THE URGENT NEED FOR MENTAL HEALTH INTEGRATION IN UNIVERSAL HEALTH COVERAGE

“NO HEALTH WITHOUT MENTAL HEALTH”:

UNITED FOR GLOBAL MENTAL HEALTH
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THE URGENT NEED FOR MENTAL HEALTH INTEGRATION IN UNIVERSAL HEALTH COVERAGE

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Authors:

Maxim Polyakov, Senior Consultant, Policy, Advocacy and Financing, United for Global Mental Health
James Sale, Policy and Advocacy Manager, United for Global Mental Health
Sarah Kline, Co-Founder and Deputy CEO, United for Global Mental Health
Shekhar Saxena, Professor of the Practice of Global Mental Health, Harvard TH Chan School of Public Health
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**Dr Lola Kola**  
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**Prof Crick Lund**  
University of Cape Town, South Africa; Kings College London, UK

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Mariwala Health Initiative, India

**Yves Miel Zuniga**  
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**Robert Yates**  
Chatham House, UK

**Peter Yaro**  
Basic Needs Ghana, Ghana
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## Conclusion
EXECUTIVE SUMMARY
If ever there was a time to invest in mental health, it’s now ... We must take this opportunity to build mental health services that are fit for the future: inclusive, community-based, and affordable. Because, ultimately, there is no health without mental health”

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, 14 May 2020

“Addressing mental health is central to achieving universal health coverage. It deserves our commitment”

Antonio Guterres, UN Secretary General, 10 Oct 2020
When world leaders met at the UN General Assembly in 2019 to discuss Universal Health Coverage (UHC), they committed to “progressively cover one billion additional people by 2023 … with a view to cover all people by 2030.” As part of this ‘health for all’ declaration, UN member states explicitly included mental health care in UHC. It was a recognition of the fact that there is no health without mental health.

Yet, despite this political commitment, which was only the latest in a series of such commitments, progress on mental health has been limited. In every country in the world there is still a huge – and often growing – need for improved mental health care.

**HOW WE'RE FAILING TO ADDRESS MENTAL HEALTH NEEDS – AND THE CONSEQUENCES OF THAT FAILURE**

In some countries, the gap in mental health care coverage for common conditions such as depression and anxiety can be as high as 90%. While the services that are available are often poor-quality, are not cost-effectively delivered and in some cases violate the human rights of people living with mental health conditions.

This appalling situation is not surprising: governments around the world spend on average under 2% of their health budgets on mental health, while less than 1% of global development assistance for health has been directed towards mental health. All too often, these resources are spent on costly and low-quality in-patient care when higher quality, more cost-effective and rights-based community alternatives are available. For instance, in low- and middle-income countries, 80% of mental health budgets are spent on in-patient care (contrary to the wishes of many mental health activists for alternative care models, and the advice of experts including the World Health Organisation (WHO)).

At the same time, the need for high-quality, rights-based mental health care is vast. Nearly 1 billion people around the world live with a mental health or a substance use condition. Globally, there are 264 million people with anxiety and 322 million with depression. Tragically, around 800,000 suicides take place every year – one death every 40 seconds; suicide is the second leading cause of death among young people aged 15-29. As many as 10-20% of children and adolescents experience mental health disorders worldwide, while an estimated 15-23% of children live with a parent with a mental health condition – with potentially damaging consequences for their cognitive, emotional and physical development. Mental health conditions also disproportionately affect socioeconomically vulnerable populations, creating a vicious circle of mental health problems and socioeconomic disadvantage.

The COVID-19 pandemic has exacerbated these problems. One study has suggested that depressive symptoms tripled during the pandemic, and countries around the world are seeing higher rates of suicide or suicidal ideation. At the same time, the crisis has disrupted the provision of mental health services in over 90% of countries, according to the WHO.

