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'Invisible problem' to global priority: The inclusion of mental health in the Sustainable Development Goals (SDGs)

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ABSTRACT

Mental health is currently in a process of transformation from being described as an 'invisible problem' in international development to being framed as one of the most pressing development issues of our time. The concern that mental health is both absent within international development agendas and an obstacle to the achievement of development goals lies at the heart of the recent inclusion of mental health in the Sustainable Development Goals (SDGs). This article critically examines three intersecting axes key to the inclusion of mental health in the SDGs: the conceptualization and calculation of the contribution of mental disorder to global burden of disease; the quantification of mental disorder as an economic burden; and the relationship between mental distress and poverty. The inclusion of mental health within development marks an important historic moment to foster a more nuanced understanding of the interplay between mental health and development and of how these two fields at times work together in producing reductionist, economistic, individualized and psychologized responses to poverty.

Keywords: burden, development, economism, global mental health, poverty, psy-expertise.

FROM AN 'INVISIBLE PROBLEM' TO A 'PRESSING DEVELOPMENT ISSUE'

Mental health is in a process of transformation from being described as an 'invisible problem in international development' (Chambers, 2010), to being framed as 'one of the most pressing development issues of our time' (FundamentalSDG, 2014: 1). The concern that mental health has been absent within the development agenda despite being an 'obstacle' to the achievement of development goals lies at the heart of the recent (2015) inclusion of mental health within the Sustainable Development Goals (SDGs). According to #FundaMentalSDG, an initiative that campaigned for the inclusion and now the strengthening of mental health in the post-2015 development agenda (see www.fundamentalsdg.org/), this marks a 'historic step for mental health'. This (re)conceptualization of mental health as a development priority is embedded within the growth of The Movement for Global Mental Health, as an area of study and a global movement that attempts to scale up access to mental health services in low and middle-income countries (LMICs) (Lancet Global Mental Health Group, 2007); and wider advocacy from international organizations, such as the World Health Organization (WHO), and the World Bank, to frame mental health as a global priority (WHO Atlas, 2011; Tomlinson, 2013).

This article argues that there has been insufficient cross-pollination between the fields of mental health and development, meaning that there is a tendency within the literature for each to adopt concepts from the other without critical reflection. This is a critical time to foster a more nuanced understanding of the interplay between mental health and development. Therefore, this article critically examines the inclusion of mental health in the SDGs and the main claims and frames of reference upon which this has proceeded. It focuses on three intersecting axes in the framing of mental health as a 'problem' for, and central to the achievement of, development: the conceptualization and calculation of the contribution of mental disorder to global burden of disease; the quantification of mental disorder as an economic burden; and the relationship between mental health problems and poverty. In doing this, the article brings together usually separate strands of critique - critical disability and mental health, and critical development literature - to further an understanding of how these two fields at times work together in producing individualized and psychologized responses to poverty. Concern is raised that the reconfiguration of poverty at an individualized level, obscures and naturalizes structural determinants of distress, disablement and impoverishment, contributes to the economism of everyday life, and frames global populations as amenable to the increasingly globalized knowledge systems and practices of psychiatry, psychology and psychotherapy (Howell, 2011; Klein, 2016; Mills, 2014; Mills and Klein, 2017).

The successful inclusion of mental health within the SDGs should be celebrated for bringing much needed policy attention to mental health. However, it is timely and significant to take this opportunity to critically engage with both mental health and development so as not to reproduce the power inequalities and harmful practises that both have been associated with at a global scale. First, it is worth first outlining the core literature that constructs mental health as a development priority, followed by a section unpacking definitions of key concepts.

GETTING MENTAL HEALTH ONTO THE DEVELOPMENT AGENDA

Attempts to include mental health within the SDGs can be traced to claims that mental health was missing from the Millennium Development Goals (MDGs). Writing about the MDGs, in 2005, Miranda and Patel pointed out that the 'complete absence' of mental health from the MDGs, reinforced 'the position that mental health has little role to play in major development-related health agendas' (p.0962).[1] Similarly, Tomlinson argued that mental health must be ensured 'a place at the post-MDG table' so that it 'is not side-lined in future initiatives as they have been to date with regards to the MDGs' (2013: 2). Others pointed out the MDGs couldn't be achieved without addressing mental health, especially given the relationship between mental health and dimensions of human development, such as poverty, education, HIV, and environmental factors (Skeen et al., 2010). Furthermore, Skeen et al. recommend researching the impact of development projects on mental health outcomes.

[1] In a response to the article by Miranda and Patel, Sachs and Sachs (2007), while agreeing there is no health without mental health, did not agree that mental health is missing from the global health agenda.

One of the first reports to focus explicitly on *Mental Health and Development* was published by the WHO in 2010, and produced as part of the 'The Mental Health and Poverty Project' (MHaPP) funded by the Department for International Development (DFID) (UK). This report centred on the vulnerability of people with mental health problems, calling attention to the fact that they have been 'overlooked as a target for development work', and 'excluded from development opportunities' (WHO, 2010a: xxiv&34). This exclusion refers to the ways that people with mental health problems are sometimes explicitly excluded from development initiatives, for example those that require recipients to be 'mentally and physically sound' to qualify for assistance (WHO, 2010a:3); and because mental illness is conceived of as a barrier to the achievement of development goals due to its high contribution to the global burden of disease. In this report the WHO (2010a:xxv) emphasize two development paradigms that should be considered 'to ensure people with mental health conditions are included in development programmes' – these are 'the need to improve aid effectiveness', and a human rights approach. Prior to this report, WHO MIND (Mental Health in Development) was launched to work with LMICs on improving mental health services.

