.” *International Psychiatry* 7:7–8.

<sup>65</sup> Personal communication with Shekhar Saxena, Director, Department of Mental Health and Substance Abuse and Mark van Ommeren, Public Mental Health Adviser, WHO, November 11, 2016.

### **Box 1: Mental care effort in Syria**

In Syria, the World Health Organization (WHO) is working with partners to cope with emerging needs of the affected population. Despite the challenges presented by the ongoing conflict, mental health services are becoming more widely available in Syria than ever before. Mental health care is now being offered in primary and secondary health facilities in some of the most affected governorates in Syria (Damascus, Rural Damascus, Homs, Suwayda, Aleppo, Al Hassakeh, Hama, Tartous and Lattakia). This is in contrast to the situation before the conflict, at which time mental health care was provided in at only three hospitals and in just Damascus and Aleppo.

Key to addressing this gap was training and continuous technical supervision of primary health care physicians on the management of stress, depression, psychosis, suicide and psychosomatic disorders. The WHO mhGAP Intervention Guide, an integrated guide for the management of priority mental health conditions was the main tool used. WHO recruited a team of field based national supervisors, to support this process. mhGAP training materials were translated into Arabic and adapted for use in the Syrian context by Syrian mental health professionals, with support from WHO.

WHO supported the training of Syrian health professionals and provision of psychotropic medicines through not only its office in Damascus, but also its sub-offices in Homs, Aleppo and its field presence in Gaziantep/Turkey.

Key achievements to-date include the following:

- Mental health is now seen as a public health priority in Syria.
- A team of Syrian mental health professionals play a leadership role in prevention and treatment of mental health conditions in Syria.
- Mental health services are provided for people with mental disorders at primary care facilities in Damascus, Rural Damascus, Homs, Aleppo, Hama, Lattaki Hasaka and Tartus. These services are provided by non-specialist general practitioners under the supervision of specialists, all trained through the WHO mhGAP program.
- A team of psychologists is providing a wide range of psychotherapeutic interventions through multidisciplinary teams at the primary and secondary care levels.
- Psychotropic medication provided through WHO and partners is available at primary and secondary care levels for the first time in the country.
- An inpatient unit for mental disorders has been established for the first time in a general hospital in the country located in Damascus, and 2 more are expected to open soon.

### *9. Are these mental health interventions affordable and cost-effective?*

**A WHO-led study<sup>66</sup> prepared for the WBG/WHO global mental health event at the 2016 WBG/IMF Spring Meetings estimated cost of treatment interventions** at the community level for moderate to severe cases of depression, including basic psychosocial treatment for mild cases and either basic or more intensive psychosocial treatment plus antidepressant drug for moderate to severe cases.

The study included **key categories of resource use**, including: medication, with 6 months continual generic antidepressants for moderate to severe cases; outpatient and primary care, including regular visits for all cases ranging from four per case per year for basic psychosocial treatment, and up to 14–18 visits for moderate to severe cases receiving antidepressant medication and intensive psychosocial treatment (half of whom are assumed to receive this on an individual basis, the other half in groups); and inpatient care, with few cases expected to be admitted to hospital (2–3% of moderate to severe cases only, for an average length of stay of 14 days). An assumption for this study was that this care and follow-up would largely be undertaken in non-specialist health care settings by doctors, nurses and psychosocial care providers trained in the identification, assessment, and management of depression and anxiety disorders

Estimations also included **expected levels of program costs and shared health system resources needed to deliver interventions as part of integrated model of chronic disease management**. These included program management and administration, training and supervision, drug safety monitoring, health promotion and awareness campaigns, and strengthened logistics and information systems. The latter were estimated as on-cost to the estimated direct healthcare costs. The baseline value for on-cost was 10% (and therefore grows in absolute terms during scale-up).

