Integrating mental health and social development in theory and practice

Sophie Plagerson*

Centre for Social Development in Africa, University of Johannesburg, Auckland Park, Johannesburg 2006, South Africa

*Corresponding author. Centre for Social Development in Africa, University of Johannesburg, PO Box 524, Auckland Park, Johannesburg 2006, South Africa. E-mail: sophieplagerson@hotmail.co.uk

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In many low and middle income countries, attention to mental illness remains compartmentalized and consigned as a matter for specialist policy. Despite great advances in global mental health, mental health policy and practice dovetail only to a limited degree with social development efforts. They often lag behind broader approaches to health and development. This gap ignores the small but growing evidence that social development unavoidably impacts the mental health of those affected, and that this influence can be both positive and negative. This article examines the theoretical and practical challenges that need to be overcome for a more effective integration of social development and mental health policy. From a theoretical perspective, this article demonstrates compatibility between social development and mental health paradigms. In particular, the capability approach is shown to provide a strong framework for integrating mental health and development. Yet, capability-oriented critiques on ‘happiness’ have recently been applied to mental health with potentially detrimental outcomes. With regard to policy and practice, horizontal and vertical integration strategies are suggested. Horizontal strategies require stronger devolution of mental health care to the primary care level, more unified messages regarding mental health care provision and the gradual expansion of mental health packages of care. Vertical integration refers to the alignment of mental health with related policy domains (particularly the social, economic and political domains). Evidence from mental health research reinforces aspects of social development theory in a way that can have tangible implications on practice. First, it encourages a focus on avoiding exclusion of those affected by or at risk of mental illness. Secondly, it underscores the importance of the process of implementation as an integral component of successful policies. Finally, by retaining a focus on the individual, it seeks to avoid uneven approaches to development.

Keywords  Mental health, depression, health policy, social development, capabilities
KEY MESSAGES

- The alignment of an area of health policy (mental health) with intersectoral social development policy requires both theoretical and practical barriers to be overcome.
- Despite great advances in global mental health, mental health policy and practice dovetail only to a limited degree with social development efforts, and lag behind broader synergistic approaches to health and development.
- Greater integration of the mental health and social development policy in low and middle income countries can generate mutual benefits for both sectors.
- Policy priorities include the need for vertical and horizontal integration strategies, a stronger focus on avoiding social exclusion, a more resolute attention to implementation processes and a determination to avoid uneven progress in development.

Introduction

Mental illnesses, and depression and anxiety in particular, are widespread and cause great distress, to those who experience them, their households and their communities (Kleinman 2009). The distribution of depression and anxiety in a population characteristically reflects the social and economic inequalities embedded in many societies (Marmot 2005; Lund et al. 2007).

This article explores the theoretical and policy gaps that prevent greater integration between the mental health and social development sectors in developing countries. First, concepts of mental health and illness are defined. Secondly, approaches to mental health are outlined from health and from social development perspectives, respectively. Despite a clear convergence between health and development approaches, it is shown how these have not yet translated into a broad integration of mental health into social development paradigms. In the final section, some conceptual and policy implications of integrating mental health and development are reviewed, guided by the criterion that these should benefit both sectors.

Mental health and mental illness: definitions and distribution

Definitions of mental health vary by discipline and culture. The World Health Organization (WHO) offers a broad and inclusive definition of mental health as ‘a state of wellbeing in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’ (WHO 2001b).

In this article, the term ‘mental health’ is used to refer to the mental health sector, whereas positive mental health indicates the focus on the holistic pursuit of mental wellness. Although the idea of promoting positive mental health is endorsed, the primary concern in this article is with mental illness and its interactions with poverty. The most common mental illnesses (and therefore the focus of this article) are depression and anxiety, characterized by symptoms such as low mood, negative views of self, others and the future, loss of interest in activities, prolonged apprehension and suicidal thoughts. The combination and severity of these symptoms, accompanied by personal distress and impaired functioning, lead to definitions of depression and anxiety (WHO 1994).