The WHO's *Comprehensive Mental Health Action Plan 2013-2020* frames the marginalisation of people with 'mental disorders' as a significant impediment to the achievement of national and international development goals (WHO, 2013:8); states that development agencies will play a key role in the effective implementation of global mental health (11); and advocates mainstreaming 'mental health interventions into health, poverty reduction, development policies, strategies and interventions' (p.13). From the WHO's action plan we can see development start to be more explicitly embedded within important documents that outline mental health as a global priority.

A year after the publication of the *Action Plan*, came the publication of the All Party Parliamentary Groups (APPG) report on *Mental Health and Sustainable Development* (DeSilva and Roland, 2014), which outlines cross political party responses to what the UK Government can do in relation to increasing access to, and improving services for, mental health globally. The report details three central reasons why 'mental health matters globally and why development activity will not be truly successful without tackling mental health issues' (p.5): the health case; the human rights case; and the social and economic case. The report concludes with 'the simple message…that progress in development will not be made without improvements in mental health…Improving mental health is therefore a vital part of a successful development programme' (DeSilva and Roland, 2014:4).

Building on the argument that mental health is missing from the MDGs, many started to make the case for the inclusion of mental health in the SDGs. According to Thornicroft and Patel (2014:1) there is a compelling case for including mental health on the SDGs, because mental health cuts across the other sustainable development goals and because of the 'unmet needs of the 450 million people in the world with mental illness'. Inclusion on the SDGs is important because the goals influence priority setting and investment at national and international levels. The justification to include mental health within the SDGs is made

through showing the ways mental health cuts across other key goals. For example, according to Thornicroft and Patel (2014: 1) poor mental health is framed as a 'precursor to reduced resilience to conflict'; a barrier to goals that aim to promote peaceful and inclusive societies; improvement in mental health services is said to have a role in making settlements, and particularly urban areas, safer and more sustainable; and mental health is said to be relevant to ending hunger (as it is a risk factor for child undernutrition).

The right to health as espoused in the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) is also mentioned by Thornicroft and Patel (2014) who state that universal health coverage must include provision of treatment for mental illness, while Tomlinson (2013) suggests integrating mental health care into primary healthcare systems but without presupposing established health infrastructure or high level health-system functioning.

In the lead up to decisions on the SDGs, Thornicroft and Patel (2014) used the above claims to call upon the United Nations to include a separate target within the broader health related goal of the SDGs, to enable 'the provision of mental and physical health and social care services for people with mental disorders, in parity with resources for services addressing physical health.' Similarly, the *FundaMentalSDG* initiative advocated for 'a specific mental health target' based on the assertion that 'there can be no health without mental health, and no sustainable development without including mental health into the post-2015 SDG agenda' (2014: 3). Thornicroft and Patel (2014) proposed two key indicators (through which to measure success) currently identified within the WHO Mental Health Action Plan 2013-2020: a 20 per cent increase in service coverage for 'severe mental disorders' by 2020; and a 10 per cent reduction in suicide rates by 2020 (based on the assumption that suicide is largely an outcome of mental disorder, an assumption not without its critics, see Marsh, 2010).

In 2015 mental health was included within the Sustainable Development Goals (SDGs) as outlined in the UN report *Transforming our World: the 2030 Agenda for Sustainable Development* (UN 2015). Mental health appears in Article 26 of the declaration, which states that 'to promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care' (n.p.). The article goes onto express commitment 'to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development'. Mental health also appears in 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' (n.p.).

Following the inclusion of mental health in the SDGS, the World Bank and the International Monetary Fund (IMF) have started to take mental health seriously as a development issue, for example, hosting the 2016 event - *Out of the Shadows: Making Mental Health a Global Development Priority* (April, 2016), which aimed 'to move mental health from the margins to the mainstream of the global development agenda' (World bank, online) and to build a

'collaborative response to tackle mental health as a development challenge' (Kleinman et al. 2016: 2274). Furthermore, the *Lancet Psychiatry* launched a Commission on Global Mental Health (to be published in 2017), aiming to 'show the centrality of mental health to the SDGs, both the specific health goal, and the other relevant SDGs, for example, the goals on peace and justice, climate action, and gender equality' (Patel, et al. 2016: 1144).

Alongside the push to understand mental health as a development priority from international and supranational organizations, some non-governmental organizations (NGOs) explicitly integrate mental health and development in their practice. A notable example is the international NGO BasicNeeds, which operates a community-based integrated Mental Health and Development (MHD) model, an approach that aims to deal with the issue of mental health in the context of development (BasicNeeds. 2008; Raja, et al. 2012). This approach aims to create sustainable livelihood programmes to help people to start earning a living after being given access to community-based treatment.