**The results of the estimation, which would need to be adjusted and adapted to the particular conditions of given emergency contexts, show that the cost of scaling up the delivery of these interventions is relatively quite low.** The average annual cost during 15 years of scaled-up investment is \$.08 per person in low-income countries, \$0.34 in lower middle-income countries, \$1.12 in upper middle-income countries, and \$3.89 in high-income countries. Per person costs for treatment of anxiety disorders are nearly half that of depression. **Across country income groups, resulting benefit to cost ratios amount to 2.3–3.0 to 1 when economic benefits only are considered, and 3.3–5.7 to 1 when the value of health returns is also included.**

### *10. Mental health care over the long term*

Projects funded by the World Bank Group (WBG) and other organizations utilize a bottom-up, multidisciplinary approach to re-integrate displaced population groups after conflicts and natural disasters. Incorporating integrated care and treatment for mental illness into these existing projects would help to overcome barriers to securing employment among the poor and vulnerable. Further investment in education, social protection, and employment training would help prevent social exclusion and build social resilience by serving the unique needs of vulnerable groups.

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<sup>66</sup> Chisholm D, Sweeny K, Sheehan P, et al. 2016. "Scaling-up treatment of depression and anxiety: a global return on investment analysis. *Lancet Psychiatry* 3: 415–24.

**To the above end, development efforts in post-conflict and post-disaster societies should include expanding mental health services that are well integrated into primary care and the health system structures.** Box 2<sup>67</sup> provides case examples of countries/regions that have seized opportunities during and after emergencies to build better mental health care. They represent a wide range of emergency situations and political contexts, and provide evidence that it is possible to take action in emergencies to make systemic change to build better mental health systems.

**Building out mental health services, that are well integrated into primary care and public health in countries hosting refugees and in post-conflict and post-disaster societies, would require treating mental and substance use disorders like other chronic health conditions.**<sup>19</sup>

After all, these are disorders of the brain, an equally important organ in the human body as the heart, liver, or the lungs. Nor, in fact, are they truly separable: if untreated, mental disorders can negatively affect the risk for and the management of such co-occurring diseases as tuberculosis and HIV, diabetes, hypertension, cardiovascular disease, and cancer.

In moving forward, a firm commitment is needed from national and international actors to champion mental health parity in the provision of health and social services, as part of dedicated development support and assistance programs (see Box 3 on recent Peru's experience). This is needed to help displaced people and refugees overcome their vulnerabilities, build mental resilience, and take full advantage of poverty reduction programs, economic opportunities and legal protections, particularly with regard to widespread stigma and discrimination.<sup>68</sup>

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<sup>67</sup> World Health Organization (WHO). 2013. Building back better: sustainable mental health care after emergencies. WHO: Geneva.

<sup>68</sup> Marquez, P.V. (2016). "Invisible wounds: Mental health among displaced people and refugees." The World Bank Blogs, October 11, 2016. Available at: <http://blogs.worldbank.org/voices/invisible-wounds-mental-health-among-displaced-people-and-refugees>.

## **Box 2: Country/Regions Examples of Sustainable Mental Health Care after Conflicts and Emergencies**

**Afghanistan:** Following the fall of the Taliban government in 2001, mental health was declared a priority health issue and was included in the country's Basic Package of Health Services. Much progress has been made. For example, since 2001, more than 1000 health workers have been trained in basic mental health care and close to 100 000 people have been diagnosed and treated in Nangarhar Province.

**Burundi:** Modern mental health services were almost non-existent prior to the past decade, but today the government supplies essential psychiatric medications through its national drug distribution center, and outpatient mental health clinics are established in several provincial hospitals. From 2000 to 2008, more than 27 000 people were helped by newly established mental health and psychosocial services.

**Indonesia (Aceh):** In a matter of years following the tsunami of 2004, Aceh's mental health services were transformed from a sole mental hospital to a basic system of mental health care, grounded by primary health services and supported by secondary care offered through district general hospitals. Now, 13 of 23 districts have specific mental health budgets, compared with none a decade ago. Aceh's mental health system is viewed as a model for other provinces in Indonesia.

