



**Making Mental Health a Global Development Priority**

April 13-14, 2016 • Washington DC

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**OUT OF THE SHADOWS:  
MAKING MENTAL HEALTH A GLOBAL DEVELOPMENT  
PRIORITY**

**ORGANIZED BY:  
WORLD BANK GROUP/WORLD HEALTH ORGANIZATION**

**WORLD BANK GROUP  
APRIL 13-14, 2016 • WASHINGTON, D.C.**

**Report of Proceedings of Event**



To access dedicated site, visit:

<http://www.worldbank.org/en/events/2016/03/09/out-of-the-shadows-making-mental-health-a-global-priority>

## Acknowledgements

**This summary report was prepared in May 2016 by a WBG/WHO team including Patricio V. Marquez, Shekhar Saxena, Sheila Dutta, Dan Chisholm, Natalia Tejada, Laura Lozano-Montes and Ishani Premaratne, on the basis of reports prepared by Takashi Izutsu, Daniel Vigo, Margarita Puerto Gomez, Alys Willman, Beverly Pringle, Dévora Kestel, Joshua Chauvin, Alison Brunier, Dan Chisholm, and Andrew Blasi, the rapporteurs of the event, and other event documentation. Comments provided by Prof. Arthur Kleinman, Harvard University Asia Center, and Pamela Collins, US National Institute of Mental Health.**

For any additional information about the event or related documentation, please contact Patricio V. Marquez, Lead Health Specialist, World Bank Group: [pmarquez@worldbank.org](mailto:pmarquez@worldbank.org).

The event was convened by the World Bank Group (WBG) and the World Health Organization (WHO), with the support of an Organizing Committee and the collaboration of International Partners, as follows:

### ***Core Organizing Committee***

World Bank Group (WBG): Patricio Marquez, Lead Public Health Specialist, HNP Global Practice, Tim Evans, Senior Director, HNP Global Practice.

World Health Organization (WHO) Lead: Shekhar Saxena, Dan Chisholm, and Laura Lozano Montes, Department of Mental Health and Substance Abuse, World Health Organization.

Chair of the Working Group: Professor Arthur Kleinman, Harvard University Asia Center.

The Mental Health Innovation Network, with the support of Wellcome Trust, Grand Challenges Canada, and the U.S. National Institute of Mental Health, were responsible for the Innovation Fair.

**The organizers of the event appreciate all the support provided by the Office of the United States Executive Director for the World Bank Group, and particularly having Matthew McGuire, the US Executive Director, who hosted the event's April 13, 2016 reception.**

### ***Members of International Working Group***

The organization of the event is the product of almost two years of activities completed by a Working Group chaired and directed by Arthur Kleinman (Harvard University Asia Center). The Working Group consists of Timothy Evans (World Bank Group), Patricio Marquez (World Bank Group), Shekhar Saxena (World Health Organization), Daniel Chisholm (World Health Organization), Anne Becker (Harvard Medical School), Pamela Collins (U.S. National Institute of Mental Health), Mary de Silva (Wellcome Trust), Pablo Farias (Harvard Medical School), Roberto Iunes (World Bank Group), Akiko Ito (United Nations Department of Economic and Social Affairs), Dean Jamison (University of Washington), Yoshiharu Kim (National Institute of Mental Health, Japan), Judith Klein (Open Society Foundations), Vikram Patel (London School of Hygiene and Tropical Medicine), and Benedetto Saraceno (NOVA University of Lisbon). In addition to members of the Working Group, it included research by Pim Cuipers (Vrije Universiteit Amsterdam), Amanda Glassman (Center for Global Development), Bruce Rasmussen (Victoria University), Peter Sheehan (Victoria University), Filip Smit (Vrije Universiteit Amsterdam), Kim Sweeny (Victoria University), Leslie B. Tarver (Massachusetts General Hospital), and Daniel Vigo (Harvard University). The Working Group acknowledges the contributions of Seth Mnookin (MIT), Mary Dethavong, Annikki Herranen-Tabibi, and members of the staffs of the World Bank Group and the World Health Organization. It also would like to thank The National Academies of Sciences, Engineering, and Medicine's Health and Medicine Division for its support of a meeting of the Working Group on April 20, 2015.

***International Advisory Group (names available upon request)***

### ***Partners***

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### ***WBG Lead Global Practice: Health, Nutrition and Population Global Practice***

Core Technical Team: Tim Evans (Senior Director, HNP GP), Patricio Marquez (Lead Health Specialist), Sheila Dutta (Senior Health Specialist), Jaime Nicolas Bayona Garcia (Senior Health Specialist), Ishani Premaratne (Consultant).

WBG Partner Global Practices: Alys Willman (Fragility, Conflict, and Violence), Joel Reyes (Education Global Practice), Charlotte Vuyiswa McClain-Nhlapo (Urban, and Resilience Global Practice), Brian Davey (World Bank Group's Health Services Department).

Communications Team: WBG: Carolyn Reynolds, Anugraha Palan, Sheryl Silverman, Lysette Cohen, Kitchie Hermoso, Ramatoulaye George-Allyne; WHO: Alison Ruth Brunier, Sarah Russell.

Administrative Support: Akosua Dakwa, Yvette Akins, Bianca Tayari, Mary Dowling, Juliet Teodosio

Additional Consultation and Support: Solange Guyot, Senior Executive Assistant, Office of the United States Executive Director for the World Bank Group, and Nancy Clifford, IAOAN - International Affairs N America

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## Executive Summary

At the 2016 World Bank Group (WBG) and International Monetary Fund (IMF) Spring Meetings, the WBG and the World Health Organization (WHO) co-hosted a high-level event to bring mental health from the periphery to the center of the global development agenda<sup>1</sup>. This event came to fruition due to the commitment and effort of **Prof. Arthur Kleinman, Director, Harvard University Asia Center**, in partnership with WBG and WHO. This two-day, high-level event featured technical panel discussions that included a mix of experts and advocates, ministers of finance and health, civil society representatives and development partners. The first day was kicked off with an *Innovation Fair* that showcased effective, generalizable, replicable and sustainable innovative approaches that can improve access to care. The fair was later followed by a **high-level keynote panel, featuring World Bank President Dr. Jim Kim, WHO Director-General Dr. Margaret Chan, and other global leaders and influencers**. The first day wrapped up with a **reception hosted by the U.S. Executive Director for the WBG, Matthew McGuire**, along with champions/ambassadors, representatives of adolescent and youth groups, as well as a wide range of others who represented relevant stakeholder organizations.

The second day consisted of a series of high-level panels focusing on challenges and innovations for service delivery at the community level for priority population groups, including displaced populations, refugees, women and children, and youth. Moreover, multi-sectoral entry points were identified to respond to this development issue (e.g. human rights, education, social protection and jobs, fragility, conflict and violence, disability-inclusive development, etc.), leveraging technologies, civil society participation, and innovative financing mechanisms. A seven-minute **3-D documentary** on the global faces of mental health called *Francis* also premiered during this event, as well as the WBG *“Making Mental Health a Global Development Priority”* animation video, the WHO video *“I had a black dog, his name was depression,”* produced in collaboration with writer and illustrator Matthew Johnstone, and the documentary *“Global Mental Health Challenges”* produced by the Harvard Global Mental Health Coalition, were also presented at the event. Information and links to these videos are attached in Annex 2 and 3 of this report.

A Technical Report *“Out of the Shadows: Making Mental Health a Global Development Priority”* was prepared for distribution at the event. The report can be downloaded at: <http://documents.worldbank.org/curated/en/2016/04/26281016/out-shadows-making-mental-health-global-development-priority>

Also, the research paper *“Scaling-up treatment of depression and anxiety: a global return on investment analysis”* was prepared and published by *Lancet Psychiatry* (Volume 3, No. 5, p415–424, May 2016). The paper can be downloaded (without charge) at: [http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(16\)30024-4/abstract](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(16)30024-4/abstract)

A **press release** was issued and a press conference on the event was held on April 12, 2016. To read the press release, visit: <http://www.worldbank.org/en/news/press-release/2016/04/13/investing-in-treatment-for-depression-anxiety-leads-to-fourfold-return>

A Commentary, *“Time for mental health to come out of the shadows”* by Arthur Kleinman, Georgia Lockwood Estrin, Shamaila Usmani, Dan Chisholm, Patricio V Marquez, Tim G Evans, and Shekhar Saxena, summarizing meeting deliberations and commitments made was published at The Lancet on June 3, 2016: > [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(16\)30655-9.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)30655-9.pdf)

More than 400 participants were in attendance and more than 80 panelists took part in the 11 panels held during the meeting.

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<sup>1</sup> To see the Agenda for the Out of the Shadows event, please visit:

<http://www.worldbank.org/en/events/2016/03/09/out-of-the-shadows-making-mental-health-a-global-priority>

## Introduction

### Making Mental Health a Global Development Priority

Mental health is an integral part of health and social services provision, but has received inadequate attention by policy makers and also by society in general. Mental disorders impose an enormous disease burden and an increasing obstacle to development in countries around the world.

Studies estimate that at least 10% of the world's population is affected and that 20% of children and adolescents suffer from some form of mental disorder. In fact, mental disorders account for 30% of the non-fatal disease burden worldwide and 10% of the overall disease burden, including death and disability. Worsened by low levels of investment and effective treatment coverage, mental disorders also have serious economic consequences and may limit the effectiveness or potential impact of development assistance.

Not only does mental illness represent a significant disease burden, it is also very costly to country economies. In 2010, the global cost of mental disorders was estimated to be approximately US\$2.5 trillion; by 2030, that figure is projected to go up by 240%, to US\$6.0 trillion. In 2010, 54% of that burden was borne by low- and middle-income countries (LMICs); by 2030, that is projected to reach 58%. The overwhelming majority — roughly two-thirds — of those costs are indirect costs of mental health — the economic consequences attributable to disease, disorders, or injury resulting in lost resources, but which do not involve direct payments related to the disease. This includes the value of lost production due to unemployment, absences from work, presenteeism or premature mortality.

There is also significant evidence showing that social conditions associated with poverty create stress and trigger mental disorders, and that the labor insecurity and the health care costs associated with mental disorders in turn move many into poverty. This circular relationship between mental disorders and poverty creates a cycle that leads to ever-rising rates for both. Several recent studies in high-income countries have found that the total costs associated with mental disorders total between 2.3% and 4.4% of GDP. The proportion of total public health expenditure allocated to mental health care is often very small. For example, mental disorders are responsible for 23% of England's total burden of disease, but receive 13% of National Health Service health expenditures. According to WHO's Mental Health Atlas 2014 survey, governments spend on average 3% of their health budgets on mental health, ranging from less than 1% in low-income countries to 5% in high-income countries.

Most countries are ill-equipped to deal with this “invisible” and oft-ignored challenge — which is amplified by the growing conflict and refugee crisis in the Middle East and other parts of the world. Communities living in these contexts require a range of psychosocial support. Addressing mental health needs is critical in times of crises and recovery, in addition to sustainable development. Despite its enormous social burden, mental disorders continue to be driven into the shadows by stigma, prejudice, fear of disclosing an affliction because a job may be lost, ruined social standing, or simply because health and social support services are not available or are out of reach for the afflicted and their families.

In spite of these challenges, there is a need across the world to begin a new era in which mental health moves from the periphery to the center of the global health agenda and into the larger development context. There are evidence-based, inter-sectoral strategies and interventions to promote, protect and restore mental health. Properly implemented, these interventions represent “best buys” for any society, with significant returns in terms of health and economic gains. The burden of depression, anxiety and other mental disorders calls for a concerted, multi-sectoral response that not only raises public awareness and political commitment about this often overlooked and stigmatized issue, but also puts in place an array of treatment and prevention strategies capable of reducing the large, and growing, human, social and economic losses attributable to them.

In order to fully embrace and support the progressive realization of UHC, it is critical to ensure that prevention, treatment and care services for mental disorders at the community level, along with psychosocial support mechanisms, are integral parts of accessible service delivery platforms and are covered under financial protection arrangements. Additionally, there is a need to advocate for and identify “entry points” across sectors to help tackle the social and economic factors that contribute to the onset and perpetuation of mental disorders.

A global event jointly organized by WBG, WHO, the Harvard University Asia Center and its director, Dr. Arthur Kleinman, and a number of other partners, took place at The World Bank Group premises as well as at George Washington University (GWU) on April 13 and 14, 2016 to bring mental health from the periphery to the center of the global development agenda. A great deal of work was done by both the Working Group and an Advisory Group on Global Mental Health in anticipation of this meeting. While the overall topic of the meeting was mental health, the focus of the event was on common mental disorders (depression, anxiety disorders) due to their high prevalence and burden as well as the availability of cost-effective interventions that can be mainstreamed into health care systems and across other sectors.

The aim of this event was to engage finance ministers, multilateral and bilateral organizations, the business community, technology innovators, and civil society about the urgent investments needed in mental health and psychosocial support, and the expected returns in terms of health, social and economic benefits. Consequently, this meeting framed mental health as a development priority, not just a neglected health issue. Coinciding with this event, a WHO-led paper was published in *The Lancet Psychiatry*, which outlines the extent of the mental health disease burden, its effect on economies, and what the return on investment is for every dollar invested in mental health.

Apart from the high level panel and reception that took place at WBG, GWU hosted an innovation fair highlighting on-the-ground innovations in mental health service delivery (see annex 1). It also hosted a day-long series of panels on various aspects of mental health and development, including a keynote address by **Rep. Patrick Kennedy** and the launch of a new **Volume of the Disease Control Priorities 3 (DCP3)** series devoted to mental, neurological and substance use disorders.

### Objectives of the Conference

- To increase awareness and to mobilize a global, multi-sectoral coalition for the need to scale up mental health services in primary care and community settings, as a key issue in the global health and development agenda.
- To engage finance ministers, multilateral and bilateral organizations, the business community, technology innovators, and civil society on the economic and social benefits of investing in mental health and psychosocial support, identifying cost-effective, affordable and feasible interventions, and including their integration into primary care and community settings as part of the progressive realization of UHC. This is in addition to the expected returns on investment in terms of health, social and economic benefits.
- To identify entry points for renewed action and investment at the country, regional and global levels, including consideration of innovative mechanisms for enhanced financial and social protection, as well as expanded service access, through health and other sectors.



## Panel Reports

Each panel had a moderator who presented the panelists, the panel objectives and moderated the session. Each panelist had three minutes to present an overview of their key points, following which the moderator posed questions to presenters and then opened the floor for questions from the audience.

## High Level Opening Panel: Making Mental Health a Development Priority

**John Prideaux**, U.S. Editor for The Economist, was the moderator for the session. He opened the panel by welcoming the audience in the room and the remote audience joining online. Later, a short video was presented highlighting why it is important to talk about mental health. Immediately following, Mr. Prideaux gave the floor to Dr. Jim Kim to offer his opening remarks.

**Jim Yong Kim**, President of The World Bank Group, presented the following remarks:

*Good afternoon and welcome. I want to acknowledge and thank my friend, Margaret Chan, and my mentor from Harvard, Arthur Kleinman, for their important leadership on this important issue and for joining us here today.*

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

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

*Today, we are here to bring mental health into the spotlight and squarely on the global development agenda where it belongs. Why should we care? Here are some facts:*

- *It's a major health problem.*
  - *Estimates are that 10 percent of the world's population, including 20 percent of children and adolescents, suffer from some sort of mental disorder.*
  - *Mental illness is the leading cause of years lived with disability and is linked to higher risks for major killers like heart disease, diabetes, HIV, tuberculosis and obesity.*
  - *Among young women, suicide has become the leading cause of death, surpassing maternal mortality. The children of mothers who suffer from mental illness are much less likely to survive and more likely to be stunted.*
- *It's a growing health problem.*
  - *A 2015 Lancet study found that the prevalence of anxiety disorders increased by 42 percent and depressive disorders by 54 percent between 1990 and 2013.*
- *And it's a major constraint to development. It is not simply an imperative for our efforts to achieve Universal Health Coverage. It also constitutes an imperative for development.*
  - *The vast majority - 80 percent - of people are likely to experience an episode of mental disorder live in low and middle income countries.*
  - *We know that by 2030, 90 percent of the extreme poor will live in settings of conflict and violence. Refugees and those affected by conflict, humanitarian and natural disasters suffer increased rates of anxiety and depression. If their care needs remain unacknowledged and unmet, their employment and their children's future is irreversibly compromised.*
- *Despite its health and development importance, the resources being put into mental health services do not come close to meeting the public health and economic burdens caused by this silent epidemic.*
  - *On average, low-income countries devote less than one percent of their health budgets to treating mental illness.*



- *Even high-income countries devote on average five percent of their health budgets to mental health, which is better but still unequal to the scale of the challenge.*

*We all pay the price for this lack of investment. In addition to their health and human impact, mental disorders cause a significant economic burden when people are unable to go to school and work and participate fully in society.*

*Today we are releasing new estimates showing that the global cost of lost productivity due to mental illness amounts to more than 10 billion days of lost work annually; the equivalent of US\$1 trillion dollars per year. For economies to be competitive and have sustainable and inclusive growth, this is \$1 trillion dollars we simply cannot afford to lose.*

*The good news is that the two most common forms of mental illness, anxiety and depression, respond well to a variety of low-cost treatments. And the returns on this investment are substantial, both in terms of increased productivity and community participation.*

- *Each dollar invested in easily scalable mental health treatment and services for depression and anxiety returns about US\$4 in improved health and ability to work.*
- *Even more compelling is the growing evidence of countries from Afghanistan to Ghana to Peru. They have shown that it is possible to scale up and integrate mental health services, even in difficult and resource-poor environments.*

*I have seen this first-hand in Carabayllo, Peru, where I have been visiting since 1994. Back then, I led an initiative to implement the first community-based approach to control multidrug-resistant tuberculosis (MDR-TB). Now Carabayllo is on the frontlines of another big change, this time in mental health. It is one of 21 community centers in Peru, which integrate mental health services into primary health care.*

- *It requires the direct involvement of the community and the family of patients. Where once all patients were hospitalized, most now receive integrated services through home visits.*
- *This change has happened because of the coordinated efforts of the Ministry of Health, the National Institute of Mental Health, the local government of Carabayllo, and several international and national organizations.*

*Other communities can learn from Carabayllo's experience.*

*In closing, Sustainable Development Goal 3 has set a target for Universal Health Coverage by 2030. If we are going to achieve that – and if we are going to end extreme poverty and build shared prosperity – we can't let this invisible epidemic impair individuals, communities and economies.*

*So today, together with WHO and many partners represented in this room, we are kicking off an important global conversation – and a call to action. We want all of you in this room, and those listening in, to join us.*

*Let's bring the issue of mental health into the spotlight – and let's keep it there. This isn't just a health issue – it's a global development issue.*

*Governments, international partners, health professionals, community and humanitarian workers – let's all do our part to ensure that the world invests in **#MentalHealthNow**.*

The moderator then gives the floor to Dr. Margaret Chan, Director-General of the World Health Organization, to share her opening remarks with the audience.