Before exploring literature that raises concerns over the way mental health has been included within the SDGs, it is first worth unpacking how relevant advocacy and literature conceive of and define mental health and development.

DEFINING THE INDEFINABLE: MENTAL HEALTH AND DEVELOPMENT

The language/s available within a culture provide the conceptual tools with which to name, understand and act on experiences, and are thus central to discussions of what comes under the rubric of psychological or emotional wellbeing. Thus, how an experience is named, for example, as 'illness' or as distress, has material effects on possibilities for action. The WHO have produced a number of reports that are significant for discussion here, including: *Mental Health and Development* (2010), the *Mental Health Gap Action Programme* (mhGAP 2008), the *mhGAP intervention guide* version 2.0 (mhGAP) (WHO, 2016), and the *Comprehensive Mental Health Action Plan 2013-2020* (WHO, 2013). In these reports, mental, neurological and substance-use disorders are subsumed into one category, which includes 'Moderate–Severe Depression, Psychosis, Bipolar Disorder, Epilepsy/Seizures, Developmental Disorders, Behavioural Disorders, Dementia, Alcohol Use and Alcohol Use Disorders, Drug Use and Drug Use Disorders, Self-harm/Suicide, and "Other Significant Emotional or Medically Unexplained Complaints"' (WHO, 2010a: iii). However, the reports differ in the label they give this list of diverse experiences: the WHO *Mental Health and Development* (2010a) report calls them 'mental health conditions', whereas the mhGAP Intervention Guide (WHO, 2016) calls them mental, neurological and substance use (MNS) disorders. The *Comprehensive Mental Health Action Plan 2013-2020* and the APPG *Mental Health and Development* report (DaSilva and Roland, 2014) use the terms 'mental health problems', 'mental illness' and 'mental disorders' interchangeably (and do not use the term 'neuropsychiatric disorders'). The APPG loosely defines these as: 'a set of medical conditions that affect a person's thinking, feeling, mood, ability to relate to others, and daily functioning' (DaSilva and Roland, 2014: 8). The *Comprehensive Mental Health Action Plan*

2013-2020 states that 'Mental well-being is a fundamental component of WHO's definition of health', and means that people are able to cope with 'normal stresses', realize their potential, work productively, and contribute to communities (WHO, 2013:5). The *UN 2015 Sustainable Development Goals* mention both mental health and mental well-being, but do not mention 'mental illness'. Instead it frames distress as a non-communicable disease 'including, behavioural, developmental and neurological disorder' (article 26), and expresses commitment to prevention and treatment.

In the above reports what might be called *distress* is spoken about as a 'problem' or 'disorder', while the term 'neuropsychiatric' disorder firmly locates this 'problem' within the brain. For example, the WHO states that 'mental disorders…have a physical basis in the brain…[and] can affect everyone, everywhere' (WHO, 2001b: x), and the mhGAP intervention guide (WHO, 2016: iii) conceives of these disorders as 'highly prevalent, accounting for a large burden of disease and disability globally'. Framing distress as brain-based highly prevalent disorders underpins the call 'to scale up the coverage of services for mental disorders in all countries, but especially in low-income and middle-income countries' (Lancet Global Mental Health Group, 2007: 87).

Different parts of the world name and understand their experiences of distress in ways that are culturally meaningful and valid to them, and this includes definitions that differ from allopathic 'western' psychiatric language. Antonovsky (1979) argues that the available meanings that people in difficult or distressing circumstances give to their lived realities shapes their sense of coherence, which then impacts on ability to cope. This means the promotion of standardized approaches, such as the mhGAP intervention guide (WHO, 2016) risk overlooking or discrediting different ways of understanding distress that have coherence in vernacular spaces. Writing from Palestine, Rabaia, Saleh and Giacaman (2014) explain that,

> In mental health, what is understood in some cultures has no meaning in others. This is not an issue of finding the right word in translation, or semantics, it is about a way of being, of living, of reacting to stress and trauma linked to a mindset where meaning, culture and context are of the essence (p. 179).

The move away from understanding mental distress as 'illness' is not evident in literature framing mental health as a development priority, where divergent but largely individualized and medicalized understandings tend to prevail. While some argue that framing distress as 'illness' helps to normalize the experience and encourages people to take mental health as seriously as its physical counterpart, others claim this framing may be problematic, especially bearing in mind research showing that biological and brain-based explanations of mental distress (as an 'illness like any other') have been found to increase the stigmatisation of those who experience distress, compared to explanations that emphasize social factors, for example distress as response to trauma or life circumstances (Angermeyer and Matschinger, 2005; Read et al. 2006). This may in part explain why many people who identify as psychosocially

disabled, as mad positive, as users of mental health services, or as 'survivors' of psychiatry, tend to explicitly reject the framing of their experiences within an illness model, instead situating people's experiences within their personal life history and mobilizing around the discursive ensemble of 'trauma/abuse/distress' (Cresswell and Spandler, 2009: 138). It is important to state that recognizing the issues above does not necessarily mean completely rejecting the biomedical psychiatry underlying many mental health services in the global North and South. However, this criticality enables an understanding that biomedicine might be useful, at times, as a partial frame, 'but incomplete and inadequate for much of what we want to accomplish' (McGruder, 2001: 77).

