CBM UK policy briefing
May 2019

Creating a global enabling environment for mental health to flourish

CBM is a global development organisation working to transform the lives of people living with disabilities and their families and communities, in the world's poorest places. With over a century's experience of working with people with disabilities, and more than 600 programmes across the world, we work to end the cycle of poverty and disability through practical programmes, research and advocacy.

Introduction

Mental and emotional wellbeing are as vital as physical wellbeing for the flourishing of individuals, families and communities, and as the World Health Organisation acknowledges, "Neither mental nor physical health can exist alone. Mental, physical, and social functioning are interdependent".[1] Good mental health contributes to increased resilience and decreased vulnerability to poor social outcomes, especially for those exposed to intersecting adversities; and good mental health policy can help ensure that people with severe mental illness and psychosocial disabilities are not left behind.

The importance of mental health and recognition that it is a global issue has been increasingly understood in recent years, and is now addressed in international agreements. The Convention on the Rights of Persons with Disabilities includes mental health, as well as physical, intellectual and sensory impairments, in interaction with social barriers, in the definition of disability; and Sustainable Development Goal 3 includes a target to promote mental health and well-being. The World Health

---

[1] *Promoting mental health: concepts, emerging evidence, practice: summary report*. The World Health Organization, Department of Mental Health and Substance Abuse in collaboration with the Victorian Health Promotion Foundation (VicHealth) and the University of Melbourne. WHO, 2004.

Organisation has also decided to extend its first ever Comprehensive Mental Health Action Plan to 2030, aligning it to the SDGs.[2]

The UK government has paid increasing attention to mental health as an international development priority, most recently through the inclusion of mental health as a new 'additional work area' in the Department for International Development's (DFID) Strategy for Disability Inclusive Development 2018-23 and its ambition to become a global leader in this area.[3]

As an institutional donor, policy maker and global advocate, **the UK government through its aid, development and foreign policy work has an important role to play** not only in implementing measures that support individuals with psychosocial disability and their communities, but crucially in **preventing systemic risk factors associated for mental illness and psychosocial disability.** This involves creating an environment where mental health is recognised as a cross-cutting issue, from education and health, to gender based violence and poverty reduction.

Over the last 15 years, CBM has provided three million people in low-income settings with support through our Community Mental Health programmes, enabling people to participate in society and realise their rights through peer support and self-help groups, access to mental health care, participation in school-based mental health programmes and livelihood activities. In addition, our technical expertise has been bolstered by the merger of BasicNeeds with CBM UK in 2017.

To complement the technical advice CBM provides on evidence-based practice, **this policy briefing offers reflections and recommendations on UK government policy, including a call to introduce mental health impact assessments on UK international development, foreign policy and economic decision-making** (page 9).

Definitions

According to the World Health Organisation (WHO), "**mental disorder**" or **"mental illness"** is associated with abnormal thoughts, emotions, behaviour and relationships with others.[4] As well as conditions such as schizophrenia and depression, the WHO also includes intellectual disabilities and substance abuse disorders under this umbrella - however, this paper will not include a distinct focus on the latter two, nor on neurological disorders, apart from where they intersect with mental illness.

The term **psychosocial disability** has been adopted by the disability community to refer to disabilities associated with mental health conditions that in addition to causing functional impairment in their own right, result in social exclusion caused by stigma and discrimination.[5] As with physical disability, the application of the social model to psychosocial disability demonstrates that the environment and support available are a critical part of a person's experience.

CBM is also mindful that 'Definition[s] of abnormality and normality vary throughout the world, and mental health which are based upon the measurement of certain

---

[2] Mental Health Action Plan 2013-2020. World Health Organisation, 2013

[3] *DFID's Strategy for Disability Inclusive Development 2018-23: Now Is The Time.* Department for International Development, December 2018

[4] https://www.who.int/mental_health/management/en/

[5] Pan African Network of People with Psychosocial Disabilities. The Cape Town Declaration. Disability and the Global South, 2014; 1(2):385-386

physiological and other variables, are also based on what society considers to be normal or abnormal.'[6] Mental health and illness exist on a spectrum, rather than as a binary model, and we advocate that people themselves tend to be the best judge of their own needs.

This is even more the case when working across different cultures, and much of the criticism aimed at the current movement for Global Mental Health is on the basis that it seeks to apply one perspective of mental health - from the global North – to the rest of the world. Local health beliefs and traditions explaining mental illness, idioms of distress and ways of dealing with these all vary from culture to culture.[7] Hence, in seeking to work with and support people across the world, CBM is also concerned not to make assumptions of cross-cultural applicability of interventions; instead always working on the basis of local expertise, informed by a global evidence base.