**Margaret Chan**, Director-General of the World Health Organization, presented the following remarks:

*Honorable ministers of health and finance, colleagues at the World Bank; ladies and gentlemen.*

*We stand at the beginning of the era of sustainable development. One of the pledges the world has made in the 2030 agenda is to leave no one behind. If we in public health stand by this pledge, then it is time to bring mental health out of the shadows.*

*The cultural and historical contexts for taking action in different countries vary considerably, but all face one common barrier: stigma. Mental disorders are something people don't want to know about. They don't want to hear about them, talk about them, or deal with them. This must change, and I see some encouraging signs. Mental health is a high priority for WHO's 194 Member States, who adopted a Comprehensive Mental Health Action Plan three years ago.*

*The WHO mhGAP Intervention Guide sets out evidence-based strategies for preventing and treating priority mental disorders. The guide has been translated into 20 languages and is currently being used in more than 90 countries.*

*The momentum is building, and this is entirely appropriate for a number of reasons.*

*Common mental disorders are on the rise. They now affect nearly 10% of the world's population. That is a very large number of people who must not be left behind. These disorders are costly, for economies as well as individuals and their families. We now have good evidence that depression and anxiety disorders alone cost the global economy more than one trillion dollars each year. We also have evidence that every dollar spent on scaling up treatment for these common conditions brings about a return of four dollars in improved health and the ability to work. That is an excellent return on investment.*

*But the gap between need and access to treatment remains far too wide. More countries need technical support and guidance to scale up evidence-based strategies and interventions that have been shown to work.*

*Making mental health a priority for development means bringing these issues under the spotlight.*

*To implement action plans, countries also need funding. As our latest evidence shows, this will be money well spent.*

*The more we talk about mental health, the better. As I close, I am pleased to announce that the theme for next year's World Health Day will be depression and suicide. This will be another excellent occasion to increase awareness on this important public health and development priority and step up our collective action.*

**Arthur Kleinman**, of Harvard University, started by highlighting the importance of this meeting in giving credibility and visibility to mental disorders worldwide. He identified three common misconceptions about mental disorders: (1) they are untreatable, (2) they are not important, and (3) treating them is not cost-effective. This meeting is an outcome of long-term efforts, including those made two decades ago in 1995 by his team in working for the release of a mental health report at the United Nations. Today, as more stakeholders get together for mental health, it is the time to allow for major breakthroughs in how we treat and provide care for our fellow humans. There is a need for more advances in creating moral and just societies for economies to operate more effectively and efficiently. Dr. Kleinman reminded the audience that there are real human beings behind all data, and that psychological pain can be as devastating as physical pain. It kills just like any other major physical disease. He pointed out that vulnerability, stigmatization and the suffering of the social network caused by anxiety and depression creates important disabilities, which are no less challenging as those that result from cancer,

infectious diseases and other diseases. Fortunately, he continues, there is a range of cost-effective and affordable treatments, which present the opportunity for true transformation at individual, family and communal levels. There are very basic and affordable community-based programs, psychotherapy, medications and virtual technologies that can alleviate the suffering caused by mental illness. This needs to move beyond words and now elicit commitments from international organizations and governments towards addressing the mental health disease burden. This must include commitments to devote resources to treatment, and to scaling up those interventions which are proven effective. These efforts to respond to human suffering will lead to a stronger economy. *We can and must act now.*

**William Francis Morneau**, Minister of Finance for Canada, started his speech by confirming that making mental health a priority is economically viable. He draws from his own past experience in the private sector, where he built the largest human resources company in the country, and learned that investing in helping people with mental health challenges provides a good return. It can make the organization more productive by making employees abler and motivated to achieve corporate objectives. In Canada, he explained, 1 in 5 Canadians has some sort of mental health challenge or illness, and so supporting those people with mental illness who ask for support is also a moral imperative. He shares the experience of the Government of Canada in setting standards regarding the mental health of employees in private companies, and the large impacts that enforcing such standards can have. However, even in advanced economies like Canada, responding to mental health challenges is not easy. The countermeasure needs to be done in a cross-sectoral manner through health, corporate, justice systems, housing, education and other sectors. Moreover, Canada is currently welcoming the largest number of immigrants in 100 years, so the government is addressing the challenges regarding resettlement and integration by funding efforts to ensure immigrants' good mental health. Minister Morneau highlighted effective programs such as the Grand Challenge Canada (GCC), which has supported mental health initiatives around the world. One example is a project in Zimbabwe that provides a safe community space for individuals and trains health workers in screening and treating common mental disorders.

Commitments:

1. Canada remains committed to the Global Mental Health Agenda. We are proud that Canada has been acknowledged by the World Health Organization as one of the world's leading funders of global mental health innovation.
2. We value this leadership role and look forward to engaging with others on this important issue.

**Mustapha Kaloko**, Commissioner for Social Affairs of the African Union Commission started his remarks by stating that Africa is in a transition phase in that it is raising the profile of mental health to almost that of NCDs. He thinks that the SDGs are pushing forward a notion of people-centered development in Africa. This is occurring in concert with the establishment of their Agenda 2063, which emphasizes inclusion in social and economic development. For him, this is where mental health can be seen as a key priority for inclusion in the development agenda. He told the audience that mental health is a big challenge in Africa because of the large prevalence as well as the burden presented to families who are providing care. Additionally, the grave lack of human resources, including limited infrastructure and medicine still represent important challenges for this agenda. Furthermore, mental health issues can be misunderstood as something akin to witchcraft or the supernatural. Despite these barriers, the African leadership is taking clear steps towards realizing UHC through the bolstering of primary health care services. Moreover, the Comprehensive Mental Health Action Plan 2013-2020 developed by WHO is helping to promote the inclusion of mental health on the development agenda. Mr. Kaloko then identified the need to strengthen available data in mental health and to invest in young people, who will soon represent half the population of Africa.

Commitments:

1. AUC is committed to the 2030 Agenda for Sustainable Development (2030 Agenda) contained in the document entitled "Transforming Our World: The 2030 Agenda for Sustainable Development" which was adopted by the United Nations General Assembly on 25 September 2015. The AUC is ready to

partner with international agencies to mainstream mental health into policy deliberations at the regional and country levels.

**Alan Bollard**, Executive Director of APEC (Asia-Pacific Economic Cooperation), told the audience that APEC consists of 21 countries around the Pacific, whose populations are mainly middle income and ageing. APEC is paying particular attention to the compromised productivity related to chronic diseases and mental health. He stated that the annual global cost of mental health (US\$2.5 trillion) is almost equivalent to a global financial crisis. Based on this, he believes that in 15 years, the cost could increase and represent a greater economic burden than cancer, pulmonary diseases and diabetes combined. Policy makers require data regarding cost and benefit (among other data points), but the impact of mental illness can be hard to quantify due to the strong stigma attached to it. Among challenges he identified in this field are that many countries still do not have policies, legislation or programs that address mental health, and the mental health budget represents less than 1% of health budgets in low-income countries.

APEC has started to work on WHO's Comprehensive Mental Health Action Plan 2013-2020 by forming a technical working group and developing a roadmap within APEC. Additionally, he told the audience, APEC is planning to launch a digital hub of innovations in mental health. The digital hub will showcase good practices from 21 economies and make them accessible so that this effort can contribute to building capacity worldwide. The digital hub will be a place for testing ideas, customizing and scaling up innovations, storing information, facilitating partnership and mapping all involved stakeholders. Research and training activities will be also hosted in the hub. This effort will require cooperation among various stakeholders.

#### Commitments:

1. APEC commits to prioritizing and drawing heightened attention to mental health, as instructed by APEC Economic Leaders and Ministers, as a necessary condition to achieving our goal of sustainable economic growth and prosperity for the Asia-Pacific region.
2. APEC commits to full implementation of our Roadmap to 2020 for mental health, including the launch and growth of the APEC Digital Hub for Best and Innovative Practices in Mental Health Partnerships.

**Jen Hyatt**, Founder and CEO of Big White Wall started her remarks by saying that compared to 10 years ago, the situation around mental health has vastly transformed. Nowadays, the technology gap is smaller than the mental health gap. And some estimates show that by 2025, over 90% of people aged 16-19 will have a smart phone worldwide. Given this reality, using technology to improve access to mental health care is not a choice but an absolute imperative. Furthermore, the demand for mental health services is very large, and so there is a need to take action to increase access.

She proposed that technology be at the center of the agenda for realizing mental health parity. She then offered at least three ways in which technology can innovate within mental health care: (1) people can self-manage their conditions to the fullest extent possible without even leaving their homes, (2) clinicians can manage a greater number of patients, and (3) data collection and application can be more accessible in the field. Some examples of innovations are an online patient-clinician communication system, the facilitation of a peer community where one clinician might be able to simultaneously work with 5000 people, and therapy-based programs. Lastly, she identified the use of artificial intelligence as an opportunity to make mental health services more accessible, particularly for those who are hesitant to speak up about their mental health issues.

Finally, Ms. Hyatt advised that the utilization of technology requires clinical governance, which is necessary to protect privacy and ensure that only evidence-based interventions are utilized.

Commitments:

1. To promote universal access to affordable, evidence-based digital mental health care worldwide.

The panel concluded after the moderator asked each speaker to state his or her commitment to mental health issues going forward and invited participants to attend the reception hosted by Mathew McGuire, US Government Executive Director to the WBG. At the reception, participants heard testimonies from members of *The Voices of Youth* and from **Lara Logan** from CBS TV. Attendees also received a custom-designed t-shirt promoting mental health awareness that was made specifically for the event.

## Opening Session of the Second Day

Welcome remarks were made to start off the session. **Patricio Marquez**, Lead Public Health Specialist from the WBG, told the audience that service providers, the broader community, and the political community must be engaged if we are to realize mental health parity. To accomplish this, it is very important to demystify the centuries-old stigma surrounding mental illness. **Shekhar Saxena**, director of Mental Health and Substance Abuse at WHO stated that there is a need to find ways in which these conversations can be translated into action. How can progress be made to move forward? **Tim Evans**, Senior Director of the HNP-GP from the WBG praised the Innovation Fair, which he said reminded him that individual action is very important and that people also need to be ambassadors of change. **Arthur Kleinman**, Professor at Harvard University, reminded the audience of his remark at the opening panel that real human beings are always behind data points that describe suffering. Finally, **Zoe Adams**, from the Strong Heart Group (who presented a virtual reality film at the event) said that virtual reality technology has the potential to change the way in which people relate to the world.

**Patrick Kennedy**, former member of the U.S. House of Representatives, subsequently gave a keynote presentation. He shared with the audience that even though the Mental Health Parity and Addiction Equity Act passed 10 years ago in the U.S. Congress, its implementation is not yet complete. This law today is a medical civil rights act. In the U.S., he explained, although insurance premiums have been eliminated, the outright denial of care is still legal and practiced in the country. He said that he believes this continues to happen because of the persistent denial that mental and substance use disorders are real illnesses. This denial constitutes an issue of discrimination. Mr. Kennedy invited the audience to challenge the stigma surrounding mental illness, and help break down the barriers inculcated in all of us, by telling someone else about a struggle that we or others in our lives have had with mental health. This will help change hearts and, in turn, promote the change of public policy.

**Bernice Dahn**, the Minister of Health of Liberia, told the audience that mental illness is a global problem, but environmental and social health issues are more concentrated in developing countries than developed ones. For instance, in Liberia, a study showed that 40% of the population suffers from Post-Traumatic Stress Disorder (PTSD), and in the aftermath of the Ebola crisis, large portions of the population are also struggling with mental health issues. The problem in Liberia, she stated, is that mental health has been ignored in the national budget due to competing priorities. For instance, there is a national mental health strategy in place but it does not have the necessary support. It is about time that we consider the 400,000 persons who do not have the necessary care and start incorporating their needs into the national budget.

Next, **Jagannath Lamichhane**, Director of the Nepal Mental Health Foundation, mentioned that Nepal has gone through 10 years of civil conflict and more recently, the tragedy of the earthquake that occurred one year ago. These complex emergencies have taken a toll on the mental health of Nepali people. In light of this daunting scenario, Mr. Lamichhane called for the support of the WBG in pushing forward with the movement for mental health parity. It is a time for the WBG to intervene radically and for governments to show commitment and rebalance their healthcare systems to make services accessible. There should not be division between physical and mental health systems. He also stated that mental health issues are not an excuse to violate human rights, and mental health is no exception.



**Melanie Walker**, from the WBG, provided take-away messages from the panel. She said that mental health is about human infrastructure, and so it is time for health experts and policymakers to see mental health as part of a broader development project. She challenged the audience to be creative and bring something different to the problem of mental health. There is a need for creative ideas that will help achieve mental health parity. She also highlighted the idea of bringing mental health into the common lexicon so that the public is not afraid to discuss it openly.

## **Plenary Panel: Mental health in the Global Development Agenda: Challenges and Options**

Objectives of the Panel:

1. To establish the need to include mental health as a global development priority
2. To examine different opportunities and mechanisms through which mental health can be better placed in the developmental agenda (internationally and nationally)

**Phillip Campbell**, Editor-in-Chief of *Nature*, served as the moderator of the panel and opened by welcoming participants, introducing himself and the rapporteur, stating the panel objectives, and introducing the panelists.

**Vikram Patel**, of the Centre for Global Mental Health at the London School of Hygiene & Tropical Medicine, started the presentation by pointing out that mental disorders are strongly associated with other non-communicable diseases (NCDs), such as diabetes and cardiovascular diseases. The co-occurrence of these conditions is associated with worse health, social, and economic outcomes. Also, this suffering is socially graded: it is more common amongst the poor. Mental health should be integrated fully into the NCD agenda because the integration of care for common mental and substance use disorders with that of NCD care is effective, cost-effective, and consistent with high standards of person-centered care. Collaborative care with a non-specialist care coordinator who can provide a range of psychosocial interventions and coordinate care with primary and specialist providers is the key innovation to achieve such integration, and it should be scaled up across the globe.

**Lawrence Gostin**, Professor at Georgetown University, told a story from the 1970s: he was placed as a pseudo-patient in a neuropsychiatric institution. Seeing the lives of patients from the inside changed his life, and he became an advocate. His experience in the neuropsychiatric hospital always haunted him: Why have we done so well with some diseases, most notably HIV, and so miserably with mental illness? Why is it that global attention, the Global Fund, and high level UN declarations ignore mental health? Many of the elements are there, as with AIDS: the stigma, the burden. What is missing? The key missing ingredient for him is social mobilization.

Next, **Shekhar Saxena**, Director of the Mental Health and Substance Abuse Department of WHO, pointed out that many other priority areas of health have clear links to mental health. Dr. Saxena proposes linking mental health with those priorities in order to increase investment. These priorities include NCDs, child health and development, post-partum depression, and HIV. He also pointed out that natural disasters, wars, and pandemics impose a large mental health and psychosocial burden on communities and health systems. Global or national crises can be leveraged as opportunities to rebuild the health system. A great deal can be achieved by integrating mental health care within other priority programs. Not only do mental health outcomes improve, but other outcomes improve as well.

### Commitments:

1. WHO will keep mental health and psychosocial aspects more clearly integrated within its technical assistance to countries on other priority areas.