Like mental health, development also does not have one universal definition, and is widely critiqued, for example, for promoting free market ideals of limitless growth and privatisation of resources, ushering in capitalism to countries of the global South, and operating as a form of (neo)colonialism: enabling 'the production and reiteration of the colonial mindset' (Chakrabarti and Dhar, 2009: 35; Escobar 1995/2012) (see later discussion). Yet development remains undefined, untheorised and largely unproblematised within the mental health and development literature already outlined (WHO, 2010a). Evident within the literature is the reduction of development initiatives to forms of poverty management or alleviation.

MENTAL HEALTH IN THE SUSTAINABLE DEVELOPMENT GOALS: SUCCESS AND RESISTANCE

While advocacy to take mental health seriously and to integrate it within development is laudable, the evidence base and terms of reference through which mental health has been included on the development agenda have not passed without resistance and critique. The models of mental health currently being mainstreamed within development may be problematic for many reasons (too numerous to detail here). These models have been critiqued as the products of specific social, cultural, economic and historical trajectories that reduce social complexity to diagnoses of illness (Fernando, 2014) that are alien to many cultures (Summerfield, 2008), and that are sometimes exported in a 'top down' manner that reasserts colonial assumptions about western expertise and superiority (Mills, 2014; Titchkosky and Aubrecht, 2015). There are currently no biological diagnostic tests for most mental disorders - meaning that diagnosis remains highly subjective (Timimi and Radcliffe, 2005). Medications tend to dominate treatment options and are highly disputed and critiqued, in large part because they are associated with unpleasant side-effects, and there is evidence that they can cause harm and increased mortality, especially when taken long-term (Bracken et al., 2012; Moncrieff, 2009).

Many critics writing from the global South emphasize that the export of understandings of mental health and of service models from global North to South damage the social fabric of local ecologies of care and support by discrediting and diverting resources away from culturally valid and localised forms of healing (Davar, 2014). The Pan African Network of

People with Psychosocial Disabilities (PANUSP), run by people who identify as psychosocially disabled, make clear that '[s]ervices and support must be delivered in non-paternalistic and non-patriarchal frameworks with choices available outside of the medical framework' (2012: 2-3). Indeed, there has been much documentation (including by those advocating for global mental health) not only of human rights violations in some 'traditional' or indigenous healing sites but also within psychiatric institutions and community care globally, including 'degrading and even harmful care and treatment practices' (WHO, 2003:5), and forced interventions and deprivations of legal capacity (Minkowitz and Dhanda, 2006).

Now that divergent definitions of development and mental health have been explored, it is important to turn our attention to the three intersecting axes that have been central in the inclusion of mental health within the SDGs: global burden of disease; economic burden; and the relationship between mental health and poverty

MENTAL DISORDER AND THE GLOBAL BURDEN OF DISEASE

Definitions of mental health and distress not only have implications for people's identities and types of support and intervention, they also shape attempts to quantify both burden of disease, and the economic burden of mental disorder (each of which I will now explore in turn). The first Global Burden of Disease (GBD) Studies (first launched by the World Bank and the World Health Organization in 1991) (Murray and Lopez, 1996), warrant discussion here because they are understood as providing the evidence base that has constructed mental health as a global development priority and led mental health to be included in the SDGs (Vos et al. 2015:1578). The 2015 GBD study, consistent with earlier studies, found that mental and substance use disorders were 'the most important contributors to global [Years Lost due to Disability] YLDs', accounting for 18·4 per cent of YLDs (Vos et al. 2015:1577). According to Reddy (2016: 1448), these findings 'provide a vital link' between the MDGs and the SDGs.

The Disability Adjusted Life Year (DALY) is a health metric used within the GBD studies to compare, in terms of mortality and morbidity, different disease categories. DALYs are calculated by adding together the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with a health condition and its consequences in functional capacity: DALY=YLL+YLD (Murray and Lopez, 1996; WHO, online). When added together across a population, the sum of these DALYs represents the 'burden of disease'- a summary measure of population health. Despite well-known criticisms of the DALY, ranging from issues of quality and data availability, to underlying value judgements and conceptualizations of health and disability (Anand and Hanson, 1997; Bickenbach, 2008; Fox-Rushby, 2001; Mathers, 2007), it is used as a tool with which to make visible disparities between the 'burden' and relative resourcing of different diseases.

Unlike the first GBD study, subsequent studies, including the 2015 study, estimated the burden of mental and substance use disorders separately from neurological disorders

(Naghavi et al. 2015). The separation of neurological disorders from mental and substance-use disorders, alongside lack of attention to the ways that mental disorder contributes to increased mortality, are factors identified by Vigo, Thornicroft, and Atun (2016) as contributing to what they see as an underestimation by more than a third of the burden of disease of mental disorder.