There is also a clear link between mental and physical health: people with mental health conditions are more vulnerable to both infectious and non-communicable physical diseases. For example, people living with mental health conditions are four times more likely to have HIV, while depression can reduce compliance with treatment for diseases such as cancer. The relationship between mental and physical health holds true also for COVID-19, and research has shown that a recent mental health diagnosis is strongly linked to a higher risk of a COVID-19 infection.
In addition, people living with mental health conditions can be among the most vulnerable in society, enduring incarceration, chaining, coercion, overmedicalisation, institutionalisation, stigma and exclusion. They can experience these abuses both in their families and local communities, and also in mental health systems. Moreover, in most communities around the world the right to health of people living with mental health conditions is not being met. That people with severe mental disorders tend to die up to 20 years earlier than people without these conditions is a stark indication of that fact.

THE ARGUMENTS FOR INTEGRATING MENTAL HEALTH IN UHC

The most effective way to address all of the problems set out above is to integrate mental health in UHC. This is a critical component of making UHC a success, and delivering holistic, person-centred care. When we talk about integrating mental health in UHC, this is what we mean:

- including mental health care in all relevant aspects of health systems, such as health promotion, illness prevention, treatment and rehabilitation
- putting mental health care on a par with and – where relevant – accompanying physical health care
- ensuring mental health conditions are covered by population-wide financial protection measures.

Based on the data and policies of globally recognised authorities, there are three arguments to support the integration of mental health in UHC:

- **A health argument:** There is a staggering – and growing – need to address mental health outcomes. Moreover, mental health and physical health are inextricably linked – improving mental health cannot fail to improve other areas of health. To achieve truly universal health coverage, and save countless lives, mental health care must be included in UHC.

- **An economic argument:** Investment in mental health should be seen as just that – an investment for a future economic return and an opportunity to increase national prosperity. Investment in common mental health conditions is estimated to generate $5 in productivity gains and value-of-health benefits for every $1 spent. Integrating mental health in UHC is also highly cost-effective, and can make health spending more efficient: it could reduce expenditure in other parts of the health sector by improving prevention and treatment compliance for physical conditions. Given the positive impact of good mental health on early childhood development, it can be further argued that mental health should be explicitly added as a component of the World Bank’s Human Capital Index.

- **A rights argument:** The right to health, which UHC aims to uphold, includes the right to mental health: without including mental health, UHC cannot be a mechanism by which the right to health is put into action. Integrating high-quality, rights-based, evidence-based mental health practices in health systems – with a focus on primary and community-based care – would reduce the opportunities for the kinds of human rights abuses already described. It would also support the implementation of the Convention on the Rights of Persons with Disabilities (CPRD) to achieve the full range of rights of people living with mental health conditions (including the right to health).
HOW THE INTEGRATION OF MENTAL HEALTH IN UHC CAN BE ACHIEVED

It is paramount for the health outcomes of entire populations, as well as for economic prosperity, to ensure that mental health is rapidly integrated in health systems and rights-based, high quality services are afforded sufficient and sustainable funding. In addition, the full realisation of UHC necessitates that mental health should be a fully integrated component within it. The good news is that key global blueprints on how to achieve this already exist. Integrating mental health in UHC is a relatively low hanging fruit.

The key global framework for the scale-up of mental health within the context of UHC is the WHO’s Mental Health Action Plan 2013-2020. (The Action Plan is due to be updated and approved at the World Health Assembly in 2021 for a further 10 years: 2021-2030). The Action Plan incorporates UHC as a cross-cutting principle, and focuses on a number of key objectives, including setting up “comprehensive, integrated and responsive mental health and social care services in community-based settings”, as well as the implementation of “strategies for promotion and prevention in mental health”. It is supported by a number of key technical publications by leading UN and international agencies, such as the WHO’s Mental Health Gap Action Programme (mhGAP) Intervention Guide, as well as a number of World Bank publications.

Separately, a key catalytic programme for integrating mental health in UHC was launched in 2019 by the WHO, called the Special Initiative for Mental Health (2019-2023). This initiative aims to provide $60 million in funding and technical support across 12 countries over five years, to scale up the integration of mental health in UHC and extend quality services to 100 million additional people.