**Kay Jamison**, Professor of Psychiatry at Johns Hopkins University, stressed her perspective as a patient and advocate. After a psychotic break during her youth, she was diagnosed with severe bipolar disorder. Despite that, she was able to get better and work productively. Unfortunately, people that get well tend to



keep quiet: they feel their work would be affected if they acknowledge their own experience with mental illness and treatment. The result is that the public only sees the severely affected and untreated. It would be very helpful if people who have positive outcomes after treatment for mental illness spoke openly about it. Also, in Dr. Jamison's view, a fundamental but somewhat neglected field is the study of non-adherence. Mental illnesses often strike at a young age and can lead to people killing themselves, so adherence is a major research, clinical, and societal problem. Regarding the use of specific words, she finds that *discrimination* has useful legal implications, whereas *stigma* is itself stigmatizing. Finally, she finds that discrimination has been particularly damaging in the field of philanthropy. This is changing, however, because everyone knows someone affected by mental illness, and as people improve with treatment, families show their appreciation.

**Oleg Kucheryavenko**, HNP consultant for the World Bank Group, focused on the need to effectively include sexual minorities in the conversation. Within the field of mental health, LGBT people are not given enough attention. Also, diversity within the LGBT population must be acknowledged, in order to avoid common stereotypes. Different groups have specific needs, and Dr. Kucheryavenko pointed out that the most vulnerable persons within the LGBT community – the children and the elders – are frequently left out, resulting in appalling outcomes. LGBT youth are much more likely to attempt suicide, with transgender youth at the highest risk. LGBT elders, on the other hand, have an increased sense of isolation, and fewer people to resort to. Finally, he highlighted the main problem, which is the absence of credible data for LGBT mental health. His message is that we have the instruments to make equality a reality and we need to take sexual minorities out of the shadows to do so.

**Murali Doraiswamy**, Professor of Psychiatry at Duke University, stressed the need to go beyond symptomatic approaches, and focus on helping people and societies flourish. To this aim, he highlights three Rs: resilience, rehabilitation and research. Resilience, he says, should especially focus on children because the stress threshold is determined during childhood. Building resilience helps people use adversity to develop self-protective skills and grow, so the biggest return on investment is provided by investing early. Also, improving one's environment and lifestyle may decrease the risk of mental illnesses and offer opportunities for prevention. Rehabilitation, which refers to getting people back to work, is another critical priority. The concept of neuro-diversity means that everyone has a unique skill set, and we should focus on matching an individual skill set with the most-suited task. Finally, research should be bolstered through public-private partnerships that are geared at creating innovative tools. An area of critical need is the study of biomarkers, since our syndromic diagnostic criteria don't work properly in different cultural settings.

#### Commitments:

1. My lab is testing mobile tools to implement resilience and cognitive skills training.
2. My lab is conducting clinical trials to examine the impact of lifestyle on mental wellbeing.

**Aryeh Neier**, president emeritus of the Open Society Foundation highlighted the importance of a rights-based approach to providing mental health services, and said that the Convention on Rights of Persons with Disabilities provides an actionable framework. Despite the fact that Article 12 establishes the legal capacity of the disabled to make decisions on their own behalf, the mentally disabled are often denied that capacity. He shared the story of a Peruvian girl with Down Syndrome, who protested because the disabled didn't have the right to vote. She was finally allowed to do so, but she continued to protest because she wanted everyone to be able to exercise that right. He also highlighted that Article 19 of the Convention expresses a strong preference for community-based care for the mentally disabled. Persons with mental disabilities should be able to live independently in the community and should have access to a range of community support services that facilitate inclusion. In general, there is a dearth of support dealing with employment, education, and health services. De-institutionalization frequently results in *trans-institutionalization* (i.e. from the asylum to jails and prison) because of the absence of community services.

Commitments:

1. To strengthen mental health services in primary health care and in the community.
2. To promote a family-based approach for detecting mental health problems.

**Akmal Taher** from the Ministry of Health of Indonesia points out that despite the need to reduce stigma and the treatment gap by facilitating access to high quality, evidence-based services in developing countries, there are still severe challenges. In Indonesia, a mental health act was passed after 10 years, but inequality persists: most health investments go to cardiovascular diseases, cancer, and other priorities. One of the main reasons for this is that Indonesia doesn't have local data on mental illnesses. However, because of the urgency, mental health has been integrated into the primary care system, and one of twelve indicators—which include maternal health, infant mortality, diabetes, among others—is specific to mental health. One of the key challenges now is scaling up this approach nationwide, which would require these standards to be taken up by local governments.

**Francesca Colombo**, Head of the OECD Health Division, pointed out two books published by OECD: *Making Mental Health Count*, which addresses the cost of mental health, and *Fit Mind Fit Jobs*, which conveys the message that people who are fit are more likely to be productive. In her view, mental illness presents a huge challenge but also enormous opportunities: it is an area of high cost and high neglect, which leads to high potential payoff. The direct and indirect costs of mental illness can exceed 4% of GDP. Though mental health spending represents a big part of OECD health budget (5 to 18%), it remains low relative to need. The longevity gap is as high as 20 years, and people with severe mental illness are six to seven times less likely to have a job, indicating areas of enormous potential impact. Despite this, in OECD countries 50% of people with severe mental illness are not treated, and only 10% of people with common mental illness are treated. To summarize her message, Ms. Colombo closed with the following remarks: “act early in another’s life; act based on evidence; and act in an integrated manner.”

Commitments:

1. We will carry on building a robust, internationally comparable evidence base on mental illness.
2. We will work to strengthen data collection and spending on mental health care.
3. We will use the 2015 OECD Council recommendation in “Integrated Mental Health, Skills and Work Policies” to hold countries accountable in their commitment to developing more integrated, cross-sectoral mental health policy approaches.

**Discussion**

In the discussion that followed, participants mentioned that without the push from civil society, the top down push will be much more difficult. Also, the experience of the social response around the HIV epidemic was evoked repeatedly as a template for social mobilization and decision-maker commitment around mental health. A mechanism for pooling funds -the Global Fund- was fundamental in the case of HIV, and such mechanisms should be explored for mental illness.

Both the economic argument and the ethical argument are fundamental. WHO highlighted the human rights approach it has been taking for the past 20 years, which achieved numerous advances at the country level. The OECD finds the economic case needs to be strengthened through quality and expenditure data, as well as enforceable accountability mechanisms.

Finally, given the mutually reinforcing relationship between poverty and mental illness, poverty alleviation efforts should integrate mental health interventions, and the development agenda should prioritize mental health, in particular preventive and multi-sectoral interventions.

## Innovations in Mental Health Promotion, Protection, Care and Funding

Objectives of the Panel:

1. To identify the role of innovation in advancing mental health as a global development priority
2. To hear from a range of panelists from health ministries, NGOs and academia about new and ongoing efforts to promote, integrate and scale-up access to mental health services
3. To identify and discuss barriers and solutions to successful innovation and service development

**Kesetebirhan Admasu**, Minister of Health of Ethiopia, opened up the panel talking about the scale up of mental health services at the community level in his country. The key contributing factors for promoting mental health based on the Ethiopian experience, he mentioned, were political commitment and the ownership of the process by the community and national institutions. It was a community-driven initiative with the goal of integrating mental health services into the existing health care delivery system.

Similarly, **Chhum Vannarith**, from the Ministry of Health of Cambodia, discussed the experience of scaling up mental health services at the community level in Cambodia. The mental health care context in Cambodia is marked by few specialist staff and non-existent mental hospitals. Given these constraints, the experience in Cambodia shows the importance of both informal and formal care to promote and deliver mental health services. Therefore, these programs need families, communities and all government institutions and partners to assist those with mental health problems. Mr. Vannarith explained that mental illness is fundamentally a human rights issue wherein people with an illness can have their rights denied in many ways. Because of this, it is essential that governments build legislation to guide practice, protect rights, and integrate mental health care into the general health system. Finally, he thinks that without equitable and protected funding, the realization of the promotion, protection, and care of mental health is unattainable.

### Commitments:

1. To mobilize more budgetary resources to support the development of mental health services in Cambodia. There is a need for increased service and policy expenditure. This would result in improved mental health policy, strategy, legislation promotion and services development.
2. To develop and expand formal community-based treatment for people with mental illness. With limited capacity and resources, most of mental health care and treatment could be provided in a low threshold manner.

Panelist **Melvyn Freeman**, from the National Department of Health in South Africa, shared two key points about mental health at the community level in his country. First, minds are shaped by environments, thus social determinants define minds; equally, environments are shaped by minds and individuals. It is therefore critical to simultaneously promote environments that promote healthy minds while ensuring healthy minds that promote thriving environments. Second, primary mental health care is the cornerstone to population mental health. This entails that mental health can and must be integrated into general primary care services.

### Commitments:

1. To work within the South African context to promote environments that lead to good mental health and to continue integration of mental health into general health to promote social and economic development.
2. To share experiences of successes of integrated mental health care in South Africa with other low-and middle-income countries (should they want this).

Following these experiences, **Eliot Sorel**, from George Washington University, explained that mental illnesses begin early in life - 50% by age 14, 75% by age 24 – and have multiple determinants. Mental diseases are often co-morbid with other non-communicable diseases and together contribute substantially to estimates of the global burden of disease and to years lived with disability. They also heavily impact countries' economies (4% of GDP in OECD nations). Considering this, he thinks that mental health

promotion, protection, illness prevention and early screening and interventions are essential for nations' development. In agreement with other panellists, he said that the integration of mental health into primary care is an avenue to achieve this. Finally, he reminded the audience that mental health screening tools and effective integrated treatments are now available and must be made part of total health integration.

Commitments:

1. To develop and implement mental health promotion, protection, illness prevention, screenings and interventions training in tandem with appropriate public, private and NGO partners.
2. To develop and implement trainings for integrated primary care, mental health and public health teams in an effective Total Health model in collaboration with public, private and NGO partners.

**Juan Pablo Uribe**, from Foundation Santa Fe in Colombia, stated that universal health coverage enables better access to mental health care. However, UHC is not enough on its own since other significant barriers remain that prevent people, families and communities from accessing the support they need. Another essential aspect of mental health care is the quality of the care provided. It is not only about providing services, but also how effective those services are. In order to raise the quality of care, it is crucial to provide education, training and increased awareness of mental health to all health care providers.

Commitments:

1. To pursue ongoing work on the quality of care.
2. To support institutional developments with communities in post-conflict scenarios.

**Somsak Chunharas**, from the National Health Foundation in Thailand, started his remarks by stating that one of the major challenges for the global mental health movement is trying to quantify how much positive mental health can be brought about. He explained that since good mental health is not only a private benefit but also impacts society (positive or negative) as a whole, the most crucial role of the WBG and WHO—as influential global agencies for a better world—is in advocating to the broader society and policy makers that good mental health is essential for world peace as well as justice. On this point, governments can and must devise policies geared at achieving equity, justice with the view to creating fairness for those with unequal rights, opportunities, and access. He then continued to explain the need to build a health system that better integrates the psychosocial dimension of care, continuity of care, community-based actions for health and better coordinated care from primary to tertiary care. In this challenge, he sees that media and organizations have a significant contribution to make to improve mental health by creating an environment where positive engagement and interaction are better communicated, encouraged and promoted, and where those with mental health risks and problems are not stigmatized.

Commitments:

1. The National Health Foundation (NHF) will make use of this global movement as an opportunity to further promote evidence-based policy and system development towards a more caring health service system.
2. NHF is ready to work with any regional or global actors to promote evidence-based policy and system development whereby public policies and health system development can benefit from better evidence leading to better mental health.

**Yohei Sasakawa**, from the Nippon Foundation, shared his experience working to eliminate leprosy globally and achieve the integration of leprosy care services with mental health. He said that the Foundation's approach in the fight against leprosy could provide insights in this discussion on mental health. Three means that define their approach to eliminating leprosy include: directly appealing to political leadership, expanding public awareness, and promoting community involvement. He stated that appealing to political leadership and expanding public awareness were relevant to eliminate leprosy. In his experience, early intervention and treatment are crucial and one can promote the other. Community involvement has been enormously helpful in encouraging untreated people to seek early treatment. This lesson could be helpful in combating mental health issues worldwide.

**Victoria Matiso**, from the Africa Mental Health Foundation, briefed the participants about the challenges in mental health, such as the chronicity and disability associated with these illnesses, which complicates the treatment for comorbid medical conditions. Early recognition, diagnosis and treatment are all part of a holistic approach to treatment at the primary health care level. This can greatly reduce the stigma associated with mental illness and promote social integration. She concluded by stating that a comprehensive approach at the primary care level would ultimately improve the wellbeing of individuals and families, and therefore improve the strength of country economies overall.

Commitments:

1. To work towards the early integration of mental health services into primary health care, which will reduce the costs associated with unnecessary medical treatments for untreated mental illness.
2. To promote the uptake of the already available, accessible and proven interventions in mental health.
3. To advocate for national health budgets to include mental health budgets, and for the allocated funds to be on par with other medical conditions.

**Stan Kutcher** from teen mental health discussed his work addressing youth depression in Malawi and Tanzania. He argued that since about 50% of all cases of depression can be diagnosed prior to age 25, and since LMIC's have population pyramids heavily weighted towards youth, the process of promotion, protection and care must begin with young people. He also stated that the largest expected return on investment in depression is based on early identification and rapid access to effective care that can be best realized through a horizontally integrated pathway to youth mental health care. The teen mental health program in Malawi and Tanzania, he explained, is a parsimonious, effective and inexpensive coordinated pathway to care model that uses electronic communication (radio) and trainings for educators to enhance mental health literacy for both teachers and students. Moreover, a training to build diagnostic and treatment competencies in primary health care providers exists and has been demonstrated to work in both countries. This model and its components are now available for scale up in LMIC's, where small amounts of investment can be expected to lead to large positive returns.

Commitments:

1. Our team is now ready and willing to work with Governments, funding bodies and NGOs in LMICs to apply and evaluate our evidence-based model, with local partners and tailored to local realities, based on a horizontally integrated pathway to youth mental health care.

Before opening up the conversation with the audience, **Julian Eaton**, from the London School of Hygiene and Tropical Medicine, talked about overcoming barriers for people with sensory impairment in accessing mental health services. He told the audience that mental illness is much more common in people with sensory impairments, but often goes unrecognized. Hence, mental health care should be integrated into services for people with sensory impairments, for example ensuring that service users themselves, and health and education personnel, are made sensitive to these needs and are aware of how to address them. Some of the specific barriers that people with sensory impairments face should be specifically addressed in messaging relating to mental health by paying attention to accessible formats and creating inclusive environments.

Commitments:

1. CBM's mental health work will be made accessible to people with sensory and other impairments, and we will continue to support stronger integration of mental health into our partner disability programs in general.
2. The International Agency for the Prevention of Blindness (IAPB) will promote within their membership the inclusion of mental health services in their policies and programs. These will address the additional barriers that people with both mental illness and sensory impairments face.



## Addressing the Mental Health Needs of Vulnerable Populations Across Sectors

Objectives of the Panel:

1. To underscore and highlight the plight of a range of vulnerable groups and populations with mental health needs
2. To identify critical strategies for addressing the mental health needs of vulnerable populations

The panel was moderated by **Saroj Kumar** and **Alys Willman** from The World Bank Group. Mr. Kumar remarked on the importance of working in mental health through multiple sectors and also highlighted the need to engage the entire government. He said that there is still a lot of work to do internally to help Global Practices within the WBG engage different ministries responsible for different aspects of mental health and psychosocial support.

**Akiko Ito**, Chief Secretariat for the UN Convention on the Rights of Persons with Disabilities, started the panel by discussing the fact that mental and intellectual disabilities have been neglected and marginalized in the international community for a long time. In other words, mental and intellectual disabilities have long been “invisible.” Ms. Ito stressed that this has been especially true in fragile states and emergency settings. Persons with mental and intellectual disabilities tend to be left behind, given no information, ostracized or forgotten. However, the UN and the global community have started to change the situation during the last decade to make the invisible visible, and have started to take numerous actions in the international dialogue to further the work on mental health and psychosocial support. For example, the Convention on the Rights of Persons with Disabilities is a legally binding tool that focuses on human rights and the inclusion of people with disabilities. Moreover, the 2030 development agenda, the SDGs, the world humanitarian summit, and Habitat III are important opportunities. She finished her remarks by highlighting the importance of involving civil society in this effort and working closely with them.

### Commitments:

1. The SDG Agenda emphasizes the interconnectedness of the economic, social and environmental issues that affect our world. This means that we have to work collectively and collaboratively as a global community of people for a people-centered future, including persons with mental and other disabilities.
2. The human rights and dignity of children, youth, women and men, older persons, indigenous persons and others with mental disabilities are a part of our collective future and we must pursue these ambitious goals for them and with them.
3. The 2030 development agenda needs to be implemented by, for, and with persons with disabilities- in particular those who are most difficult to reach, such as persons with mental disabilities and mental health conditions.