As we have seen, the WHO (2016) categorizes mental, neurological and substance-use (MNS) disorders together, conflating disorders that have no known organic 'cause' (Moncrieff, 2009) or neuroanatomy (Vigo et al. 2016), such as depression and suicide, with 'disorders' that have a known neurological anatomy, such as dementia and epilepsy. Such a conflation may well be strategic in that it promotes taking mental distress as seriously as physical and neurological disorders, particularly when some disorders, such as epilepsy, can be highly stigmatized and organization of primary care in many LMICs do not separate neurological from mental disorders (Whiteford, et al. 2015). Furthermore, the neurological-psychiatric interface might be seen as in flux, with many disorders not clearly one or the other (Vigo et al. 2016).

This has led some, such as Vigo et al. to question the GBD studies' calculation of neurological disorder as a separate category because its inclusion would increase DALYs for MNS disorders. This illuminates the importance of categorization of mental disorder and subsequent impact on quantification. Yet the merging of mental and neurological disorders could be seen as problematic when we consider the evidence discussed earlier that there is no universal definition of mental distress, much dispute over whether distress should be understood as 'illness' in the way that neurological disorders tend to be, and controversies surrounding the use of psycho-pharmaceuticals for many mental disorders. Whiteford et al. (2015) highlight that 'western' definitions of mental disorders may not be sensitive to 'non-western' presentation, an issue that they suggest may lead to an underestimation of prevalence in developing regions. Yet others have raised the opposite concern - that use of surveys based on 'western' diagnoses, and standardized algorithmic diagnostic approaches (such as the WHO's mhGAP Intervention Guide 2016), may over-estimate prevalence and enable 'mass pathologisation' of 'normal' distress (Horwitz and Wakefield, 2007) (see later discussion).

A further problem with the GBD is attribution of mortality to a single cause, making it difficult to comprehend the complex co-occurrence of multiple disorders (or multiple forms of oppression and distress), and contextual factors (life stressors), and their co-contribution to mortality. This is important for mental health because some mental disorders may be associated with higher mortality (and morbidity) because of the effects of the medication taken as treatment, or linked to stigma and discrimination, and not because of something inherent to the experience of a particular diagnostic category (Whitaker, 2010).

The GBD studies have also been critiqued for focusing quantification around 'health loss', while not considering loss of welfare related to distress, that for some, is associated with a psychiatric diagnosis itself (such as forced interventions), and the multiple consequences for

families and society of distress and of psychiatric diagnoses (Whiteford et al. 2015), including the economic cost of mental disorder.

MENTAL HEALTH AND GLOBAL WEALTH: THE ECONOMIC BURDEN OF MENTAL DISORDER

Alongside the burden of disease, the economic 'burden' of 'mental disorder' is a core advocacy claim in staking out mental health as a development priority. A key study in calculating the economic cost of mental disorder (as well as other NCDs) was carried out by Bloom et al. (2011: 27) for the World Economic Forum. In this study, the global cost of mental disorder was estimated at US$ 2.5 trillion, with the cost projected to surge to US$ 6.0 trillion by 2030. The study concluded that non-communicable diseases (NCDs) 'pose a threat to development, economic growth and poverty alleviation' (p.35), with mental health and cardiovascular diseases accounting for the largest share of economic burden and lost output.

Set in comparison to the high economic costs of mental illness, it is possible to compare the relatively low costs of treatment and likely 'return on investment' in mental health. Chisholm et al.'s (2016) study has been influential in this regard – finding that every $1 invested in treatment for depression and anxiety can lead to a $4 return in better health. The study calculated treatment costs and health outcomes in 36 countries between 2016 and 2030, using the WHO's Mental Health Gap Action Programme (mhGAP) as a guide to recommended treatment (psychosocial treatment and anti-depressant drugs) (prevention was not considered). Chisholm et al. found that 'across the 36 largest countries in the world, in the absence of scaled-up treatment, it is projected that more than 12 billion days of lost productivity (equivalent to more than 50 million years of work) are attributable to depression and anxiety disorders every year, at an estimated cost of US$925 billion' (p. 419).

Bloom et al. (2011) and Chisholm et al. (2016) recognize that their use of methods (in the studies above) involved making assumptions that are open to challenge and difficult to test. A number of these assumptions warrant discussion here. Similar to much of the logic of many development interventions (Klein, 2016), Bloom et al.'s study assumes that people are the rational, self-sufficient, economic actors of *homo economicus* (McMahon, 2015), weighing risk/benefit and able to choose between viable alternatives. For example, the study assumes that people weigh the risk of dangerous work with the benefit of higher pay. Yet much of the population do not receive higher wages or compensation for insecure and dangerous work, and low paid insecure work is largely normalized.

Through the literature, and in the studies above, there is an assumption that mental disorders (and other NCDs) are chronic, require long-term management, lead to loss in productivity and are thus economically costly. For example, Chisholm et al (2016:415) state that 'depression and anxiety disorders are highly prevalent and disabling disorders…[and] result in an enormous amount of human misery and lost health'. Claims that mental disorders are disabling need some unpacking. The social model of disability has long made a distinction

between impairment and disability, where disability refers to the experience of being disabled by a system that discriminates against difference, i.e. against those with an impairment (the UNCRPD has proceeded on this distinction). While evidence for mental distress as a physical impairment is limited, this model is still useful in understanding why distress may result in 'disability' i.e. through stigma, discrimination, and societal intolerance of different kinds of cognition and of neurodiversity. Within this model then it is possible to take seriously that mental distress may operate as an impairment in that a person feels unable to live a life of value to them (including but not exclusive to being unable to engage in paid work). Many would argue that a diagnosis and treatment can be useful in such contexts, for example, if a person is highly distressed to the point of not being able to sleep, then short-term use of drugs might enable them to rest and make connections with others in order to act on and change their social environment (Moncrieff, 2009). This is a different perspective from the one outlined above that assumes that mental disorders are themselves inherently disabling and that drugs act specifically on disease. This difference is more than semantic because it is a distinction in causal attribution, which has material affects in directing focus onto where transformation is most needed (i.e. at an indvidual and/or societal level).