Prevalence of mental illness

There are complexities in ascertaining with certainty the prevalence of mental illness across the world because of the challenges of definition, non-disclosure due to stigma, poor health information systems, paucity of research and lack of data collection – hence data may now be considered dated; but the best estimate is that **around 13% of the global population – or one in eight – currently has a mental health or substance use condition**.[8]

In further detail, out of the global population in 2017:

- 2.5 – 6.5% experienced depression
- 2.5 – 6.5% experienced anxiety
- 0.4 – 1.5% experienced bipolar disorder
- 0.2 – 0.45% experienced schizophrenia[9]

The World Health Organisation ranked depressive disorders as the third leading cause of disability globally in 2017[10] and has projected that by 2030, unipolar depression will be the single largest cause of disability globally.[11] It is estimated that for depressive disorders only one in five people in high-income countries, and one in 27 people in low and middle-income countries, receives 'minimally adequate' treatment.[12]

---

[6] CJ Gletus Matthews CN Jacobs, Kogilah Narayanasamy, Dr. Abbas Hardani (Corresponding author) *The Effect of Western Psychiatric Models of Mental Illness on a Non–Western Culture.* International Journal of Social Science Research 2015, Vol. 3, No. 2
[7] Rachel Tribe, *Culture, Politics and Global Mental Health.* Disability and the Global South, 2014. Vol.1, No. 2, 251-265
[8] Mental Health Action Plan 2013-2020, WHO
[9] https://ourworldindata.org/mental-health
[10] Institute for Health Metrics and Evaluation (IHME). Findings from the Global Burden of Disease Study 2017. Seattle, WA: IHME, 2018.
[11] Nicole Votruba, Julian Eaton, Martin Prince and Graham Thornicroft (2014) *The importance of global mental health for the Sustainable Development Goals*, Journal of Mental Health, 23:6, 283-286
[12] The Lancet Commission on global mental health and sustainable development. October 2018

Determinants and impact of mental illness

Biological
Poor mental health is attributed to genetic and biological factors and the external environment, particularly in utero and during early childhood; and there is considerable research into heritability and overlaps in genetic architecture across mental and physical conditions.[13]

There are, however, concerns about the lack of efficacy of medication in dealing with many mental health conditions, especially when provided without consideration of psychosocial needs.[14] There is also a critique that biological explanations tend to be reductionist and do not recognise the complexities of people's lives; and despite the tendency to favour biomedical explanations in health services, the attribution of a biological causation does not help to reduce stigma.

Social
This paper acknowledges the biological explanation but will focus primarily on the social determinants of mental illness. The Lancet Commission on Global Mental Health and Sustainable Development breaks down external determinants into a number of areas and outlines their impact:

- **Demographic such as gender, age and race** – women and men typically experience differing rates of different mental illness; most mental illnesses originate during childhood and adolescence
- **Economic** – lower economic status is 'independently associated with a range of adverse mental health outcomes'; and there is an association between depression and income inequality
- **Neighbourhood** – characteristics such as urbanisation, levels of poverty and violence and crime can impact mental health
- **Environment** – disasters, conflict and migration can have an adverse effect on mental health
- **Social and cultural** – social attachments, stability, support and education all have a positive effect on mental health, and culture can provide a sense of shared meaning and identity. Family relationships can both support mental health and increase risk of mental illness.

The Commission also takes a convergent approach which seeks to offer 'a unified perspective to tie together findings emerging from developmental science, neuroscience, intervention science and epidemiology', for example in exploring the impact of family income and socioeconomic status on brain stimulation and development in childhood.[15]

Poverty and inequality
Much of the research and literature on mental health addresses the two-way or circular relationship between mental illness and social factors, in particular poverty: 'The interactions between mental health and these issues are multifaceted and often cyclical. For example, poverty is a potent risk factor and predictor for worse outcomes for a wide range of mental disorders.... Conversely, mental illness is a driver for

---

[13] ibid
[14] Ross White and S.P. Sashidharan, *Reciprocity in Global Mental Health Policy.* Disability and the Global South, 2014. Vol.1, No. 2, 227-250
[15] The Lancet Commission on global mental health and sustainable development

poverty.'[16] Strong associations have also been found between 'common mental disorders and low education, food insecurity, inadequate housing… low social class, low socio-economic status and financial stress, but less consistent associations with reduced income and consumption.'[17]

