The importance of mental health in the Sustainable Development Goals

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The United Nations' draft Sustainable Development Goals (SDGs) only briefly mention mental health. In the context of a growing burden of disease due to mental disorders and psychosocial disabilities, the inclusion of a clear mental health target and indicators in the SDGs will acknowledge the needs and rights of hundreds of millions of people. It will mobilise international funding and policy development, and support other SDGs; it will also strengthen mental health structures, governance and services in low- and middle-income countries. We argue that for a just, sustainable and inclusive post-2015 development agenda, it is vital that the United Nations includes a clear mental health target and indicators in the SDGs.

Mental disorders and psychosocial disability are among the greatest global health challenges and yet are largely ignored in international development strategies. One in four people experience a mental health problem in their lifetime, and most of them (85%) live in low- and middle-income countries (Wang *et al*, 2007). Millions of these people worldwide face stigma, discrimination and severe human rights abuses every day (Thornicroft, 2006).

Since 2000, the Millennium Development Goals (MDGs) have motivated nations and organisations to take action for development; however, they made no reference to mental illness. In his review of the MDGs, the Secretary-General of the United Nations (UN), Ban Ki-Moon, stated that more must be done to secure the well-being, dignity and rights of those at the margins (Ki-Moon, 2013). The UN's Post-2015 Development Agenda is intended to provide 'a life of dignity for all' and to improve health, including mental health (United Nations, 2013). While the MDGs have had some success in promoting basic development, we now need to tackle an issue that was left out: mental health. It is vital that the UN includes a clear mental health target and indicators in its new Sustainable Development Goals (SDGs), for the following reasons.

The case is clear

Mental disorders and psychosocial disabilities are globally under-financed, in both government spending and development aid. In most middle- and low-income countries, government investments in mental health services and human resources utterly fail to respond to the level of need (Saxena *et al*, 2007). This is why most people with mental disorders do not have access to effective treatment (World Health Organization, 2011). In low-income countries, this treatment gap is up to 98% for more severe illnesses (World Health Organization, 2008). This is a breach of the fundamental right to access healthcare, as set out in the Convention on the Rights of Persons with Disabilities.

Amina J. Mohammed, a special advisor to Ban Ki-Moon, stated that with the new SDGs the voices of people will be 'lifted up and brought to … attention' (Mohammed, 2013). Most people who suffer from mental disorders and psychosocial disabilities cannot raise their voice, either because they are figuratively 'locked in' by their mental illness or because they are literally locked in, in mental health institutions or prisons, or locked out by their societies. Making mental health a target in the SDGs will help to strengthen their fundamental rights and give these people a voice.

Referring to the core values of development

The Rio+20 Conference in 2012 reaffirmed the values of global development: freedom, peace and security. When aiming to support these values, we need to recognise that many people with mental illness remain vulnerable, either in our communities, because of exclusion from normal citizenship, or in hospitals, where their human rights are more likely to be violated, for example by degrading conditions, neglect or inhumane treatment.

Including a mental health target in the SDGs responds to one of the core ideas of development, to 'leave no one behind' (Ki-Moon, 2013). For the new SDGs to be inclusive, they must focus on the needs of the least privileged people. People with mental health problems are among the most marginalised communities in the world; up to now they have been largely overlooked by global development, as well as national policies. A clear mental health target will include these hundreds of millions of people in development, and strengthen their fundamental rights and freedoms.

Motivation and mobilisation

Including mental health in the SDGs will motivate and mobilise nations, organisations and donors to take action, and allocate resources, for mental health development. Global development budgets have increasingly provided for the need to address psychosocial disabilities. The World Health Organization, the European Union and several high-income donor governments have focused on

scaling up services for mental health in low- and middle-income countries.

Globally, the average yearly spending on mental health is currently less than US$2 per person, but in low-income countries it is less than 25 cents per person (World Health Organization, 2011). This is clearly insufficient to treat even basic mental disorders. A mental health target in the SDGs will help to mobilise internal and external investment for psychosocial disability treatment and services, and it will attract international donors to invest in mental health systems, services and projects.

Measurability and accountability

Including mental health in the SDGs will also motivate countries; it will give governments a clearer focus on inclusive health policy-making and support good governance. This requires the global use of a small set of agreed indicators of mental health system performance. The use of measurable indicators of change will also help governments attract international donor funds to strengthen their service provision.

We therefore need a mental health target and indicators in order to measure progress and hold ourselves to account. As Lynne Featherstone stressed when she was the UK's under-secretary of state for international development, hundreds of millions of people with disabilities currently 'simply don't count' (Jones, 2014) and will be left out if we do not record data. Monitoring average development is not enough: progress must be measured specifically for people with mental and psychosocial disabilities.

A clear target and indicators will help to define responsibilities and mechanisms to which nations and donors can commit. It will enable the global community to monitor progress and to hold nations and organisations to account for the delivery of mental health services and policies.