Framing mental disorder itself as disabling is also problematic in that it does not take into account the effects of medication on outcomes and recovery, or different reported rates of recovery internationally. Too vast to discuss at length, from the 1950s onwards evidence from the global North suggest that long-term effects of anti-psychotic treatment may actually worsen outcomes for many patients (Harrow and Jobe, 2007; Rappaport et al. 1978). Calculations of the economic cost of mental illness also assume that LMICs will face the same experience of chronicity, 'non-productivity' and disability as HICs in relation to mental distress. This is depsite the WHO's own (much disputed) findings that outcomes for people diagnosed with schizophrenia are better in some 'developing' countries, including in contexts where people were less likely to be medicated (see the International Pilot Study for Schizophrenia, the Determinants of Serious Mental Disorders (DOS-MED), and the International Study of Schizophrenia (WHO, 1973, 1979). This points to similar conclusions as Warner's (1985) important work on the political economy of schizophrenia and recovery, which finds that structural 'socio-economic conditions shape the course of schizophrenia' (p.147), which in turn impact ability to work.

The focus of Bloom et al.'s report and the wider literature centres on how NCDs, including mental disorder, 'cause decreased productivity in the workplace, prolonged disability and diminished resources within families' (p.5). Similarly, Thornicroft and Patel (2014:1) state that 'people with untreated mental disorders have a negative effect on global wealth'…'costing the world in excess of $16tr (£9.5tr; €12tr) a year in lost economic output'. Mentioned less in this literature are the well documented adverse effects of inequalities in global wealth on mental wellbeing: that income inequality produces psychosocial stress, negatively impacting on mental health (Murali and Oyebode, 2004; Wilkinson, 1996). Although Bloom et al. do briefly mention the potential influence of macro-level factors in

shaping the social determinants of health, including how the promotion of free market systems leads to individualistic health systems and fewer social safety nets.

To complicate matters, both the framing of mental disorders as disabling, and the assumptions of the social model of disability outlined above, can be critiqued as shying away from analysis of the global politics of disablement - the ways that living and working conditions disable people through the production of impairment (injuries, exhaustion, stress) linked to increasingly flexible and unregulated working conditions globally, alongside heightened demands of productivity (Meekosha, 2011; Mills, 2015a).

Highlighting the economic burden of mental disorder is likely an effective strategy in getting increased attention and resources channeled into mental health. Yet caution is required even in the most well intentioned mobilizations of 'burden', as these risk evoking oppressive practices of sanism (LeFrançois, Menzies and Reaume, 2014), disablism and ableism (Goodley, 2014) that denigrate people with psychosocial disabilities for being a 'burden' and sit in opposition to disabled people's own conceptualizations of the value of their lives. Denigration in this context rests on the (often unwritten) assumption that 'productive' (paid) work is a core baseline of human value, where human worth is measured through utility (Mitchell and Snyder, 2015) (even when demands for productivity may make people ill). This denigration is enacted through the stigmatization of poverty. For example, in the UK, media portrayals construct those who claim welfare as a burden on the economy, which for Tyler (2013:8), 'legitimizes the reproduction and entrenchment of inequalities and injustices', garners public consent for punitive cuts and welfare reforms, is linked to increases in disability hate crime (Baumberg, Bell and Gaffney, 2012), and to increases in suicides, self-reported mental health problems and antidepressant prescribing (Barr et al. 2015). To supplant a stigmatizing poverty discourse with a stigmatizing psy-discourse is thus problematic, especially as both individualize and pathologize impoverishment. In light of this, the next section aims to explore a core assumption underlying claims that mental disorder contributes to economic burden - the relationship between poverty and mental disorder.

THE MENTAL HEALTH-POVERTY NEXUS

The positive association between poverty and mental health problems is 'one of the most well established in all of psychiatric epidemiology' (Belle, 1990: 385) and key to making the case for the inclusion of mental health within the SDGs. Yet despite this, there is little conclusive, and sometimes conflicting, evidence about the nature, direction and mechanisms of the mental health-poverty nexus (Mills, 2015b), with it usually being conceptualized as a vicious cycle (Patel and Kleinman, 2003). One half of this cycle assumes that mental ill health increases the likelihood of becoming (or remaining) poor (social drift), and the other half postulates that poverty increases people's risk of developing mental health problems (social causation).

The conceptualization of these causal pathways between poverty and mental ill health has been influential, with the social drift hypothesis tending to dominate in the literature. For example, The APPG's report *Mental Health for Sustainable Development* recognizes both hypotheses when it states that:

> Mental health problems are a brake on development as they cause (and are caused by) poverty. This fuels social failures including poor parenting and school failure, domestic violence, and toxic stress, preventing people with problems and their families from earning a living (DaSilva and Roland, 2014: 5).

