



# MENTAL HEALTH FOR ALL:

What can we achieve if we meaningfully  
integrate mental health into UHC

---

UHC POLICY BRIEF SERIES

UNITED  
FOR  
GLOBAL  
MENTAL  
HEALTH



**“The world is accepting the concept of universal health coverage. Mental health must be an integral part of UHC. Nobody should be denied access to mental health care because she or he is poor or lives in a remote place.”**

**Dr Tedros Adhanom Ghebreyesus,**  
Director-General of the WHO (2019)

**Authors:**

**Ali Hasnain, James Sale, Sarah Kline** – United for Global Mental Health

**Research by:**

**Yong Yi Lee** – Research Fellow, Health Economics Division, Public Health and Preventive Medicine, Monash University

**Advisory Board:**

**Shekhar Saxena** – Professor of Global Mental Health, Harvard TH Chan School of Public Health

**Paul Bolton** – Mental Health and Psychosocial Support Coordinator, USAID

**Mark Van Ommeren** – Public Mental Health Adviser, WHO

**Professor Sir Graham Thornicroft** – Professor of Community Psychiatry, Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience, Kings College London.



**World leaders have committed to address these mental health treatment coverage gaps at several international meetings.**

## EXECUTIVE SUMMARY

Universal Health Coverage (UHC) is the concept that everyone, everywhere should be able to access the good-quality health (including mental health) services they need without suffering financial hardship. There is an increasing acknowledgment of the importance of integrating mental health care into UHC.

### Why mental health care needs to be integrated into UHC

The [World Health Organisation’s constitution](#) recognises mental health as an integral part of its definition of health (the H in UHC). Therefore, there can be no UHC without the meaningful integration of mental health. Yet, today the treatment gap for common mental health conditions can be as high as [90% in low-income countries](#). And most often it is the poorest and most marginalised people who lack access to services. Moreover, most of the funding for mental health services is disproportionately spent on institutionalised care, rather than primary and community-based care.

World leaders have committed to address these mental health treatment coverage gaps at several international meetings, including at the UN high-level meeting on UHC in 2019, and as part of the Sustainable Development Goals under SDG3. UHC is one of the six cross-cutting principles of the [WHO’s Comprehensive Mental Health Action Plan 2013-2030](#), agreed by all health ministers, which aims to increase service coverage for mental health conditions by 50% by 2030. It also aspires to move mental health funding away from institutional care towards primary and community-based health care, as part of a system including strong secondary health care and referral pathways.

What integrating mental health into UHC makes possible

According to new UnitedGMH research (see methodology annex 2), scaling up coverage for five common mental and neurological conditions (depression, anxiety, bi-polar disorders, psychosis and epilepsy) could have substantial health benefits (detailed in tables 2, 3, 4 and 5 on pages 8, 9 and 10). For example, hitting the WHO’s target of increasing service coverage for the five conditions listed above by 50% by 2030 could contribute to avoiding nearly half a million deaths, averting around 51.5 million cases of common mental and neurological conditions and see almost 24 million healthy life years gained.

If the world achieves UHC (over 90% coverage), the projected gains for the five conditions are even more pronounced, as shown in table 1.

Table 1: Approximate projected global health outcomes of achieving universal mental health service coverage

Achieving universal (90% plus) mental health service coverage	Prevalent cases averted	Healthy life years gained	Deaths avoided
By 2030	299.7 million	126 million	1.6 million
By 2050	1.4 billion	531 million	6.1 million

The link between mental and physical health in creating ‘comorbidities’ is also well established. For example, common mental health conditions such as anxiety and depression are known risk factors for [HIV, TB, cardio-vascular diseases, diabetes and cancer](#). And HIV, TB, cardio-vascular diseases, diabetes and cancer are all conditions that can lead to higher rates of anxiety and depression among other mental health conditions. That’s why it’s crucial to integrate mental health services into UHC – doing so will lead to tangible improvements in people’s mental and physical health.

How the integration of mental health into UHC is possible

UnitedGMH and our partners have published a series of [reports and briefings](#) exploring why integrating mental health into UHC is important and how it can be achieved. Specific approaches to integrating mental health, such as the [WHO’s UHC compendium](#), are beyond the scope of this brief, but leading international organisations, such as the WHO and the World Bank, agree on two key principles:

- **transitioning from institutional care to primary and community-based mental health care (a term the WHO uses to refer to any mental health care provided outside of a psychiatric hospital)**
- **adopting a multi-sectoral approach to mental health care.**

Achieving UHC is a core part of the Sustainable Development Goals under SDG3. It is also increasingly a part of the world’s response to and recovery from Covid-19, as well as future pandemic preparedness efforts. This creates an historic opportunity to strengthen UHC around the world.

Today, the focus on UHC, and on integrating mental health into UHC – as set out in the WHO’s Comprehensive Mental Health Action Plan 2013-2030 and through efforts such as the WHO Special Initiative for Mental Health – makes this the right time to meaningfully integrate mental health into UHC reforms.

EPILEPSY

Epilepsy is a chronic noncommunicable disease of the brain that affects people of all ages. According to the WHO, around 50 million people worldwide have epilepsy, making it one of the most common neurological diseases globally. Nearly 80% of people with epilepsy live in low- and middle-income countries. It is estimated that up to 70% of people living with epilepsy could live seizure- free if properly diagnosed and treated. The risk of premature death

in people with epilepsy is up to three times higher than for the general population. Three quarters of people with epilepsy living in low-income countries do not get the treatment they need. Epilepsy is included in this paper and in the analysis commissioned by United for Global Mental Health here since the treatment of this condition is usually done within the mental health care system, especially in Low and Middle Income Countries.



