



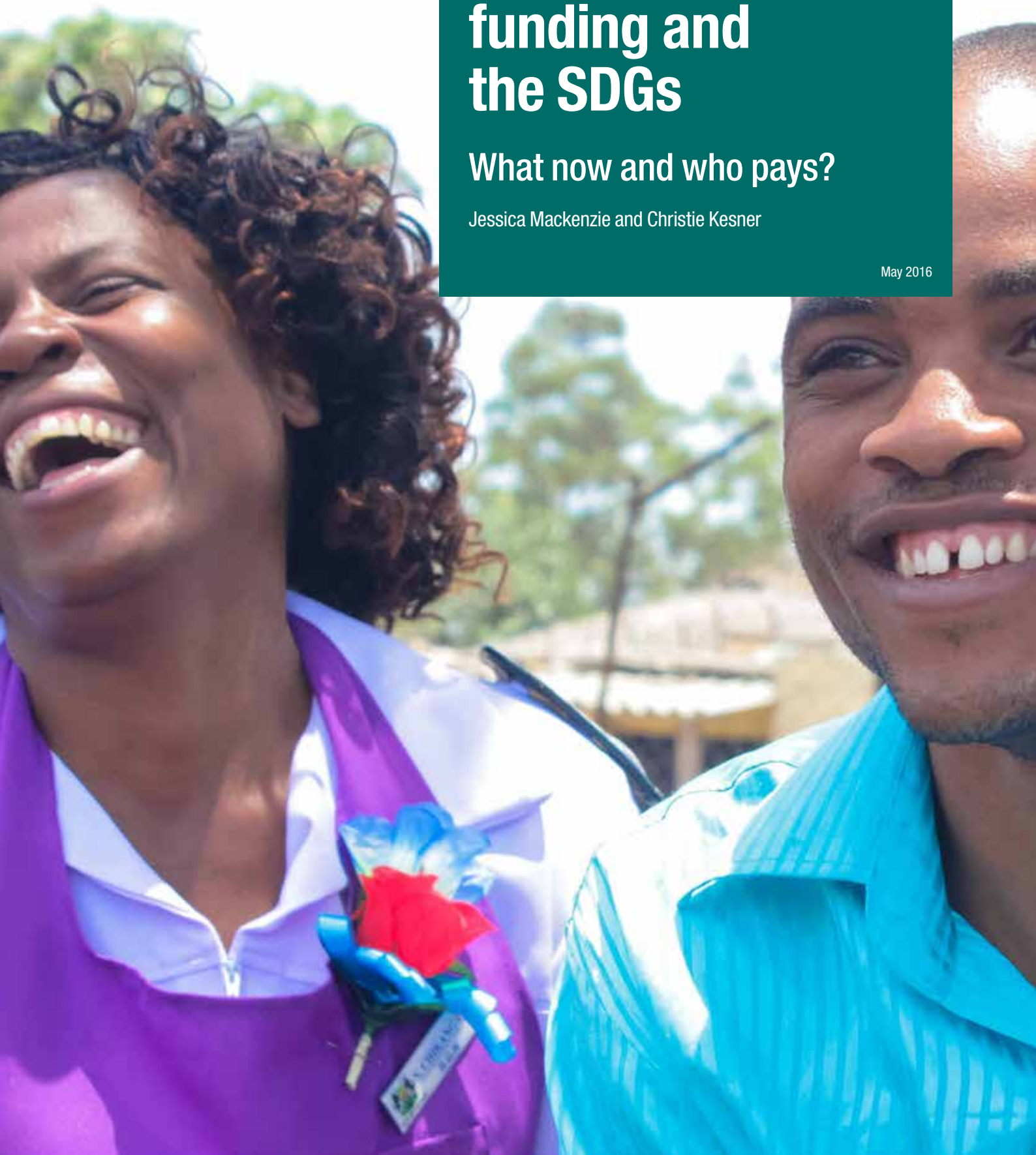
Report

Mental health funding and the SDGs

What now and who pays?

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Terminology

This report uses a variety of terms that have several working definitions, so it is important to clarify these from the outset. The terms ‘mental health’, ‘mental illness’ and ‘mental, neurological and substance use disorders’ (MNS disorders) are used regularly. ‘Mental health’ is defined by the World Health Organization (WHO) as ‘a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community’. We use the term in this way, to mean health and wellbeing, inclusive of social determinants.

‘Mental illness’, on the other hand, refers to suffering, disability or morbidity due to mental, neurological and substance use disorders, which can arise due to the genetic, biological and psychological make-up of individuals as well as adverse social or environment factors.

The term ‘mental health worker’ refers to those actors working towards attaining broader improved experiences of mental health across a variety of conditions and MNS

disorders. We defer to the WHO definition, which states that mental health workers possess some training in health or mental health care, but do not fit into any of the defined professional categories (e.g. medical doctors, nurses, psychologists, social workers, occupational therapists).¹

‘Stigma’ is defined as ‘the phenomenon whereby an individual with an attribute which is deeply discredited by his/her society is rejected as a result of the attribute (Goffman, 1963). The term ‘stigma’ refers to problems of knowledge (ignorance), attitudes (prejudice) and behaviour attitudes (prejudice) and behaviour (discrimination)’ (Thornicroft et al., 2008).

The term ‘global mental health’ is used throughout this report mainly to refer to the needs, actions and priorities of low- and middle-income countries, while acknowledging that higher-income countries (HICs) nevertheless have much to contribute towards, and benefit from, advances in global mental health.

¹ The term includes non-doctor/non-nurse primary care workers, professional and paraprofessional psychosocial counsellors, special mental health educators and auxiliary staff. This group does not include general staff for support services within health or mental health care settings (e.g. cooking, cleaning or security).

Acronyms

APEC	Asia Pacific Economic Community
APPG	All Party Parliamentary Group
CMDs	common mental disorders
DAC	Development Assistance Committee
DAH	Development Assistance to Health
DALYs	disability-adjusted life years
DAMH	Development Assistance to Mental Health
DFAT	Department of Foreign Affairs and Trade
DFID	Department for International Development
EU	European Union
GCC	Grand Challenges Canada
HIC	high-income country
IASC	Inter-Agency Standing Committee
IMF	International Monetary Fund
INGO	international non-governmental organisation
KPP	Knowledge Policy and Power framework
LIC	low-income country
LMIC	lower-middle-income country
MDGs	Millennium Development Goals
MHIN	Mental Health Innovation Network
MHPSS	mental health psychosocial support
MNS	mental, neurological and substance use
NGO	non-governmental organisation
NHS	National Health Service (UK)
NIMH	National Institute for Mental Health
ODA	Official Development Assistance
PRIME	Programme for Improving Mental Health
SDGs	Sustainable Development Goals
SGBV	sexual and gender-based violence
SIDA	Swedish International Development Cooperation Agency
SMEs	small and medium enterprises
UK	United Kingdom
UMICs	upper-middle-income countries
UN	United Nations
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children's Fund
UNODC	United Nations Office on Drugs and Crime
US	United States
USAID	United States Agency for International Development
WBG	World Bank Group
WEF	World Economic Forum
WHO	World Health Organization

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Executive summary

Mental disorders affect one in four of us over a lifetime. They represent a huge cost to our health care systems and to the global economy, and affect some of the world's most vulnerable people, through stigma and lack of understanding. The shortfall of services means that millions of people are left behind in terms of treatment.

In 2015 the world took a huge step forward by including mental health in the Sustainable Development Goals (SDGs), which set the global agenda for the next three decades. Now that they have been agreed, the world is looking to how the SDGs will be funded and how progress towards achieving them will be measured.

Mental health is severely underfunded. Despite the huge burden it places on global health, it receives a fraction of the funding of other diseases. In fact, it is underfunded no matter what you compare it to; more is spent on takeaway coffee in a single week in the UK than is spent on development assistance for mental health in low- and

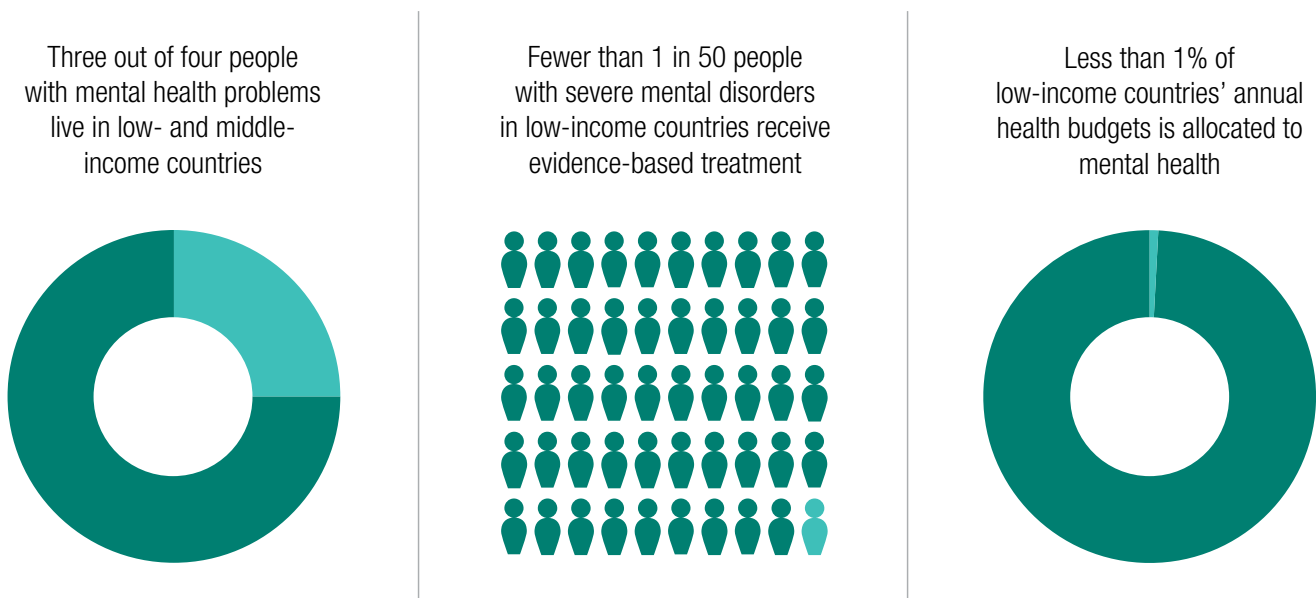
middle-income countries in a year (Allegra Strategies, 2012; Gilbert et al., 2015).²

Sadly, the precise shortfall of mental health funding is still unclear – reporting of mental health spending by country governments and donors is inconsistent, and tracking of spending all but non-existent (as it is often rolled into general health budgets).

This report provides an overview of who is currently funding mental health and who isn't, but could be. It is a synthesis of research previously conducted in this field and analyses both existing and new funders. It highlights how little information there is on what donors are spending on mental health globally, what types of activities are funded and why funding mental health delivers a variety of benefits, and it suggests how to frame the issue to encourage more investment.

Strong momentum has been created thanks to a select few efforts. Mental health has an excellent start on advocacy, thanks to a multitude of organisations, such as

Figure 1: The state of mental health



Source: Ryan et al. (2016). Reproduced with permission from the London School of Hygiene and Tropical Medicine.

² Gilbert et al. (2015) calculated the mean expenditure on development assistance for mental health in developing countries during the period 2007-2013 to be US\$133.57 million, increasing from US\$53.67 million in 2007 to a peak of US\$196.62 million in 2013. This includes only those countries that report their spending, within the criteria adopted by the authors, which are detailed further in Chapter 1 of this report. We compare this figure with US\$161.3 million – the estimated weekly turnover of UK coffee shops in 2012 based on data from Allegra Strategies (2012).

the World Federation of Mental Health (which has been working for decades in the mental health sector) and, more recently, Grand Challenges Canada (GCC), including the innovation projects they fund and initiatives like the Mental Health Innovation Network (MHIN).

Now is the right time for change to occur, given the agreement secured across 194 countries in the World Health Organization's Mental Health Action Plan 2013-2020 (WHO, 2013a) and the inclusion of mental health in the SDGs. It is important that the notion of 'leaving no one behind' in the SDGs is understood to include mental health, as people living with mental, neurological and substance use (MNS) disorders are often the most vulnerable groups. Relatedly, 'universal health care' means including mental health as a priority in national health policies.

Based on the findings of this report, we make several recommendations:

1. The global mental health community must communicate more clearly that investing in mental health increases economic productivity and can help other development programmes to achieve their goals more effectively, and that governments cannot reach their SDG targets without addressing it. What's more, progress in mental health can in fact be measured, despite concerns that appropriate metrics have not yet been developed.
2. Existing funders must track their mental health spending in a more transparent and accountable way. Only with clear figures can the mental health community make the case to change the current low funding levels and analyse the types of activities that the funding goes to (whether for short-term relief in humanitarian emergencies³ or to longer-term programmes and systems building).
3. A targeted advocacy campaign for funding the gap, harnessing the SGDs, needs to be developed and echoed throughout the global mental health community consistently by multiple players. A strong message would be that universal health care must include mental health because 'there is no health without mental health'. Or an alternative message would characterise 'leaving no one behind' as necessarily including mental health goals and indicators.
4. There are a variety of groups, listed in Chapter 3, who can be approached for global mental health funding. The global mental health community needs to prioritise, sequence and tailor advocacy plans as part of the next steps towards attracting these alternative funders.
5. Country governments need to prioritise mental health.⁴ The development banks and donors and their own economies will respond in turn. Any efforts to improve global mental health are ultimately undermined if we cannot mobilise country governments. Despite the assistance of donor funding, the SDGs will be monitored and adapted to local contexts by domestic governments, and so it is ultimately their interpretation and application of the SDGs which matters most.