Here social causation is recognized but bracketed and instead focus shifts to how mental disorder 'fuels social failures' and leads to poverty. Similarly, the WHO (2008) state that:

> By treating many of the debilitating mental disorders and by promoting mental health, people will ... be able to work and rise out of poverty, provide their children with the right social and emotional environment to flourish ... contribute to the economy of their country (cited in Titchkosky and Aubrecht, 2015:79).

While social drift dominates as an explanatory model, social causation does not go unrecognized. The APPG report alludes to social causation in mentioning the potentially detrimental effects of the economy on people's health (albeit briefly): 'Improving social and economic environments as part of sustainable development so that mental health problems are less likely to occur' (DaSilva and Roland, 2014: 6). Similarly, the WHO (2010: 63) mentions (again briefly) 'the social and economic factors leading to vulnerability' linked to mental ill health.

In an influential study that compared interventions based on social drift and social causation, Lund et al. (2011) concluded that 'the mental health effect of poverty alleviation interventions was inconclusive' (social causation), compared to interventions that provided treatment for people with mental disorder (social drift) (although the studies that support this claim were not all statistically significant). Lund et al. (2011) use their results to argue that mental health care should be scaled up 'not only as a public health and human rights priority, but also as a development priority', and thus to 'include mental health on international development agendas' (Lund et al., 2011:1502).

Lund et al.'s study suffers from a problem encountered in much of the literature – a tendency to measure social causation in a way that treats poverty as an individual issue, i.e. treatable through cash transfers and microfinance. Furthermore, where social causation is measured, it is problematic to do so using tools based on individual level global North diagnostic criteria. Such diagnostic tools have been critiqued for reifying psychiatric diagnostic categories that individualize distress and work to psychiatrically reconfigure 'symptoms' of oppression, poverty, and inequality as 'symptoms' of 'discreet and apolitical' psychiatric diagnoses (McGibbon and MacPherson 2013: 74). For example, participatory research with people living

in poverty shows people's immense distress at their living conditions (ATD Fourth World, 2012). Lack of future planning and a fatalistic outlook could be understood as symptoms of depression but may also be strategies enabling people to cope with living in chronic poverty (Fine et al, 2016). Similarly, Bourdieu and Wacquant (1992:74) document how increased labour precariousness, leading to material deprivation, temporal uncertainty and personal anxiety, alongside stigmatization of poverty, can lead to a 'socially constituted agrophobia' [sic] enacted when people exclude themselves from activities that structurally exclude them. This raises questions about how useful or ethical it is to frame this behaviour and distress as constituting something called a 'mental illness'. Ascertaining *why* people are distressed (i.e. what people think has caused or contributed to their distress) is important because this carries implications for the kinds of action that can be taken – from individual treatment to wider structural change (Mills, 2016). However, analysis of the context of distress is often missing from standardized algorithmic diagnostic procedures, and prevelence surveys.

The (re)configuration of structural inequalities and conditions of poverty into individual deficiencies arguably enables inter/national focus to hinge on changing individual mentalities and behaviour (Schram 2000), creating the possibility for development to become increasingly individualized and more explicitly psychologized. Howell (2011: 20) notes this when she writes about the way that 'mental illness has been deemed an obstacle to development' by agencies such as the WHO, resulting in psy interventions (mental health services, such as increased access to medication and/or forms of counselling) being positioned as '(technical and medical) solutions to (political) "problems"'. In this way, 'development has increasingly become a problem of the mind' (Howell, 2011: 98). This is also evident in the positive psychology and behavioural economics employed within the World Development Report (World Bank, 2015), which has been critiqued for focusing on changing behaviour and mentalities, over structural change in conditions of impoverishment (Fine et al. 2016; Klein, 2016). While individualized treatments may well be useful to some people living in poverty –it is arguable whether such treatments should be prioritized over addressing the systemic causes of poverty that contribute to distress in the first place.

THE BURDEN AND EMERGENT MARKET OF 'MENTAL DISORDER'

While currently medication seems to dominate return on investment analyses (see Hyman, 2006; and Patel, 2007) and algorithmic approaches to diagnosis (see WHO mhGAP, 2016), there is some recognition in the literature about other kinds of treatment. For example, Patel et al. (2016:1672) state that: 'a wide variety of effective interventions, including drugs, psychological treatments, and social interventions, can prevent and treat MNS disorders', and the WHO mhGAP (2016) recommends always offering psychosocial interventions, and only offering medication where indicated in the Intervention Guide (p.11). Yet despite this, concerns have been raised about the increasingly global 'uncritical acceptance of the dominance of biological and pharmaceutical approaches to mental health' (Fernando and Weerackody, 2009: 197), which, for example in India, dominate even community mental health provision (Jain and Jadhav, 2009). Pharmaceutical interventions tend to be a quick and

cheap option, yet this may divert resources away from providing psychosocial support and from interventions aiming more widely for social justice and societal transformation.