## WHY MENTAL HEALTH NEEDS TO BE INTEGRATED INTO UHC POLICIES AND PROGRAMMES

Mental health is an integral and essential component of health (the H in UHC), which has been defined by the [WHO constitution](#) as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Just as there is no health without mental health, there cannot be UHC without the integration of mental health care into its policies and programmes.

As things stand, however, the treatment gap for common mental health and neurological conditions such as depression, anxiety, bi-polar disorder, psychosis and epilepsy is as high as [90% in low income countries](#). This is largely because mental and neurological health care is [inadequately funded](#), with mental health budgets accounting for only 2.1% of global median government health expenditure. The [WHO's Mental Health Atlas 2020](#) reports that [66% of this spending goes to mental hospitals](#), leaving little in reserve for primary, secondary and community based care, or promotion and prevention programmes.

This lack of investment also results in a disparity between the demand for and supply of mental health workers. The Atlas reports that there are fewer than 1.4 mental health workers per 100,000 people in low-income countries and only 13 per 100,000 globally. The numbers of mental health workers specialising in care for particular vulnerable groups, such as children and caregivers, are even fewer, with 0.01 per 100,000 in low-income countries and 3.4 per 100,000 globally.

Low mental health service usage rates due to stigma, lack of awareness and a variety of other factors are also a problem. A [2022 research report](#) indicates that mental health service use for depression ranged from 33% in high-income countries to 8% in low- and lower-income countries. The [WHO's Mental Health Atlas 2020](#) (using data on psychosis as a proxy for severe mental health conditions) reported a global service-utilisation rate of persons with psychosis at just 212.4 per 100,000 people in 2020, with high- and upper-middle-income countries showing more than seven times higher utilisation rates than low-income countries.

This is partially down to the lack of minimally adequate treatment (i.e. a combination of treatment strategies established by research to be minimally sufficient in treating mental health conditions). For example, persons suffering from depression receiving minimally adequate treatment range from 22.4% in high-income countries to only 3.7% in lower-middle-income countries. The [stigma associated with mental health conditions and a lack of awareness](#) about mental health conditions and the availability of treatment are also major barriers to accessing mental health services.

Low mental health service usage rates due to stigma, lack of awareness and a variety of other factors are also a problem



These barriers impact different demographic groups differently, and the utilisation of services does not reflect actual needs. For example, service use for conditions such as depression or substance use [increased with a corresponding increase in age](#), despite these conditions also being significant causes of morbidity and mortality in young people. All of these factors need to be taken into consideration when designing optimal policies and programmes to integrate mental health into UHC.

## WHAT INTEGRATING MENTAL HEALTH CARE INTO UHC MAKES POSSIBLE

Mental health must be meaningfully integrated into UHC. That means including it in accessible promotive, preventive, curative, rehabilitative and palliative care. It means increasing the number of trained mental and physical health workers is essential to prevent, manage and treat mental health conditions. And it means making sure appropriate medication is available and free at the point of use. Mental health's meaningful integration into UHC could have significant physical and mental health benefits.

### The mental health outcomes of increased access to services

Our new research (see methodology annex 2) looks at the potential health benefits of scaling up mental health service coverage by 2030 and 2050 for four mental health conditions (anxiety, bi-polar disorder, depression and psychosis) and a neurological condition (epilepsy). The results of this new research indicate that addressing the gap in service coverage can result in substantial positive health outcomes.

Depression, for example, is one of the world's [most common but serious mental health conditions](#) and is a major contributor to the global disease burden. Table 2 shows that if low- and lower-middle-income countries increase their mental health service coverage for depression by just half of its current level by 2030, as recommended by the WHO's Comprehensive Mental Health Action Plan, they stand to gain over 4 million healthy life years, avert 10.4 million cases of depression and avoid just over 20,000 depression-related deaths. Achieving universal coverage of mental health services for depression by 2030, for both low-income and lower-middle-income countries (LICs and LMICs), could see these gains increase approximately tenfold.

**Table 2: Approximate projected health outcomes for LICs and LMICs of reaching selected service coverage targets for depression by 2030**

Target for increase in mental health service coverage	Income group	Prevalent cases averted	Healthy life years gained	Deaths avoided
Increasing service coverage by half (WHO CMHAP target)	LICs	1,199,361	482,447	1991
	LMICs	9,208,711	3,672,798	18620
Achieving universal (90% plus) coverage	LICs	16,907,602	6,702,227	28,317
	LMICs	90,589,708	35,643,555	184,666

Similar gains are projected for increasing service coverage for epilepsy, and are captured in table 3. By increasing service coverage for epilepsy by 50% by 2030, the world can avert nearly 2 million epilepsy cases, avoid more than 168,000 epilepsy-related deaths and gain over 3 million healthy life years.

**Table 3: Approximate projected global health outcomes of reaching the WHO CMHAP 2013-2030 recommended coverage target for epilepsy by 2030**

Target for increase in mental health service coverage	Income group	Prevalent cases averted	Healthy life years gained	Deaths avoided
Increasing service coverage by half (WHO CMHAP target)	LICs	139,905	229,794	820
	LMICs	1,127,612	1,652,263	6,284
	UMICs	410,671	780,896	2,477
	HICs	202,971	404,732	158,837
	<b>Total</b>	<b>1,881,159</b>	<b>3,067,685</b>	<b>168,418</b>

The overall projected global health outcomes of scaling up mental health service coverage to different recommended levels for the five mental health conditions listed above have been summarised in the tables below.

Table 4 shows that increasing service coverage by 50% for the five common mental health and neurological conditions would avert 51.5 million prevalent cases, gain 23.9 million healthy life years and avoid more than 478,400 deaths. It also shows that if UHC for mental health services (i.e. 90% plus coverage) is achieved by 2030, 299.7 million prevalent cases of the four mental health conditions and epilepsy will be averted, 126 million healthy life years will be gained, and 1.6 million deaths avoided.