3 This report acknowledges that mental health work in humanitarian emergencies also takes the form of longer-term systems building, thanks to the efforts of the United Nations High Commissioner for Refugees (UNHCR) and others.

4 Especially beyond the funding of mental hospitals to include funding for community-based services.

Introduction: The needs of the global mental health sector

Mental health is severely underfunded. MNS disorders affect one in four people over their lifetime and one in ten at any given time, and thus affect billions of lives globally. MNS disorders are the leading cause of disability worldwide and account for high levels of premature death and low productivity across many workplaces and economies. As the WHO stated in 2013, ‘the current and projected burdens of mental disorders are of significant concern not only for public health but also for [global] economic development and social welfare’ (WHO, 2013b: 5). In high-income countries (HICs), men with severe MNS disorders die up to 20 years earlier than men without such disorders; for women, the figure is 15 years (De Silva and Roland, 2014).⁵ The costs of providing prevention and treatment are high for households to bear, and programmes are desperately needed (WHO, 2003b).⁶

Despite this, not nearly enough funding is allocated to mental health globally.⁷ Currently, low-income countries (LICs) allocate only 0.5% of their total health budgets to mental health, while lower-middle-income countries (LMICs) allocate 1.9% (WHO, 2013b). In upper-middle-income countries (UMICs) and HICs the situation is just as dire, with UMICs allocating 2.4% and HICs 5.1% (WHO, 2013b). WHO (2013b) observes that this level of funding is far from proportionate to the burden that MNS disorders cause, and thus drastically undervalues the wellbeing of whole populations.

Even with the small amount of funding that is provided (from domestic and international sources), it remains unclear where this funding goes due to a lack of transparency in mental health reporting. One reason for this is that mental health budgets are often folded into general health budgets. For example, as Jane Edmondson, Head of Human Development at the Department for International Development (DFID), stated in 2014 during

a United Kingdom (UK) All Party Parliamentary Group (APPG) meeting on global health: ‘We don’t have an allocation for mental health within our resources. We don’t allocate resources in that way, mainly because...we cover it largely through our health systems strengthening’ (Ryan and Usmani, 2014). This suggests that through their work strengthening health systems as a whole, DFID hopes to cover mental health needs via a blanket approach (it should be noted that DFID does also fund some mental health-specific activities referred to later in this report). With no budget line for mental health spending, it is unclear precisely how low spending actually is or what funding goes towards mental health programmes in the field, which remain largely neglected across the world.

‘As nations of this world, our duty is to carry human rights acts and actions to full implementation for people with mental disabilities’

*Her Royal Highness Princess Muna Al Hussein of Jordan
(Funk et al., 2010)*

It is not only DFID that lacks a specific budget for mental health. Most other bilateral organisations have no specified publicly available budget, including the United States Agency for International Development (USAID), which also does not mention mental health programmes in its 2012-2016 Global Health Strategic Framework. Other organisations, such as the Swedish International Development Cooperation Agency (SIDA), the European Commission’s International Cooperation and Development Programme and the Australian Aid Programme within the

5 There is emerging evidence of these statistics being reflected in lower-middle-income countries, such as Ethiopia (Fekadu et al., 2015).

6 Though cost-effective and scalable solutions have been recommended by WHO, including scaling up a low-cost, essential package of mental health care (WHO, 2013b).

7 For this report, the term ‘global mental health’ refers to mental health in low- and middle-income countries, rather than higher-income countries (though they also have much to contribute towards, and benefit from, advances in global mental health).

Department of Foreign Affairs and Trade (DFAT), are in a similar position, as their mental health programmes are subsumed within their general health programmes and other emergency programmes.⁸ The United Nations High Commissioner for Refugees (UNHCR), which supports interventions for mental health and psychosocial support (MHPSS), does not have a specific budget line for mental health. Its activities are funded through general budgets for health, protection, sexual and gender-based violence (SGBV) or child protection. That said, UNHCR does require its primary health care programmes for refugees to contain a mental health component (UNHCR, 2013).

It is crucial to understand where this small amount of funding is directed so as to determine which activities are the most neglected. Interviews conducted for this report reveal that, of the funding that is provided, capital is channelled towards four categories of mental health activities: (i) capacity building of service providers;⁹ (ii) research and evaluation (to build the evidence base, including understanding what works); (iii) MHPSS work in humanitarian emergencies; and (iv) the delivery of mental health programmes (including the provision of medication)¹⁰ or systems building of mental health services.¹¹

Of these four categories, MHPSS work in humanitarian emergencies (or their aftermath) receives approximately a quarter of all funding for mental health, according to the reporting available.¹² Sometimes, as was the case in 2009,

MHPSS receives almost a third of development assistance funding for global mental health.¹³ While this funding is vital and provides a crucial service to those in dire need in humanitarian emergencies, more action must be taken to ensure the sustainable delivery of mental health programmes and the systems to support them as part of everyday services. It is possible and necessary to use the funds that are generated for MHPSS to contribute to longer-term systems building in mental health, as advocated by WHO in its 'building back better' approach (WHO, 2013c). Care should include addressing prevention and ongoing management of MNS disorders, and should not only be reactive.

The challenge is to prioritise activities within a neglected field (where everything can be seen as urgent) with limited information. Interviewees for this report, when pressed, prioritised three key areas as requiring urgent increases in funding: (i) community-based mental health service development (for example, integration into maternal care and general health care and as part of universal health care); (ii) emergency mental health (as explained in WHO's 'building back better' approach report); and (iii) mental health promotion (from awareness and anti-discrimination programmes to school-based programmes and wellness at work schemes).¹⁴ These are in fact crucial to sustainability of care and are needed if we are to make sure that, as the SDGs emphasise, 'no one is left behind'.

Box 1: Categories of mental health activities

1. Capacity building of mental health service providers
2. Research and evaluation (to build the evidence base, including understanding what works)
3. Mental health psychosocial support (MHPSS) in humanitarian emergencies
4. Delivery of mental health programmesⁱ or systems building for mental health services

Source: interviews and research. See more detail in Annex 3.

i This includes drug provision and activities that integrate mental health into general health care or into other sectors.

8 Funding for mental health need not only be channelled through a specific budget line approach. For example, work that is conducted on areas such as gender, youth or diversity often does not have its own budget line. An alternative solution would be for donors to agree that all primary health care programmes must contain a mental health component that is properly defined and resourced as a necessary condition for funding approval.

9 This includes in-service training (such as on-the-job training or refresher courses).

10 This does not necessarily mean a separate mental health programme as a vertical approach.

11 This includes activities that integrate mental health into general health care or into other sectors, as described in Patel et al. (2013).

12 Calculations for this report, with information from Gilbert et al. (2015), show that approximately 24% of development assistance recorded for mental health projects was delivered as part of responses to humanitarian emergencies.

13 Calculations for this report, with information from Gilbert et al. (2015), show that approximately 30% of development assistance recorded for mental health projects in 2009 was delivered as part of responses to humanitarian emergencies.

14 One example is the Batyr programme in Australia, which focuses on preventative education in the area of youth mental health (see www.batyr.com.au).

Chapter 1: Who is currently funding global mental health?

Country governments and households

Global mental health is funded via both domestic and international contributions. International donors currently fund a very small number of mental health activities, leaving much of the financial burden to be carried by developing country governments and individual households. As a result of resource constraints in LICs and LMICs (plus the associated stigma and low prioritisation of mental health), it is often individual households with limited disposable income that are left to finance mental health care. Of the 171 countries that contribute to the WHO 2014 Mental Health Atlas, 71% stated that their national budget was the primary source of funding for mental health, and 18% listed households as the primary source of funding (WHO, 2014: 31).

Despite being the primary global funder of mental health, even country governments are not spending much – often less than 1% of their national health budgets – on an area of health affecting a large portion of their population, and some of the most vulnerable within it. In addition, most low- and middle-income country governments' mental health spending goes largely towards mental hospitals (Figure 2). WHO has made firm recommendations that there should be a reallocation of this spending, or at least an increase in spending, to community-based mental health services (WHO, 2014: 32). In Australia, in response to a National Mental Health Commission Review, the government has set up a funding structure that is regionally led (delivered through 31 primary health networks) as part of a move towards a more community-focused funding model – something other governments may wish to take note of (Suicide Prevention Australia, 2015a). As already highlighted, LICs allocate only 0.5% of their health budget to mental health, while LMICs allocate 1.9%. In wealthier countries, the proportion is similarly meagre with UMICs allocating 2.4% and HICs allocating 5.1% (WHO, 2013b).

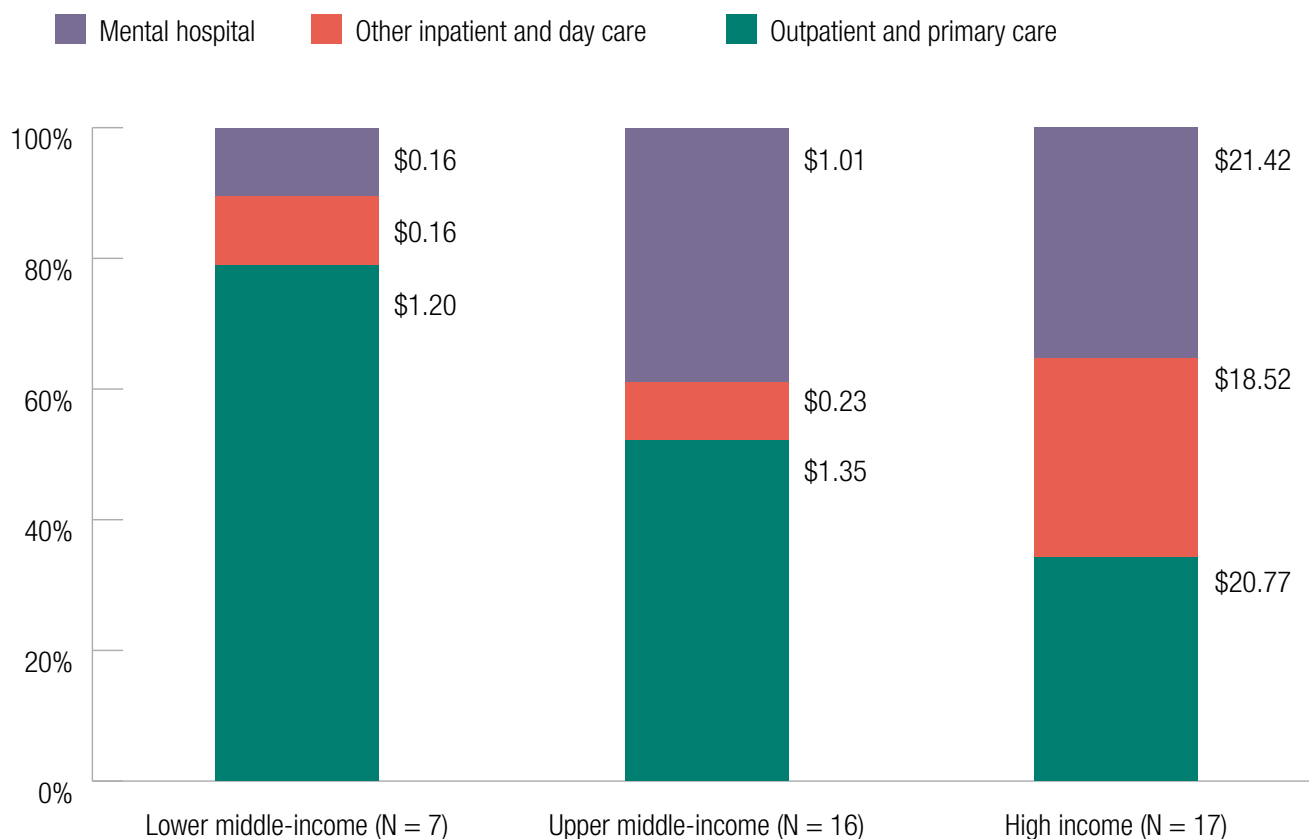
There are some rare, but powerful, examples of governments that have integrated mental health successfully into their national health policy. Uganda underwent such a change in 1996, when a mental health unit was introduced into the Ministry of Health and a Mental Health Coordinator deployed. This led to the integration of mental health into the country's First National Health Policy in 1999, which delivered a range of benefits for the Ugandan population (Baingana et al., 2011). It allowed for measurement in the change of services, improved access for remote and vulnerable populations, as well as strengthened mental health services overall. Another good example is Afghanistan, where the government included mental health as one of the seven priorities in its Basic Package of Health Services that guides the development of basic health care nationally (Ventevogel et al., 2012). Sierra Leone is also working on creating a mental health focal point to oversee public mental health planning, activities and governance.¹⁵

But such instances are few and far between; some governments do not have any dedicated mental health representatives in their ministries of health, and 30% of the 184 countries surveyed for WHO's 2005 Mental Health Atlas did not have a specified mental health budget (WHO, 2005: 20). Domestic governments must advocate for and prioritise mental health, for there to be lasting, sustainable change. Without advocacy at the domestic level first and foremost, external donors will not be able to bring about sustainable policies or channel appropriate funding to the cause.

While the total economic burden on households is yet to be established, there have been efforts to calculate these figures. One of the few studies available found that 15% of women with a common mental disorder in India spent more than 10% of household income on health-related expenditures (Patel et al., 2006). These are often the households that are least able to afford such a cost. The long-term nature of many disorders and the reduced

¹⁵ Sierra Leone's current mental health law dates back to 1902, and requires updating. Thanks to efforts in-country, there is momentum building for this process.