**Florence Baingana**, from Makerere University School of Mental Health and WHO Sierra Leone, remarked that conflict has strong psychosocial impacts on individuals and communities. Due to the nature of mental health psychosocial effects following conflicts and other complex emergencies, it is important to work across sectors to ensure that all issues are comprehensively addressed. These include health, education, and social welfare as the key sectors, but also includes other sectors such as housing, youth, gender, etc. For this, she stressed that it is critical to work with governments to strengthen the response so that reconstruction efforts can bear fruit. However, involving only ministries of health is not sufficient, and so other parts of the government need to be part of these efforts as well. Ms. Baingana said that building up services and capacity within countries is essential. For example, in Sierra Leone there is only one psychiatrist for many thousands, and so in conjunction with WHO, they are working to train new professionals using MH Gap.

### Commitments:

1. To provide support to the Ministries of Health in Sierra Leone and around the world, as well as other partners, to revise the Mental Health Act and the Mental Health Policy and Strategic Plan.



2. To work with Ministries of Health and partners to build up mental health services at the district level. This will be through strengthening the cadre of mental health nurses so that they can plan mental health services at the district level, provide support for training 100 medical doctors, and 120 community health organizations in mhGAP.

**Rodrigo Guerrero**, former Mayor of Cali, Colombia, started his presentation by stating that all efforts must build on existing sources of resilience. Mr. Guerrero considers it important to go beyond the term “mental health” alone, as this term may create confusion in isolation. These issues are broader than just the mind. He pointed out the relevance of science in informing their efforts and ways of responding to mental health problems. For example, Mr. Guerrero mentioned that we now know that chronic exposure to violence affects the functioning of the brain, which impacts the capacity for empathy and planning, essential functions of the prefrontal cortex. In this case, child abuse is shown to affect development of the prefrontal cortex, which means that children who are exposed to chronic violence may be more impulsive as a result. But we also know that the brain is highly malleable, and this type of knowledge is useful in efforts to prevent violence. The plasticity of the brain can be used to help people develop empathy.

Commitments:

1. To develop an EIC (education, information, communication program) in Cali, Colombia

**Eric Windeler**, founder of Jack.org, stated that it is important to be open about mental health challenges. Many people don’t talk about these issues (ex. suicide) because they are considered taboo. In noting this, Mr. Windeler reflected on the fact that youth are particularly at risk of struggle and loss of life due to challenges with their mental health. For this reason, it is important to lift the barriers that prevent people from seeking help. He stressed that amazing things can happen when youth are empowered to talk about mental health challenges with their own peers. The Jack.org model develops youth leadership capacity in a connected national network, a key ingredient to fundamental change across diverse communities. In this way, youth can address stigma and prevent suicide within their communities because they know how to talk to their own peers. Finally, Mr. Windeler mentioned that Jack.org has national youth summit and a network of organizations in 18 colleges, which constitutes 3,000 student leaders across Canada.

Commitments:

1. Jack.org commits to being truly youth-led. We will invest over \$1 million annually to support our national network of young leaders to become effective mental health advocates.
2. We’re committed to an open, collaborative approach and will share what we learn domestically and internationally for the benefit of the global mental health community.

**Kathryn Goetzke**, founder of IFred Schools for Hope shared with the audience that IFred started 13 years ago with a positive approach to depression: that hope can be taught and that depression is a treatable condition. Ms. Goetzke mentioned that they are working with younger kids because research shows that even kids 10-11 years old experience depression. Research on hope is also related to greater emotional and psychological well-being, increased academic performance, and enhanced personal relationships. For this, IFred created Schools of Hope, incorporating lessons to teach students valuable skills to understand, create, and maintain hope. This program works with young people on mindfulness and it has a free curriculum online.

Commitments:

1. iFred commits to keeping and maintaining a free curriculum on Hope, available for all at [www.schoolsforhope.org](http://www.schoolsforhope.org).
2. iFred commits to continuing to work to obtain additional funding for research collaborations, long term studies, expansion, and technology partners, which will allow the program to further grow and develop.

**Thom Bornemann**, Director of the Mental Health Program at The Carter Center, presented the Center’s collaboration with the Liberian Ministry of Health, which started 6 years ago to build capacity on MHPSS

issues. From this experience, he mentioned that there were major lessons learned in accountability, sustainability, integration, and scaling up mental health programs. Accountability is very important, as we need to make sure that there is a steady flow of resources for this work. Additionally, all actors need to be accountable for investments made in mental health. In terms of sustainability, international NGOs and other donors must make this a priority as challenges remain with handoff post-NGO or donor involvement. For integration, the lesson has been that mental health must be integrated into larger health care systems. Finally, it is important to scale-up the efforts that are proven successful based on rigorous impact evaluations.

Commitments:

1. The Carter Center will continue work in Liberia to sustain our progress in mental health workforce development, and in areas of addressing stigma and strengthening policy. Additionally, The Carter Center will develop a cadre of specialized Child and Adolescent Mental Health Clinicians while addressing the psychosocial impact of EVD.
2. The Carter Center is committed to completing a due diligence process in conjunction with the Government of Sierra Leone to determine how the model of the Mental Health Program in Liberia might be adapted to increase access to mental health services through health practice, policy, education, advocacy, and service integration.

**Yoshiharu Kim**, Director of the Japan National Institute of Mental Health, shared with the audience the experience of Japan in dealing with the many natural disasters they have faced in history. Their experience shows how disasters can destroy even an industrialized country. From their experience, he stated that it is critical to mainstream mental health and psychosocial perspectives in all the Disaster Risk Management policies and programs, since mental health aspects are closely related to physical health and mortality, economic loss, protection, motivation for reconstruction, and individual and community resilience. For this, it has been critical that the mental health sector provides advisory support to other sectors. For example, Mr. Yoshiharu explained that the mental health team worked closely with overall Disaster Risk Reduction teams, the education sector, and the shelter sector to discuss how to provide mental health services while maintaining the privacy of those who require them. Currently, Japan is developing a database to monitor how people are suffering and how they can be helped through this effort. He also mentioned that in providing mental health services, one must be careful not to categorize victims too much because it can contribute to isolation. One must tailor the approach to meet individual needs, but also address the community and social dynamics more generally.

**Ryotaro Oda**, from JICA, explained that mental health conditions are often more likely to improve due to interventions in the family or community as opposed to individual treatment. For this reason, he stated that it is essential that services be developed in partnership with the people affected – “we should not be just ‘providers’ of services, we should engage people and communities and empower them to be part of the intervention.” JICA is doing this in Syria, Lebanon, and Jordan through job support work for people with disabilities. This is helping to create a more inclusive environment overall.

Mr. Oda also stated that a multi-sectoral approach for mental health is more sustainable. MHPSS can be integrated into just about any sectoral project and have less risk of doing harm. By way of example, in the China post-disaster project, many researchers were asking the same questions and potentially re-traumatizing people, which also reduced the credibility of research and interventions in general due to lack of collaboration. JICA started working with trusted members of the community and promoted shared information and holistic care to address this.

Commitments:

1. JICA—as an implementing agency of Japanese ODA which handles both financial and technical assistance—will seek opportunities to promote the 'mainstreaming' of mental health issues through work in various sectors and, in doing so, accumulate good practices of multi-sectoral approaches.

2. JICA will make an effort to promote mental health based on the value of 'leaving no one behind' which is mentioned in the 'basic design for peace and health (global health cooperation)' by the Japanese government.

### **Discussion**

The discussion with participants touched upon various aspects of mainstreaming mental health such as prevention, the level of government and types of sectors involved in the institutionalization of mental health, and the ways in which these efforts might become more sustainable. Challenges were also mentioned in this field, such as the terms used and the unintended alienation of other sectors. This aspect shows the need to broaden the terminology and start including, for example, 'psychosocial support' in order to capture the attention of other sectors. Other challenges are the differential approaches used in response to different sources of stress, such as the impact of climate change in mental health, women and survivors of gender-based violence, definitions of vulnerability, risk factors, and the integration of mental health at the community level.

### **Wellness and Mental Health in the Workplace**

Objectives of the Panel:

1. To assess the impact of mental disorders on productivity and the value of wellness / mental health programs in the workplace
2. To identify key principles, strategies, and actions that employers and employees can take to promote better mental health in the workplace

**Kelly O'Brien**, Director of The Kennedy Forum Illinois, presented on the importance of changing attitudes and practices in the workplace in order to overcome mental health stigma. In her presentation she talked about four principals for leading a mentally healthy workplace: 1. Know the Impact; 2. Break the Silence; 3. Deliver affordable access; and 4. Build a culture of wellbeing. Usually, the main barrier for people seeking mental health care is that they don't want others to know. The main issue with stigma is that it drives silence, and silence prevents people from seeking help. For this, it is key to create opportunities such as contact-based experiences with individuals who struggle with mental illness as an optimal path to abolishing stigma. The opposite of stigma is understanding and respect. In this, the principal challenge is developing a culture of understanding and respect for others in the workplace. There is a high prevalence of mental illness but a low rate of help-seeking. She also discussed some good examples of existing programs for the workplace that reduce stigma and break the silence. Some of these lessons are related with tailoring programs, using leaders to model behavior, training leaders and managers, promoting Employee Assistance Programs (EAP), etc.

#### Commitments:

1. To conduct leadership events to increase global attention to critical issues in mental health.

Next, **Arnaud Bernaert** from the World Economic Forum remarked that despite the fact that mental health issues in the workplace are prevalent, the spending on them is still very low. For instance, the global costs are expected to more than double by 2030. Mr. Bernaert told the audience that an increasing number of businesses agree that investing in a mentally healthy workforce is good business, as it can lower total medical costs, increase productivity, lower absenteeism and presenteeism, and decrease disability costs. The problem is that mental health issues are still very stigmatized and, in fact, two-thirds of people who take time off for mental health issues do not report it. The Global Agenda Council (GAC) on Mental Health has developed a toolkit with seven steps that managers can use to implement wellness programs. It will be launched via a website which is aimed to help individuals – no matter where they sit in an organization – to develop and build the case for tackling mental illness in the workplace. It is essential to accelerate the deployment of this toolkit.

#### Commitments:

1. The launch of the GAC report on the mental health website on Thursday, April 14, 2016.

2. To keep mental health on the Forum agenda going forward either through ‘championed’ projects which fall under the Health Global Challenge, or through the continuation of a GAC on mental health.

**Norito Kawakami** from the School of Public Health, University of Tokyo remarked that in Japan, there is an approach used to promote positive mental health. This approach shifts from preventing worker’s “karoshi” (death due to overwork) to promoting “ikiiki” (positive mental health). There is a new inter-sector approach that targets “enhancing organizational psychosocial resources” to improve the positive aspects of the mental health of workers. In order to do this, employers should consider including this focus on positive worker mental health in their business policy and strategy.

Commitments:

1. Our Department of Mental Health of the University of Tokyo will commit to mainstreaming mental health in every aspect of the global society by creating a research hub for mental health innovation in Asia, including information dissemination via a website, technical assistance, capacity building, and research & development.

**Derek Yach**, from Vitality Health, spoke next and stated that new data have been published on the crippling impact of mental illness on workplace health and economics. Similarly, he sees that the issue of stigma can block all productive action. However, one way to address this stigma is to mobilize leading voices, such as Justin Trudeau, Prime Minister of Canada, and Kjell Magne Bondevik, former Prime Minister of Norway. Additionally, the corporate voices of CEOs need to be incorporated in addressing stigma. Mr. Yach thinks that it is time to change the framing of mental illness, and start using terms such as “Brain Health” as a reminder that we are addressing a disease that is as real as heart or lung disease. For instance, vitality’s actions for mental health and well-being include doubling down on prevention as well as providing access to services that focus on early diagnosis and treatment. Vitality’s call to action is for workplace health programs to implement effective and well-designed mental health programs such as Big White Wall, and to stop support for well-intentioned sounding Employee Assistance Programs (EAP) that are not grounded in evidence and science. For this, insurers need to follow pioneer companies’ leads in innovating for improved health and well-being throughout the workplace in order to engage employees on a personal pathway to better health.

Commitments:

1. Vitality supports the promotion of mental health and well-being in the workplace and evidence-based programs providing support to individuals. Our collaboration with Big White Wall as of Summer 2016 is a first step in that direction, and we look forward to using our data and findings to contribute to the evidence base and business case around this topic.

**Paul Litchfield** from British Telecom acknowledged that in the progression towards a knowledge-based economy, the wellbeing of staff becomes a key differentiator for businesses. Companies can prevent psychological harm and promote wellbeing by the way they run their operations. In this, companies can implement simple interventions in the workplace to make all the difference in supporting people with mental health problems. Preventing harm, supporting the distressed, and rehabilitating the sick are good practices for employees and shareholders alike.

Commitments:

1. The UK What Works Centre for Wellbeing will publish systematic reviews and secondary analyses on the wellbeing impact of job quality and transitions between work & joblessness this year.
2. The findings of an independent analysis on the economic impact (return on investment) of British Telecom’s mental health intervention service will be submitted for publication later this year.

Following, the director of the WBG Health Services Department, **Brian Davey**, presented on a model that shifts from a traditional response-oriented one towards a proactive Population Health Management model that incorporates structured and incentivized health risk identification and management.

He stated that workplace stress is pervasive in the modern working environment. An ongoing multi-organizational health risk assessment initiative in the United Nations system has shown stress to be the most prevalent reported health risk in all participating organizations. As part of the pressure-stress-mental illness progression, workplace stress is a major contributor to the overall employee health risk profile, healthcare expenditure, and the indirect costs of presenteeism, absenteeism, and disability. Workplace stress and the risk of mental illness need to be formally acknowledged during health risk assessments, should appear on the organizational risk register, and must be managed accordingly with a risk mitigation plan. Workplace health risk management programs can significantly improve individual health, reduce healthcare costs, and contribute to national healthcare efficiency initiatives.

Commitments:

1. The WBG is fully committed to a strategic shift in healthcare support for employees and their dependents, moving towards a proactive health risk management program aimed at identifying health risks, investing in wellness, and managing chronic conditions.
2. WBG will shortly pilot a Workplace Stress Management Standard. Based on the use of a validated risk identification and analysis tool, this will establish baseline metrics in six key areas (demands, controls, support, relationships, roles, change), identify areas needing attention, propose actions, and measure the impact of mitigation measures.

**Bill Wilkerson**, from Mental Health International, opened by talking about this formula: brain health + brain skills = brain productivity. Mr. Wilkerson thinks that it is important to stop calling mental illness an invisible illness because it is not invisible. It is a brain disorder with physical manifestations. In order to create effective mental health programs, first and foremost one has to stop using lousy management practices. What is needed is solid, evidence-based guidelines for managing mental illness in the workplace. Since organizations change from the top and from within, managers have a key responsibility. They need to be accountable for how they manage mental illness in the workplace. They can save lives and preserve the dignity of their employees.

Commitments:

1. Mental Health International – with leaders in business and science – will resume its ‘Breaking Through’ campaign with an ‘International Business + Science Partnership for Brain Health in the Brain Economy.’
2. Mental Health International will help facilitate governments and NGOs as employers (not policymakers) to promote and protect mental health in the workplaces of nations, and in doing so, to lead by example.

**Virginia Carcedo**, from Foundation ONCE in Spain, spoke about the importance of creating and nurturing a facilitating environment in the workplace across countries. For this, three components are very important: innovative partnership, innovative design, and technology. A good example of partnership is the Foro Inserta Responsable, which counts more than 80 members. In design, the foundation has identified the economic sectors with the most employment opportunities in Spain and is working to facilitate more efficient and effective labor inclusion through ICT employment support.

Commitments:

1. To support a collaborative economy by building a circle of collaboration among completely different companies that have nonetheless developed a common body of knowledge and best practices that are transferable.
2. To promote sectorial training that can improve candidates’ employability thanks to the fact that the skills learned during these courses are useful to the companies in partnership with our project, and to most of their competitors.



## Discussion

During the Q&A, panelists and participants discussed wellness policies and institutional procedures that have not kept pace with changing workplace environments. For instance, the Occupational Safety and Health Administration (OSHA), has not addressed psychological safety and health issues whatsoever. They mentioned that if work causes harm, it makes no difference if the harm is physical or mental; the harm needs to be prevented when possible and treated when it does occur. In the discussion, panelists mentioned that large companies including mental health and wellness requirements serve as examples of how to create an inclusive workplace and change the social norm for smaller-scale workplaces. Lastly, the resistance of some business owners should be addressed by showing that diversity is the key to maximum productivity and is the right thing to do. Inclusive workplaces need to become the norm, not the exception. In order to achieve this, it is essential to develop key mental health metrics for the workplace so that the mental health status of workplaces is assessed and thus, change can be measured as new policies and practices are implemented.

## Engaging Communities, Engaging Governments: Taking Action for Mental Health

Objectives of the Panel:

1. To hear from a range of stakeholders about their vision for how to better engage communities and governments in taking action to promote, protect, and restore mental health
2. To pick out common themes, strategies, and recommendations that can be used to engage new partners and actors

**Judy Kuriansky**, Chair, Psychology Coalition at the United Nations (PCUN), talked about the Campaign at the United Nations to get mental health and well-being into the global agenda. The inclusion of “promote mental health and well-being” in Sustainable Development Goal 3.4: “*By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being*” provided an excellent foundation for the goal of this meeting, which is to move mental health from the margins to the mainstream of the global development agenda. She shared with the audience that the inclusion of the words “promote mental health and wellbeing” was the result of a strong and collaborative advocacy effort.