In 2010, mental and behavioural disorders accounted for 7.4% of the global burden of disease, a 38% increase from 1990 estimates. In the same time period, major depressive disorder increased from 15th to 11th rank globally as a leading cause of disease, with major increases recorded in many low and middle income areas (Murray et al. 2013; Whiteford et al. 2013). Suicide is one of the leading causes of death globally for all ages. By 2020, it is estimated that between 15 and 30 million per year will attempt suicide, and 1.5 million people will commit suicide (Bertolote and Flieschmann 2002). In addition, because of the interaction between mental illness and other health conditions, mental disorders increase risk for communicable (such as HIV/AIDS) and non-communicable diseases (such as cardiovascular disease). In turn, many health conditions increase the risk for mental disorder. The occurrence of comorbidity affects the treatment and prognosis of mental disorders (Prince et al. 2007).

Mental health: perspectives from health

Historically mental health has remained at the margins of health research, systems and practice. Yet over the last 15 years, staggering estimates of global mental health needs and compelling evidence regarding the essential interactions between mental disorders and health have emerged (Prince et al. 2007). Subsequently mental health issues have been integrated to a greater degree into broader health policies, programmes and partnerships (Raviola et al. 2011).

Mental health research has emerged predominantly from a health-based discourse, but has been influenced by an increasing awareness of the multiple and complex biological, psychological and social factors that shape mental illnesses (WHO 2001a). In the literature from high, medium and low income countries, there is an emerging consensus that poor and marginalized people are at greater risk of suffering from common mental disorders (Patel and Kleinman 2003; Lund et al. 2007).

Mental ill-health has not traditionally been identified as a disease of poverty, but in fact many dimensions of poverty have been associated with higher levels of depression and anxiety in low income countries. Axes of social stratification, commonly associated with poverty traps, are often found to coincide with
poorer mental health. Women of reproductive age are consistently found to experience twice the levels of depression as their male counterparts (Weich et al. 1998). African, Latin American and Asian studies have found lower levels of education and poor quality of housing to be closely associated with depression (Abas and Broadhead 1997; Bhagwanjee et al. 1998; Husain et al. 2000; Araya et al. 2001, 2003; Pothen et al. 2003). In India, hunger and inability to buy food predicted higher levels of depression (Patel et al. 1998, 2006; Pothen et al. 2003). Intergenerational effects have been demonstrated with maternal depression associated with under-nutrition and stunting in babies and children (Miranda and Patel 2005). Financial strain and debt have been linked to depression (Patel et al. 1998; Pothen et al. 2003). A study from India highlighted perturbing rates of suicide among farmers affected by economic shocks and livelihood volatility (Sundar 1999).

Research has highlighted many plausible bi-directional causal links between poverty and mental illness (Lund et al. 2007). The poor are disproportionately vulnerable to natural shocks and economic, social, political and health risks. Poor people are more likely to face threatening, humiliating and entrapping life events (WHO 2010a). Depression also leads to impoverishment through increased costs of health care, often being sought through private providers, as well as significant economic and social costs (Hu 2004).

Similarly to depression and anxiety, the aetiology and impact of severe mental disorders (such as schizophrenia) are also related to lower socio-economic status, and global poverty-related trends such as immigration, out-migration and urbanization. Deprivation and adversity can affect the incidence, lifetime and point prevalence of severe mental disorders, as well as access to health and social interventions (Saraceno et al. 2005; Bhugra 2007).

This considerable body of research has galvanized a concerted focus on the provision of mental health services as a public health priority (Whiteford et al. 2013). In low and middle income countries, there is a need for strategic interventions within and beyond the health sector which can help to break the cycle of mental illness and poverty (Lund et al. 2011; Patel 2011).