Figure 2: Distribution of mental health expenditure per capita, by care setting



Source: adapted from WHO (2014: Figure 3.1.2).

earnings that can accompany them, mean that the costs of MNS disorders can be catastrophic for individuals and families. Further research is needed in this area to better understand what these costs are, the range of effects they have and how to help alleviate them.

Donors via development assistance

Beyond household and national government funding, development assistance to mental health has slowly increased. But this rise is from an incredibly low base and remains drastically inadequate. In a study published in 2015, Gilbert et al. found that, although funding had tripled, it still accounted for less than 1% of total health spending. This means it has not grown at levels equivalent to other forms of health spending, and it was low to begin with.

The information in Gilbert et al. (2015) was compiled using the aid activities database for the Development Assistance Committee (DAC) Creditor Reporting System. This is generally considered the most comprehensive and authoritative data source on development assistance projects.¹⁶ For the purposes of the study, development assistance to mental health (DAMH) was defined as ‘aid spent on projects whose primary purpose was promoting

Box 2: Francis’s story, Ghana

Francis spent nearly a year and a half bound to a log in Ghana because of his mental health problems. This was partly because his family could not afford the US\$17 for medication that would have stabilised his condition and enabled him to be released. Francis said, ‘I felt very sad, neglected and abused, having my leg pinned to a log like an animal. It did not feel like home to me. I felt immeasurable pain from the weight of the log, especially whenever I wanted to reposition myself...’.

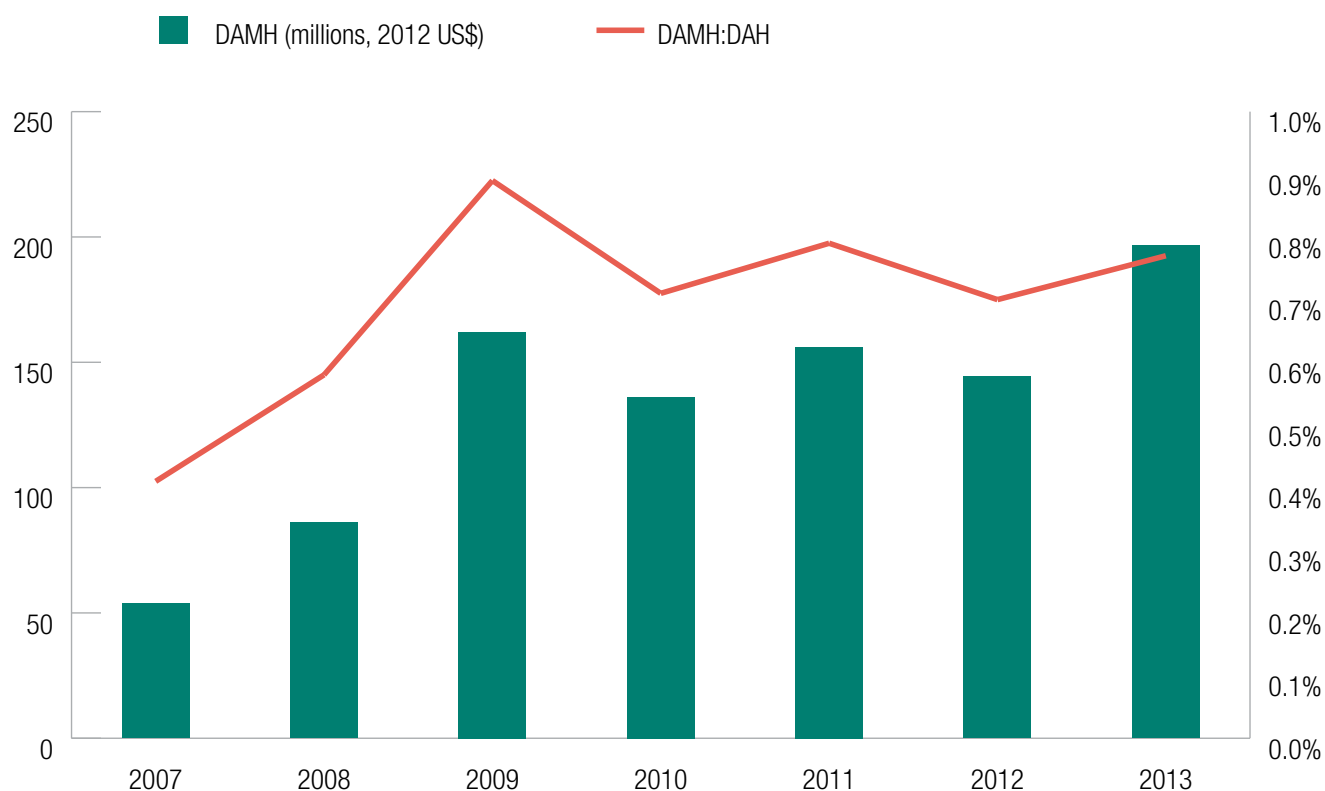
Following support from his friend Samuel, a community psychiatric nurse, and the efforts of the NGO BasicNeeds, Francis is well and teaching again. He said, ‘But for you, I possibly would have been dead today.’

Source: BasicNeeds in Mental Health Working Group 2013.

mental health or preventing or treating mental and substance-use disorders’ (Gilbert et al., 2015: 2).

Of the 55 donors¹⁷ who reported to the DAC Creditor Reporting System, 38 disbursed funding to mental health

Figure 3: Development assistance for mental health (2007-2013)



Source: Gilbert et al. (2015).

projects (Gilbert et al., 2015). The top three donors giving development assistance to mental health are WHO,¹⁸ European Union (EU) Institutions and the United States.¹⁹ As the lead UN agency for health, WHO has a well-established and active mental health programme. However, its role is to provide technical advice and support to its Member States rather than to fund the development of services on the ground, and its activities are limited by the fact that mental health only receives just over 1% of the overall WHO budget.²⁰ Alongside these, other positive

examples include the government of Canada, which is funding the world's largest body of global mental health research projects through Grand Challenges Canada (GCC), and the UK, which funds the Programme for Improving Mental Health (PRIME), a research study to develop and evaluate mental health care plans in Africa and Asia (De Silva and Roland, 2014). And yet even these examples represent relatively small contributions when compared with those to other health programmes.

16 The database was accessed by the authors between June 2014 and March 2015. It contains information on aid activities reported directly by DAC member country governments (mandatory), multilateral organisations (such as the UN and the World Bank), global health initiatives (such as the Global Fund to fight AIDS, Tuberculosis and Malaria), non-DAC countries and private donors (such as the Bill & Melinda Gates Foundation). The authors identified mental health spending by using a series of key words constructed from disorders listed in the Tenth Revision of the International Classification of Diseases. For a full explanation of the methodology, see Gilbert et al. (2015: 2).

17 The term 'donors' in this report refers to national development agencies, and predominantly bilateral aid programmes. For the sake of brevity, this section of the report will also mention development banks, multilateral organisations and international organisations. This is because these additional funders were included in the DAC Creditor Reporting System and the analysis drawn upon from Gilbert et al. (2015). Elsewhere in the report they are considered distinct groups.

18 WHO is a technical agency, so funding is largely channelled towards its operating budget rather than the delivery of mental health programmes in-country.

19 Total DAMH disbursement from 2007 to 2013 for WHO was \$211.04 million, for EU institutions it was \$152.85 million, and for the US it was \$88.14 million.

20 WHO's programme budget (2016-2017) shows that the mental health budget for all offices for the 2016-2017 biennium is \$46 million, which is equivalent to 1.05% of the total WHO budget of \$4.384 billion. A number of other UN agencies – including the UN Office on Drugs and Crime (UNODC), UNHCR and the UN Children's Fund (UNICEF) – have targeted programmes on mental health and substance abuse, including psychosocial support for children, refugees and other vulnerable groups. For UNHCR and UNICEF, these programmes do not represent a large part of their functional activities or budget, indicating that mental health is not a high strategic priority (WHO, 2015a).

Table 1: Top funders of development assistance to mental health

Funder	Amount spent, 2007-2013 (US\$ million)
1. WHO ⁱ	211.04
2. EU institutions	152.85
3. United States	88.14
4. Norway	72.19
5. Germany	62.75
6. Global Fund ⁱⁱ	59.27
7. Spain	43.07
8. Canada	35.94
9. Switzerland	29.71
10. Belgium	25.97

Source: Gilbert et al. (2015).

- i The WHO is a technical agency, so its funds are used largely for its operating budget.
- ii The Global Fund is a financing institution, providing support to countries in the response to AIDS, tuberculosis and malaria.

Table 1, and the report by Gilbert et al., demonstrates the lack of funding being channelled towards global mental health. Over seven years (2007-2013), total spending by DAC-reporting funders as an aggregate was shockingly low: an average of US\$133.57 million per year was spent on development assistance to global mental health (Gilbert et al., 2015). This spending was spread across 148 recipient countries, so only a fraction of this amount went to any one country (Gilbert et al., 2015). To put this into context, US\$133.57 million is less than the UK spends on takeaway coffee *in a week* (Allegra Strategies, 2012), and well under half of what the American population spends on Halloween costumes for pets each year (National Retail Federation 2015). Within the health sector, a helpful comparison is HIV, which causes less than half (44%) the global burden of disease that MNS disorders cause yet receives nearly 50 times the funding (Figure 4).²¹

‘My family depends on my income. But due to my [mental] illness I wasn’t able to work... In my country [Nepal] there are many others like me who... are stigmatised and avoided by society. I am fortunate to have recovered. Now I raise goats, cattle and buffalo... I want to be healthy and sustain my family so I will carry on taking my medicines.’

Shiva Sharma. Shiva, who has psychosis and severe depression, was supported through a community-based mental health and development programme delivered by the Livelihoods Education and Development Society Nepal, in partnership with BasicNeeds (McQuail, 2016).

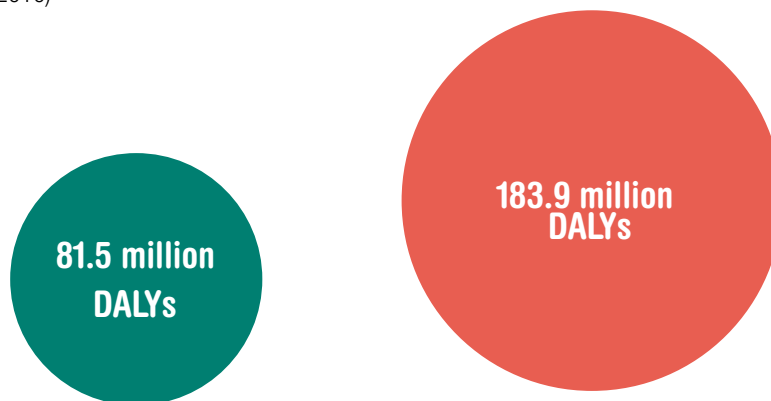
21 The authors of this report acknowledge that HIV has higher mortality levels, which can affect funding levels. Mental and substance-use disorders afflict as many as 700 million people worldwide, which may be an underestimate given the complexity of diagnosis and underreporting (Whiteford et al., 2013: 4). Figure 4 was informed by the following sources and calculations: (i) spending on development assistance to mental health in 2010 was \$136.12 million (Gilbert et al., 2015: 2); (ii) in 2010, mental disorders accounted for 183.9 million disability-adjusted life years (DALYs) or 7.4% of all DALYs worldwide (Whiteford et al., 2013: 3); (iii) development assistance to health spending on HIV in 2010 was US\$6.8 billion (Ortblad et al., 2013: 1); and (iv) in 2010, HIV accounted for 81.547 million DALYs or 3.3% of all DALYs worldwide (Ortblad et al., 2013: 3).

22 Even in economies where tracking of finances occurs (such as the UK), it can be hard to aggregate spending across specialist mental health care, general hospital care, primary care, social care and services, criminal justice services, employment services and other forms of mental health services.

Figure 4: Global health burden vs development assistance spending in LICs

Comparative disease burden (2010)

- HIV
- Mental health



Comparative global development assistance spending (2010)

- HIV
- Mental health



Source: Ortblad et al. (2013); Gilbert et al. (2015).

The second issue raised by Table 1, and implicit in the report by Gilbert et al. (2015), is that there is some overlap between the listed actors: WHO receives funds from various countries, as do the Global Fund and EU institutions. The lack of transparent financial tracking prohibits a clear picture of what is actually being channelled by the sector and by whom. For instance, while DFID does fund a number of global mental health actions, there is limited information about how much they are channelling to the sector as their funding tends to be lumped in with other ‘health systems’ programmes, so is not clearly categorised (or reflected in Table 1). This makes it difficult to present a clear understanding of who the top mental health donors are. This lack of clear budget lines for mental health is an essential starting point for the donor

community to address. We know global mental health funding is desperately low, but we cannot get clear figures to say precisely *how* low.²²

One issue raised in Australia was that much of the funding to mental health is in the form of short-term contracts, meaning the continuation of funding is uncertain (Suicide Prevention Australia, 2015b). This presents challenges in that services are only able to plan for the short term and are often forced to terminate their programmes when funding is discontinued. Suicide Prevention Australia found that this disruption has serious effects on the health and wellbeing of its service users (Ortblad et al., 2013: 2). As well as the funding being increased, it is essential that it moves towards the longer-term certainty that is required by frontline service providers and is critical to service users.

23 See <http://givingpledge.org>.

24 A total of 136 innovations in mental health are registered with MHIN, many with several funders (<http://mhinnovation.net>).