It is critical to establish that, where the practicalities of integrating mental health in UHC are concerned, there can be no ‘one-size-fits-all’ approach. However, given the current situation of most mental health systems around the world, there are a number of changes that will likely need to take place, such as:

• The creation and implementation of national mental health laws and mental health policies that are aligned with international human rights conventions, to ensure that the rights of people living with mental health conditions are always protected and upheld
• An amplification of the voice of lived experience in policy design and implementation to improve the services and support provided through UHC
• Integration of mental health in all UHC strategies and planning, and the inclusion of mental health services within the basic package of essential services
• Increase in sustainable funding for mental health, to 5-10% of the health budget (depending on resource setting)
• A focus on prevention, promotion and rehabilitation, including through intersectoral collaboration (e.g. life skills programmes in schools; parent coaching; peer support)
• Strengthening the national workforce for mental health, both supporting mental health specialists and upskilling general health staff and other relevant professions (e.g. teachers, police, social workers)
• Shifting service delivery towards non-specialised settings in the community
• Setting up a robust monitoring and evaluation system for mental health

(Note: Part II of the main report provides more detail on these action points.)
Given the current low levels of funding for mental health in most countries, such a significant change in mental health and UHC policies and practice will not happen without further investment. Increasing expenditure on mental health to just 5-10% of total health budgets (as suggested by The Lancet Commission on Global Mental Health and Sustainable Development) would increase coverage by 40-80%, depending on the resource setting. Ideally, the funding should come from domestic financing to ensure sustainability and in-country ‘ownership’; although in some settings catalytic investment by international and national donors may be necessary. This funding must be directed towards support that upholds the human rights of all those with mental health needs.

We have never been better informed about how to successfully integrate mental health in UHC, and the rewards this could bring. At the same time, the need for action has never been greater. **We therefore call on all key stakeholders to move together on this – and move now:**

- **International agencies:** Strengthen the case for integrating rights-based mental health in UHC through policy development, supporting evidence generation and dissemination, and galvanising political will
- **National governments:** Fully integrate mental health into national health legislation, policies and programmes, in particular within UHC reforms, adopting a rights-based approach and committing 5-10% of health budgets to mental health accordingly
- **International and national funders:** Support integration of mental health in UHC by providing catalytic funding, including through priority health programmes (e.g. COVID-19 response, HIV/AIDS and TB, and maternal and child health programmes), in support of the delivery of a rights-based approach
- **Academic community:** Further strengthen the evidence base for integration and rights-based interventions
- **Civil society:** Advocate for the urgent need to integrate mental health in UHC in a way that upholds human rights, holding national governments and global institutions to account for the commitments made

As the world grapples with the impact of COVID-19 and designs the future of healthcare, we need the global community to come together now and commit its political will towards action and investment in mental health.

**THERE IS NO HEALTH WITHOUT MENTAL HEALTH.**

**THE TIME FOR ACTION IS NOW.**
"No Health without Mental Health": the Urgent Need for Mental Health Integration in Universal Health Coverage

INTRODUCTION

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Article 12.1 of the International Covenant on Economic, Social and Cultural Rights

The right to the highest attainable standard of physical and mental health was first set out in preamble of the 1946 Constitution of the World Health Organisation (WHO). It defined health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

The 1948 Universal Declaration of Human Rights includes health as part of the right to an adequate standard of living (art. 25).

This was reaffirmed in the 1976 International Covenant on Economic, Social and Cultural Rights (art. 12).

Moreover, the right to health explicitly encompasses all individuals, including people living with “long-term physical, mental, intellectual or sensory impairments”. This was set out in article 25 of the 2006 Convention on the Rights of Persons with Disabilities (CRPD): “States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.”

Although it still covers only about half of the world’s population, Universal Health Coverage (UHC) is, for many people, the most effective means of securing the right to health. Yet, while the right to good physical health has been largely acknowledged – and reflected in health systems and financing – the right to good mental health has been largely absent from existing UHC systems. Moreover, while mental health policy guidance and even global plans have included the need for mental health care to be integrated into health systems, member states have not systematically done so.