Table 4: Approximate projected global health outcomes of reaching selected coverage targets by 2030\*

Target for increase in mental health service coverage	Prevalent cases averted	Healthy life years gained	Deaths avoided
Increasing service coverage by half (WHO CMHAP target)	51.5 million	23.9 million	478,406
Increasing service coverage to 50%	117 million	54 million	657,224
Increasing service coverage to 80%	259 million	108.8 million	1.4 million
Achieving universal (90% plus) coverage	299.7 million	126 million	1.6 million

\*data on deaths avoided for anxiety and psychosis and cases averted for psychosis and bipolar disorder are not included (see methodology)

Table 5 shows that if UHC for mental health services is achieved by 2050, 1.4 billion prevalent cases of the five common mental health and neurological conditions will be averted, 531 million healthy life years will be gained, and 6.1 million deaths will be avoided.

Table 5: Approximate projected global health outcomes of reaching select coverage targets by 2050\*

Target for increase in mental health service coverage	Prevalent cases averted	Healthy life years gained	Deaths avoided
Increasing service coverage by half (WHO CMHAP target)	233 million	96 million	1.2 million
Increasing service coverage to 50%	635 million	233 million	2.4 million
Increasing service coverage to 80%	1.2 billion	459 million	5.2 million
Achieving universal (90% plus) coverage	1.4 billion	531 million	6.1 million

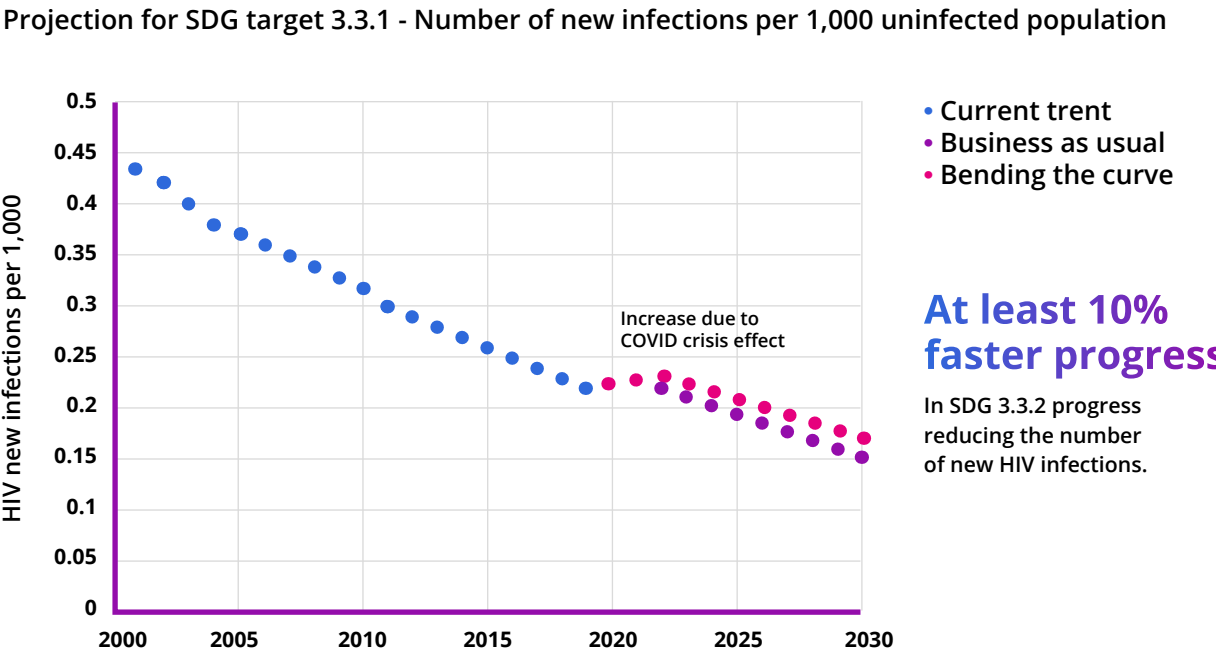
\*data on deaths avoided for anxiety and psychosis and cases averted for psychosis and bipolar disorder are not included (see methodology)

The link between mental and physical health

Comorbidities between mental and physical health, concerning both communicable and particularly non-communicable diseases, are well documented and have serious implications for the quality and duration of people’s lives. For example, a recent study found that people with comorbidities had a six times higher mortality rate and 11.5 years lower life expectancy than the general population. As well as harming people’s quality of life, depression can also reduce their adherence to treatment, including for potentially life-threatening physical health conditions, and has been known to reduce productivity and cause functional disability in individuals with chronic physical health conditions.