However, distress caused by economic circumstances or other adversities is not necessarily mental illness: 'It is important not to conflate a state of poverty and possible associated feelings of hopelessness, helplessness or impotence with a label of clinical depression or poor mental health'; and thus 'Diagnosing and treating with anti-depressants may do little to deal with the structural inequalities and poverty which may be making people feel sad; an intervention based on poverty reduction might perhaps be more beneficial'.[18] A similar distinction is clearly articulated in the field of mental health and psychosocial support (MHPSS) in humanitarian emergencies, where population resilience and healing using existing social supports is recognised as the primary means of recovery for the great majority of people, whose response to stress should not be medicalised.[19]

There is evidence, too, that in some contexts depression does not significantly impact on a person's likelihood of employment or typical hours of work but may still lead to decreased earnings. Additionally, the informal job sector may offer greater opportunities for employment for those with depression because there is greater flexibility and more routine work available.[20]

It may be that inequality rather than poverty has a greater impact on mental health – certainly there is a significant association between inequality and national rates of mental illness in high income countries[21]; although this is 'yet to be confirmed or refuted in LMICs, mainly because of the limited number of nationally representative epidemiological studies in these countries'.[22] However, as reducing global inequalities across a range of indicators is core to the achievement of the Sustainable Development Goals, and a core value of the UN CRPD, this current lack of evidence should serve as a call to boost research, rather than to discount the likelihood of association.

Attention should also be paid to inequalities **between** countries and within global systems, as well as within national borders – Global Health Watch puts it: 'At the international level, legislation on a wide range of issues, including international trade, can result in inequalities that have an impact on mental health'.[23] This suggests that any government claiming a serious interest in global mental health needs to consider the impact of its economic decision-making on global inequality and other risk factors to mental health.

---

[16] Julian Eaton, Mary DeSilva, Marguerite Regan, Jagannath Lamichhane, Graham Thornicroft, *There is no wealth without mental health,* The Lancet Psychiatry Vol 1 September 2014

[17] Crick Lund, *Poverty and mental health: a review of practice and policies.* Neuropsychiatry (2012) 2(3), 213-219

[18] Rachel Tribe, *Culture, Politics and Global Mental Health*

[19] Guidelines for MHPSS in Emergency Settings. Inter-Agency Standing Committee; Geneva: WHO 2007

[20] Kitae Sohn, *Depressive symptoms are not related to labor market outcomes in Indonesia.* Hitotsubashi Journal of Economics 59 (2018), pp.45-60

[21] Wilkinson R and Pickett K. *The Spirit Level: Why More Equal Societies Almost Always Do Better.* London, Allen Lane: 2009

[22] Crick Lund, *Poverty and mental health: a review of practice and policies.* Neuropsychiatry 2012; 2(3):213–21

[23] *Mental Health and Inequality*, Global Health Watch 3. 2011, People's Health Movement

Humanitarian contexts

The need to address mental health within humanitarian settings has been increasingly recognised since the Balkan wars in the 1990s and South Asian Tsunami in 2004, where the risk that conflict and disaster pose to mental wellbeing became obvious – 'mental health and psychosocial issues in humanitarian emergencies are highly interconnected. People in humanitarian crises experience a wide range of psychological and social problems at the individual, family, community and societal levels. Such problems can predate the emergency… They can also be directly related to the emergency experience e.g. social problems such as family separation; disruption of social networks and destruction of community structures and psychological problems (acute stress, grief, depression and anxiety disorders, including PTSD).'[24]

Additionally, humanitarian response itself may also cause distress 'e.g. anxiety due to a lack of information about food distribution, feelings of powerlessness and humiliation due to the way assistance is provided'[25]; or indeed bring risk of harm from physical, emotional and sexual abuse in displacement camp settings, where those with disabilities are at greater risk of abuse and exploitation.[26]

There are important guidelines in place for addressing mental health in humanitarian response, such as the Sphere Handbook[27] and the IASC Guidelines for Mental Health and Psychosocial Support on Emergency Settings.[28] It is important that sight is not lost of the social model and psychosocial disability in these contexts, where the focus may be more on 'medical and rehabilitative provision for conflict-related direct physical impairment'[29] or where the mental health focus is on 'the 'trauma approach', which regards 'psychological trauma as the most important issue at stake, and, consequently, places trauma-focused interventions at the centre of the humanitarian mental health response.'[30]

As with economic policy decision making there is, perhaps even more so, an imperative for governments to consider the impact of policy decisions that contribute to conflict, disaster and environmental degradation on the mental health of resident populations.

