WHO ARE THE "BOTTOM BILLION"? PEOPLE WITH MENTAL HEALTH CONDITIONS

INTRODUCTION

One in four people will develop a mental health condition in their lifetime, and even prior to the COVID-19 pandemic, the number of people with mental health conditions was expected to increase dramatically in LMICs in coming years.[i] Mental health, neurological and substance use conditions (all referred to as mental health conditions in this profile[ii],[iii]) are a heterogeneous range of conditions that originate from a range of genetic, biological, psychological and social factors. They include diagnoses such as depression and schizophrenia (mental health conditions), dementia and epilepsy (neurological conditions), and alcohol or drug dependence (substance use conditions). This profile summarises the data and evidence on poverty and mental health conditions to highlight how people with mental health conditions are likely to be disproportionately impacted by poverty.[iv]

The evidence in this profile pre-dates the COVID-19 pandemic, but early available data suggests that people with mental health conditions are being disproportionately impacted compared to people without mental health conditions. For example people in psychiatric institutions are at a higher risk of contracting COVID-19 due to their proximity to large numbers of people, sometimes unsanitary conditions, and reliance on staff who may not have adequate resources or training to prevent outbreaks.[v] Early evidence also suggests that physical distancing measures, global uncertainty and economic crisis are increasing mental health effects in previously healthy people and those with pre-existing conditions.[vi]

EVIDENCE ON POVERTY AND EXCLUSION

Mental health conditions can be both a cause and a consequence of poverty, and social, political, economic and environmental inequalities.[vii] Poverty increases the likelihood of developing mental health conditions, for example through greater exposure to stress or violence, and people with mental health conditions are more likely to live in poverty, for example through loss of employment and higher health costs (see Figure 1).[viii]

Income poverty: Research from LMICs shows that there is a relatively consistent and strong association between common mental health conditions and lower levels of education, food insecurity, financial distress, poor quality of housing, social class, and socio-economic status, however the evidence on the links between common mental health conditions and income, employment, and particularly consumption is more equivocal.[ix]

Health and education: **T**he available data shows significant disparities in health and education for people with mental health conditions compared with the general population, including:

- Mental health conditions, especially severe mental health conditions, are linked with poorer health outcomes and increased mortality, and there is a high level of co-morbidity between many physical health and mental health conditions.[x] Globally, people with severe mental health conditions have a 10 to 25 year life expectancy reduction.[xi]
- In LMICs, 75% to 85% of people with severe mental health conditions do not have access to mental health treatment, and people with severe mental health conditions are also less likely to receive treatment for physical health conditions.[xii]
- The 2017 WHO Mental Health Atlas reports that in approximately one quarter of all LMICs, there is no government social support at all for people with psychosocial disabilities.[xiii]
- Participation in education can reduce the likelihood of developing common mental health conditions, but many children with mental health conditions are excluded from education or drop out early.[xiv] A survey of 15,579 people with mental health conditions in seven LMICs found that 16.6% of respondents did not complete primary education; 46.1% of those who completed primary education left school before completing secondary education; 40.1% of those who completed secondary education did not enter tertiary education; and 55.1% of those who entered tertiary education did not complete it.[xv]
- In Burundi, research from 2008 found that children with mental health conditions were usually the first to be denied education because they were deemed unworthy of the investment by their families.[xvi] In Timor-Leste, research from 2019 found that approximately half of 85 research participants with mental health conditions had attended secondary school, but the duration of their attendance was reduced due to their mental health condition and lack of family resources.[xvii]

Broader exclusion: Evidence from a number of LMICs shows disparities in access to employment and experiences of discrimination and violence:

- **Employment and financial exclusion:** People with mental health conditions are much less likely to be employed, especially people with severe conditions.[xviii] A cross-sectional survey of people diagnosed with schizophrenia in 27 countries found that 44% of participants reported discrimination in finding or keeping work.[xix] Studies from Uganda suggest that financing institutions may also be hesitant to extend credit to people with psychosocial disabilities.[xx]
- **Stigma, discrimination and violence** against people with mental health conditions and psychosocial disabilities is common and can result in harmful treatments; exclusion from family, community, work, civic life, health and social services; injury; poor health; and even death.[xxi] Research in India found that people with schizophrenia reported high rates of perceived stigma, particularly from their community (46%) and family members (42%).[xxii] Research with people with major depressive disorders in Nigeria found that 51.5% of participants tried to conceal their condition due to anticipated discrimination.[xxiii]
- **Homelessness**: Homelessness is a risk factor for and a consequence of mental disorders, and the prevalence of mental disorders is significantly higher among children and young people who are homeless.[xxiv] Research in LMICs has found the prevalence of severe mental health conditions among people who are homeless ranges from 8% to 47.4%.[xxv]

- **Institutionalisation:** People with psychosocial disabilities are often placed in residential institutions such as health facilities, social care institutions, prisons and religious healing centres, where experiences of coercion, forced restraint, prolonged seclusion, sexual assault and other forms of violence are common.[xxvi] In many countries people cannot contest or appeal their detention in such facilities.[xxvii]

HOW POVERTY AND MENTAL HEALTH INTERACT WITH OTHER IDENTITIES

Mental health stigma and discrimination interacts with gender inequality and other factors such as age, to compound how people with mental health conditions experience of poverty. Evidence includes:

- **Women and girls with mental health conditions:** Common mental health conditions such as depression and anxiety are approximately twice as common in women.[xxviii] In LMICs, 20 to 40% of women experience depression during pregnancy or after childbirth.[xxix] Studies have consistently found a relationship between economic stress or financial difficulties and postnatal depression in LMICs.[xxx] Women and girls with mental health conditions are particularly at risk of physical and sexual violence, and women and girls who experience violence are more likely to develop mental health conditions.[xxxi] Women who experience intimate partner violence are twice as likely to have depression or abuse alcohol.[xxxii] Survivors of rape and sexual abuse have a threefold higher risk of experiencing anxiety, depression, or post-traumatic stress and a fourfold higher risk of attempting suicide.[xxxiii]
- **Older people with mental health conditions:** The number of people with dementia (including Alzheimer's disease) nearly doubles every 20 years, with the largest increases in LMICs (particularly in Asia), where nearly 60% of all people with dementia live.[xxxiv] Research has found that caregiving for people with dementia in LMICs is associated with substantial economic disadvantage because a high proportion of caregivers must reduce their paid work to care, and the cost of broader health services is high.[xxxv]
- **Young people with mental health conditions:** Around 20% of the world's children and adolescents have mental health conditions and psychosocial disabilities, about half of which begin before the age of 14.[xxxvi] Research from LMICs is limited, but available studies suggest similar rates of mental health conditions in some LMICs.[xxxvii] Research in Ethiopia found that 30.9% of unemployed people between the ages of 18 and 30 had depression.[xxxviii] Suicide, which is often linked to mental health conditions, is the second leading cause of death among young people worldwide and the leading cause of death among adolescent girls.[xxxix] [xl]
- **Indigenous peoples, people from minority ethnic and religious groups, and LGBT+ people with mental health conditions:** there is limited research available from LMICs. Mental health conditions and suicide among Indigenous peoples and minority ethnic groups are commonly associated with cultural disruption.[xli] In the state of Amazonas in Brazil, Indigenous people comprise 4.8% of the population but 19% of all suicides.[xlii] In Mexico, a National Survey on Homophobic Bullying conducted in 2012