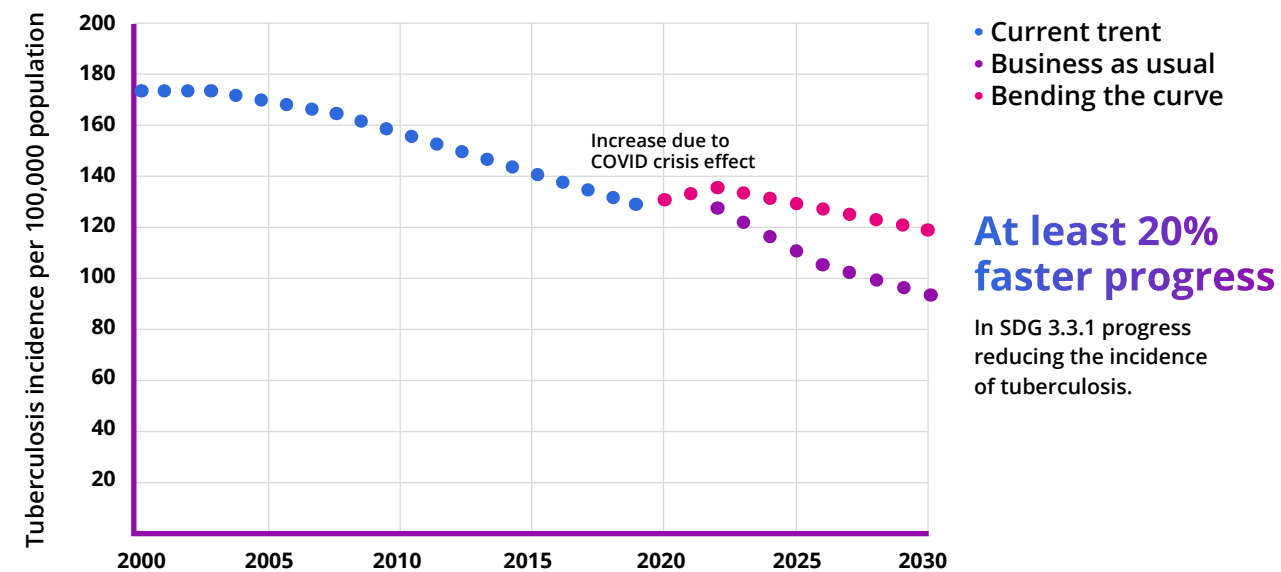
Given the impact they have on one another, mental and physical health conditions should not be viewed or treated in isolation. Managing mental health conditions as part of physical health care has been known to improve mortality rates while health systems that include mental health promotion and prevention programmes can reduce the infection rates of diseases such as HIV and TB.

Research commissioned by UnitedGMH in 2021 looked into the physical health outcomes of integrating mental health into HIV and TB programmes (our methodology is available to share upon request). UNAIDS data projections indicated the rate of new HIV cases could be reduced by between 10 and 16.5% - “bending the curve” - by integrating basic mental health care and psychosocial support into HIV programmes. In practice, doing so would mean that over 924,000 new HIV infections could be avoided by 2030.



The potential impact on TB case rates is even higher. The WHO's official data estimates that integrating mental health care and psychosocial support into TB and HIV programmes would mean a 12.6% to 20% faster rate of reduction in TB cases - "bending the curve" - so that as many as 14 million TB infections could be avoided by 2030.

Projection for SDG target 3.3.1 - Tuberculosis incidence per 100,000 population



The positive impact of integrating mental health into physical health care concerning just two physical conditions – HIV and TB – shows the huge potential it has for maximising overall health outcomes.

#### Case Study: Josephine's Story (Liberia)

The 2014 Ebola outbreak in Liberia changed Josephine Karwah's life forever.

She was diagnosed with Ebola and went to an Ebola Treatment Unit (ETU) operated by Médecins Sans Frontières, where she received treatment and mental health counselling. Returning to her community, Josephine entered a world that was not the same as before Ebola. The stigma surrounding the disease, including baseless myths about contracting the disease, permeated her community, making her return to normal life impossible.

At this time, she was introduced to the Carter Center, which was working to transform Liberia's mental health system. It provided Josephine with access to services and counselling to help her cope with the mental anguish of being stigmatised. She is now living what she refers to as a 'normal' life in the community and is studying biology. Without the integration of mental health services into her treatment, this would not be possible.

It provided Josephine with access to services and counselling to help her cope with the mental anguish of being stigmatised.



The integration of mental health services into health care is a key part of our response to epidemics and pandemics, as Josphine's story, above, illustrates. The mental health impacts of the Ebola virus were preventing her from leading a normal life. She needed counselling, as well as physical health care, to fully recover from all the effects of the virus on her wellbeing.

There are well-documented [comorbidities between non-communicable diseases \(NCDs\) and mental health](#). The prevalence of such comorbidities [is increasing rapidly in many low- and lower-middle-income countries](#). A [summary of the evidence](#) provides multiple illustrations of these comorbidities. Risk factors for NCDs, such as physical inactivity, unhealthy diets and use of tobacco or alcohol, are linked to a range of mental disorders including serious mental disorders. Anxiety and depression are recognised as [risk factors in cardio-vascular diseases](#), but support to prevent these conditions is rarely part of routine clinical practice. The [World Mental Health Surveys](#) found an excess mortality of 8-12% among people with common mental disorders through smoking, diabetes, history of myocardial infarction, and hypertension. It has also been reported that [one in four cancer patients suffer from depression, and the risk of becoming depressed is five times higher in cancer patients](#) than for the general population. It is therefore critically important that mental health services are a fully integrated part of the prevention and treatment of non-communicable diseases.

The integration of mental health services into health care is a key part of our response to epidemics and pandemics, as Josphine's story illustrates.



## HOW THE INTEGRATION OF MENTAL HEALTH INTO UHC IS POSSIBLE

The WHO's Comprehensive Mental Health Action Plan 2013-2030 is the key global framework for increasing the coverage of mental health services using UHC. It describes establishing 'comprehensive, integrated and responsive mental health and social care services in community based settings whilst implementing strategies for promotion and prevention in mental health.'

Detailing specific approaches to achieving UHC are beyond the scope of this brief, but they may be found in the helpful resources created by the WHO, World Bank and other key stakeholders (see Annex 1).

One such resource is the [UHC Compendium](#). It was compiled by the WHO based on extensive reviews of research to help countries decide what to include in UHC service packages. This global repository covers more than 3,500 evidence-based interventions across all areas of health. They include more than 200 actions for mental health conditions, addressing the spectrum of promotive, preventive, diagnostic, curative and rehabilitative interventions, and are largely based on the [mhGAP Evidence Resource Centre](#), which contains the background material, process documents, and the evidence profiles and recommendations in electronic format for mhGAP guidelines for mental, neurological, and substance use disorders.

These resources are essential reading. But this section will instead focus on two important principles fundamental to the successful integration of mental health into UHC: prioritising primary and community care, and taking a multi-sectoral approach.