Table 2: Overview of funders and their spending in mental health

Funder type	Providing funding to mental health? ⁱ
Country governments	Yes (all those reporting to the WHO) (WHO, 2014: 22)
Households	Yes (almost all of those affected) (WHO, 2014: 22)
Development agencies	Yes (28 bilateral donors) (Gilbert et al., 2015: 3)
Development banks, international or UN organisations (in part via bilateral development agency funding)	Yes (9 multilateral organisations, including UNHCR and UNICEF) (Gilbert et al., 2015: 3)
Foundations, NGOs, international NGOs and research organisations ⁱⁱ	Yes (limited) (see Annex 3)
Private-sector foundations	Rare examples (very limited)
Philanthropists	Rare examples (very limited)

i Estimation based on DAC reporting, interviews and research for this report, including adapting data from the Institute for Mental Health Metrics and Evaluation (2015).

ii It is important not to conflate NGO programmes (which tend to be relatively modest) with those of private foundations (such as the Gates Foundation). Private foundation programmes tend to be larger and more complex. For reasons of brevity, however, they have been categorised together in this report.

Who isn't funding mental health?

This report identifies the main funders of global mental health as country governments, individual households and donors (which, due to the DAC Creditor Reporting System, included reference to development banks and international and UN organisations for brevity). There are several other groups that do not currently provide major funding to mental health but are significant actors in the international development sector, many of which have a focus on health programmes, and so warrant introduction. These groups are: (i) foundations, NGOs, international NGOs and research organisations (such as the Bill & Melinda Gates Foundation (the 'Gates Foundation') or Save the Children); (ii) private-sector foundations (such as The MasterCard Foundation); and (iii) philanthropists (such as those listed with the Giving Pledge).²³

In the absence of a comprehensive database registering spending for mental health, we have compiled Table 2 as a guide for readers, based on the DAC Creditor Reporting System, interviews and research for this report. As part of the primary research for this report, a table of all funders registered with the Mental Health Innovation Network (MHIN) was created.²⁴ For more information on Table 2, and a more comprehensive list of funders, see Annexes 1, 2 and 3 to this report. It is worth noting that many of the foundations or multilateral donors operating are funded via development assistance that they receive from donors. This can lead to 'double counting' of the spending in mental health, and so caution is required when calculating spending to avoid duplication. This further reinforces the need for a comprehensive database of spending on the area from the development community.

What's missing?

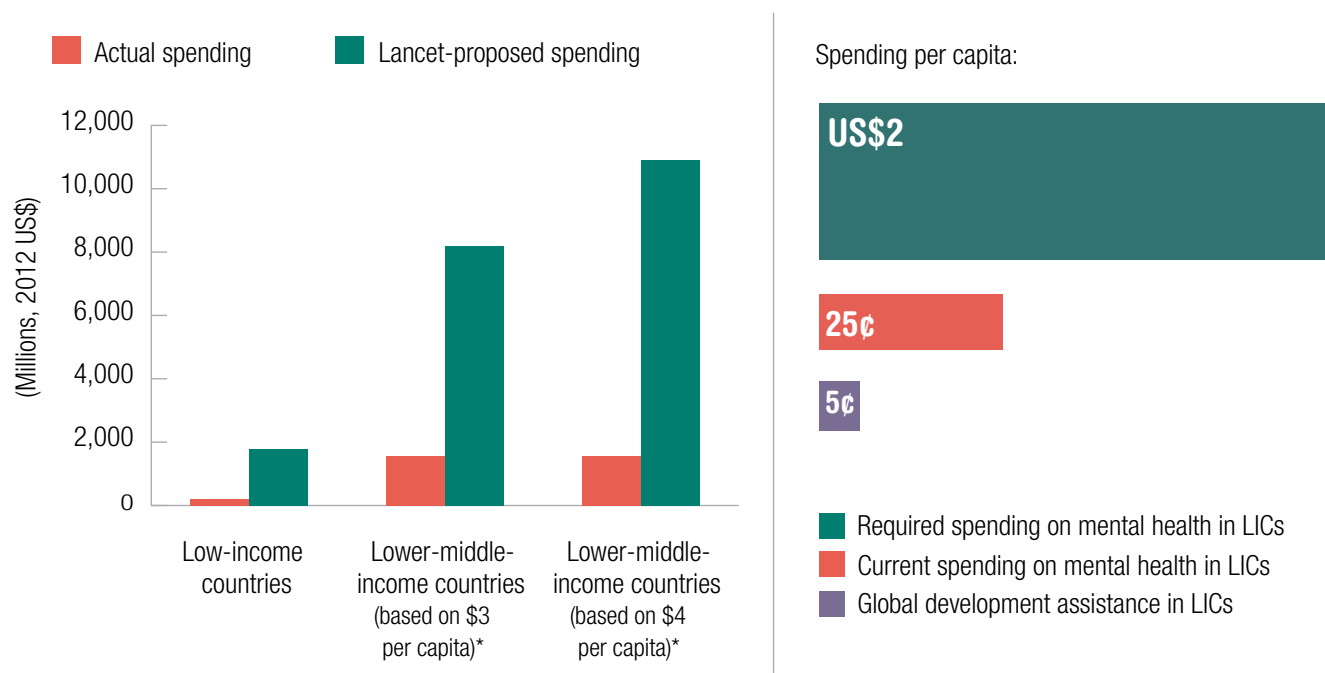
The combined spending of two key groups identified (country governments and development agency assistance)²⁵ is far below what is required to meet the basic needs of the sector based on the call for action by the Lancet Global Mental Health Group in 2007 (see Figure 5). The Lancet Global Mental Health Group estimated the minimum needs to be scaling up a basic mental health care package to US\$2 per capita per year in low-income countries (Lancet, 2007). In 2011, the WHO Mental Health Atlas estimated mental health expenditure in low-income countries to be US\$0.20 per capita, with donor assistance (recorded with the DAC Creditor Reporting System) adding a further US\$0.05 per capita (Gilbert et al., 2015: 3). This means that only 25 cents per capita is spent, compared to the US\$2.00 per capita that is needed to meet basic mental health care costs. To meet this minimum needed, as asserted by global experts, we need to find the remaining \$1.75 per person.

In practice, this shortfall means that there are large gaps between what is provided and what is needed in the field of mental health. Workforce shortages are high, with LICs having, on average, one psychiatrist for every two million inhabitants (WHO, 2013b). As an indicator, there is only one psychiatrist in Sierra Leone.²⁶ This figure is staggering, particularly when compared to any other health care service. It was estimated that by 2015, if the supply of mental health workers were to remain unchanged from 2005, the mental health worker shortage would increase from 1.18 million workers to 1.71 million workers (a 45% increase) (WHO, 2011).

25 Households and other groups have been discounted due to the difficulties in tracking funding responsibly.

26 Reported at the 22 February 2016 UK APPG meeting on 'Mental Health for Sustainable Development: The Role of International NGOs'.

Figure 5: The mental health funding gap



* Lancet Global Mental Health Group Estimation. Source: Gilbert et al. (2015) (left panel); Mackenzie, adapted from Gilbert et al. (2015) (right panel).

These gaps represent an enormous shortfall, and demonstrate that mental health systems must be strengthened if sustainable care is to be provided. Approximately 76% to 85% of people with severe mental disorders receive no treatment in LICs and MICs (WHO, 2013a). This means that millions of people in need of treatment are neglected and are already being ‘left behind’.

There are further gaps when you consider the type of funding that mental health is aligned with, such as responses to humanitarian emergencies. This is because while mental health may be listed as part of the response the funding is not ring-fenced or earmarked and is sometimes eroded as other, more visible and urgent needs present themselves. Additionally, the funding provided in these emergencies is in part a short-term response – as in the case of the provision of psychological first aid – and is

not always able to address the wider situation or support the broader, sustainable mental health programmes or systems. While this short-term support is crucial, the systems desperately need to be built also.²⁷ And beyond MHPSS in emergencies, there are other areas of mental health that are also in dire need of resources.

In conclusion, country governments and households carry the majority of the burden of mental health spending in developing countries. Tracking of what funding goes towards mental health, with clear budget lines in donor reporting, is desperately needed to fully respond to the problem. The shortfall in services means that millions of people are left behind in terms of treatment, especially outside of crises.²⁸ Reprioritisation of mental health and a dramatic increase in spending by the development community are urgently needed.

27 At present, Iraq, Afghanistan, the West Bank and Gaza remain the top recipients of development assistance for mental health, where these protracted emergencies have seen mental health support turn towards systems building (Gilbert et al., 2015).

28 This report does not intend to imply that mental health programmes in emergencies are always well funded. In fact, mental health regularly forms a very small percentage of the budget for emergencies, and this should certainly be increased.

Chapter 2: Why global mental health funding needs to change, now

There is momentum

In both local and international communities, increasing attention is being paid to the issue of mental health problems and pragmatic solutions are being sought. In 2013, a comprehensive Mental Health Action Plan (2013-2020) was endorsed by all 194 WHO Member States, codifying the objectives for the field. This means that, for almost the first time, there is broad agreement about what to do and who should do it – but no substantial funding to implement the plan.

The World Bank and WHO also co-hosted a meeting in April 2016 to discuss global financing needs for depression, with finance and health ministers attending from representative countries. This event coincided with the World Bank Group (WBG) and the International Monetary Fund (IMF) spring meeting, to raise awareness among important new audiences. Specifically, the World Bank is focusing on scaling up services for depression and anxiety, and the event provided a platform to put the case for investing in mental health in front of finance and health ministers. These events are pivotal to raising awareness and funding for mental health.

Seventeen new Sustainable Development Goals (SDGs) were agreed in 2015, with several sub-clauses. Three of the health-related SDG targets relate to MNS disorders, which call to ‘promote mental health and wellbeing’, promote ‘universal health care coverage’ and ‘strengthen the prevention and treatment of substance abuse’.²⁹ As mental health was not included in the Millennium Development Goals (MDGs), and so was not prioritised by many country governments in their targets and

development strategies), this marks a significant turning point.³⁰ Inclusion in the SDGs will help to highlight the importance of mental health and pave the way to secure tangible commitments from the development community.³¹ If there is to be any progress in this area, we next need to start looking at who will pay for that change (Rogerson et al., 2014). For example, the popular argument that there is no health without mental health (Prince et al., 2007) implies it is imperative that universal health care include mental health services to ensure that no one is left behind. This is no small ask: universal health care is estimated to cost US\$50-80 billion, a figure that donors are already grappling with how to finance (Martin and Walker, 2015). But with the SDGs as a platform, discussion of first targets and indicators, and then financing, can begin.³²

Given that mental health is significantly underfunded, practitioners and researchers are currently trying to (i) compile existing data into accessible formats to determine the state of mental health globally, and (ii) construct a much-needed evidence base for what works in the field. For the former, the production of the WHO Atlas is a strong start, and has involved collating much needed evidence from across many countries on mental health activity since 2001. For the evidence base of what works in the field, international NGOs (INGOs), such as BasicNeeds, are providing cost-effective models for what works in different countries (and documenting and sharing their approach through platforms like MHIN), which others can replicate or learn from (De Menil et al., 2015). The evidence base is markedly lower in LICs and MICs compared to the amount of research in HICs. LICs and MICs contribute only 3-6%

29 See targets 3.4, 3.5 and 3.8 of the SDGs at <https://sustainabledevelopment.un.org>.

30 In large part thanks to the advocacy efforts of groups like FundaMentalSDG (www.fundamentalsdg.org).

31 To complement those in the Mental Health Action Plan 2013-2030, which, at the time of writing, is beginning to be implemented with guidance from WHO.

32 Like those helpfully set out in the Mental Health Action Plan 2013-2030

of the mental health research published in indexed journals, despite representing the majority of the world's population (Academy of Medical Sciences, 2008). It is important that this changes. LICs and MICs require localised and cost-effective strategies to meet the mental health needs of their populations. Without research, the exact needs are unclear, much less how to solve them. There are a select few examples of this shortfall being addressed directly, including Grand Challenges Canada (GCC) funding the aforementioned MHIN and an international portfolio of over 70 innovations in 28 countries, as well as considerable investment by the Wellcome Trust in mental health research, and DFID's funding for PRIME and other projects.

It makes economic sense

Arguments for supporting mental health abound (WHO, 2013b),³³ but one of the most compelling is the economic argument, especially over the long term. WHO and the World Economic Forum (WEF) estimate that the global impact of mental disorders will amount to a loss of economic output of \$16 trillion over the next 20 years (WHO, 2013b: 7). Quite simply, this is a cost that the global economy cannot afford. The private costs are almost impossible to determine. Yet with an estimated 650 million people worldwide suffering from a common mental disorder (such as depression or anxiety) – and almost three-quarters of this burden in LICs and MICs – the global community needs to find a way to fill this gap (WHO, 2013b: 17).

It is worth reinforcing that there are important gains to be made from investing in mental health, not only losses to be avoided. When cost-effective, community-level treatment is available, there is a substantial improvement in workforce productivity (Beeharry et al., 2002). A study in the UK determined that workplace health promotion programmes generate a £9.69 return on investment per £1 spent (Knapp et al., 2011: 9, 39). Another study in Australia found that every dollar spent on workplace mental health generated US\$2.30 in organisational benefit (PwC, 2014). In the McDonnell Douglas EAP programme (1990), adequate treatment for mental health problems reduced lost work days by 25% and produced an 8%

Box 3: The Chain-Free Initiative, Somalia

In Somalia it is estimated that 170,000 people with mental health problems are kept in chains. The Chain-Free Initiative aims to improve the quality of life of people with mental health problems through combating discrimination and facilitating humane treatments in hospitals, at home and in communities.