Mental health: perspectives from social development

Development discourse has moved closer to the mental health realm through advances in theoretical and empirical research. Frameworks for understanding and evaluating poverty, developed by economists and social scientists, have moved from a monetary approach towards the use of multi-dimensional and non-monetary indicators for evaluating deprivation. Income is now rarely deemed an adequate proxy for poverty (Burchardt 2004). Poverty theorists are increasingly aware that defining poverty involves value judgements of what constitutes a good quality of life or a bad one. Accordingly, combined objective and subjective assessments of ‘wellbeing’ or ‘quality of life’ have replaced traditional income-related poverty measurements (Gough et al. 2006).

Although these approaches to development are compatible with an inclusive approach to mental health, mental health in general and mental illness in particular have typically remained absent or implicit in development paradigms. There is, for example, no ‘psychological capital’ in the sustainable livelihoods framework (Ashley and Carney 1999). Similarly, it has often been noted that mental health is completely absent from the Millennium Development Goals though it is an implicit prerequisite to many of them (Miranda and Patel 2005). There are however indicators of a growing vision for mental health, for example the inclusion by economists of measures for psychological wellbeing in several large scale household surveys, reporting high levels of depression and stress among poor populations in India and South Africa (Case and Deaton 2009).

In parallel with this evolution in development paradigms, lessons from evaluation research have also supported a growing interest in mental health. Mental health effects have been hypothesized as explanations for unexpectedly low take-up or poor levels of success of certain development initiatives, and for achievements beyond the stated objectives and resource-inputs of poverty alleviation programmes (Duflo 2012). A growing awareness that mental health is affected intentionally or unintentionally by development initiatives has been demonstrated by a growing number of studies evaluating mental health impacts of cash transfer and income-generating programmes (Paxson 2007; Fernald et al. 2008; Baird et al. 2010; Lund et al. 2011).

Mental health and the capabilities approach

Particular attention is given here to assessing the role of mental health within the capabilities approach, which over the past three decades, has played a major role in redirecting the philosophy, research and practice of social development. The capabilities framework developed by Sen (1999) conceptualizes the disadvantage experienced by individuals in society and emphasizes social, economic and environmental barriers to equality. Capabilities denote an individual’s opportunities to achieve desirable outcomes.

Mental health and mental wellbeing have featured in theoretical debates within a capability framework (Crocker 1995; Robeyns 2003), and are compatible with capability approaches. Both mental health and capability proponents argue that quality of life is as important as quantity of life (Crocker 1995). In their book Promoting Mental Health in Scarce-Resource Contexts, mental health practitioners engage with capability theory to help situate mental health promotion within a broader developmental context (Petersen et al. 2010).

Yet, there are also suggestions of a discrepancy between capability-oriented development and mental health approaches. The capability framework has emerged in response to utilitarian economics, hence criticism of happiness as a social end is a central tenet (Burchardt 2004). From a political perspective, Sen rejects both happiness as the fundamental ‘object of value’ assumed by pure utilitarianism and income as its associated indicator (Sen 1980). Sen has emphasized firstly how a blindness to structural disadvantage results from utilitarianism and secondly that preferences, desires, expectations and attitudes adapt to individual circumstances and social contexts, so that the very capability-deprived ‘accept their lot’ (Crabtree 2010). Sen (1999) writes that ‘[t]he mental metric of pleasure or desire is just too malleable to be a firm guide to deprivation
and disadvantage’. The application of similar arguments to mental health has led to criticism of interventions to prevent mental illness and promote mental health, expressing a concern that such approaches may condone injustice, and detract attention from the promotion of human rights (Stewart 2012).

Integrating mental health and social development conceptually
The issues highlighted so far provide an example of the interplay between an area of health policy and current development paradigms. In the remainder of the paper, the discussion focuses on how to move towards a greater integration of mental health and social development in theory and practice. Two aspects of capability theory which may hinder theoretical integration are addressed below.

Happiness and mental health
A critique of ‘happiness’ as a central aim of social development is integral to capability approaches. To avoid the risk of confusing happiness with mental health, it is worth pausing to critically assess areas of overlap and difference between these fields of study and practice.