**Iraq:** Mental health reform has been ongoing since 2004. Community mental health units now function within general hospitals, and benefit from more stable resources. Since 2004, 80–85% of psychiatrists, more than 50% of general practitioners, and 20–30% of nurses, psychologists, and social workers working in the country have received mental health training.

**Japan:** A series of catastrophic earthquakes in Japan, including the 1995 Hanshin-Awaji earthquake, the 2006 Niigata Chuetsu earthquake, and the 2011 Great East Japan earthquake, has provided evidence that mental health and psychosocial support can also be effectively integrated into humanitarian response and disaster risk management.

**Jordan:** The influx of displaced Iraqis into Jordan drew substantial support from aid agencies. Within this context, community-based mental health care was initiated. The project's many achievements built momentum for broader change across the country. New community-based mental health clinics helped more than 3550 people in need from 2009 to 2011.

**Kosovo:** After the conflict, rapid political change generated an opportunity to reform Kosovo's mental health system. A mental health taskforce created a new strategic plan to guide and coordinate efforts. Today, each of Kosovo's seven regions offers a range of community-based mental health services.

**Somalia:** The governance structure in Somalia has been fragmented for more than 20 years, and during most of that time the country has been riddled with conflict and emergencies. Despite these challenges, mental health services have improved. From 2007 to 2010, chains were removed from more than 1700 people with mental disorders.

**Sri Lanka:** In the aftermath of the 2004 tsunami, Sri Lanka made rapid progress in the development of basic mental health services, extending beyond tsunami-affected zones to most parts of the country. A new national mental health policy has been guiding the development of decentralized and community-based care. Today, 20 of the country's 27 districts have mental health services infrastructure, compared with 10 before the tsunami.

**Timor-Leste:** Building from a complete absence of mental health services in 1999, the country now has a comprehensive community-based mental health system. Today, the Timor-Leste National Mental Health Strategy is part of the Ministry of Health's overall long-term strategic plan. Mental health-trained general nurses are available in around one quarter of the country's 65 community health centers, compared with none before the emergency.

**West Bank and Gaza Strip:** Significant improvements in the mental health system have been made over the past decade, towards community-based care and integration of mental health into primary care. In 2010, more than 3000 people were managed in community-based mental health centers across the West Bank and Gaza Strip.

**If the World Bank and WHO are to fully embrace and support the progressive realization of universal health coverage, we must work to ensure that prevention, treatment, and care services for mental disorders at the community level, along with psychosocial support mechanisms, are integrated into existing service delivery platforms, are accessible, and are covered under financial protection arrangements.<sup>69</sup>**

In the United States, as well as countries such as Chile, Colombia, and Ghana, attempts to promote treatment equality for mental disorders including addiction programs have run up against clauses that deny health insurance coverage for pre-existing conditions, a common barrier. When this hurdle is overcome, the next barrier has included determination of what is covered and funded at the provider level. This leads to a host of additional questions, such as what conditions to cover, how to select a menu of evidence-based treatments to be offered by service providers at different levels of care (as is commonly done for other health conditions), and how these services will be

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<sup>69</sup>Marquez, P.M. (2016). "Time to put "health" into universal health coverage". ? The World Bank Blogs, January 14, 2016. Available at: <http://blogs.worldbank.org/health/time-put-health-universal-health-coverage>.

funded and reimbursed without perpetuating indirect medical discrimination through high deductibles, copayments, and lifetime limitations in coverage.<sup>70</sup>

### **Box 3. Bringing Mental Health Services to Those Who Need Them Most: Peru’s Carabayllo Experience**

“Welcome to my house!” said World Bank Group President Jim Yong Kim during his opening remarks to the Peruvian President, First Lady, Minister of Health and Mayor of the district of Carabayllo. Dr. Kim felt like he was at home because he had been a regular visitor to Carabayllo since 1994, when he led an initiative to implement the first community-based approach to control multidrug-resistant tuberculosis (MDR-TB) in a resource-poor setting.