Currently, only about 60% of countries have a clear mental health policy and only 72% have a mental health plan (World Health Organization, 2011). Including mental health in the SDGs will encourage countries to develop a dedicated mental health policy, plan and legislation. Mental health legislation and governance make systems for people with mental disorders more reliable and accountable.

Economic growth

Mental disorders and psychosocial disabilities are big obstacles to social and economic progress. Mental and behavioural problems account for nearly a quarter (23%) of the global burden of disease (Whiteford et al, 2013). They are the biggest single cause of disability, more than cardiovascular diseases and cancer combined. In high-income countries, men with mental health problems die on average 20 years earlier and women with mental health problems 15 years earlier than the rest of the population; in low-income countries this mortality gap is likely to be even wider (Wahlbeck et al, 2011). This is a huge loss of the workforce – which is

only one aspect of the excessive costs of untreated mental health conditions. The World Economic Forum has calculated the global cost of mental health conditions at US$2.5 trillion for 2010, and estimates the costs to rise to US$6.0 trillion by 2030 (Bloom et al, 2011). Societies' economic development is linked to the mental health condition of their people. Sustainable, inclusive and equitable growth can happen only when we include the quarter of the world's population who have experience of mental health problems.

Mental health has strong links with many of the thematic areas of the SDGs; for instance, it is critical to success in addressing poverty and economic development (World Health Organization, 2013). Armed conflict, violence, insecurity and injustice often have roots in social and economic deprivation and inequalities. Mental health is a key to social benefits, economic growth and equality.

Conclusion

FundaMentalSDG is a global initiative aiming to include a specific mental health target in the post-2015 development agenda; it has called on the UN to create the conditions in which people can realise their basic rights and fundamental freedoms (Thornicroft & Patel, 2014).

The UN plays a key role in securing the human rights of people with mental and psychosocial disabilities. It needs to include mental health in the new development agenda, to enhance both foreign and national investment and policy-making. Adding a clear mental health target and specific indicators to the SDGs will motivate international actors and mobilise funds, help to measure progress and success, and guarantee accountability; it will also contribute to global and regional economic growth. Overall, this will further the social and economic inclusion of people with mental and psychosocial disabilities, and it will promote access to basic mental healthcare, human rights and the foundations for a decent life.

Considering the urgent global situation, and the cross-cutting influence of mental health on the planned SDGs, including a mental health target in the SDGs, and thus making mental health integral to development, is a global imperative. Without including mental health in the SDGs, many hundreds of millions of people will be left behind in development, especially those who are least able to help themselves.

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International partnerships in psychiatry: introductory reflections from a seasoned sojourner

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The three thematic papers in this launch issue of *BJPsych International* are intended to inform and motivate College members around the world to reflect on the challenges of bilateral links between high- and low-income countries, on the exhilaration of being a new sojourner in a new land – and on the diaspora searching for almost forgotten cultural roots in a home country. They all illustrate the way in which twinning structures between National Health Service trusts, universities and research councils have facilitated these exchanges of personnel between high- and low-income countries which have benefited, at least in the short term, both parties – and facilitated the professional development of both psychiatrists and other health professionals.

They illustrate also the excitement and creative challenge of being caught between two cultures and of how to arrange revalidation and registration in the UK when working abroad. Globalisation, immediate communication by Skype or email, and low-cost travel can give a false sense of the universalism of values and of mental illness attributions which, though consoling in the honeymoon phase of cultural adjustment, may be succeeded by greater awareness of cultural and language difference in the disenchantment phase. Reverse culture shock on return home after a prolonged stay abroad can further complicate revalidation and adjustment to the swiftly changing demands of the National Health Service (NHS).

Julian Eaton and his colleagues aptly describe at an individual level the benefits of their innovative overseas peer group for continuing professional development (CPD), which meets by Skype and provides opportunity to review specific clinical problems when resources are scarce, and mutual encouragement about directed reading in clinical or research domains and, importantly, how to overcome revalidation and appraisal problems.

Athula Sumathipala *et al* report on the massive contribution to Sri Lankan and UK psychiatry of bilateral partnership between health institutions and universities in the two countries, including an important twin register. There are five times as many Sri Lankan psychiatrists in the UK (250) as in Sri Lanka at the present time (50). The diaspora is crucial to these bilateral links.

The third paper, by Dave Baillie and colleagues, considers the benefits specifically of a multidisciplinary link between the East London Mental Health Trust and Butabika Hospital Kampala (where I held my first consultant post), in Uganda. This present initiative is sustained by the Ugandan diaspora in the UK. The paper describes the mutual benefits of training psychiatric support workers. The authors illustrate the way in which these experiences benefit staff in East London – although they do acknowledge that this can be challenging if the Trust cannot see beyond the local financial constraints or is unsupportive of meeting the needs of a low-income African country whose family values may not mesh with those of postmodern Britain. The British diaspora in East Africa – an element not considered in the papers – as well as the abilities of East African doctors and nursing