'When the doctor requested me to remove the chains, and the wife started to object, I did not know what to do...[however,] as the doctor was insisting to remove [the chains], I had to decide, and I started to remove [them]...to my surprise and the bewilderment of everyone present, the patient stood up and kissed my face.' — *Dr Aden Haji Ibrahim, Transitional Federal Government Minister of Health and Human Services Somalia*

MHIN, Chain-Free Initiative

reduction in turnover for people with mental disorders (Beeharry et al., 2002). Funding to mental health is an investment and is better framed as such, with strong economic returns (on top of other very valuable social and personal benefits). To frame these potential benefits on a more global scale, and based on international studies of the prevalence of common mental disorders and associated days out of work, it can be estimated that a total of more than 10 billion days of productivity (equivalent to approximately 45 million years of work) are lost each year due to depression and anxiety disorders.³⁴

Not all of these lost 'years of work' can be restored to the economy, but mental health treatments can make a difference. It is worth noting that, while few recent trials showing a significant impact of mental health treatments on productivity have been published,³⁵ a small number undertaken in India, Korea and the US are helpful (Rost et al. 2004; Rollman et al. 2005; Wang et al. 2007; Woo et al. 2011; Buttorff et al. 2013).³⁶ These studies found the decrease in absenteeism was close to one day per month. Only two studies reported on presenteeism separately (as distinct from absenteeism). In the Korean study, patients who received treatment had 24 more productive hours per

33 With the frames of the arguments ranging from social and wellbeing, to human rights driven, to productivity.

34 This calculation is based on findings from the Global Burden of Disease study (Whiteford et al., 2013), the World Mental Health Survey (Table 1), Alonso et al. (2011), Bruffaerts et al. (2012) and personal communication with Dan Chisholm, Health Systems Advisor in the Department of Mental Health and Substance Abuse at WHO.

35 A review of 352 published trials of psychological and pharmaceutical interventions for depression, by researchers at VU Amsterdam and the Trimbos Institute showed that very few trials reported results on economic outcomes, and those that did showed a relatively small gain (Dan Chisholm, personal communication). This was corroborated by a review by Harvey et al. (2012).

36 The studies focused on the benefit of treatment interventions for common mental disorders, in terms of productivity.

37 And allow for both the onset of effect as well as the time lag between improved health or functioning and return to work (a downward adjustment of 25%, or three months in a year).

month (Woo et al., 2011), while in the Indian study patients receiving the collaborative care had four less partial days lost (Buttorff et al., 2013). With the conservative assumption that one partial day is equivalent to one third of a whole day, this means that approximately one complete day of unimpaired work is restored per month through these treatment programmes. If this is considered as a proportion of total working days per year (i.e. 220 days),³⁷ a 4-5% increase in working days is gained through reduced absenteeism, and a 5% increase through reduced presenteeism. Multiplied across the millions of cases who could benefit from treatment, this would produce a huge increase in productivity for any economy. Accordingly, the potential for restored productivity in economies should be more widely recognised and fought for.

It can help improve the effectiveness of other development programmes

Investing in mental health also delivers benefits to other international development programmes. This is sometimes referred to as ‘bi-directionality’ in the literature, and could more often form a natural component of many sectoral programmes. Essentially, given the negative impacts of mental disorders on daily functioning, there is space to include components addressing mental health in many programmes. The more obvious examples include addressing the following combinations: agriculture with suicide; debt with depression; climate change with mental health resilience; and maternal, new-born and child health with maternal depression (Steel et al., 2009; Bogic et al., 2015; Ventevogel et al., 2015).³⁸ Investing in mental health helps to deliver real benefits to these programmes. An interesting case study is that of the Friendship Bench in Zimbabwe. This project provides counselling services to people living with HIV, helping to prevent suicide and improving adherence to anti-retroviral therapy, which in

turn improves the outcomes of the HIV programme as a whole (Chibanda et al., 2011). Another illustration is found in the maternal mental health interventions that demonstrate that programmes can improve not only the mothers’ symptoms (Thinking Healthy, MHIN), but also child development (a South African case study by Cooper et al., 2002).

There are cost-effective solutions

Finally, it needn’t be expensive to provide basic services for mental health. There is an expanding body of evidence suggesting that sustainable mental health care can be effectively provided by harnessing non-specialists. Studies in LMICs have demonstrated the cost-effectiveness of ‘task sharing’,³⁹ which enables countries to overcome the deficit of trained mental health professionals by sharing responsibilities with non-specialists, often lay health workers with no formal accreditation in mental health.⁴⁰ This is considered a more efficient use of available human resources, which can help meet the urgent needs of millions of people living with MNS disorders. Ideally, this would be provided in coordination with capacity-building strategies to increase the number of trained mental health professionals in a country (Buttorff et al., 2012; WHO, 2007). WHO’s mental health Gap Action Programme (mhGAP) provides guidelines of this type for clinical decision-making in non-specialist settings, helping non-specialists to adopt this role. Far more programmes could implement task sharing as a cost effective way of reaching those in need.

Given its inclusion in the SDGs, the World Bank-WHO meeting in April 2016, the agreement crystallised in the WHO Mental Health Action Plan, the economic argument and the gains to be made, and the benefits to existing sectoral programmes, now is the time to be investing in mental health – and in gathering evidence of what works.

38 The treatment of depression and grief in humanitarian emergencies (where the substantial amount of mental health funding is channelled) demonstrates the logic of this bi-directionality.

39 A concept used across the health sector, not only in mental health.

40 Task sharing (also known as ‘task shifting’) is defined as ‘delegating tasks to existing or new cadres with either less training or narrowly tailored training’, is an essential response to shortages in human resources for mental health (Jenkins et al., 2010a).

Box 4: The Friendship Bench, Zimbabwe



The Friendship Bench is a project in Zimbabwe led by Dr. Dixon Chibanda from the Zimbabwean AIDS Prevention Programme and funded by Grand Challenges Canada. Benches are placed outside clinics where people come to access services for a variety of health conditions, including HIV/AIDS. The project trains lay health workers, known as ‘Grandmothers’, to offer problem-solving therapy to people who are referred to the benches by clinicians, helping to prevent suicide and improving adherence to anti-retroviral therapy, which in turn improves the outcomes of the HIV programme as a whole.

‘With other pressing issues, like Typhoid or HIV, [if I was told to make]...the main concentration [of our work]...mental health? That idea used to be out of this world. Then [I came across] this project... I began to see the other benefits of [mental health work]: a cost effective way for the system, a way of really delivering services. We don’t have the psychiatrists in Harare. This project is really filling that gap. It’s cheap. And we can see the way they demonstrate the impact. The people [who were suicidal] are there; ...they are here now... alive.’ — *Dr Chonzi, Director of Health Services in City of Harare, Zimbabwe*

Interview with Dr Chonzi. Photo: A Friendship Bench service user and ‘Grandmother’, Zimbabwe. © Bogani Kumbula/ODI 2015.

Chapter 3: Who could fund global mental health in the future?

Earlier chapters have outlined the actors currently funding mental health and why the group of core funders must expand and change urgently, given the needs of the sector. In this chapter, the question of who could fund mental health in the future is addressed. The suggestions in this chapter are presented with the caveat that this research was conducted over a brief period, and so must speculate to some extent. Light criteria were adopted for the selection of potential funders.⁴¹ An application of the Overseas Development Institute's (ODI) Knowledge Policy and Power framework (KPP) (Jones et al., 2013), research, and interviews with industry representatives suggests that

Table 3: Identifying funders for the future

Funder type	Funding mental health?
Country governments	Existing funder
Households	Existing funder
Development agencies	Existing funder
Foundations, NGOs, INGOs and research organisations	Funders who could do more in mental health
Development banks	Funders who could do more in mental health
International or UN organisations	Funders who could do more in mental health
Private sector foundations	Less traditional players
Philanthropists	Less traditional players

Source: adapted from Gilbert et al. (2015). Before 2011, bilateral donors spent more on aid to global mental health than multilateral donors but multilateral donors have been increasing their spending since 2007 and took the lead between 2011 and 2013. It is acknowledged that there is overlap between these groups as bilateral agencies give funding to multilaterals, so the division can be somewhat artificial.

the key barriers to groups funding mental health currently include: (i) lack of knowledge about mental health (either its prevalence or the extent of its negative impacts); (ii) stigma; (iii) the fact that mental health is not considered a priority above other development issues or sectors; (iv) the belief that metrics to measure progress in mental health do not exist, are unreliable, or are too hard to implement. An assessment of these barriers can be found in Annex 2, and more detail on the characteristics that hinder mental health from gaining policy traction is available in an earlier ODI publication (Mackenzie, 2014).

To answer the question of who could fund mental health in the future, three broad options present themselves: (a) seeking more financing from existing funders; (b) attracting conventional health funders into funding mental health when they have not done so in the past; (c) approaching less traditional players and financing mechanisms.

Seeking more financing from existing funders

Country governments and households

The first option is to motivate existing funders to channel more spending to global mental health programmes. Chapter 1 listed the main existing funders as country governments, households and donors. Individual households are most likely spending at capacity, doing what they can for family members while under pressure from potentially reduced household income, and so are not an appropriate source of further resources. Indeed, a central thrust of universal health coverage is to protect households from the potentially impoverishing costs of mental and other health disorders. Given that most developing country governments have stretched resources and their funding is at capacity dealing with various health

⁴¹ The criteria included an assessment of the following: likely availability of funding; broad strategic objectives or those that could be aligned to or incorporate mental health; flexibility of geographic regions; those that may not have been approached or considered in the past.

priorities, it is difficult to ask them to spend more.⁴² Most have made what commitments they can (though have not yet committed the funding) to improve according to targets set in the Mental Health Action Plan 2013-2020.

The exception to this would be the emerging economies (China, India, Russia, Indonesia, South Korea, Brazil, etc.) who are in a position to do more. As well as the greater surplus of available funds for public investment that emerging economies enjoy, there is growing evidence to suggest that rapid urbanisation and economic growth in countries like China are placing increased demands on mental health systems, and that the problem is worsening (Xiang et al., 2012; Srivastava, 2009). Evidence from studies in Sweden suggests that urbanisation is increasing the risk of psychiatric disorders such as major depression and schizophrenia (Sundquist, 2004). As their economies go through large structural changes (which place new pressures on their populations), mental health is a sensible area for emerging country governments to invest in to prevent future costs and to protect the wellbeing of their populations (and the productivity of their workforces).

Development agencies (including bilateral aid programmes)

After country governments and households, the next group to consider is development agencies. In terms of the identified barriers to funding mental health, donors are to some extent aware of mental health as an issue, some understand that metrics are available, and most are not affected by stigma. According to interviews and research for this report, the key barrier to funding mental health that applies to donors is the fact that mental health is not considered a priority compared to other areas. The difficulty is that donors have many competing priorities and finite budgets. While their priorities will vary according to the donor agency as well as their current domestic political context, generally speaking, donors determine their funding priorities in a combination of five ways: (i) through their strategic plan, which outlines their aid programme's priorities (the major bilateral aid programmes' strategic plans barely mention mental health);⁴³ (ii) responding to (sometimes ad hoc) political priorities (for example, ministerial announcements at public events or during visits); (iii) international commitments (such as the SDGs); (iv) responding to what works well through monitoring and evaluation systems (accountability-driven investments);

and (v) responding to taxpayer concerns or pressure. Any advocacy effort to promote mental health spending would need to take account of these avenues. None of these is likely to be an immediate entry point for mental health. There is, however, space for change through international commitments via the SDGs, or if political pressure succeeds in seeing mental health added to strategic plans. Any advocacy plan would need to assess those avenues specific to the donors identified as 'friendly' to supporting mental health, and plan accordingly.⁴⁴ For instance, DFID's 2014 publication of a Disability Framework with a mental health focus could be seen as demonstrating their commitment to ensuring that their development work empowers all in society, leaving no one behind (DFID, 2014).

'After [the community health worker] came many times, I kept on improving. He told me how you get the illness, how you should avoid it. He told me all that. I followed what he told me and now I feel good.'

Suraj, beneficiary of the Care for People with Schizophrenia in India Project (MHIN)

At the country level, there is certainly potential to use political pressure and the SDGs as a platform to seek more funding from donors to help support mental health systems and services. There are movements underway in Australia, Canada and the UK that can be built upon. DFID is coming under increased scrutiny following release of the 2014 APPG report on global mental health (Ryan and Usmani, 2014) and from the British population generally through increased awareness generated via mental health campaigns in the public domain. As a cooperative move, the disability community has been making important strides in the SDGs agenda with development agencies and would be a strong natural ally for the mental health community.⁴⁵ This is the type of political pressure that could see mental health placed in a more prominent position within DFID's funding priorities.

42 It is true that in order to compel development banks and donors to reprioritise mental health, there is a role for developing country governments to play in advocating for mental health. Similarly, spending on mental health should ultimately be handled by domestic governments, but until that is feasible, donors need to be compelled to fill the funding gap.

43 Research for this report included canvassing strategic plans from DFID, USAID, the Australian Aid Programme within DFAT, and SIDA. Of these, DFID and USAID mention that mental health is essential for well-being, but do not highlight any programmes or initiatives to support this in their strategies.

44 It is important that any future contributions to mental health by donors are not siloed, but mainstreamed. One of the problems with mental health is that it is often forgotten or stigmatised. A better approach would be for the Global Health Financing Fund to include mental health (rather than creating its own standalone fund).