This time, Carabayllo was making history again. The President had recently signed a law that protected the rights of people with mental health problems. The regulation includes a set of community mental health services integrated at the primary health care level, which require the direct involvement of the community and the family of the patients. It is a first step to decentralize mental health services through the implementation of the new model of community care for mental health, including general and specialized care services for mental health.

Across six regions in Peru, there are 21 community centers for mental health. The coordinated effort—of the Ministry of Health, the National Institute of Mental Health, local government of Carabayllo, and several international and national organizations—is promoting social participation and is strengthening the network of mental health community-based approaches to implement psychosocial interventions in families with problems and mental disorders. In the past, mental health patients were hospitalized; now, in this new model of health care delivery, patients are ambulatory. The community health workers conduct home visits to beneficiaries and provide psycho-education, support adherence to treatment, and encourage the participation of family members in the recovery of the patient with mental health problems.

Anxiety and depression are common problems in Peru. In Carabayllo, as in other districts with high levels of poverty, social problems like domestic violence, sale and consumption of drugs, gangs, prostitution, assaults, and robberies are common. Community organizations in Carabayllo are trying to implement a comprehensive approach to deal with these complex challenges.

Efforts in Carabayllo include opening the first home for people with severe mental disorders in socially neglected situations. Six therapeutic caregivers, who are community health workers with ad-hoc training, are taking care of eight women, ranging from 21 to 63 years old. They are responsible for overseeing the treatment of the residents, for providing new skills training, and for enabling the socialization and reintegration of patients into the community. The National Institute of Mental Health is providing technical advice, training, monitoring and therapeutic support to caregivers.

As we left the district of Carabayllo, I thought about the great challenges the community is still facing to become a healthy society. Undoubtedly, the lessons from the past allow for an active community participation, creating a platform for true collaboration among government bodies and community-based organizations. With this new mental health initiative, Carabayllo once again—despite its persistent challenges—could become a model for innovation and learning, just as it was for MDR-TB.

*Source: Bayona, J. 2015. “Bringing Mental Health Services to Those Who Need Them Most”. The World Bank Blogs, October 30, 2015. Available at <http://blogs.worldbank.org/health/bringing-mental-health-services-those-who-need-them-most>.*

This is not an easy task. Strategies and plans for the medium term are required to integrate mental health care into health services delivery platforms that focus on the whole person rather than an aggregation of diseases. Even if these policy and service delivery changes were adopted, the need

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<sup>70</sup> Kennedy, P., and Fried, S. (2015). *A Common Struggle: A Personal Journey through the Past and Future of Mental Illness and Addiction*. Blue Rider Press.

would remain for unrelenting efforts to support affected persons and their families, empowering them to defy the stigma of being seen as “mentally ill” and to get essential services and adhere to prescribed treatments. . Also, there is the need to advocate for and identify entry points across sectors to address the social and economic factors that contribute to the onset and perpetuation of mental disorders.

**The exploration of alternative sources of financing to support mental-health parity in the health system and to mainstream across other “entry points” should be a priority action.** For example, if development lifts lives, and new and innovative approaches for funding development are seen as “game changers,” then one could consider the argument that the development community, in accordance with the 2015 Financing for Development Addis Ababa Action Agenda,<sup>71</sup> needs to redouble its commitment to advocate with national governments and society at large for raising “sin taxes” such as taxes on tobacco, alcohol and sugary drinks, which are a win-win for public health and domestic revenue mobilization.