In an historic campaign on the international level at the United Nations, Members States, led by the Mission of Palau (Ambassador Dr. Caleb Otto, a public health physician), partnered with civil society, led by the Psychology Coalition of NGOs accredited at the UN (chaired by Ms. Kuriansky). Different programs present at the WHO/World Bank meeting can point to this target as they push for policy change and programmatic scale-up in their countries. Both top-down (at the international level at the UN) and bottom-up advocacy, are valuable. Finally, Ms. Kuriansky stated that more work is needed in identifying indicators and “means of implementation,” forming multi-stakeholder partnerships, and participating in financing for the development process. She also recommended that when talking about mental health, it is better to use language that resonates with the development community (e.g. “well-being” as used in SDG3 of Goal 3: “Ensure healthy lives and promote wellbeing for all at all ages.”

### Commitments:

1. PCUN is launching a dissemination campaign to educate the broad mental health and psychological community about this new SDG agenda. As other interested stakeholders, I invite you to join the Coalition at the UN in advocacy efforts about MHWB at the United Nations, on behalf of both civil society and government. These efforts include scaling up mental health financing for development (in the negotiations about FfD); identifying indicators as is being done by the Statistical Commission; and establishing models of gold standard, “best practices” and evidence-based “means of implementation” for the target of MHWB worldwide.

**Gabriel Ivbijaro**, President of the World Federation for Mental Health, started his presentation by saying that the Federation has been working on World Mental Health Day for a number of years. This year’s



theme is psychological and mental health first aid for all. The Federation invited the collaboration of all those present in this year's campaign. He also stated that people with mental health difficulties, their families, caregivers, governments, nongovernmental organizations (NGOs), professionals of all kinds, and the associations that represent them want to see people with mental health issues treated with dignity.. Making dignity in mental health a reality requires everyone to work together and make mental health conditions visible, and is not something to be ashamed of. Symptoms are not a barrier to recovery – but attitude is. Stigma and discrimination are significant barriers to obtaining good mental health care and to accessing the everyday social activities that keep us mentally well. Stigma interferes with people's full participation in society and deprives them of their dignity. The voice of people with mental health difficulties needs to be heard. There is no health without mental health but there is also no single, universally-recognized symbol to represent mental health.

Commitments:

1. Despite the number of people in all walks of life who experience mental illness, there is no global symbol that people can rally around to show either their sympathy or acceptance. We will empower people to take action to promote mental health through the dignity symbol.
2. To define best practices in promoting mental health in the workplace and to identify a broad coalition of individuals and organizations to implement these. Mental health in the workplace will be the theme of World Mental Health Day 2017.

**Rafael Alvarez**, Mayor, Carabayllo Municipal District, Peru, discussed the role of local governments in integrating mental health services in primary care. In Carabayllo District, Peru, policies and plans to address neglected health issues have been put in place. Among these health issues is violence towards women and children. The approach taken by the municipal team is respectful of human rights and supportive of gender equality. The mental health institute has been reformed, and community-based strategies for the improvement of mental health have been established (e.g. a women's organization whose volunteers visit people suffering at home to ensure they continue with treatment). A residential program for people suffering from mental health disorders exists for people without a social support network.

Commitments:

1. To encourage the seven districts of North Lima to take action to improve the mental health of their population, through a participatory mental health plan
2. To encourage the seven districts of North Lima to strengthen and expand mental health services

**Sarah Harrison**, Coordinator, IASC MHPSS Reference Group and Technical Advisor, Reference Centre for Psychosocial Support, International Federation of Red Cross and Red Crescent Societies, followed with a presentation about mental health and psychosocial support in humanitarian responses.

In emergency situations, discrimination can prevent people with mental health conditions from getting the support they need. In addition, psychiatric inpatients can be abandoned in emergency situations, either because staff cannot reach the hospital due to damage to infrastructure (such as in natural disasters), or due to insecurity in a conflict situation. Lack of access to mental health care during an emergency situation is a human rights issue. The Inter-Agency Standing Committee (for inter-agency coordination of humanitarian assistance) has developed guidelines for *Mental Health and Psychosocial Support in Emergency Settings*,<sup>2</sup> which she recommends reading along with the WHO publication *Building Back better: sustainable mental health care after emergencies*<sup>3</sup>. It is recommended that the governments

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<sup>2</sup> <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings>

<sup>3</sup> [http://www.who.int/mental\\_health/emergencies/building\\_back\\_better/en/](http://www.who.int/mental_health/emergencies/building_back_better/en/).

integrate the guidelines for *Mental Health and Psychosocial Support in Emergency Settings*, into their emergency preparedness and response plans.

Scaling-up mental health services is the responsibility of multiple sectors, including actors from health, nutrition, education, and protection. Emergencies provide an opportunity to reach beyond the health sector to increase the awareness of and support for persons with mental health concerns. Greater efforts are needed in the promotion of mental health and the prevention of mental health disorders to make populations more resilient following emergencies.

Ms. Harrison made a request to governments and multilateral funding agencies to ensure that sufficient funds are allocated for mental health needs and, in the absence of additional funding, recommends injecting this funding after the initial phase of the emergency has passed, so as to best meet the needs of persons with pre-existing mental health concerns. Lastly, she invited the World Bank Group to join the IASC Reference Group on Mental health and Psychosocial Support in Emergency Settings.

Commitments:

1. The IASC RG is ready to support NGOs and National Governments in implementing MHPSS programmes in emergency settings through coordination, guidance documents, the mapping of projects, development of national mental health and psychosocial support strategies, and knowledge dissemination.

**Kaz de Jong**, from *Médecins Sans Frontières* (MSF) spoke about the humanitarian response to mental trauma in conflict-affected societies. The assessments on mental health and psychosocial needs in communities confronted with violence and natural disaster should focus on distress and vulnerability (e.g. recovery environment, daily stressors), and not necessarily on mental health signs and symptoms, although these are relevant when addressing the top of the pyramid of the MHPSS needs. De Jong explained that in these complex emergencies, the best psychosocial programs are those in which participants are leading in setting priorities, and that services should be organized to address the locally developed concepts of illness. Also, successful programs consider and incorporate best practices from around the world. Mr. de Jong mentioned that efficacy in mental health is what works for the client. Therefore, asking for direct feedback on the efficacy of service for the beneficiaries in daily life (for instance in terms of functionality) is more meaningful than the outcomes on efficacy measured through questionnaires. He remarked on the importance of the cultural adaptation of approaches since they won't necessarily follow a linear path. In order to improve cultural diagnostics and the measurement of efficacy, mental health in non-western settings should adapt its approach from linear causality thinking into a symptom continuum.

Commitments:

1. MSF will increase its effort to deliver psychiatric care at the primary health care level.
2. MSF will continue to step up its efforts to deliver psychosocial care and mental health services in complex emergencies and marginalized settings (e.g. prisons), among marginalized groups (such as migrants, drug users, unaccompanied refugee minors), and in concert with traditional medical care (e.g. HIV-TB).

**Chris Underhill**, Founder and President of BasicNeeds, focused his remarks on collective action models for increased social entrepreneurship in global mental health. Basic Needs has put in place a program that addresses both people's illnesses and their economic and social well-being. This model creates a partnership among people living with mental illness. Impact evaluations show the efficacy of the model. The team has learned a lot over the years about what works. He highlighted the importance of giving practical field-level solutions the utmost prioritization so as to break the treatment gap barrier. Similarly, he called for increasing the funding needed to make the best practice models available. Otherwise, the mentally ill will continue to suffer unnecessarily.

Commitments:

1. By promoting best practices, social entrepreneurship, and disruptive financing solutions, Basic Needs commits to the considerable reduction of the treatment gap over the next five years (goals and targets will be set by fall 2016).
2. The launching of a collective action with others mhNOW ([www.mhnow.net](http://www.mhnow.net)) was announced.

**Sean Mayberry**, Founder and Executive Director of StrongMinds, talked about dealing with mental health challenges in Africa. He explained that Strong Minds is a community-based organization focusing on the mental health of women in Africa. Specifically, the organization uses talk therapy groups to treat depression. The model shows that depression can be successfully treated at the community level. Part of their success, he explains, is related to a strong partnership with community leaders in Uganda as well as their work with the government to ensure quality of care and to evaluate practice. The innovation within this model is mainly its use of task shifting from clinicians to people in the community who receive continuous training and support. This has resulted in improved access to care for women with depression in Africa.

Commitments:

1. StrongMinds will treat 2 million depressed women in Africa by the year 2025.
2. StrongMinds will expand from Uganda, into Kenya, beginning in 2018.

**Elizabeth Carll**, UN Representative, International Council of Women and Focal Point for Health/Mental Health and Noncommunicable Diseases, New York; Executive Committee Member and Former Chair, United Nations NGO Committee on Mental Health, New York, started her remarks by mentioning that The International Council of Women (ICW) provides a transnational platform for promoting health issues. She added that NCDs are a key entry point for the integration of mental health into primary health care. In addition, mental health disorders, such as depression, cut across the other NCDs (e.g. cardiovascular disease, cancer, diabetes and respiratory illness).

ICW works with consortiums of organizations such as the UN NGO Committee on Mental Health, New York and the NGO Forum for Health, Geneva to successfully include mental health in key materials such as the recent NCD High-Level Review Declaration. This advocacy work focuses on the importance of integrating mental health into primary healthcare to achieve universal health coverage and parity, which will especially benefit women who experience higher rates of poverty, discrimination, and lack of access to services.

Ms. Carll pointed out that there are differences in the way that men and women are treated for health issues and NCDs. It is important that work continues to build the evidence base that will guide appropriate policy and guidelines on women's healthcare.

Commitments:

1. The International Council of Women (ICW) commits to continuing targeted and focused advocacy to promote women's health and, particularly in relation addressing NCDs. The ICW will continue to collaborate with existing multidisciplinary consortiums, such as the UN NGO Committee on Mental Health, New York and the NGO Forum for Health, Geneva to advance the health, mental health, and well-being of women worldwide.

**Inka Weissbecker**, Mental Health Advisor from International Medical Corps, focused her presentation on the role of international NGOs in mental health for sustainable development. International Medical Corps is providing psychosocial support in more than 20 countries and is also presenting a call for action from the NGOs4MentalHealth group today. The group has identified barriers and possible solutions for achieving the World Health Organization Mental Health Action Plan 2013-2020 and the Sustainable Development Goals (SDGs). Ms. Weissbecker requested the audience to sign the petition for the NGOs4MentalHealth Call for Action, which can be found here:

[https://www.change.org/p/development-partners-prioritise-mental-health-in-global-development?recruiter=527221946&utm\\_source=share\\_petition&utm\\_medium=facebook&utm\\_campaign=share\\_facebook\\_responsive&utm\\_term=des-lg-no\\_src-custom\\_msg&fb\\_ref=Default](https://www.change.org/p/development-partners-prioritise-mental-health-in-global-development?recruiter=527221946&utm_source=share_petition&utm_medium=facebook&utm_campaign=share_facebook_responsive&utm_term=des-lg-no_src-custom_msg&fb_ref=Default)

#### Commitments:

1. The NGO4MentalHealth Group is releasing the Call for Action today which calls on development partners, including multilateral agencies, government, funders, other NGOs, people living with mental health problems and carers, to join us in addressing identified barriers and jointly working on solutions. The call has already been endorsed by many NGOs and the group is continuing to collect endorsements and signatures.
2. In 2016, IMC is committed to continue building national level capacity and providing mental health services in at least 12 countries that have been affected by conflict, crises and/or are hosting refugees including Syria, Lebanon, Jordan, Iraq, Turkey, Yemen, Ethiopia, South Sudan, Central African Republic, Cameroon, Liberia and Nepal.

#### **Discussion**

Issues raised during the discussion and Q&A touched upon the importance of including patients and communities affected in designing/scaling-up programs, the need to map out the work of different agencies working in mental health to avoid duplication and increase impact, the need to raise awareness of possible solutions among the general public and lastly, the importance of creating more engagement at all levels in policy, services, and financing.

## **Leveraging New Technologies for Improving Access to Care and Designing New Interventions**

#### Objectives of the Panel:

1. To hear and learn how information and communication technologies can contribute to enhancing mental health promotion, prevention, service access and care
2. To set out key needs and gaps across different resource settings that can be filled by ICT

To set the stage, the moderator **Luis Gallegos** highlighted the importance of leveraging new technology for care and designing new interventions. It was recognized that technology has the potential to make an enormous difference in care. It was also noted that intellectual disability has been left out. For example, there was no mention of disability in the UNDG's SDGs. More ought to be done to eliminate disability.

**Niraj Singh**, Executive VP of Vodafone Global, opened the panel by stating that nowadays, a lot more people have access to phones, and mobile phones have become a basic utility. As such, it's important to ask: how do we use this current technology to improve people's lives? How can we use the current technology for good? He presented two examples from work funded by Vodafone in Mozambique called *SMS for Life*. This initiative was created after they noticed that a lot of people were dying because malaria and essential medicines could not be delivered in time. Using basic SMS, they could reduce the amount they needed to stock and deliver the medicine when it was needed. This is an opportunity to consider parallels with what we can do in the mental health space. A second example is with a partnership between a Pharma company and the Ministry of Health to meet the challenge of getting rural children vaccinated. The platform created for mobile phones facilitated registration and was used for mothers and newborn children to make sure reminders were being sent and the supply of medicine was available when they arrived at the clinic. This is important considering the distance they would need to travel. This was a supply/demand side amalgamation of the platform.

#### Commitments:

1. Vodafone: Last year (in terms of SDGs), they committed to educate 3 million girls with a focus on refugee camps. They believe that if they educate these people, everything else follows, including good health.

**Jyoti Mishra**, Psychiatry Professor at University of California, San Francisco, pointed out that mental health is a problem and 10-20% of people globally are suffering from mental health issues, especially children. However, scientists, clinicians, and industrialists can come together to solve global mental health problems. For instance, Mishra and her team published a paper in *Nature Translation Psychiatry* and deployed a novel digital therapy for children with ADD in India, as a brain-plasticity therapeutic. This tool was remotely delivered online. The therapy was successful, children's health status was normalized, and benefits were sustained at follow-up months later, with no side effects. These results are significant because even drugs for ADD cannot accomplish this. Nevertheless, this is still a small-scale technology example, and it can be scaled up. Ms. Mishra continued by saying that technology-based therapeutics are much easier to scale than alternatives since Randomized Control Trials can be performed simultaneously. Because of this, more digital therapeutics will be (and should be) used in the future. We need to call on the FDA to approve technologically based therapeutics like they do for pharmaceutical drugs. This will make them reimbursable treatments that can be integrated into primary care. She finished by summarizing that digital innovation is important, but needs to be combined with scientific validation studies so that digital medicine becomes part of global mental health.

Commitments:

1. To build an evidence-base for digital therapies, and specifically for neglected children and foster children.
2. To look at how digital health therapies can benefit these children. We can show that mental wellness can be brought to them and prevent them from getting ill in the future.

**Karan Singh** from Ginger.io introduced to the conversation three trends in using technology in mental health. First, is the access to online care. There is a shift around the globe in how people are accessing care. People are looking for support digitally, on demand, around the clock, and confidentially. One of the advantages to delivering support through mobile devices is the ability to reduce stigma and meet people where they are, not where you want them to be. For example, close to half a million people entered Ginger.io online, looking for support for depression and anxiety. Most were waiting in line for help for months in the U.S. health system. The second important trend is data. Data can play an incredible role in helping allocate resources effectively. For instance, the MIT data lab has conducted research on how to collect data passively from users to predict mental health state, and use 'honest signals' to understand people and intervene early in a way that was never possible before. This increase in objective measures to measure disease state in mental health is similar to the case of other physical diseases (e.g. diabetes). The third trend is the combination of technology, analytics, and people. Human capital is needed to solve the problem too. Technology is not a panacea, and so the non-traditional workforce (e.g. coaches, sports specialists) can play a key role in delivering care. Technology can enable them to practice better, and give them the ability to scale to treat more people around the globe. As we're talking about integrating mental and physical care, we need to think about integrating technology into core service delivery. This is a core part of how we deliver care, since we cannot hire our way out of this problem.

Commitments:

1. To create a company that had global/social impact. Ginger.io is looking to take their efforts international by promoting a scalable, affordable, high quality mental delivery system with technology at the center.

**A. Krishnakumar** from Royal Phillips started his presentation by explaining that mental illness is a wider issue that should be regarded as a chronic condition or disease. Consequently, there are four key principles that need to be applied for the treatment of mental illness, as in for any other chronic condition: catch it early, manage it daily, self-help tools with a grass-roots approach, and an integrated approach. In this field, one of big challenges is that large parts of a given population do not receive help. This is largely because of inadequate funding and an inadequate focus from the government on mental health. Similar to the scale of education and awareness in major diseases such as diabetes, a similar sort of education/awareness initiative is needed for mental health. Mr. Krishnakumar told the audience that at



Phillips, there are multiple relevant programs on the way: first, combining imaging (e.g. fMRI) with genetics to identify pathways along which behavioral or mental health disorders take root. Second, work in cognitive behavioural therapy. The company is leveraging digital tools for patients to use for self-help, and also for providers to use to take care of people with chronic conditions. A third key area of focus is in monitoring the activities and behavior of patients that can help them manage conditions like depression, anxiety, and dementia. Finally, they have a program on the way for looking at establishing a neural modulation approach for understanding depression.