The Canadian government has been generous to date in prioritising mental health, spearheading initiatives like the MHIN and the innovations they fund. With the election of a prime minister with a personal understanding of MNS disorders, there is potential for their leadership in the field to continue. It is crucial for these donor efforts to be able to provide the evidence base to underpin future investment, and be able to show the leadership strong cost-effective examples of what works. This is the kind of activity that MHIN is working to provide, though more efforts are needed. The Australian government has recently appointed a new Minister for International Development and the Pacific, with a strong focus on economic growth and innovation. This is a good opportunity for the Australian aid programme to position itself at the forefront of mental health initiatives to improve workforce productivity, including in the Pacific, drawing on the strong experience that Australia has domestically in supporting mental health.⁴⁶

There are opportunities outside of donor health budgets that should also be considered. Some donors are offering alternatives to traditional health programme financing, which could provide new avenues for seeking mental health funds. For example, DFID has partnered with the CDC Group⁴⁷ to start the DFID Impact Fund, a £75 million fund dedicated to supporting businesses that focus on creating personal impact in LICs and LMICS in sub-Saharan Africa and South Asia.⁴⁸ This could be a fund for mental health projects to access, through the use of metrics to provide evidence for the improvements to workforce productivity.

There are also mutual benefits to countries learning what works in health services, which means donors can bring about benefits for their domestic settings. Partnerships are underway between different countries, an example being the Brain Gain project. This project is funded by the Tropical Health Education Trust through a DFID Health Partnerships scheme and is operated through a link between the East London NHS Foundation Trust and Butabika National Referral Hospital in Uganda – an example of mutual cooperation in the mental health field. Partnership with the Uganda Diaspora Health Foundation allows for the implementation of culturally appropriate interventions in Uganda, and in turns generates evidence of good practices for the National Health Service providing care to the Ugandan diaspora community in London (Baillie et al., (2015).

Attracting other conventional health funders into financing mental health

The second option is to bring more of the major health donors on board by framing mental health in new ways, to align with existing priorities or to meet funding selection requirements.⁴⁹ Chapter 1 of this report outlined the groups that are not currently spending on global mental health (see Table 2) but that could be approached given their existing work in the health sector. These include foundations, NGOs, INGOs and research organisations, development banks and international organisations, which are addressed in turn in this section.

Foundations, NGOs, INGOs and research organisations

An application of KPP, together with information from industry representatives during interviews, suggests that the key barriers to foundations, NGOs, INGOs and research organisations funding mental health currently are not lack of knowledge about mental health or stigma; many are in fact well informed.⁵⁰ The key barriers are the fact that mental health is not prioritised compared to other health issues, and that these agents have a strong need to demonstrate results and impact to the public. Mental health is considered hard to measure, so it is a challenging area in which to show rapid results; competing priorities and concerns about metrics are the reasons why mental health rarely receives funding from this group. This means that there is a need to communicate the range and effectiveness of the metrics available for mental health programming, as well as how dire the needs of mental health are compared to other health programmes.

Key messages to demonstrate the needs of mental health to this group would likely include the statistic that one in four people are affected by MNS disorders over their lifetime, the drastically low amount of funding spent (especially using graphics to illustrate the amount spent compared to the burden of disease, such as in Figure 4 of this report), their inclusion in the SDG targets, as well as the potential benefits to other sectoral programmes (which these foundations or NGOs are implementing). A secondary line of messaging to combat misunderstanding of metrics might communicate that metrics do in fact exist for mental health, as is evident from WHO's Mental Health Action Plan 2013-2020 (WHO, 2013a), which identifies key targets and indicators to measure progress and information on how to scale up mental health services. A third approach might

45 Interview with Carrie Netting., Head of Disability Policy, DFID.

46 This could build on existing programmes funded by the New Zealand Aid Programme, with WHO, under the Pacific Islands Mental Health Network (www.who.int/mental_health/policy/country/pimhnet/en).

47 The UK's Development Finance Institution.

48 See: www.cdccgroup.com/dfid-impact-fund.aspx.

49 Some different approaches to messaging are dealt with in Annex 4.

50 Though of course generalising across such a large group is always open to inaccuracies.

include building on instances where such foundations have existing (minor) grants of a similar nature. For example, the Gates Foundation has awarded \$596,536 to grants for domestic mental health projects in the US,⁵¹ and \$670,000 to Haiti in 2010 to provide emotional and psychological support to children affected by the earthquake (Gilbert et al., 2015). While this figure is small compared to the total amount that the foundation currently spends, at least it is occurring. As the foundation is also concerned with childhood development, connecting this to mental health becomes a useful entry point for steering the conversation towards funding global mental health activities if they are willing to do so in the US. Typically, the funding priorities of foundations, NGOs, INGOs and research organisations are driven by (i) a strategic plan or mission statement, (ii) their board of governors, (iii) public pressure, and (iv) emerging evidence or needs presented at conferences or industry debates. Any advocacy plans to approach these funders would need to be tailored to these avenues.

Development banks

Development banks include institutions such as the World Bank, the Asian Development Bank, and the African Development Bank. The information gleaned from research, from interviews with industry representatives and by applying KPP suggests that the key barriers to development banks funding mental health are a lack of knowledge about mental health (either concerning its prevalence or the extent of its negative impacts), combined with the fact that they do not consider mental health a priority. While it is dangerous to generalise, development banks traditionally have a stronger focus on, and knowledge of, areas like economic growth and infrastructure. A third potential barrier is that development banks may not be aware of the metrics available for measuring progress on these types of programmes. This means that there is, firstly, a need to communicate the dire needs of people living with MNS disorders, and the extent of the problem; secondly, a need to communicate the implications that MNS disorders have for economic growth and workforce productivity for this group; and thirdly, a discussion of the potential gains to be made from investing in global mental health programmes. It may also be helpful to communicate the low investment made globally in mental health (which implies a need for loans) as well as the range and effectiveness of the metrics available for mental health programmes. Typically, the funding priorities of development banks are driven by (i) strategic plans detailing the banks' priorities, (ii) their

executive board or board of governors, (iii) responding to national government loan requests, or (iv) funding directly from donor programmes in-country for specific issues. Any advocacy plan to approach these funders should try to use these entry points – particularly by encouraging country governments to prioritise mental health in their discussions with development banks about loans, as well as through donor programming efforts in-country (where they could fund development bank programmes which could incorporate a mental health component or awareness).

'The integration of mental health into other programmes, like HIV, can improve these programmes.'

Dr David Okello, WHO, Country Representative Zimbabwe (comments during MHIN policy-maker forum, Zimbabwe, 2015)

UN organisations

The same analysis suggests that the key barriers to UN organisations funding mental health more are, firstly, a general low awareness – other than in WHO and UNODC – within their programme staff about mental health (this includes both the prevalence of MNS disorders and the low amount of funding they receive),⁵² and secondly the fact that mental health is considered a less urgent priority than other health programmes (see the example above of 1% of the WHO budget being allocated to mental health). The reasons for this are covered in a previous ODI report in more detail, and include the heterogeneity of MNS disorders, under-diagnosis, lack of data and the unobservable nature of many MNS disorders reducing their apparent prevalence and urgency (Mackenzie, 2014: 13). Like donors, UN organisations have many competing priorities and a finite budget. This means that there is a need to communicate (i) the extent and dire needs of people living with MNS disorders, (ii) the low amount of funding that exists for mental health (including the fact that reporting of spending is so incomplete), (iii) the large economic impact that this causes annually, and (iv) the potential benefit to international organisations that investing in mental health could bring to their existing development programmes (through bi-directionality). Typically, the funding priorities of international and UN Agencies are driven by (i) the UN General Assembly and any relevant council (for example, the Economic and Social Council helps govern UNHCR),

51 The largest such a grant went to Lutheran Community Services Northwest to support mental health services for refugees living in Seattle, Washington (www.gatesfoundation.org/How-We-Work/Quick-Links/Grants-Database#q/k=mental%20health).

52 It should be noted that there are several important champions of mental health within these organisations (in WHO, or those in a health advisor role or similar), but the barrier is that the majority of programme staff across the organisation who conduct the bulk of the programming, budgeting or reporting are not particularly aware of mental health.

(ii) an executive committee (which approves the agencies' programmes and corresponding budgets), (iii) responding to national government requests, and (iv) direct financing from donor programmes in-country on specific issues. Any advocacy plan to approach these funders should try to use these entry points, with the relevant messaging.

Approaching less traditional players and financing mechanisms for consideration

The third option is to approach less traditional players and financing mechanisms to help attract new spending on global mental health. These may not have been approached in the past or may not be traditionally involved in mental health, and include private foundations, philanthropists and innovative financing mechanisms.

Private-sector foundations

There are a range of private sector foundations that have large endowments to spend on philanthropic causes.⁵³ Recent reporting suggests that the share of philanthropic foundations (a group which includes private-sector foundations) is approaching 7% of donor financial flows (Johnston, 2015). These foundations differ from the foundations listed above (such as the Gates Foundation) in that they are creations of private-sector companies wanting to conform to corporate social responsibility objectives and reflect a broader philanthropic movement occurring in certain domains. They include The MasterCard Foundation, the Nippon Foundation, Google.org, the Unilever Foundation and Atlantic Philanthropies. These foundations bring about new opportunities for funding, though they remain a diverse ecosystem. Many also have particular areas of focus which pertain to their original founding company. For example, The MasterCard Foundation has a strong focus on youth employment and agriculture in its work. Certain leadership members within these institutions have a known appreciation of the importance of global mental health.⁵⁴

An application of KPP, together with research and interviews with industry representatives suggest that the key barriers to private sector foundations are firstly a general lack of knowledge about mental health programmes,⁵⁵ with possible concerns about stigma. A further potential barrier is that private-sector operating structures and cultures have a propensity for results-based payment

systems, so they may need convincing of the reliability of metrics and the ability to measure or show success quickly. This means there is a need to communicate (i) the extent of and the dire needs of people living with MNS disorders, (ii) the available metrics to measure progress, and (iii) to point to the inclusion of mental health in the SDGs. Many private-sector foundations have a strong link to the SDGs. For example, Paul Pollman of Unilever has been very vocal on his role in advocating for the SDGs. Unilever created the 'Sustainable Development Goals and the Post-2015 Agenda: Business Manifesto' (Unilever, 2015a), which was endorsed by 20 international companies and is a 'call to arms' for the business community to support the SDGs (Unilever 2015b). Businesses such as MasterCard, BT, KPMG, GlaxoSmithKline and the technology company Philips were part of this manifesto, demonstrating a willingness to scale up their philanthropic engagement, especially towards achieving the SDGs. There is also potential for mental health to link to the disability community's strong success in raising awareness with companies such as Google (resulting in initiatives like the US\$20 million Google Impact Fund),⁵⁶ given that 'the barriers that people face aren't just physical.'⁵⁷

Alternatively, there could be fourth communication focus on the role mental health can play in improving workforce productivity. The challenge is to extend this to global mental health funding beyond the borders of the UK, the US or other HICs, where the more visible proportion of these companies' workforces operate. In recognition of the fact that MNS disorders have a drastic effect on people's ability to work, some of these companies have focused on promoting workforce wellness. Examples include the City Mental Health Alliance, which has made some initial attempts to 'connect mental well-being to good business practice.'⁵⁸ While various London businesses are associated with this group, these alliances could be more beneficial to global mental health if they broadened their focus beyond UK employees to employees in developing countries, and eventually to the communities their overseas staff operate in. A fifth communications avenue would be specific to the foundations' areas of interest, to show how including mental health components can improve the work of their other programmes (such as The MasterCard Foundation's programmes on youth employment and agriculture). Typically, the funding priorities of these private-sector foundations are driven by: (i) mission

53 See more at: <http://www.mastercardfdn.org/philanthropy-and-the-post-2015-development-agenda>.

54 Such as Tom Insel of NIMH who became the new Head of Health at Google.

55 Other than among those select champions with personal experience or some other background which has led them to be supportive of mental health as an issue.

56 <https://www.google.org/impactchallenge/disabilities>.

57 Rt. Hon Justine Greening, MP (www.gov.uk/government/speeches/80-of-people-with-disabilities-live-in-developing-countries-and-the-barriers-that-people-face-arent-just-physical).

58 The City Mental Health Alliance is an organisation comprised of London-based businesses with the aim of breaking down the stigma of MNS disorders and connecting mental wellbeing to good business practice. See more at: <http://citymha.org.uk/>.

objectives, (ii) board of governors, or executive board, (iii) alignment with original company objectives, and (iv) media coverage, conferences and debates. Any advocacy plan to approach these funders should try to use these entry points, with the relevant messaging.

Philanthropists

There are many philanthropists with significant sums to contribute who are increasingly engaging in what has traditionally been considered international development territory. For example, the Giving Pledge is a commitment by the world's wealthiest individuals and families to dedicate the majority of their wealth to philanthropy. Aligned to this, Mark Zuckerberg and Priscilla Chan recently pledged that their charity, the Zuckerberg Chan Initiative, would give US\$45 billion to 'charitable causes'. In Zuckerberg and Chan's public letter providing their justification for their initiative, they specifically mention the importance of living a healthy life and advancing human potential – both of which have a mental health element that is essential to reach these goals (Goel and Wingfield, 2015). By making connections to the importance of mental health in wellbeing, initiatives such as this have the potential to fund the gap. It is hard to determine how funding priorities are set within this group of potential funders, and further analysis is needed if this is to be pursued. From the limited information available, it appears to be a combination of (i) personal experience, values and judgement; (ii) operational priorities managed by a board of governors; (iii) alignment with original company objectives (if the philanthropist accumulated their wealth through business or entrepreneurship); and (iv) discussions prevalent in the media, conferences and public debates. This is a much more volatile area than other funding groups in that less is known about philanthropists and their funding mechanisms, and they are traditionally less experienced in international development programming. The key barriers to funding mental health that would need to be addressed may be a lack of knowledge about mental health, or perhaps concerns about stigma. This group is as yet unmapped and comprises a very diverse set of actors, making it hard to generalise. Depending upon the personalities involved and their experience, values or judgement, it might be sensible to present arguments for supporting global mental health that are economic in nature, human rights driven, stipulate productivity gains or use a societal imperative argument.