**For example, taxing tobacco is one of the most cost-effective measures to reduce consumption of products that kill prematurely, make people ill with diverse diseases (e.g., cancer, heart disease, and respiratory illnesses), and burden health systems with enormous costs. In addition, hiking tobacco taxes can help expand a country’s tax base to mobilize needed public revenue to fund vital investments and essential public services that benefit the entire population and help build the human capital base of countries, such as financing the progressive realization of universal health coverage, including mental health care.**<sup>72</sup>

Indeed, data from different countries indicate that the annual tax revenue from excise taxes on tobacco can be substantial. In the US, for example, as part of the 2009 reauthorization of the Children’s Health Insurance Program approved by the US Congress that President Barack Obama signed as the first bill after being elected, a 62 percent per pack increase in the federal cigarette tax was adopted to help fund the program, increasing the total federal cigarette tax to about \$1 a pack. Federal cigarette tax revenue rose by 129 percent, from \$6.8 billion to \$15.5 billion, in the 12 months after the tax (April 2009 to March 2010), while cigarette pack sales declined by 8.3 percent in 2009 – the largest decline since 1932.<sup>73</sup>

In the Philippines, the adoption of the 2012 Sin Tax Law showed that substantial tax increases on tobacco and alcohol is good for public health impact and for resource mobilization for health investments. In the first three years of implementation of the law, \$3.9 billion in additional fiscal

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<sup>71</sup> Marquez, P.V., and Moreno-Dodson, B. (2016). “Economic slowdown and financial shocks: can tobacco tax increases help? The World Bank Blogs, Feb 8, 2016. Available at: <http://blogs.worldbank.org/voices/economic-slowdown-and-financial-shocks-can-tobacco-tax-increases-help>. Marquez, P.V. (2016). Taxing tobacco and the new vision for financing development. The World Bank Blogs, April 18, 2016. Available at: <http://blogs.worldbank.org/voices/taxing-tobacco-and-new-vision-financing-development>.

<sup>72</sup> Marquez, P. V. (2015). “Making the public health case for tobacco taxation.” The World Bank Blogs, July 7, 2015. Available at: <http://blogs.worldbank.org/health/making-public-health-case-tobacco-taxation>.

<sup>73</sup> Marquez, P.V. 2016. EXPANDING THE GLOBAL TAX BASE: TAXING TO PROMOTE PUBLIC GOODS: TOBACCO TAXES PANEL SESSION HELD AS PART OF “WINNING THE TAX WARS: GLOBAL SOLUTIONS FOR DEVELOPING COUNTRIES” CONFERENCE AT THE WORLD BANK GROUP, MAY 23-24, 2016. Summary Report



revenues was collected. The additional fiscal space increased the Department of Health budget threefold and increased the number of families whose health insurance premiums were paid by the National Government from 5.2 million primary members in 2012 to 15.3 million in 2015, or about 45 million poor Filipinos (about 50 percent of the total population). Indeed, both country initiatives show that increasing taxes on tobacco and alcohol is “low hanging fruit,” a high-yield investment in terms of raising domestic resources to attain sustainable development goals, including expanding mental health care coverage.<sup>74</sup>

## 11. *Key lessons learned*<sup>75</sup>

- **Mental health and psychosocial problems are extremely common in major crises.** There is always a need for mental health and psychosocial support services (MHPSS) in humanitarian crises. **During a humanitarian crisis prevalence surveys are not needed to justify investing in MHPSS.** In some exceptional cases, prevalence surveys, if done very well, can be justified for advocacy and scientific knowledge. The dire situation of displaced person and refugees in the world today demands that investments be made to support their mental health and well-being. An area that requires priority attention is the **mental health and psychosocial needs of children and adolescents.** This certainly has been much in focus on the southern border of the United States and also in the recent large migration in Europe.
- **Activities and programming should be integrated into wider systems** (e.g. existing community support mechanisms, formal/non-formal school systems, general health systems and services, social services, trusted protection networks etc.) as much as possible. This reaches more people, is more sustainable and carries less social stigma.
- **Relative priority should be given to those MHPSS projects that** (a) have a relatively strong evidence-basis (b) seek to demonstrate improvements in people’s daily functioning and (c) are likely to protect (i.e., reduce exposure to further adversity) among the most vulnerable, including those with severe mental disorder.
- **Investing in mental health as part of early recovery can make substantial difference to development and to the long-term availability of services for the most severely affected survivors.** Emergencies are unique opportunities to build back/up sustainable mental health care (see resources).
- **Practical tools and guidelines** exist for assessment and response (see resources).