Intersectional factors

Co-morbid conditions

There is also a significant intersection between mental illness and other impairment types and illnesses. For example, 'People with mental disorders experience disproportionately higher rates of disability and mortality… persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are left unattended (such as cancers, cardiovascular diseases, diabetes and HIV infection) and suicide.'[31]

---

[24] Ventevogel P. (2018) *Interventions for Mental Health and Psychosocial Support in Complex Humanitarian Emergencies: Moving Towards Consensus in Policy and Action?* In: Morina N., Nickerson A. (eds) Mental Health of Refugee and Conflict-Affected Populations. Springer, Cham

[25] ibid

[26] Maria Berghs and Nawaf Kabbara, *Disabled People in Conflicts and Wars,* in S. Grech, K. Soldatic (eds.), *Disability in the Global South,* International Perspectives on Social Policy, Administration, and Practice. Springer, 2016

[27] https://www.spherestandards.org/handbook/

[28] https://interagencystandingcommittee.org/

[29] ibid

[30] Ventevogel, P. (2018)

[31] Mental Health Action Plan 2013-2020, World Health Organisation

A number of studies across the world have shown associations between visual impairment and the risk of depression, where 'restricted capacity to contribute to the household or community can lead to feelings of loss of independence, feelings of being a burden on others, and reduced social status and self-esteem'.[32]

Tuberculosis presents a considerable threat to mental health, with estimates that the prevalence of depression could be up to 50% among individuals with tuberculosis.[33] The causal relationship between TB and poor mental health is 'complex and multidirectional… The extent to which different pathways contribute to the burden of comorbidity is currently unclear. For example, some researchers have suggested that patients with TB may develop depression as a result of chronic infection or related psychosocioeconomic stressors or due to the [side-]effects of treatment such as isoniazid[34]. An alternative pathway may be that TB is contracted as a result of compromised immunity and neglected self-care associated with depression. Finally, there is evidence to suggest that TB and depression may share risk factors.'[35]

The disfiguration caused by neglected tropical diseases such as leprosy and lymphatic filariasis (LF) are also associated with higher levels of depression. A study in Nigeria found that 20% of participants with LF experienced depression, compared to 3.1-5.2% of the general adult population, correlating with lower levels of self-esteem resulting from stigmatisation. The psychological difficulties associated with LF were estimated to be twice as severe as the physical difficulties.[36]

Gender
Gender has an impact on mental health and related comorbidities. Overall, women and men experience similar rates of mental illness and substance use disorder – according to Our World in Data, 16% males, 15% females - but are each more likely to experience different diagnoses, with the share of the global population experiencing:

- Depression   3% males   4.5% females
- Anxiety disorders   3% males   4.7% females
- Bipolar disorder   0.55% males   0.65% females
- Schizophrenia   0.29% males   0.28% females
- Alcohol use disorder 1.9% males   0.8% females
- Drug use disorder   1.1% males   0.5% females[37]

[32] Polack S. Restoring sight: how cataract surgery improves the lives of older adults. Community Eye Health. 2008;21(66):24–25.

[33] Sweetland AC, Jaramillo E, Wainberg ML, Chowdhary N, Oquendo MA, Medina-Marino A, Dua T *Tuberculosis: an opportunity to integrate mental health services in primary care in low-resource settings*. The Lancet Psychiatry, Vol 5, December 2018

[34] Isoniazid, also known as isonicotinylhydrazide (INH), is an antibiotic used for the treatment of tuberculosis

[35] Ambaw F, Mayston R, Hanlon C, et al. *Depression among patients with tuberculosis: determinants, course and impact on pathways to care and treatment outcomes in a primary care setting in southern Ethiopia—a study protocol*. BMJ Open 2015;5:e007653

[36] James Obindo, Jibril Abdulmalik, Emeka Nwefoh, Michael Agbir, Charles Nwoga, Aishatu Armiya'u, et al. (2017) *Prevalence of depression and associated clinical and socio-demographic factors in people living with lymphatic filariasis in Plateau State, Nigeria.* PLoS Negl Trop Dis 11(6): e0005567

[37] https://ourworldindata.org/mental-health

Women are also more at risk of depressive disorders where there are greater levels of gender inequality, whereas men are more likely to experience mental health problems when dealing with high wealth inequalities.[38] Additionally, in the global South 15.6% of women experience mental health problems during pregnancy and 19.8% after childbirth.[39]

Women and men may also experience stigma and discrimination in different ways. For example, a study on NTD-related stigma across Cameroon, Ghana, Nigeria, Tanzania and Uganda found that 'men were more concerned about limitations on their economic opportunities and women with the social impact affecting prospects for marriage and family'.[40] These observations which link men's concerns to the economic, and women's concerns to the social and familial, likely reflect gendered concerns across populations. These findings further reinforce the value of DFID's approach of mainstreaming gender throughout its work, including in the Disability Strategy.