Innovative financing mechanisms

There is increasing interest within international development in the use of innovative finance mechanisms, such as venture capitalist approaches to seed funding, development impact bonds, public–private partnerships and challenge funds. There is some potential for global mental health financing within this area, though it is largely unexplored.⁵⁹ One of the few examples is the GCC programme, which provides seed funding to mental health projects around the world with the intent to proceed to scale if results are demonstrated,⁶⁰ in an approach similar to that of the Global Innovation Fund.⁶¹ Beyond this, however, little has been explored. And though many of these mechanisms – listed in the following paragraph – may not deliver results in the short term, they are important to consider for the longer term. More immediate funding can be sought from the donors listed previously in this chapter, but a comprehensive package for financing global mental health can include both short- and long-term options.

'Before, we used think that the doctors in hospitals are our enemies who refuse to see and believe what our medicines can do in terms treating diseases. Now... they are not our competitors nor are they enemies, they are colleagues in providing care.'

Traditional Healer in a Wayo-Nero Workshop, Wayo-Nero Project (MHIN website)

The most potential (diagnosed via a light-touch investigation) lies in: (i) innovative insurance schemes; (ii) social cooperation bonds (with a mental health component in payment for services); (iii) sovereign wealth funds; and (iv) social entrepreneur funds. Each of these requires further research if it is to be considered a viable course of action for the global mental health community.⁶²

There have been recent efforts in insurance that have social development aims, and which could be harnessed for global mental health financing. One example is low-cost insurance plans (provided by large private companies like

59 One exception is the Briefing Paper for the Australian National Mental Health Commission (Burns et al., 2014: 24-26), which lists potential financing mechanisms for e-technology in mental health.

60 The GCC's approach (specific to mental health) (www.grandchallenges.ca/grand-challenges/global-mental-health).

61 The Global Innovation Fund is likened to venture capitalist approaches from Silicon Valley, but for international development projects; see their website: <http://www.globalinnovation.fund>.

62 In particular, any work in this area needs to guard against a competitive profit-focused systems, which is not the best approach for mental health service delivery financing. Rather, mental health can learn from and use some of these systems, with a commitment to fostering wellbeing (Suicide Prevention Australia, 2015b).

Swiss Reinsurance Company Ltd) offered to thousands of poor farmers in Rwanda to provide protection for their crops against extreme weather.⁶³ This allows farmers to take out low-cost insurance to protect their loans for high-yielding seeds, fertilisers, and other farm inputs. If crops are destroyed by extreme weather, the premium they (and their investors) pay covers the loss and they are financially secure. If the crops survive thanks to good weather, the return on the investment is profitable to investors. The loans are bundled in a way to reduce risk, across a portfolio of a large number of farmers, which makes it viable to investors. The micro-credit scheme approach used in Rwanda allows banks to make the insurance affordable to poor farmers. By packaging mental health into existing medical insurance schemes, a similar approach could be taken.⁶⁴ The loans could use risks associated with how much people save or lose each month from potential health shocks, set against a monthly cost of paying for the insurance premium, to provide a similar programme that is profitable to investors. In order to be practical, this would need to be offered to MICs or economies meeting a set of requirements, and be designed to avoid certain potential risks.⁶⁵ To overcome these risks, the programme could be designed to package mental health into existing medical insurance schemes and could have a pilot programme (over several years) to demonstrate profitability. This would demonstrate viability for others to invest. The development banks would be natural partners for co-financing.

There is also potentially a way to design ‘social cooperation bonds’ to include a mental health component. This could be profitable for investors and at the same time deliver benefits to global mental health.⁶⁶ The way that bonds delivering investment to companies are currently structured could make room under payment of services, where mental health could be made an additional category. This would mean that, by addressing the mental health

risks/needs of their staff alongside other health services, firms would see increased profitability (along with the other benefits delivered through the large injection of financing as part of the packaged loan). This would in turn see a return on the bonds to investors, across a portfolio, which would then increase the value of the bonds. As with the insurance scheme outlined above, establishing this kind of social cooperation bond would require meeting a set of necessary conditions and avoiding certain risks. These requirements mean that this activity would be more appropriate in emerging economies or MICs. The conditions include (i) a functioning stock market, with applied financial regulation; (ii) a number of small and medium enterprises (SMEs) operating in the formal sector (paying taxes and reporting to regulators); (iii) significant geographic density of these SMEs to create a portfolio; (iv) a low business burden; and (v) financial institutions that can manage the bond funds over time. The programme would require some form of seed funding to kick-start operations – that is, co-financing from bilateral or multilateral development banks or donors which could initially set the payment for services tranche as a grant component of the bond. Eventually, it is hoped, these would demonstrate the viability of the bonds to the market.

Sovereign wealth funds present a third potential source of financing for mental health.⁶⁷ They represent pools of capital in excess of US\$7.2 trillion,⁶⁸ which have extended time horizons enabling them to play a role as patient capital (providing long-term investment). Furthermore, many are ‘dual-impact’, meaning their mandate includes investing in activities with a development angle.⁶⁹ To channel funds to global mental health, there are several criteria that would need to be met. The first is that investments would need to be large because, structurally, sovereign wealth funds cannot deliver small amounts directly (for example, less than US\$1 million). Individual investments in the mental health space would likely need to be in the US\$15-200

63 The programme is called Kilimo Salama (‘Safe Farming’ in Kiswahili) and is a partnership between the Syngenta Foundation for Sustainable Agriculture, the Ministry of Agriculture and Animal Resources, One Acre Fund, SORAS Insurance in Rwanda, and Swiss Re Corporate Solutions. For more information, see: http://www.swissre.com/media/news_releases/nr_20121011_micro_rwanda.html.

64 Discussions with Alberto Lemma in ODI’s International Economic Development Group informed this thinking.

65 For example, mental health service providers operating in-country are a necessary condition. Furthermore, insurance companies need to be made interested in the profitability of the scheme. Challenges include the attribution of mental health to the health of a household, which can be hard to show. Other challenges include encouraging households to see mental health as worth taking insurance cover for.

66 Discussions with Alberto Lemma in ODI’s International Economic Development Group informed this thinking.

67 Sovereign wealth funds are a heterogeneous group of funds with multiple and differing policy objectives. They range from traditional resource-based sovereign wealth funds (like the Abu Dhabi Investment Authority and Kuwait Investment Authority), to those reinvesting foreign exchange reserves (like the China Investment Corporation and Singapore’s Government Investment Corporation). Some have seen fit to include other public pension funds (like Korea’s National Pension Service or Japan’s Government Pension Investment Fund) in discussions around sovereign wealth funds, since they share many key similarities. The defining characteristics of sovereign wealth funds are their theoretically infinite investment horizons, a lack of explicit liability matching, and sovereign ownership.

68 The Sovereign Wealth Fund Institute publishes an estimate of the assets of the largest sovereign wealth funds each year. The latest update in December 2015 approximates the size of these funds at US\$7.2 trillion. Source: <http://www.swfinstitute.org/fund-rankings>.

69 There is a small but growing ‘impact investment’ movement among sovereign wealth funds. However, most are primarily focused on generating impact at the local or national level first, such as Mubadala in the United Arab Emirates. They would likely want to see at least some of the impact generated occurring in their home state. For example, see: <http://www.mubadala.com/en/our-impact>.

million range and, to provide a sense of security to their institutional bureaucracies, would be more feasible if allocated through a more traditional closed-end private equity fund structure, with limited and general partners.⁷⁰ In this case, the sovereign wealth funds would commit long-term capital in their capacity as limited partners but, before doing so, would need to be assured of the suitability and sustainability of the investment thesis. Thus, it is likely that sovereign wealth funds would require third-party experts to act as advisors in the mental health investment sector, and would integrate these advisors directly into the fund. While this could theoretically be the investment manager acting as general partner, it is more likely to be a globally recognised institution with expertise in mental health (such as the WHO). The core challenge here would be balancing the different cultures and speeds so as not to undermine the ability of the fund to allocate capital efficiently.

Investment returns would either need to be attractive (as a general rule of thumb, in excess of 15% internal rate of return net of fees, which mental health is unlikely to be able to deliver) or would need to fall under the broader (more ambiguous) realm of ‘impact investment’.⁷¹ For impact investment, sovereign wealth funds can leverage the work being done by different development funders (Johnson and Lee, 2013). For example, initiatives such as *Convergence* – a platform that aims to enable blended finance deals in emerging and frontier markets – provide promising avenues (as well as grant funding to design innovative finance products that would otherwise be too risky or complex to pursue) (ReDesigning Development Finance Initiative, 2015). Integrating these innovative types of financing can significantly improve the risk-return profile of the investment fund to private investors. A mental health investment fund that successfully integrates ODA or blended finance type instruments can more feasibly be marketed to dual-impact sovereign wealth funds. However, this would limit the choice of accessible sovereign wealth funds, as dual-impact funds tend to be more limited in both scale and mandate. It is therefore likely that a pilot would be required to show benefit and general viability.

Social entrepreneur funds are a fourth potential avenue for innovative global mental health funding. One example of such a fund is Bridges Ventures, which invests in projects valued between £300,000 and £1.5 million that have a clear social element and the ability to make a large impact.⁷² To date, the fund has supported mental health by financing projects like Unforgettable, a global e-platform for people living with dementia and their carers.⁷³ Another form of innovative finance with a social focus is happening at Bain, which offers a social impact programme to form partnerships with non-profits, governments and the private sector to help support any social impact idea. While Bain Social Impact’s main areas of focus are education and economic development, there is space to include funding for global mental health. A list of businesses worth monitoring for these purposes is available.⁷⁴

The key barriers to this group funding global mental health are a lack of knowledge about mental health, or potential stigma. However, they are as yet unmapped, with a very diverse set of actors making it hard to generalise. The way that they determine their funding priorities is equally uncertain. It is possible that they might be led by a venture capitalist approach, requiring strong evidence of returns for investment beyond seed funding, that their day-to-day operations are managed by a board of governors, who would be aligned with original company objectives, and it is likely that media, conferences or debates on mental health in development would play an influential role in decision-making. This would be a less traditional avenue for the global mental health community to consider.

In conclusion, these three broad categories present a range of options for the global mental health community to consider approaching: (a) seeking more financing from existing funders; (b) attracting conventional health funders into funding mental health when they have not done so in the past; and (c) approaching less traditional players and financing mechanisms. More in-depth analysis is recommended for future, which could analyse the relative merits of each group and the key players within them, give consideration to the prioritisation and sequencing of the key actors, and then tailor individual advocacy plans and messaging.

70 Discussions with Sammy Halabi, Co-Founder of Global Risk Insights LLP and former Research Associate at HLD Partners, informed this thinking.

71 Simple examples of mechanisms could include (i) debt financing (provision of debt at either market or flexible rates to help leverage higher returns); (ii) equity financing (helping to anchor new funds); and (iii) partial or full guarantees (the development funder can protect private investors against capital losses).

72 <http://bridgesventures.com/social-sector-funds/social-entrepreneurs-fund>.

73 For more information, see their website: <http://bridgesventures.com/tag/unforgettable-org>.

74 A number of businesses engaging in social enterprise are potentially of interest for global mental health. Several businesses are being certified under ‘B Corp’ because of their ‘values and engagement with social enterprise’. For example, McKinsey on Society is an online platform that offers McKinsey’s insights and innovations on social impact; global public health is listed as an area of expertise and the platform content focuses on psychosocial services and the role the private sector can play in providing healthcare in India and Africa. A report has been released on the use psychosocial services to tackle global challenges such as public health (McKinsey and Company, 2009).

Conclusion: Next steps for the sector

This report offers five key conclusions for the mental health sector going forward at this important time (summarised in Box 5). The first is that the mental health community has made an excellent start on advocacy, evidence, and agreement on what to do and how, thanks to a multitude of organisations, including the World Federation of Mental Health (which has been working for decades in the mental health sector) and, more recently, GCC, via initiatives such as MHIN. The global mental health community must communicate more clearly that investing in mental health increases economic productivity and can help other development programmes to achieve their goals more effectively, and also that governments cannot reach their SDG targets without addressing mental health. What's more, progress in mental health can in fact be measured, despite concerns that appropriate metrics have not yet been developed

Second, it must be communicated more clearly and recognised that global mental health is severely underfunded and how there is dire, urgent need for change. As this report has highlighted, existing funding to mental health must be tracked in a more transparent and accountable way. We know that whatever the precise amount being spent, it is nowhere near enough to address the disease burden of mental health. Donors must start to track and report on their mental health spending. Only with clear figures can the mental health community make the case to change the low levels of funding, and analyse the types of activities that the funding goes to (whether for short-term relief in humanitarian emergencies, or to longer-term programmes and systems building).

There are some early indications of where future funding should be spent. This report introduced four categories of funding (see Box 1).⁷⁵ We know that sustainable mental health care programmes and systems are severely lacking,

including the lack of MHPSS funding in emergencies to work on 'building back better' beyond the initial response programmes.⁷⁶ Examples of areas requiring an urgent increase in funding include: (i) community-based mental health service development (for example, integration into maternal care, general health care and as part of universal health care); (ii) emergency mental health (as explained in WHO's 'building back better' report); and (iii) mental health promotion (from awareness and anti-discrimination programmes, to school-based programmes and wellness at work schemes). These are crucial to ensuring that, as the SDGs emphasise, 'no one is left behind'.

Third, there is an excellent entry point for this change emerging with the inclusion of mental health in the SDGs. It is important that the term 'leaving no one behind' in the SDGs is understood to include mental health (given that people living with MNS disorders are often the most

'[Mental health care] gave me the confidence and made me realize that I wasn't the only person suffering from anxiety. Everyone suffers from it sometimes, and it taught me a way of dealing with it, that it doesn't matter. So I can just get on with life rather than letting the anxiety control me.'