Classical utilitarianism, developed by the philosopher Jeremy Bentham, hinges on the maximization of happiness or ‘utility’ (Bentham 1776). Modern neo-utilitarian approaches, such as those promoted by economist Richard Layard, integrate economics with psychology and sociology, and criticize utilitarian assumptions of linearity between income and utility maximization. In his book Happiness: Lessons from a New Science, Layard (2006) supports happiness as an exclusive ultimate aim, stating that ‘It is self-evident that the best society is the happiest’ (Layard 2006). This focus on happiness-related measures, rather than income, as something to be maximized, has been accompanied by a proliferation of indices to measure happiness as a common component of economic surveys.

The field of mental health is clearly distinct from these philosophical and economic approaches to happiness, as it is rooted in a very different tradition of health and medical practice. Unlike happiness, which is often extrapolated as an ultimate and free-standing aim, the definition of mental health as the complex result of biological, psychological and social factors, inseparable from physical health, prevents such a level of abstraction. As public health approaches have been applied to mental health, the understanding of the interactions between mental health and its determinants has been strengthened. Thus the criticism by capability theorists of happiness as a sole aim cannot be applied to mental health approaches, which assume a much more integrated role for mental health within broader public health and socio-economic aims. Current definitions of mental health are closer to concepts of human flourishing, which are foundational to capability theory (Burchardt 2004). They involve both cognitive and affective factors, and retain a focus on the individual in the context of social and structural factors.

By distancing mental health from happiness, the role of mental health within the capability framework can be regarded as dynamic and essential. If mental health is only regarded as a mental state such as happiness or pleasure, it remains a desirable but supervenient accompaniment to other functioning (Crocker 1995). If instead the connections between mental health and ‘choosing’ or decision-making ability are emphasized, then its potential role in achieving desired outcomes becomes more significant. Aspects of mental illness such as fear of failure, a short-term focus on the present in decision-making and a feeling of meaninglessness helpfully frame mental health as a mediator in the conversion of capabilities into achievement.

Adaptive preferences and the ‘happy poor’
Another major criticism levelled by capability theorists at happiness, and more recently also at mental health approaches, is the potential co-existence of happiness (or positive mental health) with deprivation and injustice. The widely researched human ability to adapt to adverse situations is given particular attention within capability theory, with a consequent bias towards ‘objective’ measures of injustice and deprivation, as opposed to ‘subjective’ indices (Sen 2009).

The emphasis within mental health research is not on the ‘happy poor’ (i.e. on adaptation), but on the correspondence between deprivation and mental ill-health (i.e. on non-adaptation). Mental illness is both subjective (distress experienced by the individual) and objective (deeply rooted in structural determinants). A mental health approach typically includes treatment, prevention and promotion and recognizes the complementarity between individual and structural approaches. The linkages between material and emotional needs have been demonstrated in humanitarian contexts. (Tol et al. 2011). Tackling the devastation caused by catastrophic natural disasters requires large-scale asset and institution reconstruction, which cannot be executed without sensitivity to mental distress. A consensus has emerged between the humanitarian and mental health communities that disaster-affected populations are faced with a wide range of effects. These range from non-pathological psychological distress to severe disorders and require a range of social, psychosocial and biomedical interventions (Bromet and Havensaa 2002; van Ommeren et al. 2005).

That mental health is integral to any programme designed to ameliorate material deprivation is evident in the extreme case of natural disasters, but the schism between material and emotional provision remains largely unquestioned in many programmes to reach the poor in both high and low income countries. A broad understanding of the integrity of mental health as a means and end to development, as an internally and externally determined source of agency, and as a subjective and objective component of wellbeing sets the scene for a composite approach to interrupting the cycle between mental illness and poverty.