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<sup>74</sup> Ibid.

<sup>75</sup> Personal communication with Shekhar Saxena, Director, Department of Mental Health and Substance Abuse and Mark van Ommeren, Public Mental Health Adviser, WHO, October 18, 2016.

## *12. The Role of the World Bank Group (WBG)*

To highlight the scale of the mental health issues, and the gains from addressing them, **the WBG and WHO co-hosted the Out of the Shadows: Making Mental Health a Global Priority event in April, 2016 as part of the Spring Meetings of the IMF/WBG.**<sup>76</sup> This event aimed to put the mental health agenda at the center of global health and development priorities by spurring efforts to: increase awareness about mental health as a development challenge and the associated economic and social costs of inaction; debate the economic and social benefits of investing in mental health; and identify ways for stakeholders to act across sectors.

Jim Y. Kim, President of the WBG, and Margaret Chan, Director-General of WHO, along with other leaders,<sup>77</sup> called for a collaborative response to tackle mental health as a development challenge by pursuing multidisciplinary approaches that encompass integrated health services at the community level, in schools and in workplace programs, and initiatives to address the mental health and psychosocial needs of displaced populations.

**Addressing mental health as an integral part of the global development agenda also brings added value for increasing the effectiveness of programs in other sectors such as health, maternal and child health, livelihoods, and education.** Mental health problems are especially common in conflict and crisis affected populations and impair the ability of those affected and their families to take advantage of any type development program. Addressing mental health alongside other sectors can unlock additional human potential, contribute to a more inclusive and rights based approach and help accelerate the positive impact of programs on affected communities.

**The WBG could bring four primary comparative advantages to support scaling up the provision of mental health services for addressing the needs of displaced people and refugees:** (1) strong influence on the global development agenda; (2) involvement in virtually all sectors, such as health, nutrition and population, education, social protection, fragility, conflict and violence, macroeconomics and finance; (3) ability to support large scaling-up of effective programs as part of broader support programs under IDA18 funding; and (4) public health and economic expertise.

**An effective response to the mental health needs of the displaced and refugees would require strengthening partnerships between the WBG, WHO, UNHCR, and other international and national partners, such as PIH and IMCs.** Because mental health affects so many aspects of development, external actors must work in unprecedented partnerships with civil society and the private sector under the leadership of governments to exploit the comparative advantage of each.

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<sup>76</sup> World Bank Group, WHO. Report of Proceedings of Event “Out of the Shadows: Making Mental Health a Global Development Priority.” Washington, DC: World Bank Group, 2016.  
<http://www.worldbank.org/en/topic/health/brief/mental-health>.

<sup>77</sup> World Bank Live. Out of the Shadows: Making Mental Health a Global Development Priority. April 13–14, 2016.  
<http://live.worldbank.org/out-ofthe-shadows-making-mental-health-a-global-development-priority>.

Support must be well-planned and coordinated to enhance synergy and avoid duplication of effort. Bureaucracy should be minimized and processing of aid dramatically accelerated. Most of all, a concerted effort to break the silence surrounding mental health needs to be made, and consolidated action taken early in crisis and post-crisis situations to ensure the timely and effective support of people affected, including displaced persons and refugees.

If this is done, as Toluwalola Kasali observed, we will be helping the affected people regain “the ability to dream, desire and work for a future, one very different from their present circumstances.”<sup>78</sup>

### ***13. WBG’s health sector activities on mental health***

Since 1994, WBG funded projects have incorporated mental health components in a number of fields including health and health systems development, early child development, conflict and emergencies, social protection, and legal and judiciary reform. The WBG’s recent work in this area has focused on developing a collaborative response to address mental health as a development challenge by pursuing multidisciplinary approaches that encompass integrated health services at the community level, in schools and in workplace programs, and initiatives to address the mental health and psychosocial needs of displaced populations. This approach builds upon previous and ongoing efforts, in addition to dialogue and support to develop new activities, as noted below.