Commitments:

1. As a member of a technology company, this is a global problem, and we need to partner with multiple stakeholders. Personal commitment to education and awareness.

The Director of the Knowledge Societies Division at UNESCO, **Indrajit Banerjee**, presented some initiatives that UNESCO is launching in response to illness and disease in general. Although they haven't done a great deal in mental health, these initiatives can serve as lessons learned. He talked about the importance of building knowledge societies, which is a concept that is taking central stage. One of the fundamental characteristics of these societies is that they should be fully inclusive, pluralistic and participatory. UNESCO brings also the human rights and respect of freedom angle with work on disability. With respect to technology, Mr. Banerjee pointed out that work around the world has shown that technology can be applied as a helpful tool by eliminating barriers, expanding education, increasing awareness, and so on. When people talk about universal access, opportunity, access to education, and protecting human rights of this population, one must look at how ICTs can empower people. One of the critical challenges is that there are tremendous silos in this area. In New Delhi, for example, they brought together government, private and social sectors since traditionally these groups rarely spoke to one another. Coordination and cooperation between these three stakeholders helped to make empowerment in among the disabled a reality. A great deal of this work involves common sense, for instance increasing accessibility and pairing up research and intervention.

Commitments:

1. We need to be realistic about what we can do with ICT. (1) Empower people with disability through knowledge, and (2) bring stakeholders together and ensure knowledge sharing is the norm, rather than the exception.

**Raymond Lam**, from APEC digital hub, briefed participants about APEC, which represents 26 countries and represents over three billion people. For sustainable growth to happen within a country, mental health is pretty fundamental. As such, it is very important that APEC recognizes mental health. They've created a strategic plan to promote mental health and to create a healthy Asia Pacific. Technology can be used as a tool for collaboration, so APEC is working to design a digital hub, which will bring innovators together and help them form partnerships. One of the strengths of APEC, Mr. Lam told the audience, is its ability to bring very different sectors into play in working on a particular problem—not just the health arena, but also more non-traditional sectors, such as trade and economic development. These other sectors are important in developing public-private partnerships that are required for scale-up. Their digital hub will help with inter-governmental communications, helping innovators to interact with one another, promoting best practices, and sharing resources. They look at bringing innovative programs together and scaling them up. This digital hub will be a secured panel for governments to have online discussions, learn from one another, and enhance collaboration.

Commitments:

1. APEC digital hub facilitates inter-governmental conversations, in a secure way, to help raise mental health as a priority issue.
2. To facilitate the scale-up of programs through regional collaborations and public-private partnerships.

Following, **Thomas Lethenborg** from Monsenso talked about the role of information technologies in better handling mental health disorders. Monsenso looks at mobile health solutions for mental health



specifically. There are about 7 billion mobile phones, and the majority are smartphones. This presents a unique basis for scaling up mental health services. For this, Mosenso gives people living with a mental illness a smartphone app to allow them to monitor themselves regularly. They do this to create awareness that health outcomes are often correlated with behavioral traits. They make this information available to clinicians remotely, and also bring in the family/informal caregivers to help them assess the patient. Altogether, they look at the data to perform advanced data analysis and predict the illness progression of mood disorders. Mr. Lethenborg explains that mobile health for mental health has a supporting function for specialized care and community mental health care, and is an enabler for informal care and self-care. Thus, it supports all levels of care. Collecting all of this data from individuals is going to create a basis for strengthening the general understanding of mental health and behavioral disorders. Eventually this will help create interventions that are far better than what we know today. It is essential to ensure that the solutions created are based on the right level of security, privacy, and evidence. Scaling up is all a matter of getting together with policy makers and fixing the reimbursement issue.

Commitments:

1. To not deviate from the focus on mental health.
2. To develop interventions that will reach more people at lower costs.

**Discussion**

Participants engaged in conversation with the speakers about the unregulated practices in IT and mental health. The panelists responded that there must be a partnership between operators, regulators, and public-private partnerships. Also it is important to think in terms of new evaluation models for iterative innovation. Quality control will need to happen by showing the evidence base and engaging consumers to garner feedback. The discussion also focused on how to ensure that technological innovations won't leave anyone behind, which can be prevented by creating collaborative relations between clinicians and people in a given context. In turn, through understanding their culture and understanding what fits, technology can be made accessible and a great many treatments can be delivered. Conclusively, technology must be regulated, but it also continues to offer a marvellous opportunity to be more connected across the globe and work for the common good.

## **The Science of Implementation: Measuring Results for Policy Formulation, Program Design, Scaling Up Care, Monitoring and Evaluating Impact**

Objectives of the Panel:

1. To better appreciate the critical elements and potential role of implementation science in the development of mental health as a health and development priority
2. To identify key gaps in our understanding of why and how intervention strategies do or do not work on the ground

After opening remarks by the moderator, **Pamela Collins** from US National Institute of Mental Health, **Gustavo Roman** from the Methodist Neurological Institute opened his presentation by stating that mental illnesses are brain diseases, although this concept has been lost over the years and ignored by policy makers. He agrees with the WHO in calling them neuropsychiatric diseases. He believes that it helps to address mental and neurological disorders as a group, where mental health is considered along with neurology. By doing this, he thinks it is important to define priorities in research based on the International Classification of Diseases (ICD-10) Mental and Behavioral Disorders – Diagnostic Criteria for Research, which should be oriented by neuropsychiatric disorders.

Commitments:

1. Neurology must join forces with Psychiatry to fight mental illness.
2. The epidemic of mental illnesses of our time: suicide (depression), senile dementia, and childhood autism should become mental health priorities.

**Glenda Wrenn** from the Morehouse School of Medicine mentioned that, unfortunately, measurement-based care is not the norm, so the usual practice of behavioral health care does not include regular use of validated and quantifiable symptom rating scales. This practice environment must change for mental health equity and focus on looking at actual outcomes in populations. She mentions that integrated care is coming in the near future and that implementation science can be instrumental in speeding up the pace and effectiveness of this transition. The problem, she states, is that we don't often study implementation rigorously enough and lessons learned are often lost. For her, it is a priority to expand the adaptation of scalable solutions to restore mental well-being and foster resilience. Finally, Dr. Wrenn reminded the audience that culture cannot be an afterthought; therefore, it is key to engage stakeholders in research and pilot test culturally-centred interventions before beginning implementation.

Commitments:

1. The Kennedy Center for Mental Health Policy and Research will engage in high impact research and policy analysis to close these gaps. Our priorities will be informed and set with a global perspective.
2. The pursuit of mental health equity will require unity of purpose and fearless, ethical leadership. The Satcher Health Leadership Institute at Morehouse School of Medicine will continue to partner and collaborate to achieve that mission.

On the discussion of scaling up mental health interventions **Robert Heinssen** from the National Institute of Mental Health mentioned that it typically takes many years for mental health research findings to impact clinical practice. There is a gap between the two, so the challenge is to reduce this gap. To promote rapid uptake of new findings, mental health research studies must take into account key characteristics of the settings where new services will be implemented, as well as the information needs of policy decision makers. By way of example, The Recovery After an Initial Schizophrenia Episode (RAISE) research initiative shows that effective treatment for first episode psychosis is feasible in community treatment settings, is cost-effective, and is scalable. This experience has also reduced the time needed to move from research to clinical practice. The findings of this research, he continues, changed federal policies, resulting in new financing for early intervention services and broad implementation of evidence-based treatment in the U.S. healthcare system. A key element was the involvement of policy makers (i.e. the knowledge users) from the very beginning. This contributed to the rapid uptake of research findings.

Commitments:

1. SAMSHA and NIMH are embarking on a large-scale effort to measure the fidelity, quality, and clinical impact of treatment for first-episode psychosis as delivered in community-based clinics.

**Jing Wu**, and **Yueqin Huang** from China CDC, started off their presentation by mentioning that China has been promoting mental health with economic growth and social stability. As a WHO member state, the advanced global design, measurement, and evaluation efforts for mental health have been launched in China. The national survey on mental disorders, disease burden and mental health service utilization has been accomplished, and the results will be released on October 10, Mental Health Day. This study included 30,000 respondents from 157 surveillance points. China has a recently approved mental health law and a new reporting system for mental health.

Commitments:

1. Mental health promotion will be given priority for policy making and service provision in China.
2. Social mobilization for mental health will be developed with multidisciplinary collaboration.

**Giuseppe Raviola** from Partners In Health explained that his organization is committed to rigorously evaluating clinical outcomes of sustained mental health programs to demonstrate feasibility and effectiveness of task sharing models. In order to do this, resources are needed to ensure that 1) clinical

services are accessible, of quality, and sustainable; and there is 2) organizational capability to build and maintain the infrastructure needed to evaluate clinical work on an ongoing basis. For him, implementation science projects have been shown to be feasible in Haiti and Rwanda, and such efforts hold promise to inform policy formulation, program design, and spread and scale-up in those countries. Innovative training and educational models like these are needed to reinforce local capacities to lead the integration of mental health service delivery, training, and research. One of the goals in this is to link implementation to training that is contextually relevant. There is a need to bridge partnerships, resources, and understandings.

Commitments:

1. Over the next 5 years Partners In Health will continue to grow its sustained service delivery, training, and academic research commitments to mental health system strengthening across its 10 country sites in collaboration with government ministries of health and other partners.
2. Over the next 2 years Partners In Health will focus internal mental health efforts to: map care pathways for priority conditions across 10 country sites consistent with a task sharing approach currently used at several sites; finalize a shared cross-site Mental Health Strategic Plan that is linked to a new overall Partners In Health Strategic Plan implementation process; improve existing tools, training materials and curricula across sites; strengthen partnerships to improve the quality of clinical mental health services delivered and supervised at beacon health facilities; and identify areas for shared measurement of outcomes and benchmarking.

**Soumya Swaminathan** from the Indian Council Medical Research commented that mental health problems are a major cause of morbidity in the Indian population, though good population level estimates do not exist. For instance, depression has overcome anaemia in terms of DALYs and is the largest contributor to DALYs in India. Moreover, suicide is a major problem—mainly in students, but also in young men, unable to cope with family and economic pressures, but without good solutions to date. One identified barrier is the stigma, which prevents people from seeking care, or even recognizing the problem. The Government of India has identified that groups in need of special attention are young people/adolescents (students) and the elderly. She also shared with the audience information about a new Mental Health policy that is comprehensive but is hard to implement because of a severe shortage of psychiatrists and other mental health professionals. Consequently, it is necessary to find models of care that involve other health care providers and community volunteers. By way of example, post-disaster psychiatric illnesses is an area where her institute has done a lot of work (examples include responses to the tsunami and Gujarat earthquake) and they see themselves as a knowledge partner along with the Ministry of Health. Finally, she remarked that some priorities include the need to address the best strategies to identify research gaps; scale up best practices; create policy briefs; work with traditional medicine (i.e. yoga, mindfulness); develop research on these practices; strengthen capacity building for research; and create networks with psychiatrists and other professionals to help others without a technical background.

Commitments:

1. ICMR is developing (through consultation) the top priorities for implementation research in mental health disorders for India, and these will be funded (through a call) in the coming year.
2. ICMR is open for partnerships with global aid and development agencies to develop and execute an implementation research agenda in mental health disorders.

**Alain Beaudet**, from the Canadian Institutes of Health Research, explained that research is fundamental to the global response to mental health. Research must include implementation science, which is intimately connected to communities, policy makers, and funders. Dr. Beaudet, currently president of the board of the Global Alliance for Chronic Diseases, mentioned that the GACD, a collection of the world's largest public research funding agencies, has prioritized five areas of focus for its scientific agenda. Currently, the GACD members are collectively addressing three areas including: hypertension, diabetes, and lung diseases. Through these research programmes, the GACD has invested approximately \$100M, which is supporting 36 projects in 30 countries. In recognition of this important moment – as mental

health is emerging as a global development priority – he announced that the GACD will be launching its fourth research program on mental health by committing US\$50M. As the GACD and its research programs continue to evolve, further engagement of partners, such as ministries of health in implementation countries and development banks and agencies, will enable broad scale-up of effective interventions for a measurable impact on health. He closed his remarks by stating the importance of considering the biological and social determinants of mental health and the importance of addressing the gap between research results and implementation to bring results into practice.

Commitments:

1. The Global Alliance for Chronic Diseases commits to launching an international research program in 2016 focused on the implementation of mental health interventions for the improved prevention, identification, and treatment of disorders in low-and-middle income countries and among vulnerable populations in high-income countries. <http://www.gacd.org/homepage/news/GACDMentalhealthcall>
2. The GACD is also committed to actively engaging successful applicants and decision makers in an international implementation science research network in global mental health.

**Discussion**

Speakers and participants talked about implementation research and the need to show generalizable results and send feedback to clinicians. The partnerships and collaborations are crucial to share knowledge and to overcome obstacles. Similarly, the discussion focused on the importance of involving the ministry of health in all aspects of research, including in designing the research question. Once the project is over, ensuring the dissemination of results is equally important. During the discussion, the importance of the perspective of users and family members also came up as being important to better understand the different meanings attached to illness. Finally, an area that needs to be better developed in implementation science is resilience and its promotion, as well as communication between research and humanitarian actors.

**Plenary Panel: Financing for Development Action Agenda and Private Sector Asset Development: How to support scaling-up of mental health innovations across sectors?**

Objectives of the Panel:

1. To highlight the funding gap for mental health (high need, low investment).
2. To identify and examine different financing mechanisms for progressing mental health as a health and development priority.

**John Prideaux**, U.S. Editor of The Economist, opened the discussion by sharing his views about the local situation in the U.S. He noted that while there is an economic incentive on the part of private insurers to support or ensure early identification and intervention (of first episode psychosis, for example), he saw inherent weaknesses and fragility in the publicly funded systems of care, with many people ending up in prisons as a result of slow or non-existent treatment or support for persons with mental disorders. He therefore saw a need for more philanthropic funds to support the development of this sector. A social movement for mental health is important in garnering new or continued funding from philanthropic and other sources.

**Michael Myers** from the Rockefeller Foundation approached the discussion from a different angle, asserting that mental health is key to community resilience, which is itself a core foundation of a resilient health system. To build resilience, he argued that we need to think beyond hard assets and resources (like clinics and community mental health workers) and also consider soft assets. It's important, therefore, to focus also on building trust, practicing transparency, and providing a sense of justice and fairness. In partnership with the World Bank, the Rockefeller Foundation will be directing new funds towards this goal over the coming year.

Commitments:

1. We are committed to this agenda through our work to build resilient health systems. Under this program, we are formulating a new partnership with the World Bank to consider ways to promote health system resilience, including mental health.

The experiences and achievements of three countries were then presented. **Jeremias Paul** (Ministry of Finance, The Philippines) started off by showing how new funding for universal health coverage can be secured via so-called 'sin taxes' on tobacco and other products, based on the remarkable success shown in his home country. The 2012 Philippines "Sin Tax" Law has raised and simplified tobacco and alcohol excises, increased government revenues, improved the country's international credit rating by Standard & Poor's and Moody's, and reduced smoking levels.

**Jeanette Vega** from the Chile National Health Insurance Fund identified several entry points across sectors that can facilitate the integration of persons affected by mental disabilities as valuable members of society, from the community level to specialized treatment centers. Benefit packages of care (such as those already introduced in Chile) should include legal entitlements in terms of access, quality, opportunity, and financial coverage for mental conditions. Increasing the mental health share in the public health budget and implementing a transformation of psychiatric services are the foundations for reorienting the mental health system.

**Nat Otoo** from the Ghana National Health Insurance Authority agreed that strategies for effectively integrating mental health into national health insurance benefits packages should be vigorously pursued, but pointed out that in Ghana less than 5% of those in need of mental health care currently receive care, and there is a struggle to raise new funds for mental health service development. Thus, while the mental health act of 2012 allows for the setting up of a mental health fund, continued advocacy is needed to ensure that funds are actually committed by the NHIS and other sources.

Commitments:

1. The Ghana National Health Insurance Scheme Review process will seek inputs from the Ghana Health Service with regards to the sustainable integration of mental health into the scheme.
2. The Ghana National Health Insurance Scheme will make available budgetary allocations for psychotropic medicines in the year 2016.

Commenting on these and other efforts to date, **Amanda Glassman**, from the Centre for Global Development, set out a number of key points from a newly released report on mental health financing. First, more work is needed to include common mental health disorders in primary care as part of guaranteed packages of health benefits under UHC. More funds are evidently required in order to achieve enhanced coverage of mental disorders at scale, and one international instrument for this would be including mental health within the remit and reach of the Global Financing Facility recently established to support implementation of the United Nations Global Strategy for Every Woman and Every Child. Cash transfers could serve as a further source of funding and support, in particular for preventive strategies.