Integrating mental health and development in policy and practice
The previous section has illustrated the need to avoid a polarized view of mental health and social development as mutually exclusive approaches. An integrated paradigm can aim
to influence mainstream social development efforts towards the creation of ‘self-reliant sustainable communities’ (Petersen 2010). Some suggestions are proposed below regarding a more strategic integration of the mental health and social development ‘industries’, with their respective professions and institutions.

An integrated view of mental health and development requires both an understanding of the intrinsic value of mental health and a broad concept of development, to include mental health as a constituent component. At the same time, the integration of multiple domains of public policy, required by an understanding of the social determinants of health, cannot ignore the distinctiveness and complementarity of multiple policy domains (Ruger 2004). Integrating mental health and development need not entail a loss of distinction of the domains they represent and should involve a plurality of ‘separate yet interdependent’ institutions. Both horizontal and vertical integration of policies are needed (Ruger 2004). The horizontal dimension necessitates a broadening of the mental health sector to include a comprehensive package of complementary interventions to improve mental health. It also requires a stronger co-ordination of mental health with the health sector in general. Vertical integration refers to the alignment of mental health with related policy domains (particularly the social, economic and political domains).

**Horizontal dimensions of integration**

Achieving the horizontal dimension of integration requires the development and diffusion of cost-effective and easily deliverable packages of care. In the case of HIV, such packages have included: health education; behaviour modification; social, economic and political environments that allow individuals to protect themselves against infection; condom promotion; HIV counselling and testing; blood safety; reduction in mother-to-child transmission; needle-exchange programmes; and treatments for sexually transmitted infections (Ruger 2004). There are definite moves towards ‘mental health packages’ which can be scaled up within the mental health sector (WHO 2010b; Patel 2011). For example, a basic mental health care package consisting of treatment for selected severe and common disorders can be delivered for $3–4 per head of population per year in sub-Saharan Africa and south Asia (Patel et al. 2007). To achieve the breadth of interventions offered synergistically for HIV, such a package would need to be gradually expanded to include preventive strategies such as educational interventions for common mental disorders and community-based rehabilitation programmes for severe mental disorders which have proved successful in low income settings (Patel et al. 2007). Additionally, psychosocial interventions need to be developed that can be inserted into existing health care systems for communicable and non-communicable diseases. These can help to address the comorbidity of mental disorders with other health conditions (Prince et al. 2007).

For such interventions to work in tandem with social development efforts, a number of ‘horizontal’ challenges need to be overcome. These include the need for greater cohesion within the mental health community, and for decentralization of mental health services to primary health care (Saraceno et al. 2007). Ongoing progress on these fronts will continue to aid the communication of clear messages regarding effective interventions for mental health that will enable operative partnerships with social development actors (Tomlinson and Lund 2012). Within the mental health care community, the construct of mental health and approaches to treatment and prevention are to some extent still contested (Tomlinson and Lund 2012). Differences can emerge across professional boundaries, relating to the classification, causes and treatment of mental illness. Despite more unified messages coming to the fore regarding the global scale of mental illness and strategies for its alleviation (Tomlinson and Lund 2012), these differences have contributed to a disjointed representation of the mental health sector.

Partly in reaction to these perceptions, two responses can be observed from outside the domain of those professionally trained in mental health service provision, including many engaged in social development. On the one hand, mental illness is perceived as a specialist issue, to be addressed within specialist health and psychosocial services. This leads to an avoidance of mental health needs and a focus on ‘material’ provision. Yet, it is argued in this article that the option of a compartmentalized approach is precluded by the sheer scale of the burden of mental illness. On the other hand, suspicion of medical approaches to mental health can lead to a wary avoidance of the health sector, even when services are present, despite a commitment to engaging with psychosocial dimensions of development. This stands in contrast with attitudes to the health sector in general, recognized as an integral and complementary partner in development. Concerted efforts to transfer the weight of mental health care from specialized tertiary health institutions to primary health care can help to soften these concerns (Saraceno et al. 2007). Similarly, in order to combat issues of comorbidity, mental health awareness and treatment can be integrated into existing health activities, such as HIV or diabetes treatment and prevention programmes (Prince et al. 2007).