**A summary of the WBG’s health sector activities on mental health appears below:**

#### **Country-level operations:**

Previous examples of WBG’s mental health support to countries include the following:

- Different country projects implemented over the 2000 decade included psychosocial support components under the **African and the Caribbean Multi-Country Programs for the Control of HIV/AIDS**.
- Support for de-institutionalization of people with mental illness in **Albania, Lithuania and Romania** under Health Sector Reform Projects;
- Technical support to the Ministry of Health in **Thailand** for mental health reform;
- Technical support in mental health to the **Afghanistan** Health Project;
- Technical support to **Lesotho** in mental health policy development, community health assessment and mental health’s inclusion in the District Health Package.
- The integration of mental health into primary health care in **Bosnia**, funded by the Post Conflict Unit of the World Bank, by training primary health care physicians in the management of common mental disorders. In Bosnia, the Harvard Trauma Questionnaire and Beck Depression Inventory were integrated as a module in the Living Standards Measurement Survey (LSMS).

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<sup>78</sup> Kasali, T. (2016). Internally Displaced Persons (IDPs): An Integrated Approach to Rehabilitating IDPs with Dignity. Available at: <http://www.slideshare.net/ToluwalolaKasali/internally-displaced-persons-an-integrated-approach-to-rehabilitating-idps-with-dignity-updated-february-2016>.

- The integration of mental health into primary health care in the **West Bank and Gaza** by streamlining referral mechanisms, addressing children’s mental health needs, and developing an in-patient care master plan and mental health information system;
- Technical support to **Turkey** in the development and implementation of an emergency mental health response to earthquakes, within the framework of a new national mental health policy.
- Providing technical support in mental health as part of a Legal and Judiciary Reform project in **Sierra Leone**. The project included assessing the feasibility of integrating mental health components in Legal Aid Clinics and within Peace and Reconstruction activities.

**Examples of active and pipeline country projects with mental health components include the following:**

- **Liberia (active):** This project responds to the intermediate psychosocial/mental health impact of the Ebola crisis and to build long-term psychosocial health and resilience at the individual and community levels in defined project target areas. Support is provided to: training and capacity building of new and existing cadres of mental health providers and the implementation of mental health interventions at the individual, family, and community levels.
- **Great Lakes Emergency Sexual and Gender Based Violence and Women’s Health Project: (covering DRC, Burundi, Rwanda; active project):** This regional operation expands utilization of a package of health interventions targeted to poor and vulnerable females (including those impacted by sexual and gender-based violence), and includes mental health and psychosocial support subcomponents.
- **Nigeria (active):** This project includes mental health support to internally displaced people in northeast Nigeria (who have been impacted by the Boko Haram insurgency).
- **Yemen (pipeline):** The Emergency Health and Nutrition Project will be financing mental health and psychosocial support interventions, as part of a comprehensive package of health services that will be delivered in partnership with UNICEF and WHO.
- **Lebanon (pipeline):** A scale-up of Lebanon’s National Volunteer Service Program is currently being prepared to address: (i) the unmet social service delivery needs (including mental health) in some of the most vulnerable Lebanese communities hosting Syrian refugees, as well as (ii) the fragile inter-communal relations and social tensions between Lebanese citizens and Syrian refugees living in the selected host communities.
- **Nepal (pipeline):** A project under preparation to support the reconstruction of the affected regions from the recent earthquake would incorporate a component on psychosocial support to affected population as part of a larger effort to reintegrate them into economic and social activities.
- **Colombia (pipeline):** The anticipated approval of the Peace Agreement is opening the door to scale up support on mental health and psychosocial support to the 7 million internal displaced population.
- **GFF:** As part of ongoing discussions with the GFF team, it is visualized that there are future opportunities to push the mental health agenda forward as part of GFF supported projects, particularly to address maternal depression and mental health in early childhood.