### Transitioning from tertiary-focused to primary and community-based care

The WHO Comprehensive Mental Health Action Plan points out that of the already limited budget allocation for mental health, 67% goes to mental hospitals in low-income countries, despite their association with poor health outcomes and [rights violations](#). It recommends "systematically shifting the locus of care away from long-stay mental hospitals towards non-specialized health settings." Moreover, the forthcoming WHO World Mental Health Report recommends mental health systems should, "Move away from custodial care in psychiatric hospitals as community-based services become available by simultaneously improving quality of all inpatient and residential care, reducing admissions to long-stay psychiatric hospitals and increasing discharges of long-term residents. This requires a carefully planned participatory process that prepares residents for life in the community and that follows up on them after discharge."

Placing [non-specialised service providers](#) and [trained health workers at primary level](#), and [community-based models that involve personal contact](#) between caregivers and patients have proven to be effective in combating stigma and increasing demand for mental health services. Primary and community health care are important parts of a health system that must also include strong secondary health care and referral pathways.



A [staged approach](#) with interventions based on symptom severity can reduce the burden on tertiary care facilities. It involves referring people who need intensive support to specialised providers, while mild, early-stage or transient mental health conditions are addressed through self care and non-specialist providers with appropriate skills.

Primary and community-based care models also align with the [‘5C’ approach to integrating mental health into UHC](#). They are person-centred, account for continuity of care, engage with the community to combat barriers to access, promote collaborative care to address coverage gaps and foster a compassionate stance with health promotion at its core. This all helps build a strong case for putting primary and community-based mental health care at the core of UHC reforms.

However, as was particularly evident during the [Covid-19 pandemic](#), health care providers also need support for their mental and physical health. This is a key factor in delivering integrated care.

### Adopting a multi-sectoral approach

A multi-sectoral integrated approach to mental health care means making mental health a priority in sectors beyond the health system. It shifts sole responsibility away from the health system and [recognises the role that a wide range of actors](#) can play in promoting good mental health and psychosocial support – by addressing the underlying socio-economic factors detrimental to mental health, for example.

With [one in seven children and young people experiencing mental health conditions](#), the education sector can play a major role in addressing contributing factors such as bullying, social exclusion, and pressures to perform. It can also encourage children and young people to seek help themselves or through caregivers.

Similarly, with unemployed people at higher risk of depression, and an unhealthy work environment potentially leading to physical and mental health conditions, the employment and social welfare sectors have a part to play in promoting good mental health for those in and out of work. The social welfare sector can help protect at-risk children and young people, and support the unemployed and those struggling financially. And the housing and environmental sectors can tackle the [poor housing conditions](#) and [lack of access to green spaces](#) that both contribute to poor mental health.

These are just some of the ways in which different sectors can promote better mental health.

[Their importance to UHC cannot be overstated](#)

[Health-promotion and illness-prevention programmes, which are at the heart of UHC](#), cannot be developed or implemented without multi-sectoral support. By integrating mental health care into these sectors’ budgets and involving them in promotion and prevention, governments can reduce both the financial and resource burden on health systems and improve the chances of UHC’s success.

### The opportunity

Governments must now put the principles of UHC into action. Covid-19 has sparked global and national discussions on the coverage gaps in health services, particularly mental health services given the [significant increase in stress and anxiety across the world](#) caused by the pandemic. It is in this context that UHC is now being discussed at high-level political fora, including at the [G20 leaders’ summit in Rome](#) in 2021.

*“The huge gap in health coverage is one reason why Covid-19 has caused so much pain and suffering. We need Universal Health Coverage, including mental health coverage, now, to strengthen efforts against the pandemic and prepare for future crises.”*

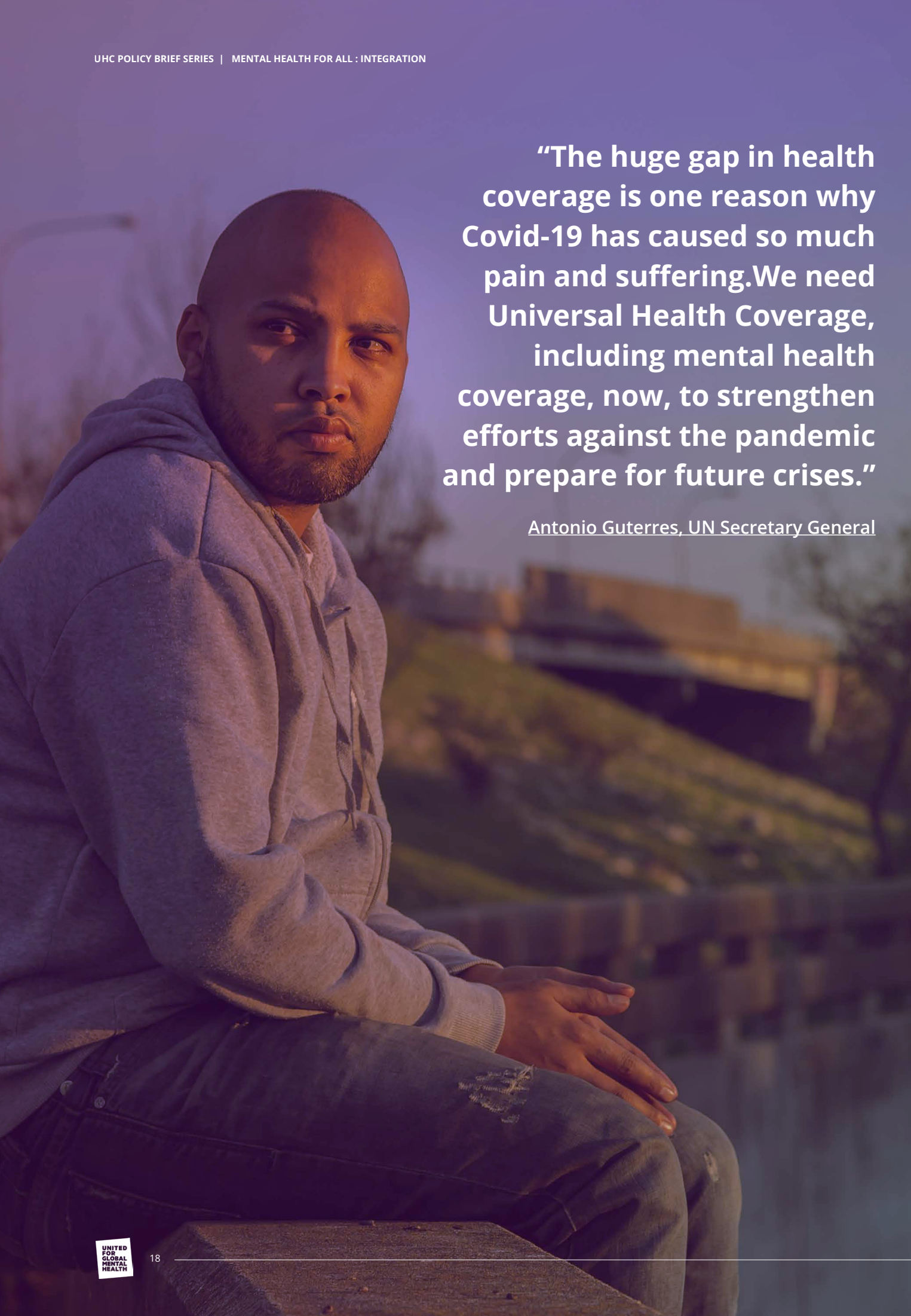
[Antonio Guterres, UN Secretary General](#)