Reticence for working in partnership with mental health services can also be caused by a perception of mental illness as a culturally specific phenomenon, unsuited to large scale interventions. In response to this concern, anthropological and epidemiological research has demonstrated that although cultural idioms, levels of disclosure and somatic symptoms may vary across cultures, a common core of psychological symptoms (such as loss of interest in daily activities and suicidal thoughts) are characteristically also experienced (Patel 2001).

**Vertical dimensions of integration**

The vertical dimension integrates domains of public policy that build upon each other (Ruger 2004). A strategic vertical integration of the mental health sector with the social development sector has a number of potential benefits for both mental health and development. First, the cross-sectoral co-ordination of efforts allows for a much more linear progression between treatment, prevention of mental illness and promotion of mental health, which are often disjointed (Skeen et al. 2010), thus responding to a whole spectrum of mental health needs across entire populations. Secondly, greater vertical integration would allow development actors to acknowledge and respond to psychosocial needs as integral to development, and provide a real boost to the exacting process of
scaling up mental health service provision globally (Eaton et al. 2011). Thirdly, considering the economic consequences of not investing in mental health provides further motivation for vertical integration strategies. The long-term financial benefits of investing in mental health to employment and work productivity, education, social security, criminal justice and social services have not been extensively documented in developing countries but are likely to mirror the findings from research in high income countries (Patel et al. 2007; Mcdaid and La Park 2011).

There are some recent examples of intersectoral investment in mental health by bilateral development institutions (Tomlinson and Lund 2012) and of involvement in mental health service delivery by non-specialist health professionals, lay workers, affected individuals and caregivers with appropriate supervision by mental health specialists (Kakuma et al. 2011).

An important way to promote greater integration is the use of indicators to assess impacts across policy domains, for example mental health outcomes of socio-economic programmes and socio-economic outcomes of mental health initiatives. For example, a systematic review of mental health interventions in low and middle income countries concluded that, in the cases where data were available, these were frequently associated with improved economic outcomes (Lund et al. 2011). Conversely, available evidence on the impacts of poverty alleviation programmes (e.g. cash transfer programmes, asset promotion and microfinance) on mental health has shown mixed results and draws attention to the need for care in assessing each component of multifaceted policies or programmes (Lund 2012).

Furthering vertical integration means endorsing social development that promotes positive mental health and prevents mental illness. Evidence from mental health research reinforces aspects of social development theory in a way that can have tangible implications on practice: firstly, it encourages a focus on avoiding exclusion; secondly, it underscores the importance of the process of implementation as an integral component of successful policies; and finally, by retaining a focus on the individual, it seeks to avoid uneven approaches to development. These points are expanded on below.

**Avoiding exclusion**

Stigma concerning mental illness is common. Prejudiced attitudes result from misconceptions about the causes and nature of mental illness (Sartorius 2007). Causation is often attributed to personal weakness or supernatural forces (WHO 2010a). Stigma impacts individuals affected by mental illness through significant social and economic deprivation. As a result of the self-imposed or societally imposed isolation mental illness often incurs, even those who are eligible to participate in programmes designed to empower the poor, may in reality be excluded. An evaluation of a microfinance programme in West Bengal, targeting the most destitute reported that more than a third of invited participants did not take up offer of a free asset as they did not trust that they could successfully take care of it (Banerjee et al. 2011). A mother with post-natal depression may well be less likely to access programmes designed to assist her in ensuring the health and wellbeing of her child (Cooper et al. 1999). Stigma also contributes to a lingering notion that mental illness is an intractable or negligible public health problem (Tomlinson and Lund 2012).