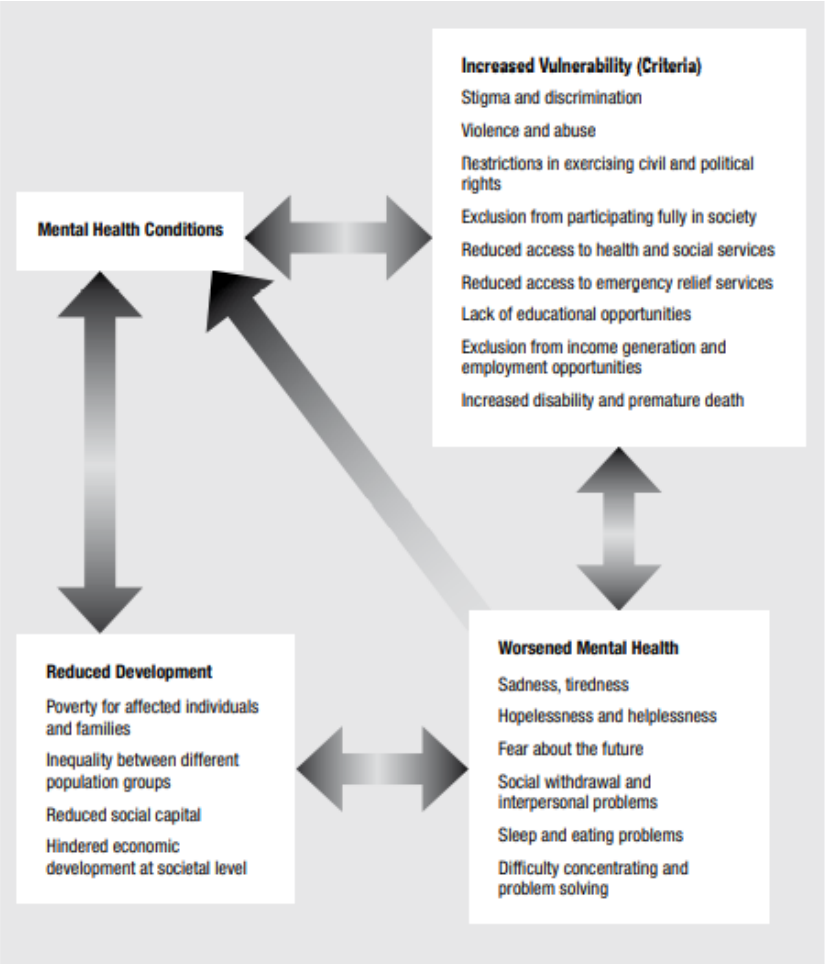
found that one in four LGBT people had thought about suicide as a result of the bullying they suffered at school.[xliii]

DISABILITY, POVERTY AND GEOGRAPHY

Contextual factors such as rural or urban location, conflict and displacement influence the experience of poverty for people with mental health conditions. For example:

- **Rural/urban divide:** Research has found higher rates of anxiety disorders in urban areas than in rural areas in several Latin American and Asian countries, while common perinatal mental disorders (depression and substance use conditions) are more common among women in rural areas of Vietnam.[xliv] Research in Ethiopia found that urban residents with severe mental health conditions were significantly more likely to have experienced unfair treatment from friends, the police, and employers, compared to those living in rural areas.[xlv] Mental health services in LMICs are usually based in urban centres and are often not accessible to people in rural areas.[xlvi]
- **Conflict and displacement:** According to WHO prevalence estimates from 39 conflict-affected countries, 22% of people have a mental health condition such as depression, anxiety, post-traumatic stress disorder (PTSD), bipolar disorder or schizophrenia.[xlvii] In Syria, one in four children are at risk of developing mental health disorders.[xlviii]
- **Climate change:** there is increasing evidence that extreme weather events, which are more frequent, intense and complex due to climate change, can trigger post-traumatic stress disorder (PTSD), major depressive disorder (MDD), anxiety, depression, complicated grief, survivor guilt, vicarious trauma, recovery fatigue, substance use conditions and suicidal ideation.[xlix] Rising temperatures, rising sea levels and episodic drought can also lead to financial and relationship stress, increase risks of violence and aggression, and displace entire communities, with consequences for mental health.[l]