UHC is likely to continue to feature prominently in discussions about strengthening health systems and preparing for and responding to future pandemics – especially in the lead up to and at the [UN High Level Meeting on UHC in 2023](#). UnitedGMH and our partners are campaigning for this meeting to produce an action-oriented political declaration that commits all countries to fulfilling the goals set out in the WHO Comprehensive Mental Health Action Plan and the SDGs. The aim: to achieve UHC for physical and mental health for all by 2030.

UHC has been expressly included as SDG target 3.8. It requires governments to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”

More and more countries ([Indonesia](#) and the [Philippines](#) are prime examples) base their UHC and health financing reforms on attaining SDG targets. So failure to integrate mental health into these reforms could set mental health progress back by at least 15-30 years – that is, until the next round of global goals are complete.

It is crucial, therefore, that mental health is meaningfully included in these discussions about UHC. It must be reflected in international political declarations and commitments, as well as national reforms, so that when gaps in health coverage are filled, mental health is not left behind.



**“The huge gap in health coverage is one reason why Covid-19 has caused so much pain and suffering. We need Universal Health Coverage, including mental health coverage, now, to strengthen efforts against the pandemic and prepare for future crises.”**

Antonio Guterres, UN Secretary General

## RECOMMENDATIONS ON INTEGRATING MENTAL HEALTH INTO UHC

How UHC is implemented in any given country depends heavily on the local context. But the WHO's Comprehensive Mental Health Action Plan 2013-2030 provides some useful recommendations for member state governments, which can be implemented across different economic settings. Several have been covered at various points in this brief:

- **Integrate mental health into UHC policies and programmes, keeping people with lived experience at the core of planning and implementation**
- **Expand coverage for mental health services by shifting the focus of care away from an almost exclusive focus on institutional and tertiary care settings towards evidence-based primary and community care that is supported by institutional and tertiary care**
- **Train, supervise and support health workers to deliver evidence-based, culturally appropriate and rights-based mental health and social care services in non-specialised settings**
- **Coordinate and implement a multi-sectoral strategy that combines universal and targeted interventions for promoting mental health and preventing mental health conditions**

Further recommendations, based on the work of WHO and other leaders in the mental health field, include:

- **Investing in public education campaigns to reduce stigma and encourage people who need help to seek it**
- **Including mental health care in emergency (including pandemics) preparedness, response and recovery planning and programmes**
- **Integrate mental health into health data collection and identify, collate, routinely report and use core mental health data disaggregated by sex and age in order to improve mental health service delivery, and promotion and prevention strategies**

A lot of the work has already been done to identify core principles and create comprehensive frameworks for integrating mental health into UHC. It is now time to put those frameworks into action. Only then can we reduce the coverage gap of mental health services and reap the rewards for both physical and mental health.

Some useful resources are included on the next page.



Annex 1: Additional Information to Assist Implementation of WHO Mental Health Integration Recommendations

WHO recommendation	Additional information
Integrate mental health into UHC policies and programmes, keeping people with lived experience at the core of planning and implementation	<ul style="list-style-type: none"><li>• <a href="#">WHO Comprehensive Mental Health Action Plan (2013-2030)</a></li><li>• <a href="#">WHO Mental Health Gap Action Programme (mhGAP)</a></li><li>• <a href="#">WHO Draft menu of cost-effective interventions for mental health</a></li><li>• <a href="#">WHO Quality Rights</a></li><li>• <a href="#">WHO Mental health policy and service guidance package</a></li><li>• <a href="#">WHO UHC Compendium</a></li><li>• Forthcoming WHO World Mental Health Report (2022)</li></ul>
Expand coverage for mental health services by shifting the focus of care away from institutional and tertiary care settings towards evidence based primary and community care	<ul style="list-style-type: none"><li>• <a href="#">WHO Comprehensive Mental Health Action Plan (2013-2030)</a></li><li>• <a href="#">WHO Mental Health Gap Action Programme (mhGAP)</a></li><li>• <a href="#">WHO Quality Rights</a></li><li>• <a href="#">WHO UHC Compendium</a></li><li>• Forthcoming WHO World Mental Health Report (2022)</li></ul>
Train health workers to deliver evidence-based, culturally appropriate and rights-based mental health and social care services in non-specialised settings	<ul style="list-style-type: none"><li>• <a href="#">WHO Mental health policy and service guidance package</a></li><li>• <a href="#">WHO Quality Rights</a></li><li>• <a href="#">WHO UHC Compendium</a></li><li>• Forthcoming WHO World Mental Health Report (2022)</li></ul>
Coordinate and implement a multi-sectoral strategy that combines universal and targeted interventions for promoting mental health and preventing mental health conditions, reducing stigma and encouraging people who need help to seek it	<ul style="list-style-type: none"><li>• <a href="#">Out of the shadows: making mental health a global development priority (WB)</a></li><li>• <a href="#">Moving the needle: mental health stories from around the world (WB)</a></li><li>• <a href="#">Harnessing technology to address the global mental health crisis: an introductory brief (WB)</a></li><li>• <a href="#">WHO UHC Compendium</a></li><li>• Forthcoming WHO World Mental Health Report (2022)</li></ul>