Sen (2000) describes social exclusion as a constitutive component of capability deprivation. A sensitivity to mental illness and a commitment to preventing mental disorders within the social development field can thus be framed as a means of combating social exclusion and promoting capabilities. In housing, for example, harnessing social development and mental health policy is essential, particularly in low and middle income settings. In contexts of rapid urbanization and fast growing informal settlements, low cost housing provision on a large scale is a major concern for many governments (e.g. the Reconstruction and Development Programme in South Africa) (Goebel 2007). Variables related to housing including type and quality of housing and levels of overcrowding have all been observed to be associated with mental health (Lund et al. 2007, Thomson et al. 2009). Housing affects mental health with regard to treatment, prevention and promotion. Actively ensuring non-exclusionary access to sustainable housing for those affected by mental illness or at risk of mental ill-health, and promoting strategies that take mental health into account, is one area where integrated policy can bring health, financial and developmental benefits.

While recognizing the role for determined local and international action to remove stigma (Sartorius 2007; Tomlinson and Lund 2012), the social development sector can play a vital role in engaging with communities, and addressing the underlying barriers of discrimination.

**A focus on process**

The capabilities approach to social justice emphasizes both opportunities and processes as crucial to the substantive realization of an individual’s freedom. A focus on mental health stresses that process is more than an administrative sideline to development. Accessing programmes or benefits and engaging with official institutions can comprise a barrier which disproportionately affects those vulnerable to mental distress or disability. The extent to which policies or programmes manage decision-making requirements, and set achievable cumulative goals, can avoid compromising the participation of those experiencing depression and anxiety (Duflo 2012). Thus policies that view implementation as integral to their design (Barry et al. 2005), and which recognize stress as a currency for the evaluation of experiences of social development, are vital for securing progressive mental health outcomes (Plagerson et al. 2011).

**Simultaneous progress on different fronts**

Mental health of individuals and communities is influenced by personal, social and environmental factors and experiences, and in turn affects each of these domains. A greater attention to mental health thus supports Sen’s call for ‘simultaneous progress on different fronts, including different institutions, which reinforce each other’ (Sen 1999). This need for balance necessitated by a focus on mental health has three implications. First, it emphasizes the need to avoid uneven action between interdependent multiple (economic, social, health and political) domains. Development indicators of success tend to be evaluated within the narrow confines of one of these sectors, with other impacts viewed as positive or negative secondary
‘externalities’ (Macauslan and Riemenschneider 2011). Secondly, the likelihood of development policies and programmes having effects that reverberate through personal, social and environmental levels, with mental impacts at each of these, requires a broader scope for systematic weighting of individual, community and structural effects. Thirdly, a consideration that flows from a view of the individual as an integral whole is the need to promote mental health not only in the short term but also in the long term, favouring policies that promote security and reliability over time.

An example of an opportunity for intersectoral collaboration is in the area of risk insurance. In a context in which much poverty is set against a backdrop of social, financial and labour insecurity, Wolff and De-Shalit (2007) introduce the concept of ‘capability security’ and contend that public policy must provide opportunities that can be counted on for the future. The importance of reducing risks (and fear of risks) of environmental, financial or health adverse events is critical to the prevention of mental illness (Duflo 2012).

Conclusion

The alignment of an area of health policy with intersectoral social development policy requires both theoretical and practical barriers to be overcome. Despite the clear interaction between mental health and development, mental health has remained a narrow, uncomfortable or absent concern within development paradigms and practice. Within the capabilities framework, barriers may include a reluctance to rely too heavily on a ‘subjective’ metric. Yet both mental health and development stand to gain from a more strategic integration, which need not dissolve the distinctiveness of the two sectors. A greater attention to mental health within development policy keeps the individual at the centre of development and underscores the need for simultaneous attention to both material and non-material outcomes in the short term and long term, at individual and collective levels. For the mental health sector, a greater synthesis with the socio-economic and political domains is likely to accelerate the quest for scaled up mental health service provision, and to foster a more effective alignment between treatment and prevention of mental illness and promotion of positive mental health.

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