Commitments:

1. As a small, independent think tank, CGD does not take institutional positions or make institutional commitments. However, I personally can commit to following up on the commitments and agreements made at the meeting, and continuing to watch and provide constructive financing and policy feedback to international agencies and donors working in this space.

**Jodi Butts**, from RISE Asset Development, Canada, highlighted another source of funding and support for persons with mental health problems, namely low interest loans. Rise Asset Development makes such loans available to men and women with a history of mental health and addiction challenges in order to support their self-employment ambitions (and enjoys a 93% payback rate). She also emphasized the need to view multi-sectoral policies through a health equity lens and warned against the risks of 'silo' budgeting that can hinder the development of more holistic funding and service development.



Commitments:

1. To engage in capacity building and ally with other loan funds looking to empower people with a history of mental health and addiction challenges.
2. To share curricula and partner with those looking to build the entrepreneurial capacity of men and women with a history of mental health and addiction challenges.

Finally, **Lourdes Marquez de la Calleja**, from the ONCE Foundation, Spain, reminded delegates that discrimination and stigma, unequal opportunities, and physical and attitudinal barriers are fundamental causes for the social exclusion and poverty of persons with disabilities. All actors have a role in addressing these issues and developing solutions, including companies (ONCE has been able to provide 60,000 clients, many with disability, with new employment opportunities). A combined approach of non-discrimination and affirmative action provides the pathway to social inclusion.

Commitments:

1. To continue being facilitators to create the appropriate framework for achieving a business commitment to social inclusion of people with disabilities.
2. To continue working for people with disabilities to be recognized as a group of legitimate and relevant interests of all organizations.

**Discussion**

A rich discussion between panelists and participants followed and the main excerpts are stated here. Initially, Patricio Marquez, World Bank Group, commented that new funding for mental health is not just the responsibility of the World Bank, but also everyone's responsibility. As reflected in the recent Financing for Development Agenda, it is ultimately national governments that are responsible for protecting the health and welfare of their populations (and it is governments who must choose what support to ask the World Bank for). However, Florence Baingana did point out that more could be done to check or inquire more directly if countries might in fact be interested in including mental health in loan requests, for example with respect to early child development. Delegates were made aware of the existence of a recently prepared internal report that documents the various mental health activities that the World Bank Group already supports.

Crick Lund also informed delegates about ongoing efforts being carried out as part of the EC-supported Emerald research program to develop a framework for identifying optimal strategies for sustainable mental health financing, including its application across a range of low- and middle-income countries.

Jeanette Vega reminded delegates that financing is only one side of the story, since countries also need to make better, more efficient use of existing resources through appropriate reforms to service organizations. Furthermore, and as emphasized by Jeremias Paul, a genuinely multi-sectoral approach is needed, spanning families, communities, local services (such as special education), and social welfare support. Linked to this, a number of panellists reemphasized the point that sustained civil society advocacy and media efforts are required in order to generate appreciable new resources for mental health and secure a new degree of accountability. There is also a need to better understand the pressures that governments have and plan accordingly.

In summing up the panel discussion, Peter Singer left delegates with two thoughts, the first of which was that recent increases in financing for mental health have been largely driven by innovation (as opposed to a social movement, for example), which is unusual. His second point was a plea to everyone present: to flip the treatment gap, so that instead of having a negligible or non-existent chance of accessing services, all persons with mental health care needs could expect to access and use services without the risk of financial impoverishment as a consequence.

## Closing Session

A closing panel concluded the day and highlighted next steps and further commitments towards advancing mental health in the global development agenda.

**Norman Ornstein** from the American Enterprise Institute shared with the audience that his family was directly impacted by mental illness. The neglect of mental health has resulted in many human tragedies, and this in turn is a public policy failure. Resources devoted to mental health would save lives as well as money. Although there are still challenges to changing the policy approach that the U.S takes towards mental health, we do have examples of success both here and around the world that can be taken to scale. We should move forward on these proven policy proposals.

**Thea Emmerling** from the European Union explained that the EU budget places an emphasis on health systems strengthening – infrastructure, training, products and services. Country ownership of health systems strengthening is a key priority. Of the 100 countries that the EU provides aid to, 18 of these have prioritized health. They have no international mental health program, but do have a focus on universal health care. However, the EU does fund pilot projects on mental health around the world. She stated the importance of having an integrated approach to mental health and that the EU is thinking about other options for treatment. She further emphasized that the SDGs should serve as a key focus in scaling up efforts to strengthen mental health.

**Paula Gaviria**, Director of the Victim's Reparation Unit in Colombia, mentioned that six decades of conflict have resulted in significant cross-cutting challenges for the country. 8 million (14%) of Colombians were impacted by conflict. Their program has a comprehensive policy of victim reparations, despite ongoing conflict. This comprehensive strategy for mental health has reached 263,000 through emotional support programs. Their strategy is community based whereby 1,970 local leaders are helping communities build a stronger social fabric in the aftermath of conflict. The Colombian case is a model for how to address challenges in Latin America and elsewhere. However, even despite the successes, three factors are still needed: more psychosocial strategies to reach more people, a more inclusive society for all sides, and a dialogue to rebuild identities among all parties to remove animosity.

**Tim Evans** from the Health, Nutrition, and Population cluster of the World Bank Group started by stating that WBG commits to changing the current discourse around mental health and to embracing the idea of "mental wealth" in line with the progressive realization of universal health coverage. There are a number of financing modalities/approaches toward achieving universal health coverage. The private sector also plays an important role. We also must make wiser investments in service delivery, which is something that health systems are still figuring out. Development metrics are key. The World Bank has catalogued all recent (2010-2015) and current projects that are – in some capacity – supporting efforts to strengthen mental health. Future World Bank projects will be inclusive of mental health.

**Shekhar Saxena** from the World Health Organization started off by praising the presence of many new, non-traditional stakeholders and leaders who are involved in this effort. Expectations for this event have been exceeded and he is glad to see that commitments are being compiled. The WHO will help stakeholders implement these commitments. He reminded the audience that WHO Member States have endorsed the Mental Health Action Plan 2013-2020, which provides WHO with a mandate to support countries in scaling up mental health services. He also announced that World Health Day in 2017 will be dedicated to the theme of depression/suicide and WHO will continue working closely with the World Bank to elevate the importance of mental health. He also stated that both organizations want to work together to integrate mental health into everything that they collectively do. He concluded by praising the substantial funding that The Global Alliance for Chronic Disease is providing to support mental health programs. Private partners will be key assets in advancing progress going forward, within the scope of WHO's framework on engagement with non-state actors.

**Arthur Kleinman** of Harvard Medical School acknowledged that all the experiences presented in the event demonstrate that substantial progress has been made. However, there is still a long way to go. For this, we need a network of networks dedicated to mental health. He said that we should recognize that most mental health care around the world, including in developed economies, is of poor quality. We should reaffirm our core values and understand the return on investment that comes with supporting mental health. He concluded by praising Grand Challenges Canada for their efforts as well.

**Maureen Goodenow** of APEC LSIF and the U.S. Department of State shared the APEC/Asia-Pacific perspective. She said that they see some worrying trends in terms of the economic impact of chronic disease, especially mental illness. However, over the past two days the audience has heard how economies can secure a steady return on investment with the right health systems in place. With APEC leaders asking for more work on the fiscal and economic impacts of ill health, APEC will continue to be a leader in this area, including mental wellness. She said that she sees the APEC mental health roadmap and the APEC Digital Hub for Best and Innovative Practices in Mental Health as important contributions. Advancing mental health is a huge challenge, but by involving multiple sectors and partners, she believes it is possible to take mental health out of the shadows. As the APEC Executive Director Dr. Bollard said yesterday, mental health is already an imperative to global development – now the world must recognize it as such.

## Annex 1: INNOVATION FAIR

### INNOVATION FAIR BOOTHS

Out of the Shadows: Making Mental Health a Global Development Priority - Innovation Fair Booths					
Innovation name	Region	Countries	Representative(s)	Organization	Twitter Handle
Strongminds	Africa	Uganda	Sean Mayberry, Kari Frame	StrongMinds, Inc.	@makestrongminds
Friendship Bench	Africa	Zimbabwe	Dixon Chibanda	University of Zimbabwe	NA
Enabling Access to Mental Health Program	Africa	Sierra Leone	Carmen Vale	CBM International	@cbminternational
An Integrated Approach to Addressing the Issue of Youth Depression	Inter-Regional	Canada, Malawi, Tanzania	Ashwin Kutty, Heather Gilberts Stanley Kutcher	Farm Radio International and TeenMentalHealth.org	@farmradio , @TMentalHealth
BasicNeeds	Inter-Regional	Kenya, Ghana, India, Nepal, China	Chris Underhill, Joyce Kingori Peter Yaro	Basic Needs International	@BasicNeedsIntl
Common elements treatment approach (CETA)	Inter-Regional	Iraq and Thailand	Paul Bolton and Laura Murray	Johns Hopkins Bloomberg School of Public Health	@JHSPH_CRDR
Collaborative Hubs for International Research in Mental Health	Inter-Regional	10 + countries	Representatives from: AFFIRM, Latin-MH, PAM-D, RedeAmericas, SHARE	National Institute of Mental Health	@NIMHgov
Programme for Improving Mental Health Care (PRIME)	Inter-Regional	Ethiopia, India, Nepal, South Africa, Uganda	Crick Lund	Alan J Flisher Centre for Public Mental Health	@CPMentalHealth
Total Health Screening for Integrated Care	Inter-Regional	China, India, Iran, Romania	Eliot Sorel	George Washington University	@Gwpublichealth
Thinking Healthy Program	Asia	Pakistan	Atif Rahman	Human Development Research Foundation (HDRF)	NA
MANAS	Asia	India	Neerja Chowdhary	Sangath	NA
686 Program	Asia	China	Ma Hong, Ma Ning	Peking University Institute of Mental Health, Beijing	NA
National program for the detection, diagnosis and integral treatment of depression	Latin America/ Caribbean	Chile	Mauricio Gomez	Ministry of Health, Chile	@ministeriosalud
Proyecto Buena Semila	Latin America/ Caribbean	Guatemala	Anne Marie Chomat	Institution of Nutrition of Central America and Panama (INCAP)	@incap_nutricion
Mental Health System Reform in Brazil	Latin America/ Caribbean	Brazil	Cinthia Lociks de Araujo	Ministry of Health, Brazil Ministério da Saúde	@minsaude
Zanmi Lasante community-based system for mental health care	Latin America/ Caribbean	Haiti	Eddy Eustache	Zanmi Lasante/Partners in Health	@PIH
Filling the gap: Strengthening mental health and psychosocial support in the Middle East through an Integrated Approach	Middle East	Jordan, Iraq, Lebanon, Syria, Turkey	Zeinab Hijazi	International Medical Corps	@IMC_worldwide
National Mental Health Programme in Lebanon	Middle East	Lebanon	Rabih El Chammay	Ministry of Public Health, Lebanon	NA
Big White Wall	HIC	New Zealand, UK, US	Nancy Cox, Beth Pausic	Big White Wall	@BigWhiteWall1
Community Partners in Care (CPIC)	HIC	US	Jeanne Miranda	UCLA Fielding School of Public Health Rand Health	@uclafsp



## INNOVATION FAIR POSTERS

Out of the Shadows: Making Mental Health a Global Development Priority - Innovation Fair Research Posters			
Innovation name	Region	Countries	Representative(s)
Africa Mental Health Foundation	Africa	Kenya	Victoria Mutiso, David M. Ndeti
Process evaluation of a randomized controlled trial of group support psychotherapy for depression treatment among people with HIV/AIDS in northern Uganda	Africa	Uganda	Ethel Mpungu
Low-intensity evidence-based intervention is effective in reducing the burden of perinatal depression	Africa	Nigeria	Bibilola Oladeji
Advancing implementation designs and costing strategies for Depression and Anxiety disorders in Kenya: An effectiveness-implementation hybrid study of HIV-positive women	Africa	Kenya	Susan Meffert
Pilot study to improve access to early intervention for autism in Africa	Africa	South Africa	Lauren Franz
Posttraumatic Stress Disorder intervention for people with severe mental illness in low- and middle-income country primary care settings	Africa	Ethiopia	Lauren C. Ng
Hybrid Effectiveness-Implementation Research to Integrate HIV and Substance Use Care in South Africa	Africa	South Africa	Jessica F. Magidson
Cobalt study: Comorbid affective disorders AIDS/HIV, and longterm health	Africa	South Africa	Graham Thornicroft, Inge Petersen
Mental Health Beyond Facilities (mhBeF)	Africa/Asia	Liberia, Nepal, Uganda	Florence Baingana
Family Networks for Children with Developmental Delays program	Asia	Pakistan	Usman Hamdani
Creating A New Channel For Mental Health Delivery To Filipinos With Mood Disorders	Asia	The Philippines	Teresita Warner
Home Again: A housing with supportive services intervention for homeless women with mental illness experiencing long term care needs	Asia	India	Lakshmi Narasimhan
>>			
Pass Plus	Asia	India	Gauri Divan
Community-led intervention for improving access to common mental health issues and social benefits for people with psychosocial disability in rural parts of India	Asia	India	Kaustubh Joag
Technological innovations for assessing attitudes and implicit bias toward mental illness in low-resource settings: adaptation and piloting of computer-based Implicit Association Tests in Nepal	Asia	Nepal	Brandon Kohrt
Livelihood Integration for Effective Depression Management (Life-DM): Findings from a controlled trial	Asia	Viet Nam	Victoria K. Ngo
Expanding Access to Mental Health Care in India: Bringing Depression Treatment into the Diabetes Clinics	Asia	India	Lydia Chwastiak
INCENSE livelihood intervention	Asia	India	Sudipto Chatterjee, Hamid Dabholkar
FundaMentalSDG	Global		Graham Thornicroft
Allillanchu: Integration of Mental Health into Primary Health Care Services	Latin America/ Caribbean	Peru	Francisco Diez Canseco
Integrating evidence-based depression treatment in primary care: Tuberculosis in Brazil as a model	Latin America/ Caribbean	Brazil	Annika C Sweetland
Suicide Prevention Alaska	HIC	US	Stacy Rasmus
iFRED	HIC	US	Kathryn Goetzke
Thrive NYC	HIC	US	Gary Belkin, Jill Bowen
It gets brighter: Bringing hope to young people experiencing mental health issues	HIC	US	Joshua Chauvin



## INNOVATION FAIR FLYER

# Innovation Fair

**Affordable ways to improve the mental health and wealth of your nation**



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mhinnovation.net



0900 – 1530 | 13 April 2016 | #mentalhealthnow

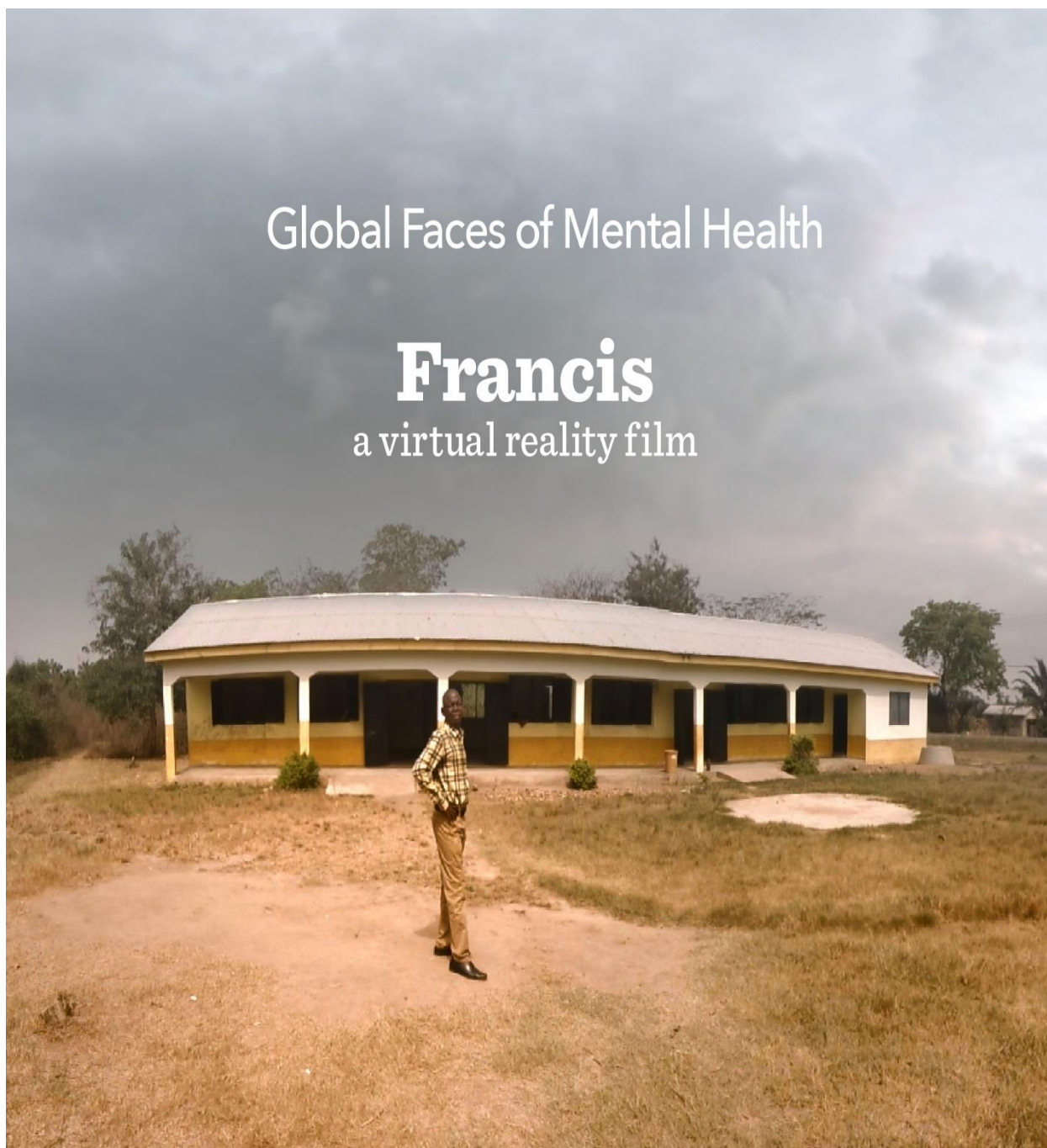
Convening Centre | Milken Institute School of Public Health | Washington D.C. | USA