Figure 1: The relationship between vulnerability, mental health conditions and adverse development outcomes (Source: Funk et al. 2010)



MEASUREMENT AND DATA

The Washington Group Extended Set of Questions on disability (rather than the short set of questions, which do not aim to identify mental health conditions) are recommended for disaggregating data by impairments related to mental health conditions.[li]

Challenges and limitations of the data include:

- Data on poverty is not routinely disaggregated by mental health status.
- Approximately 94% of published research on mental health is from high-income countries, though substantial progress has been made in global mental health collaborative research.[lii]
- Disaggregating data by mental health diagnosis is not always practical in LMIC contexts where there are few specialists trained to make diagnoses and where it may be considered stigmatising. Transdiagnostic approaches to identifying and treating people with mental health conditions is recognised as an effective and less stigmatising approach.[liii]

KEY RESOURCES:

- Ryan, G., Iemmi, V., Hanna, F., Loryman, H., and Eaton, J. (2020). Mental Health for Sustainable Development: A topic guide for development professionals. Knowledge, evidence and learning for development. **https://opendocs.ids.ac.uk/opendocs/bitstream/handle/20.500.12413/14908/K4D_MentalHealthTopicGuide_Online.pdf?sequence=2&isAllowed=y**
- Patel, V., Saxena, S., Lund, C., et al. (2018). The Lancet Commission on global mental health and sustainable development. The Lancet. **https://www.thelancet.com/commissions/global-mental-health**
- Funk, M., Drew, N., and Freeman, M. (2010). Mental Health and Development: Targeting people with mental health conditions as a vulnerable group. Geneva: Mental Health and Poverty Project, World Health Organization. **https://apps.who.int/iris/handle/10665/44257**

This profile was produced by the ***Disability Inclusion Helpdesk***, managed by ***Social Development Direct*** (SDDirect). SDDirect is a leading provider of high-quality, innovative and expert social development assistance and research services. We work to build inclusive societies in which people in all of their diversity are valued and empowered to make choices about their own development."

The Disability Inclusion Helpdesk provides research and advice to the ***Foreign Commonwealth and Development Office (FCDO***) and other UK government departments on disability inclusion in policy and programming across FCDO's five minimum standards on disability inclusion. We are a team of experienced in-house helpdesk researchers working alongside over 60 senior disability inclusion experts with experience across different themes, sectors and geographies. We can advise on disability inclusion in development, FCAS and humanitarian settings.

The Helpdesk is part of ***FCDO's Disability Inclusive Development (DID) Programme*** under the banner of ***Inclusive Futures***, led by ***Sightsavers***, which brings together 16 international development organisations, disabled people's organisations and country partners to ensure no one is left behind.

These factsheets were produced for FCDO to enhance knowledge and understanding of how different identities are impacted by poverty. The research was conducted using primarily pre-Covid sources, although the factsheets have sought to summarise the impact of COVID-19 where information is available. The researchers and authors are Harri Lee, Jessie Meaney-Davis, Veronica Ahlenback, Erika Fraser and Isabelle Cardinal.

[i] WHO (2001). Mental disorders affect one in four people. Geneva: World Health Organization. Mathers CD, Loncar D. (2006). Projections of Global Mortality and Burden of Disease from 2002 to 2030. PLoS Medicine. 2006;3(11):e442.

[ii] Much of the research on mental health conditions in LMICs refers to mental health 'disorders', which can have negative connotations. In this report the term 'disorder' is only used where it has been used in the original source.

[iii] Both this profile and the profile focusing on people with disabilities include evidence relating to people with psychosocial disabilities. A mental health condition is considered a disability if it has, or is likely to have, an effect on a person's regular day-to-day activity for 12 months.

[iv] The profile is part of a package of profile focusing on women and girls, people with disabilities, LGBT+ people, Indigenous peoples and people from minority ethnic groups, people with mental health conditions, older people, youth and people from minority religious groups.

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