WHO recommendation	Additional information
Including mental health in emergency (including pandemics) preparedness, response and recovery planning and programmes	<ul style="list-style-type: none"><li>• <a href="#">Building back better: Sustainable mental health care after emergencies (WHO)</a></li><li>• <a href="#">Mental health among displaced people and refugees: Making the case for action under humanitarian response and development programmes (WB)</a></li><li>• <a href="#">Mental Health and COVID-19: Early evidence of the pandemic's impact: Scientific brief, 2 March 2022</a></li><li>• Forthcoming WHO World Mental Health Report (2022)</li></ul>
Integrate mental health into health data collection and identify, collate, routinely report and use core mental health data disaggregated by sex and age in order to improve mental health service delivery, and promotion and prevention strategies	<ul style="list-style-type: none"><li>• <a href="#">Countdown Global Mental Health 2030: Using Data to Inform Action published by UnitedGMH 2021</a></li><li>• Forthcoming WHO World Mental Health Report (2022)</li></ul>

**Annex 2: Research Methodology****Analyst: Yong Yi Lee****Date: 18 February 2022****Introduction**

This document outlines the methods underlying an analysis conducted in OneHealth Tool (OHT) on behalf of United for Global Mental Health in February 2022. The purpose of the OHT analysis is to provide insights into the costs and health impacts that would accrue following an increase in treatment coverage as part of the achievement of universal health coverage. The main output of this analysis is an estimate of the increased per capita mental health expenditure that would occur following an increase in mental health treatment coverage globally and across four different World Bank income groups.

**Method****Analytic approach**

The OHT analysis sought to examine the costs and health impacts of scaling up different treatment coverage scenarios over two prospective time horizons: (1) scale-up from 2022 to 2030; and (2) scale-up from 2022 to 2050.

The following treatment coverage scenarios were analysed across each time horizon:

1. Target treatment coverage of 50% by the final year of scale-up;
2. Target treatment coverage of 80% by the final year of scale-up;
3. Target treatment coverage of 90% by the final year of scale-up; and
4. Target treatment coverage involving a 50% increase in current coverage by the final year of scale-up.

The following steps were implemented to estimate the costs and health impacts that would occur across each treatment coverage scenario among four World Bank income groups (i.e., low income, lower-middle income, upper-middle income and high income countries):

1. Determine current per capita mental health expenditure based on data from the WHO World Mental Health Atlas 2020;
2. Estimate current treatment coverage for five mental health conditions (i.e., major depression, anxiety disorders, psychosis, bipolar disorder and epilepsy) and apply these estimates to the various mental health interventions included in OHT (i.e., current OHT intervention coverage);

3. Determine the target OHT intervention coverage based on the desired treatment coverage scenario (i.e., 50%, 80%, 90% or a 50% increase);
4. Use OHT to estimate the intervention costs and health impacts that accrue when scaling up OHT intervention coverage from current to target levels for each mental health condition;
5. From the OHT analysis, estimate the relative increase in per capita mental health expenditure when scaling up from current coverage to target coverage; and
6. Estimate target per capital mental health expenditure by applying the relative increase in per capita mental health expenditure (calculated by the OHT analysis) to current per capital mental health expenditure (obtained from the WHO World Mental Health Atlas 2020).

**Current per capita mental health expenditure**

Current per capita mental health expenditure was determined using data obtained from the WHO World Mental Health Atlas 2020 [1].

**Mental health treatment coverage (current and target)**

Current treatment coverage for depression, anxiety disorders and bipolar disorder were based on data obtained from the World Mental Health Survey initiative, which has been conducted across 25 countries spanning each of the four World Bank income groups [2]. Current treatment coverage for psychosis was estimated using data presented in the WHO World Mental Health Atlas 2020 [1]. Current treatment coverage for epilepsy was based on a systematic review analysing the treatment gap for epilepsy across countries worldwide [3]. Target coverage in the final year of scale-up was determined based on the nominated treatment coverage scenario – i.e., 50%, 80%, 90% or a 50% increase.

**OHT intervention coverage (current and target)**

Estimates of current and target mental health treatment coverage need to be translated into corresponding coverage estimates for each of the interventions modelled by OHT (i.e., we need to translate mental health treatment coverage into OHT intervention coverage for each of the five mental health conditions). Table 1 presents a list of the 13 different interventions modelled in OHT by mental health condition. In general, estimates of treatment coverage will be directly applied to each OHT intervention. For example, if mental health treatment coverage for anxiety disorders is 9.9% then current OHT intervention coverage for, 'Basic psychosocial treatment for anxiety disorders (mild cases)', will also be 9.9%. An exception to this rule occurs in the case of basic and intensive OHT interventions which target overlapping populations – e.g., 'basic and intensive psychosocial treatment and anti-depressant medication for anxiety disorders (moderate-severe cases)'. In this case, the 9.9% coverage estimate will be split assuming a ratio of 2:1, whereby 67% of the target population will receive the basic intervention and 33% will receive the intensive intervention. This would result in current OHT treatment coverage being 6.6% and 3.3% for the basic and intensive interventions, respectively.