One factor in the global dominance of pharmaceutical treatment is that while the WHO conceive of 'mental disorder' as a burden, pharmaceutical companies who manufacture psychotropic medications are explicit in their understanding of some LMICs as an untapped and emergent market for psychopharmaceuticals. Huge pharmaceutical sales growth are forecast to come from emerging markets of the global South (Reeves, Wong and Dabbs, 2011), and particularly India and China, which are constructed as a 'new promised land for drugmakers' (Staton, 2009). The huge financial incentive to frame distress as 'mental disorder' treatable by medications and the widely documented unethical practices of the pharmaceutical industry (including concealing adverse and harmful effects of drugs found in clinical trials and testing potentially harmful new products on people living in poverty (Healy 2012; Shah 2006) marks a central area of contention for calls to mainstream mental health within development and warrants further exploration.

MENTAL DISORDER AS AN OBSTACLE TO, AND A 'BRAKE' ON, DEVELOPMENT

This article has traced the reframing of mental health from an invisible problem to a global development priority. It sought to enable cross-pollination between two fields of literature and critique (of development and mental health) that are rarely discussed together. Furthermore, it sought to trace how these two fields now work alongside each other (although rarely interrogate each other) to produce responses to poverty and distress. The article focused on key evidence underlying the inclusion of mental health within the sustainable development agenda, namely: calculations of both disease and economic burden, and the dominance of the social drift hypothesis within the mental health-poverty nexus. Despite some mention of social determinants and psychosocial interventions, concern has been raised that the literature tends to problematize distress at an individual level as 'mental disorder', and problematize 'mental disorder' at the level of the economy and productivity (Howell, 2011: 93).

The reduction of social complexity to individual behavior evident in some understandings of mental health occurs simultaneously with the reduction of social life to economic logic – the economization of life - evident in neoliberal governance. Here individuals, imagined as self-interested and utility maximizing, are incited to take responsibility for their own health – to make health their own business. The development agenda has historically been closely linked to the promotion of the free-market and to neoliberalism (Chakrabarti and Dhar, 2009), thus criticality is needed to ensure that the inclusion of mental health within development doesn't follow suit.

Within this economic logic, mental health problems and poverty are framed as individual pathologies that are both seen to act as a 'brake' on development. A central implication of

this is that interventions tend to steer towards treating mental disorder to reduce poverty, rather than advocating for structural change that would eradicate poverty. The risk here is that the problematization of poverty occurs at the level of individual psychology and behavior rather than on the structural landscapes that produce and sustain poverty.

While the literature traced throughout this article tends to conceptualize mental health as missing from the development agenda and as an obstacle to development, rarely is there mention of the sometimes problematic nature of development. This leads to simplistic formulations of mental health as a 'problem' for development, and development as a 'solution' for mental health. This framing overlooks critiques of development initiatives as producing (whether intentionally or not) forms of impoverishment, displacement and disablement linked to free market expansion, which may occur even as such programmes are tasked with alleviating poverty (Chakrabarti and Dhar, 2009). Such understandings prevent exploration of whether certain forms of development (led by a logic of limitless growth often enforced by multilateral agencies with allegiances to high-income countries and industry) may be an obstacle to, and a 'brake' on, mental wellbeing. This logic also risks naturalizing and normalizing the contemporary global and national economism of everyday life; and the framing of global populations as amenable to individualized psy-expertise.

One area for potential coalescing to inform mental health and development might be the critical 'post' movements of both mental health and psychiatry, and development (Klein and Mills, 2017). There is resistance worldwide to dominant individualized, biological and technological 'solutions' to mental health, articulated by some as a project of post-psychiatry that aims to think beyond the current paradigm, engage meaningfully with the user/survivor movement, reduce reliance on psycho-pharmaceuticals, and search for more ethical and sustainable ways to respond to distress (Bracken et al., 2012; Bracken and Thomas, 2005). This project has parallels to 'postdevelopment' thinking within international development that seeks to open up a discursive space to consider alternatives to development, and transform the 'political economy of truth' about development (Escobar, 1995/2012: xiii). That there should be similar movements that resist mainstream development and bio-psychiatry (as the dominant model for responding to distress in the global North) is perhaps not surprising when we consider that both the 'treatments' of psychiatric technology and the technocratic and economic problematization of poverty is often disembedded from lived realities and from a pluralism of locally available resources (Mills, 2016). Yet some work is already underway to situate mental health within community development work in critically and locally informed ways.[2]

Much has been achieved through the inclusion of mental health within the SDGs, particularly in laudable attempts to call attention to the previous neglect of mental health within national

[2] For example, see the Seher programme of Bapu Trust, India; and the work and activism of PANUSP, the World Network of Users and Survivors of Psychiatry (WNUSP), and MindFreedom.

policies and funding of resources. However, thanks to this success, now is the time to engage in critical interdisciplinary and multi-stakeholder debate about mental health and development, avoiding the often simplistic take up of each by the other. This engagement needs to be informed by knowledge and experience from those within the user/survivor, mad, and disabled people's movements, and within post- development activism and scholarship. It is, therefore, an important historical moment to influence the way that mental health is taken up, understood and implemented within the development agenda, and how development is conceptualized within mental health.

Bio

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