- Promotion of Mental Health Parity under UHC initiatives: **Kosovo Health Project** (active): the delivery of mental health and psychosocial support services is being facilitated through support for the mandatory health insurance system.
- **Armenia:** Technical support focusing on the integration of the mental health services into the PHC and adoption of best practices for in-patient care.

### **Key partnerships and knowledge sharing**

- Health and Wellness in the Workplace: Ongoing mental dialogue initiated with different institutions, including the IFC.
- Close partnership established with WHO, and other institutions such the United Nations Refugee Agency (UNHCR), Partners in Health (PIH), International Medical Corps (IMC), Grand Challenges Canada, and the Mental Health Innovations Network, for knowledge sharing to support WBG task teams.
- Strategic Communication Post-2016 Spring Meetings Events: To increase awareness about mental health as a development challenge and the associated economic and social costs of inaction, and the economic and social benefits of investing in mental health.
  - **WBG/WHO Global Mental Health event: Out of the Shadows: Making Mental Health a Global Development Priority. Report of Proceedings of Event, May 2016.**
  - **The Lancet Comment. Time for mental health to come out of the shadows, Vol 387 June 4, 2016 2275. By Arthur Kleinman, Georgia Lockwood Estrin, Shamaila Usmani, Dan Chisholm, Patricio V Marquez, Tim G Evans, Shekhar Saxena.**
  - **Grand Challenges Canada: Mental health funding and the SDGs What now and who pays?**
  - **How to Fix a Broken Mental-Health System by Norman Ornstein, The Atlantic, Jun 8, 2016.**
  - **Maintaining the Momentum: Out of the Shadows. A series of articles on the event posted at the Mental Health Innovations Network/London School of Hygiene and Tropical Medicine, June 2016.**
  - **[http://www.mhinnovation.net/blog/2016/jun/15/maintaining-momentum-out-shadows?mc\\_cid=b520df69c0&mc\\_eid=28df1f433d#.WBnv203fM5u](http://www.mhinnovation.net/blog/2016/jun/15/maintaining-momentum-out-shadows?mc_cid=b520df69c0&mc_eid=28df1f433d#.WBnv203fM5u)**
  - **Cerebrum/The Dana Foundation. Making Mental Health a Global Priority, by Patricio Marquez and Shekhar Saxena. August 16, 2016.**
  - **Nature. The mental-health crisis among migrants, 10 October 2016.**

### **WBG Blogs (Investing in Health, Voices sites):**

Blog: Mental health services in situations of conflict, fragility and violence: What to do?:  
<https://blogs.worldbank.org/health/mental-health-services-situations-conflict-fragility-and-violence-what-do>

Blog: Invisible wounds: Mental health among displaced people and refugees:

<http://blogs.worldbank.org/voices/invisible-wounds-mental-health-among-displaced-people-and-refugees>

Mental Health Parity in the Global Health and Development Agenda:

<http://blogs.worldbank.org/health/mental-health-parity-global-health-and-development-agenda>

Shining a light on mental illness: An “invisible disability”:

<http://blogs.worldbank.org/health/shining-light-mental-illness-invisible-disability>

Bringing Mental Health Services to Those Who Need Them Most:

<http://blogs.worldbank.org/health/bringing-mental-health-services-those-who-need-them-most>

Blog: The zero hour” for mental health: <http://blogs.worldbank.org/health/zero-hour-mental-health>

Blog: Mental Health: Time for a Broader Agenda: <http://blogs.worldbank.org/health/mental-health-time-broader-agenda>

Blog: Is Violence a Public Health Problem?: <http://blogs.worldbank.org/health/violence-public-health-problem>

Blog: Is Unemployment Bad for Your Health?:

<http://blogs.worldbank.org/health/unemployment-bad-your-health>

Blog: Healthier Workplaces = Healthy Profits: <http://blogs.worldbank.org/health/healthier-workplaces-healthy-profits>

**Dedicated WBG Mental Health website:**

<http://www.worldbank.org/en/topic/health/brief/mental-health>