Table 1 OHT interventions by mental health condition

Mental health condition	Intervention
Anxiety disorders	<ul style="list-style-type: none"><li>• Basic psychosocial treatment for anxiety disorders (mild cases)</li><li>• Basic psychosocial treatment and anti-depressant medication for anxiety disorders (moderate-severe cases) <sup>†</sup></li><li>• Intensive psychosocial treatment and anti-depressant medication for anxiety disorders (moderate-severe cases) <sup>†</sup></li></ul>
Depression	<ul style="list-style-type: none"><li>• Basic psychosocial treatment for mild depression</li><li>• Basic psychosocial treatment and anti-depressant medication of first episode moderate-severe cases<sup>†</sup></li><li>• Intensive psychosocial treatment and anti-depressant medication of first episode moderate-severe cases<sup>†</sup></li><li>• Intensive psychosocial treatment and anti-depressant medication of recurrent moderate-severe cases on an episodic basis</li><li>• Intensive psychosocial treatment and anti-depressant medication of recurrent moderate-severe cases on a maintenance basis</li></ul>
Psychosis	<ul style="list-style-type: none"><li>• Basic psychosocial support and anti-psychotic medication<sup>†</sup></li><li>• Intensive psychosocial support and anti-psychotic medication<sup>†</sup></li></ul>
Bipolar disorder	<ul style="list-style-type: none"><li>• Basic psychosocial treatment, advice, and follow-up for bipolar disorder, plus mood-stabilizing medication<sup>†</sup></li><li>• Intensive psychosocial intervention for bipolar disorder, plus mood-stabilizing medication<sup>†</sup></li></ul>
Epilepsy	<ul style="list-style-type: none"><li>• Basic psychosocial support, advice, and follow-up, plus anti-epileptic medication</li></ul>

<sup>†</sup> These basic and intensive interventions target an overlapping population within each mental health condition. OHT intervention coverage will be split between these basic and intensive interventions assuming a ratio of 2:1, whereby 67% of the target population will receive the basic intervention and 33% will receive the intensive intervention.



Costing analysis

The costing analysis was conducted in OHT using an ingredients-based approach which estimated the cost associated with each resource item consumed as part of an OHT intervention. Examples of resource items include: staff salaries (e.g., primary care doctors, specialist doctors and nurses); number of inpatient bed days; number of outpatient visits; and medications (e.g., amitriptyline, haloperidol, lithium and phenobarbital). The quantity of resources required to implement each intervention were based on the default settings implemented in OHT [4]. The unit price attached to each resource item was based on standardised cost estimates produced by WHO-CHOICE [5,6]. OHT was ultimately used to estimate the ratio of target per capita mental health expenditure relative to current mental health expenditure globally and across each World Bank income group.

Health impact modelling

OHT was used to produce health impacts in terms of healthy life years gained, prevalent cases averted and total deaths averted. Default settings used to model the effectiveness of OHT interventions for each mental health conditions have been described in full elsewhere [4]. Table 2 outlines the types of health impacts that are accounted for by each OHT intervention across each mental health condition. Health life years gained are calculated as the combined effect of health impacts in relation to reductions in prevalent cases (i.e., increased remission), reductions in deaths (i.e., decreased mortality) and increases in a person’s ability to function (i.e., decreased disability). It is important to note that, for psychosis, OHT only models health impacts related to increased function. In the case of bipolar disorder, OHT only models health impacts related to increased function and reductions in deaths.

Table 2 Summary of OHT intervention impacts on prevalence, deaths and function for each mental health condition

Mental health condition	OHT interventions Impact on prevalence? (↑ remission)	OHT interventions Impact on deaths? (↓ mortality)	OHT interventions Impact on function? (↓ disability)
Anxiety disorders	Yes	No	Yes
Depression	Yes	Yes	Yes
Psychosis	No	No	Yes
Bipolar disorder	No	Yes	Yes
Epilepsy	Yes	Yes	Yes



Target per capita mental health expenditure

Target per capita mental health expenditure, occurring in the final year of scale-up, was calculated by: taking the estimate of current per capita mental health expenditure (obtained from the WHO World Mental Health Atlas 2020); and multiplying this by the ratio of target versus current per capita mental health expenditures (calculated via the OHT analysis). Estimates of target per capita mental health expenditure were calculated by: time horizon (i.e., 2022 to 2030 and 2022 to 2050); treatment coverage scenario (i.e., 50%, 80%, 90% and a 50% increase); and World Bank income group (i.e., low income, lower-middle income, upper-middle income and high income countries).

Study limitations

Please note the following limitations of the analyses presented above:

1. Due to the analytic approach, current/target OHT intervention costs will not correspond with actual, real-world current/target mental health expenditures. Absolute OHT intervention costs will need to be interpreted with caution. Best not to quote aggregate estimates of intervention costs outright without appropriate qualification (if at all). They are only instructive for making relative (and not absolute) comparisons.
2. The interventions modelled in OHT are a simplification of reality. They do not account for any inefficiencies, workforce shortages or wastage that may adversely impact on intervention costs and, in turn, the return on investment outcomes.
3. The default intervention effect sizes implemented in OHT do not incorporate any potential reductions in mortality due to interventions for psychosis. The OHT analysis may underestimate the potential benefits that accrue from such interventions.



# MENTAL HEALTH FOR ALL:

What can we achieve if we meaningfully  
integrate mental health into UHC

---

UHC POLICY BRIEF SERIES

UNITED  
FOR  
GLOBAL  
MENTAL  
HEALTH