CBM's approach to mental health

Aim: To promote meaningful participation in communities, improve quality of life, and broaden the choices for care available for people with psychosocial disabilities.

Priorities:
1. To strengthen the voice of people with psychosocial disabilities
2. To foster community inclusion and participation
3. To support strong and person-centred systems, including health systems so that people can access a choice of quality care
4. To integrate mental health across a range of other health and non-health sectors, including humanitarian response, and Neglected Tropical Diseases

CBM's Community Mental Health Plan
CBM has worked extensively in the field of mental health for over 15 years. The main focus of CBM's work with people with psychosocial disabilities is to strengthen their voice at all levels of society.

We believe that working with families, carers, communities and leaders to raise awareness and reduce stigma will help to break down the barriers that people with psychosocial disabilities often face and that prevent them from contributing fully to society. Through this work, and by demonstrating what is possible, we can also persuade governments to strengthen policy, improve legislation and invest in the provision of mental health and social care services that are needed to promote inclusion and wellbeing.

Within CBM's Community Mental Health plan, we work across the life-course according to the different approaches needed at different stages of life. We are mindful of the gender inequalities that influence who develops mental health conditions, the social consequences, and access to care and recognise that women offer the bulk of care to those who have disabilities, which has an impact on their own lives.

---

[38] Shoukai Tu, *Uncovering the hidden impacts of inequality on mental health: a global study*, Translationational Psychiatry (2018)8:98

[39] Jane Fisher, Meena Cabral de Mello, Vikram Patel, Atif Rahman, Thach Tran, Sara Holton & Wendy Holmes, *Prevalence and determinants of common perinatal mental disorders in women in low- and lower-middle-income countries: a systematic review.* Bulletin of the World Health Organization 2012;90:139-149H

[40] Mitchell G. Weiss (2008), *Stigma and the Social Burden of Neglected Tropical Diseases.* PLoS Neg Trop Dis 2(5): e237

CBM also engages with the global mental health and development community through membership of the UN Inter-Agency Standing Committee, through close cooperation with Disabled People's Organisations, academic leaders and WHO; and with advocacy coalitions such as Bond[41] and Blue Print Group for Global Mental Health.[42]

Our current and developing Initiative interventions include:
- The integration of mental health into our Community Based Inclusive Development work, in Africa, Asia and Latin America
- Community forums, which are a practical means of ensuring culturally sensitive engagement in local communities to introduce rights-based approaches and new services, in Sierra Leone and Malawi
- Peer groups, which provide a therapeutic role and a platform for economic empowerment and strengthening of DPOs, across the world
- Incorporation of the BasicNeeds model of mental health and development, which addresses service users' medical, social, and economic needs through: capacity building, community mental health, livelihoods work, research and collaboration/ partnership building; across the world
- Anti-stigma and awareness raising in Nigeria, Kenya, Sierra Leone, Malawi, Ghana, Uganda and India
- Mental health system and service strengthening, based largely on reform of mental health service and integrating mental health into other sectors, in Burkina Faso, Malawi, Niger, Nigeria and Indonesia
- Research into mental wellbeing and neglected tropical diseases, in Nigeria

Recommendations to UK Government

> **"We need to find ways of making our cities less psychologically toxic and ways of ensuring that all children have benign childhoods. Just as the physical health of nations has been improved by eliminating or at least ameliorating environmental risk factors such as pollution and smoking, so too, governments need to consider how they can help foster psycho-civilised societies in which mental health is guaranteed for all citizens. This is a realistic ambition, but we need the vision and the will to work towards it".[43]**

The UK government has made a very promising start on global mental health efforts and there is clearly commitment within DFID. We welcome the addition of mental health and psychosocial disability to DFID's Disability Inclusive Strategy and look forward to seeing how the work develops up to 2023 – and beyond.
CBM believes the following actions would strengthen the UK's progress towards fulfilling its goal of being a world leader on mental health:

1. Ensure contextually relevant theories of change
CBM welcomes DFID's development of a theory of change on mental health, as outlined in its Disability Inclusive Development Strategy, and would encourage DFID to include the following considerations in the further development of its work:

1.1 Use research and learning on mental health from the global South, including consultation with DPOs and people with lived experience/user-led organisations; and critical reflection to analyse assumptions behind the theory of change[44]

---

[41] https://www.bond.org.uk
[42] https://unitedgmh.org/index.php/global-advocacy
[43] Richard Bentall, *Western models for mental health: A cautionary note*.
[44] For further analysis, see Ross White and S.P. Sashidharan, *Reciprocity in Global Mental Health Policy*

1.2 Ensure a context specific approach to each country or area, rather than one size fits all. This should account for:

   a. Local understanding and definitions of wellbeing and mental illness, including approaches to categorisation, diagnosis, help-seeking and reporting, treatment and recovery

   b. Conceptualisation of the self; and the role of the family and carers, community and other informal support structures

   c. Local customs and beliefs

   d. The presence and capacity of DPOs and mental health user-led groups

2. Help create a global environment that enables good mental health to flourish and reduces risk of mental illness

Global systems also have an impact on national capacities to tackle risk factors associated with psychosocial disability, especially inequality and humanitarian crises. The UK government could:

2.1 Develop and trial, with input from user-led groups, '**mental health impact assessments**' for bilateral and multilateral policies, agreements and interventions; and analyse the utility of such assessments for preventing harm to mental health in relevant populations, including through discussions with bilateral and multilateral partners

2.2 Strengthen the mental health capacity and expertise of DFID, and improve access to global mental health expertise for the Department for International Trade, Foreign and Commonwealth Office, Government Equalities Office and Stabilisation Unit; and develop cross-departmental learning and cooperation on global mental health, including with the Department for Health.

3. Mainstream mental health into international advocacy work

3.1 The Disability Inclusive Development Strategy includes a commitment to 'influence and drive collective action to deliver against the ambition set out in the UN CRPD, the SDGs and the World Health Organisation's Mental Health Action Plan' and 'provide inclusive and accessible mental health and psychosocial support (MHPSS) in conflict and emergencies'.
In order to achieve this, one practical way would be to consciously mainstream mental health considerations into international policy negotiations, in line with the CRPD, particularly into the areas of:

   a. Health, especially in relation to co-morbidities

   b. Social affairs, including a focus on gender and violence against women and girls

   c. Economic affairs and social protection

   d. Peace and security, especially in relation to mental health and psychosocial support in humanitarian emergencies

   e. Education; and mental health promotion in young people

   f. Environment

   g. Data and statistics

4. Ensure programmatic work is appropriate to local and national context and capacity

DFID's Disability Inclusive Development Strategy includes important commitments to people with psychosocial disabilities, including to support their participation and leadership to ensure access to quality services and to combat stigma and discrimination. Some specific ways to achieve this would be to:

4.1   Increase funding for mainstreamed and specific mental health interventions, taking care to ensure the amount available is manageable for local capacity and sustainability, especially when working with user-led groups

4.2   Ensure that programmatic interventions are contextually appropriate, with an understanding of levels and expressions of stigmatisation and discrimination, and typical models of caregiving; and consult with local and national user-led groups about whether scale-up of intervention is appropriate, or whether small scale, local responses are more suitable for responding to mental health needs

4.3   Ensure that those with psychosocial disabilities who are most at risk of being left behind, such as those with co-morbid conditions, women and older people, are included in the design and implementation of projects and programmes. This may involve reaching out beyond traditional/typical partners and consultation groups

4.4   Ensure that grant and contract reporting requirements and mechanisms for programmes are accessible, and provide for reasonable adjustment for people with psychosocial disabilities where necessary e.g. with timescales

5. Build data and evidence on mental health and psychosocial disability

As well as the disability inclusion business standards on data, evidence and learning in DFID's Disability strategy, the government could also strengthen its approach in the following ways:

5.1   Utilise Southern-led research and evidence on mental health and psychosocial disability to inform the UK government's understanding, policy and practice. By extension, such an approach might be used to improve participation in priority-setting for national programmes or global mental health

5.2   Build on data collection and disaggregation relating to mental health and psychosocial disability in the global South, and work with DFID country offices to build understanding of how and why data should be collected and used. There is a particular need to invest in clear measurement tools and indicators for mental health, particularly outside of diagnostic categories but that reflect levels of functional impairment, disability or wellbeing – which the Washington Group Questions currently perform poorly on.