The Innovation Fair is part of the *Out of the Shadows: Making Mental Health a Global Development Priority* meeting, co-hosted by the World Bank Group and World Health Organization



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## **Annex 2: FRANCIS: A VIRTUAL REALITY FILM**



### About the VR Documentary

*Mental health moving out of the shadows and squarely onto the world agenda as a global health and development priority is one of the focal areas of our non-profit organization, Strongheart Group. As such, it is our honor to contribute to the April WBG/WHO global forum on mental health a virtual reality film to forward and support the objectives of this important convening.*

*“Francis” is a beautifully powerful, five-minute virtual reality film based on the true story of a man named Francis. The film depicts Francis living a life that mattered to him as a husband, father and school teacher in Ghana when he had an onset of mental illness. (Although the film is set in Ghana, there is no mention of Ghana.) His family was worried for him and did what was known to them. They took him to a traditional healer. The solution determined best for Francis was to pinion his leg to a log and put him locked away in a small room, isolated from his family and community. For two years Francis remained there, unable to move. Until one day, a friend from teaching was worried about him and brought a community nurse to him. Francis was diagnosed, treated, and supported in reintegrating into his community. Francis fully recovered and returned not only to his family but to his classroom. The film is framed, around Francis’s story, by a narration and visuals that show the global expanse of the issue.*

*Why use virtual reality “VR”? I think that this article ([http://www.nytimes.com/2016/01/21/opinion/sundance-new-frontiers-virtual-reality.html?\\_r=0](http://www.nytimes.com/2016/01/21/opinion/sundance-new-frontiers-virtual-reality.html?_r=0)) captures it really well, “No matter how enlightened any one of us may be, we are fundamentally limited to our own points of view — but it is human nature to try to broaden our perspective...the medium (VR) has an extraordinary capacity to convey the kinds of feelings of presence and place...” that can cause a viewer to relate with a subject matter on a deeper level. For the viewer, being immersed in the virtual reality world creates a visceral response to the witnessing of Francis doing well, then his downfall, followed by his full recovery that enables a more personal level of care and interest. The core message that comes through is the devastating impact on an individual’s life, their family and also their community when there is a lack of effective treatment and then the positive, sustainable results that can occur when governments and community-based programs work together, implementing science-based treatments, and working inclusively with families and communities. While conveying the gravity of the issue, the film hits a hopeful, inspiring note and creates an emotional imperative for mental health treatment to be recognized as key to global development.*

*As VR has quickly become the innovative, new medium for storytelling - including explorations into its use in investigative journalism as PBS is doing here - <http://www.pbs.org/wgbh/frontline/announcement/frontline-releases-ebola-outbreak-a-virtual-journey-on-facebook-360/> - it is with great joy that the Strongheart Group provides this contribution of the film “Francis” to the WBG/WHO April forum in support of bringing the invisible issue of mental health “out of the shadows.”*

*FRANCIS was created by a top team of media professionals including social change strategist Zoë Adams, Oscar-nominated filmmaker Cori Shepherd Stern, award-winning documentary director and branded short content creator Judy Korin, and award-winning creative director Chris Gernon. FRANCIS features the extraordinary work of photojournalists from across the world including internationally known photographer Nyani Quarmyne, whose powerful images originally brought the story of Francis to the world, and powerful investigative journalism work by the Fellows of the The Global Reporting Centre.*

*The overarching aim of the virtual reality film FRANCIS is to help move mental health out of the shadows and squarely onto the world agenda as a global health and development priority.*

Zoë Adams

CEO

Strongheart Group

<http://strongheartgroup.org/francis/>

### **Annex 3: WBG, WHO and HARVARD GLOBAL MENTAL HEALTH COALITION VIDEOS**

**WBG “Making Mental Health a Global Development Priority” animation video:**

Watch the video: <https://www.youtube.com/watch?v=THT43iz9E8Y> and at <http://www.worldbank.org/en/topic/health/brief/mental-health>

**WHO video “I had a black dog, his name was depression”:**

Watch the video: <https://www.youtube.com/watch?v=XiCrniLQGYc>

**Documentary “Global Mental Health Challenges” produced by the Harvard Global Mental Health Coalition:**

Watch the video: <https://www.youtube.com/watch?v=b6XqbMJ7Ffk>

Visit the Harvard Global Mental Health Coalition Facebook page:

<https://www.facebook.com/harvardmentalhealthco/posts/844943778970126?fref=nf>



## **Annex 4: PANELISTS & SPEAKERS**

### **High Level Opening Panel: Making Mental Health a Development Priority**

#### Panelists

**Margaret Chan**, Director-General, World Health Organization

**Arthur Kleinman**, Harvard University

**William Francis Morneau**, Minister of Finance, Canada

**Alan Bollard**, Executive Director, Asia-Pacific Economic Cooperation (APEC)/Former Governor of the Reserve Bank and Secretary to the Treasury, of New Zealand

**Mustapha Kaloko**, Commissioner for Social Affairs, African Union Commission

**Jen Hyatt**, Founder, Big White Wall

Moderator: **John Prideaux**, U.S. Editor, The Economist

Rapporteur: **Takashi Izutsu**, School of Public Health, University of Tokyo

### **Opening Session of the Second Day**

#### Panelists & Speakers

**Lynn Goldman Dean**, Milken Institute School of Public Health, George Washington University

**Tim Evans**, Senior Director, Health, Nutrition and Population Global Practice, The World Bank Group

**Shekhar Saxena**, Director, Mental Health and Substance Abuse Department, WHO

**Introduction:** **Arthur Kleinman**, Harvard University, and **Zoe Adams**, Film Producer Virtual Reality Documentary: 'Global Faces of Mental Health'

**Matthew McGuire**, US Executive Director for the World Bank

**Keynote Presentation:** **Patrick Kennedy**, former member of U.S. House of Representatives and lead sponsor of the lead sponsor of the Mental Health Parity and Addiction Equity Act of the United States of 2008

**Bernice Dahn**, Minister of Health of Liberia

**Jagannath Lamichhane**, Principal Coordinator, Movement for Global Mental Health, Nepal

**Melanie Walker**, Senior Advisor to the President of the World Bank Group

Moderator: **Patricio V. Marquez**, Lead Public Health Specialist, Health, Nutrition and Population Global Practice, World Bank Group

Rapporteur: **Lysette Cohen**, World Bank Group

### **Plenary Panel Discussion: Mental Health in the Global Development Agenda: Challenges & Options**

#### Panelists

**Vikram Patel**, co-founder, Sangath and co-director of the Centre for Global Mental Health at the London School of Hygiene & Tropical Medicine

**Lawrence O. Gostin**, University Professor, O'Neill Chair in Global Health Law, Georgetown University

**Shekhar Saxena**, World Health Organization

**Kay Redfield Jamison**, Dalio Family Professor in Mood Disorders and Professor of Psychiatry, Johns Hopkins University School of Medicine

**Oleg Kucheryavenko**, Former Head of Health Policy and Influencing, ECSN Program, Oxfam, and HNP Consultant, World Bank

**Murali Doraiswamy**, Professor of Psychiatry and Behavioral Sciences, Duke University, and Chair, World Economic Forum's Global Agenda Council for Brain Research

**Aryeh Neier**, President Emeritus, Open Society Foundation

**Akmal Taher**, Special Adviser, Ministry of Health of Indonesia

**Francesca Colombo**, Head, OECD Health Division

Moderator: **Phillip Campbell**, Editor in Chief of Nature

Rapporteur: **Daniel Vigo**, Harvard University



## **Innovations in Mental Health Promotion, Protection, Care and Funding**

### Panelists

**Eliot Sorel**, Senior Scholar in the Office of Clinical Practice Innovations, Clinical Professor, Department of Global Health, Health Policy & Management, and Department of Psychiatry & Behavioral Sciences, George Washington University

**Kesetebirhan Admasu**, Minister of Health of Ethiopia

**Melvyn Freeman**, Manager NCD Cluster, National Department of Health, South Africa

**Chhum Vannarith**, Under Secretariat of State, Ministry of Health of Cambodia

**Juan Pablo Uribe**, Director General, Foundation Santa Fe, Bogota, Colombia

**Somsak Chunharas**, Vice President, National Health Foundation, Thailand

**Yohei Sasakawa**, Chairman, Nippon Foundation, WHO Ambassador for Leprosy Elimination

**Victoria Matiso**, Africa Mental Health Foundation

**Stan Kutcher**, Teen Mental Health

**Julian Eaton**, Lecturer, London School of Hygiene and Tropical Medicine, CBM International

Moderator: **Karlee Silver**, VP Programs, Grand Challenges, Canada

Rapporteur: **Margarita Puerto Gomez**, World Bank Group

## **Addressing the Mental Health Needs of Vulnerable Populations across Sectors**

### Panelists

**Akiko Ito**, Chief, Secretariat for the UN Convention On the Rights of Persons with Disabilities, Division for Social Policy and Development, United Nations

**Florence Baingana**, Makerere University School of Public Health

**Rodrigo Guerrero**, former Mayor of Cali, Colombia

**Eric Windeler**, Founder & Executive Director, Jack.org

**Prakash Goossens**, International Advocate, Brothers of Charity (Francarita International)

**Kathryn Goetzke**, Founder and Interim Executive Director, IFred

**Elizabeth Hoff**, WHO Representative in Syria

**Thomas H. Bornemann**, Director, Mental Health Program, The Carter Center

**Yoshiharu Kim**, Director, Japan National Institute of Mental Health

**Ryotaro Oda**, JICA

Moderator: **Saroj Kumar Jha**, Senior Director, WBG Fragility, Conflict and Violence CCS Group

Rapporteur: **Alys M. Willman**, World Bank

## **Wellness and Mental Health in the Workplace**

### Panelists

**Kelly O'Brien**, President & Founder, Ideaction Corps and Director, The Kennedy Forum Illinois

**Arnaud Bernaert**, World Economic Forum

**Norito Kawakami**, Head, School of Public Health, University of Tokyo

**Derek Yach**, Vitality Health

**Paul Litchfield**, British Telecom, Chief Medical Officer / Director Wellbeing, Inclusion, Safety & Health, and Chair of the What Works Centre for Wellbeing

**Brian Davey**, Director, WBG Health Services Department

**Bill Wilkerson**, Executive Chairman, Mental Health International, Target the Impact of Depression in the Workplace Initiative

**Virginia Carcedo**, Fundacion ONCE, General Director FSC Inserta, Spain

Moderator: **Tessie San Martin**, President and CEO, Plan International USA

Rapporteur: **Beverly Pringle**, US National Institute of Mental Health

## **Engaging Communities, Engaging Governments: Taking Action for Mental Health**

### Panelists

**Judy Kuriansky**, Columbia University

**Gabriel Ivbijaro**, President, World Federation for Mental Health

**Rafael Alvarez Espinoza**, Mayor, Carabayllo Municipal District, Peru

**Sarah Harrison**, Technical Advisor, Reference Centre for Psychosocial Support, Coordinator, Coordinator-IASC MHPSS Reference Group, International Federation of Red Cross and Red Crescent Societies

**Kaz de Jong**, *Médecins Sans Frontières* (MSF)

**Chris Underhill**, Founder President Basic Needs, Senior Ashoka Fellow, Skoll Foundation Social Entrepreneur, Schwab Foundation Social Entrepreneur

**Sean Mayberry**, Founder & Executive Director, Strong Minds

**Elizabeth Carll**, Elizabeth Carll, UN Representative, International Council of Women & Focal Point for Health/Mental Health and Non-Communicable Diseases, New York

**Inka Weissbecker**, Global Mental Health and Psychosocial Advisor, International Medical Corps

Moderator: **Christine Sow**, Executive Director, Global Health Council

Rapporteur: **Alison Brunier**, World Health Organization

## **Leveraging New Technologies for Improving Access to Care and Designing New Interventions**

### Panelists

**Niraj Singh**, Executive VP, International Public Sector, Vodafone Global Enterprise

**Jyoti Mishra**, Assistant Professor, Neurology, Psychiatry & Global Health Sciences, University of California San Francisco

**Karan Singh**, CEO, Co-Founder of Ginger.io

**A, Krishnakumar**, Leader Emerging Businesses, Royal Philipps

**Indrajit Banerjee**, Director, Knowledge Societies Division, Communication and Information Sector, UNESCO

**Thomas Lethenborg**, Monsenso

**Raymond W. Lam**, Executive Director of the APEC Digital Hub

Moderator: **Luis Gallegos**, Ecuador, and Chair of the Board of Directors of G3ICT, a Global Partnership for Inclusive Information and Communication Technology, and Nippon Foundation Advisor

Rapporteur: **Joshua Chauvin**, University of Oxford

## **The Science of Implementation: Measuring Results for Policy Formulation, Program Design, Scaling up Care, Monitoring and Evaluating Impact**

### Panelists

**Gustavo Roman**, Jack S. Blanton Distinguished Endowed Chair, Director, National Center, Methodist Neurological Institute, Houston, Texas

**Glenda Wrenn**, Director, Division of Behavioral Health at the Satcher Health Leadership Institute at Morehouse School of Medicine

**Robert Heinssen**, Director, Division of Services and Intervention Research, U.S. National Institute of Mental Health (NIMH)

**Jing Wu, and Huang Yueqin**, China CDC

**Giuseppe Raviola**, Director of Mental Health, Partners in Health

**Soumya Swaminathan**, Secretary to the Gov. of India/Director-General, Indian Council of Medical Research

**Alain Beaudet**, President of Canadian Institutes of Health Research (CIHR) and Chair of Global Alliance for Chronic Diseases (GACD)

Moderator: **Pamela Collins**, Director, Office for Research on Disparities & Global Mental Health/  
Director, Office of Rural Mental Health Research, US National Institute of Mental Health/NIH  
Rapporteur: **Dévora Kestel**, Pan American Health Organization/World Health Organization

**Plenary Panel: Financing for Development Action Agenda and Private Sector Asset Development: How to support scaling-up of mental health innovations across sectors?**

Panelists

**John Prideaux**, US Editor, The Economist

**Michael Myers**, Rockefeller Foundation

**Jeremias Paul**, Under Secretary of Finance of the Philippines

**Jeanette Vega**, CEO, Chile National Health Insurance Fund

**Nat Otoo**, CEO, Ghana National Health Insurance Authority

**Amanda Glassman**, Center for Global Development

**Lourdes Marquez de la Calleja**, Head, Social Relations and Strategic Planning, Fundacion ONCE, Spain

**Jodi Butts**, RISE Asset Development, Canada

Moderator: **Peter Singer**, CEO Grand Challenges

Rapporteur: **Dan Chisholm**, World Health Organization

**Closing Session**

Panelists & Speakers

**Norman Ornstein**, author, contributing editor and columnist for National Journal and The Atlantic, and Resident Scholar at the American Enterprise Institute, Washington, D.C.

**Paula Gaviria**, Director, Unit for Victims' Attention and Reparation, Government of Colombia

**Thea Emmerling**, Minister Counselor and Head of the Health, Food Safety, and Consumer Affairs Section in the Delegation of the European Union to the United States.

**Shekhar Saxena**, World Health Organization

**Timothy Evans**, World Bank Group

**Arthur Kleinman**, on behalf of the organizing Working Group

Moderator: **Maureen M. Goodenow**, Senior Advisor and Acting Director Office of Research and Science, Office of the U.S. Global AIDS Coordinator and Health Diplomacy, U.S. Department of State  
Rapporteur: **Andrew Blasi**, APEC Mental Health Team

**The complete Agenda for the Out of the Shadows event can be downloaded at:**

**World Bank Group:**

<http://www.worldbank.org/en/events/2016/03/09/out-of-the-shadows-making-mental-health-a-global-priority>

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

[http://www.who.int/mental\\_health/advocacy/WB\\_event\\_2016/en/](http://www.who.int/mental_health/advocacy/WB_event_2016/en/)