A MoodGYM service user (MHIN website)

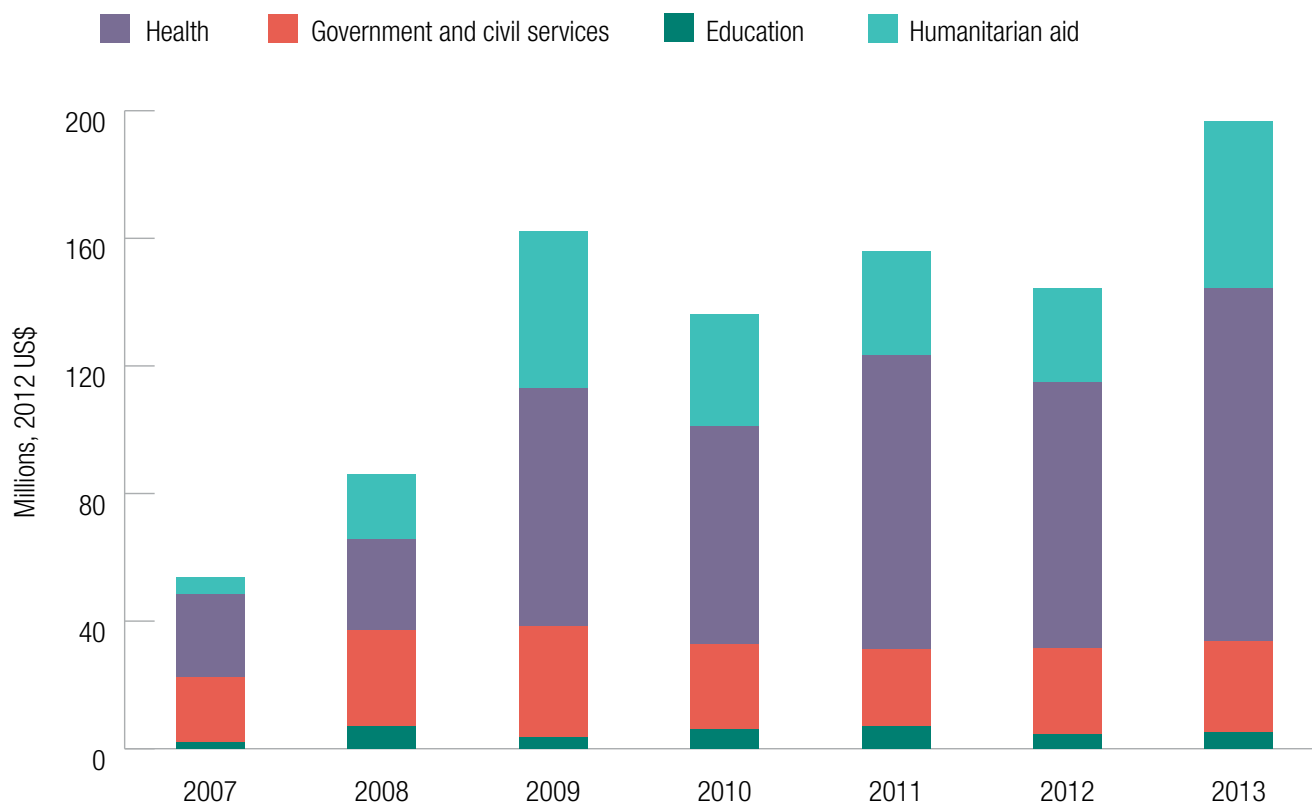
75 These are: (i) capacity building of service providers; (ii) research and evaluation (to build the evidence base, including what works); (iii) MHPSS in humanitarian emergencies; and (iv) the delivery of mental health programmes or systems building of mental health services.

76 See Annex 3 for a list of the donors that were identified for this report using the MHIN database of over 131 mental health projects around the world working in global mental health (developed for this report).

77 This message must also be made tangible either by formulating criteria by requiring specific activities, or by specifying a portion of the budget be allocated to mental health.

78 Concrete examples from Australia, Ethiopia, Uganda, or others from the MHIN website could all be drawn upon.

Figure 6: Annual DAMH by sector (2007-2013)



Source: Gilbert et al. (2015: 3).

vulnerable groups). Relatedly, ‘universal health care’ means including mental health as a priority in national health policies. A targeted advocacy campaign for funding the gap, harnessing the SDGs, needs to be developed and echoed throughout the global mental health community consistently. A strong message (or ‘policy ask’) would be that universal health care *must include mental health* because ‘there is no health without mental health’.⁷⁷ An alternative message would characterise ‘leaving no one behind’ as necessarily including mental health goals.⁷⁸ With 169 targets and indicators overall, there is a real risk that mental health could be quietly ignored when tracking the SDGs, and it will take considerable effort to prevent this from happening. Ensuring this mental health expenditure is separated out and tracked is an important part of this.

Fourth, this report has outlined that there are a variety of groups that can be approached for global mental health funding. They require prioritisation, sequencing and tailored advocacy plans as part of the next steps by the global mental health community. Chapter three touched upon some of the framing or messaging that might be applied to different groups if they were to be approached to increase spending on global mental health. Further research is required to identify key priority groups that might be ‘friendly’ to or aligned with mental health priorities, but the essential first steps with any potential funder are to identify the frames or hooks that the funder already responds to, and to adapt messaging accordingly. WHO has done some analysis on this already and has produced a helpful starting point for how to select messaging for different audiences (see Annex 4).

Finally, beyond this and in the longer term, we need to get country governments to prioritise mental health and vocalise this fact in public forums; development banks and donors will then respond in turn. Any efforts to improve global mental health are ultimately undermined if we cannot mobilise country governments. For example, generating awareness within the World Bank as a financing

mechanism is empty without the necessary next step of country government requests to the World Bank for loans or funding for mental health as a priority. Similarly, despite the assistance of donor funding, the SDGs will be monitored and adapted to local contexts by domestic governments, and so it is ultimately their interpretation and application of the SDGs which matters most.

Box 5: Summary of recommendations

1. The global mental health community must communicate more clearly that investing in mental health increases economic productivity and can help other development programmes to achieve their goals more effectively, and that governments cannot reach their SDG targets without addressing mental health. What's more, progress in mental health can in fact be measured, despite concerns that appropriate metrics have not yet been developed.
2. Existing funders must track their mental health spending in a more transparent and accountable way. Only with clear figures can the mental health community make the case to change the current low levels of funding, and analyse the types of activities that the funding goes to (whether for short-term relief in humanitarian emergencies, or to longer-term programmes and systems building).
3. A targeted advocacy campaign for funding the gap, harnessing the SDGs, needs to be developed, and echoed throughout the global mental health community from multiple players. A strong message would be that universal health care must include mental health because 'there is no health without mental health'. Or an alternative message might characterise 'leaving no one behind' as necessarily including mental health goals and indicators.
4. There are a variety of groups that can be approached for global mental health funding. The global mental health community needs to prioritise, sequence and tailor advocacy plans as part of the next steps towards increasing funding.
5. Country governments need to prioritise mental health. The development banks and donors, and their own economies, will respond in turn. Any efforts to improve global mental health are ultimately undermined if we cannot mobilise country governments. Despite the assistance of donor funding, the SDGs will be monitored and adapted to local contexts by domestic governments, and so it is ultimately their interpretation and application of the SDGs which matter most.

Annex 1: Types of health donors

	Banks (e.g. World Bank, African and Asian development banks)	Bilateral donors (e.g. DFID, USAID, SIDA, etc.)	Foundations (e.g. Bill & Melinda Gates Foundation)	Funding mechanisms (e.g. Global Fund)
Funding source	Members' capital subscriptions, private capital markets	Taxpayers	Private assets or philanthropy	Government contributions and private actors
Accountable to	Executive boards	Parliament or Congress	Co-chairs, board	Board
Leadership structure	President, managing directors, vice presidents	Executive branch of government	Co-chairs, chief financial officers, managing directors, general counsel	Executive Directors, Secretariats
Funding type	Loans	Grants	Grants	Grants
Proportion of funding given to service and research	Limited amount to research, significantly more to services ⁱ	Limited amount to research, significantly more to services ⁱⁱ	Significant amount to research, and to services ⁱⁱⁱ	Limited amount to research, significantly more to services ^{iv}
Proportion of funding given to prevention and treatment	More allocated to prevention than treatment ^v	Hard to specify but generally more allocated to treatment than prevention ^{vi}	More allocated to prevention than treatment ^{vii}	Funding integrated, not specified
Primary recipients of funds	Governments	Civil society organisations, governments	Private research, universities, civil society organisations, public-private partnerships.	Government or Country Coordinating Mechanisms
Financier has major field staff presence	Yes	Yes	No	No

Source: Adapted from Sridhar and Batniji, 2008: Table 2, 1,188. Governments and households not included as they are not traditional donors.

- i For example, in 2005 the World Bank gave 0.26% to research, 99.5% to services and 0.21% to both.
- ii For example, in 2005 the US Government via USAID gave 5% to research and 95% to services.
- iii For example, in 2005 the Bill & Melinda Gates Foundation gave 60.6% to research, 33.5% to services and 3.5% to both.
- iv For example, in 2005 the Global Fund gave 0% to research, and 100% to services.
- v For example, in 2005 the World Bank gave 77% to prevention, 0.1% to treatment and 22.9% to both.
- vi For example, in 2005 the US President's Emergency Plan for Aid Relief (PEPFAR) gave 30% to prevention, and 70% to treatment.
- vii For example, in 2005 the Gates Foundation gave 75.5% to prevention, 5.9% to treatment and 16.2% to both.

Annex 2: Suggested barriers to funding mental health

Agent (type of donor)	Lack of knowledge about mental health ⁱⁱ	Does not prioritise mental health ⁱⁱⁱ	Believes metrics are unreliable or too hard ^{iv}	Stigma ^v
Development agencies (e.g. USAID, DFID, SIDA, NORAD)	Not considered the major barrier	Key barrier	Potential barrier	Not considered the major barrier
Foundations, research and innovation agencies (e.g. Bill & Melinda Gates Foundation, National Institutes of Health, Wellcome Trust)	Not considered a major barrier	Not considered the major barrier	Potential barrier	Not considered a major barrier
Development banks (e.g. World Bank, Asian Development Bank)	Potential barrier	Key barrier	Potential barrier	Not considered a major barrier
International/JUN organisations (e.g. WHO, UNHCR, UNICEF)	Not considered a major barrier	Potential barrier	Potential barrier	Not considered a major barrier
International NGOs (e.g. Save the Children Fund)	Potential barrier	Key barrier	Key barrier	Potential barrier
Private sector	Key barrier	Potential barrier	Key barrier	Potential barrier
Developing country governments	Potential barrier	Key barrier	Not considered a major barrier	Potential barrier

Households not included. Based on information gathered during interviews, with barriers identified through application of ODI's KPP framework: www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8201.pdf.

- i For example, the impact of mental disorders is not well known.
- ii For example, mental disorders are not prioritised because they are not a leading cause of mortality in populations; other components (like welfare, income) are considered more important or urgent, or there appears to be low expressed demand for better services from affected populations.
- iii The range of cost-effective solutions and monitoring and evaluation systems for assessing progress in mental health programmes is not known or understood.
- iv Negative perceptions and attitudes about mental health.

Annex 3: Categories of mental health assistance

Capacity building of service providers	Research and evaluation	MHPSS	Delivery of mental health programmes (including drug provision)
Tropical Health and Education Trust	Wellcome Trust	UNHCR	European Commission
GCC	National Institute of Mental Health	GCC	DFID
Carter Center	DFID (Prime)	Carter Center	Sir Dorabji Tata Trust
Fogarty International Centre	GCC	UNICEF	GCC
Open Society	Qatar Foundation	USAID	Skoll Foundation
Foundation D'harcourt	European Research Council	Peter C. Alderman Foundation	Breadsticks Foundation
Minds Foundation	Sir Dorabji Tata Trust	Foundation D'harcourt	Health Alliance International
CBM	Mental Health Educators in the Diaspora	CBM	CBM
Breadsticks Foundation	Vinnova		Open Society
	Plan International		Asian Development Bank
	Health Alliance International		African Development Bank
	Carter Center		SHM Foundation
	Fogarty International Center		Households
	Mind		National governments
	CBM		Sanofi

These categories were largely informed by MHIN's 136 innovations on global mental health at <http://mhinnovation.net/>. The categories were developed via interviews and an application of ODI's Alignment Interest and Influence Matrix (AIIM).

Annex 4: Supporting arguments for, and potential barriers against, investment in mental health

Perspective	Arguments for greater investment in public mental health	Potential barriers to greater investment in public mental health
Public health	Mental disorders are a major cause of the overall disease burden; effective strategies exist to reduce this burden	Mental disorders are not a leading cause of mortality in populations
Economic welfare	Mental and physical health are core elements of individual welfare	Other components of welfare are also important (e.g. income, consumption)
Economic growth and productivity	Mental disorders reduce labour productivity and economic growth	The impact of mental disorders on economic growth is not well known (and is often assumed to be negligible)
Equity	Access to health is a human right; discrimination, neglect and abuse constitute human rights violations	Persons with a wide range of health conditions currently lack access to appropriate health care
Sociocultural influence	Social support and solidarity are core characteristics of social groupings	Negative perceptions and attitudes about mental disorders (stigma)
Political influence	Government policies should address market failures and health priorities	Low expressed demand/advocacy for better services

Source: WHO (2013b: Table 2).

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