Drawing on an extensive body of evidence, this report makes the case for integrating mental health in UHC provision – and urges policy makers to act now. It was written in the midst of the COVID-19 pandemic – an emergency which has increased the need for urgent action. However, integrating mental health in UHC is a need that goes beyond the pandemic – it is a need that existed before COVID-19, and, unless addressed, will persist after it is gone.

THE IMPORTANCE OF UHC

The concept of UHC has been decades in the making. It has its roots in, for example, New Zealand’s Social Security Act of 1938, the establishment of the UK’s National Health Service in 1948, Japan’s universal health insurance system in 1961, and, globally, the Declaration of Alma-Ata during the International Conference on Primary Health Care in 1978. The Alma-Ata Declaration introduced the concept of ‘health for all’ and focused on the cornerstone of UHC: primary healthcare.

Since then, the concept of UHC has been broadened to encompass the health system as a whole, including public health – “from health promotion to prevention, treatment, rehabilitation, and palliative care”.

INTRODUCTION
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The ‘UHC cube’

UHC can be thought of working along three dimensions – sometimes referred to as the ‘UHC cube’:
• the range of effective and high-quality services covered
• the financial accessibility of these services (i.e. financial protection of service users)
• the proportion of the population that have access to these affordable services.\(^\text{11}\)

UHC aims to fulfil all these dimensions so everyone can “obtain the services they need at a cost that is affordable to themselves and to the nation as a whole”.\(^\text{12}\) As such, UHC is a critical instrument to making the right to the best attainable health a reality for everyone – it is “the right to health in action”.\(^\text{13}\)

UHC is also a key aspect of sustainable development, and a target in its own right in the Sustainable Development Goals. SDG target 3.8 reads: “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”.\(^\text{14}\) Moreover, by improving health on a population and global level, UHC is a critical part of the broader development agenda. For instance, the World Bank sees it as key to achieving its “twin goals of ending extreme poverty and increasing equity and shared prosperity. ... UHC allows countries to make the most of their strongest asset: human capital”.\(^\text{15}\)

MENTAL HEALTH AS PART OF UHC

Thanks to the tireless work of many states, activists and advocates, the importance of UHC is now recognised globally. This was reaffirmed when, in 2019, world leaders assembled to discuss UHC at the UN General Assembly. Mental health was part of that discussion.

The session saw world leaders commit to “progressively cover 1 billion additional people by 2023 with quality essential health services and quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies, with a view to cover all people by 2030”. They also pledged to “stop the rise and reverse the trend of catastrophic out-of-pocket health expenditure”.\(^\text{16}\) Thanks to the advocacy of UN member states and
mental health activists and advocates, with the coordinated backing of the Global Mental Health Action Network, world leaders also committed to “implement measures to promote and improve mental health and well-being as an essential component of universal health coverage”. This commitment built on a series of reports and initiatives that have also made the case for the integration of mental health in UHC. These include the WHO Mental Health Action Plan 2013-2020, the WHO-World Bank collaboration Out of the Shadows (as well as a range of other World Bank publications), and The Lancet Commission on Global Mental Health and Sustainable Development. The WHO Action Plan set out targets that all member states were expected to deliver, and was based on six cross-cutting principles, the first of which was UHC. It stated that “responsive care will be stronger and more effective when mental health interventions are firmly integrated within the national health policy and plan”. It added that “the inclusion and mainstreaming of mental health issues more explicitly within other priority health programmes and partnerships ... as well as within other relevant sectors’ policies and laws ... are important means of meeting the multidimensional requirements of mental health systems and should remain central to leadership efforts of governments to improve treatment services, prevent mental disorders and promote mental health.”

It recommended “mainstream[ing] mental health interventions into health, poverty reduction, development policies, strategies and interventions” and “[e]xplicitly includ[ing] mental health within general and priority health policies, plans and research agenda.”

It is encouraging to see mental health care increasingly included in some areas of global health policy discussions and formulation, but so far this has led to only limited national policy change, and even less new investment and implementation. Moreover, many of these discussions have not fully addressed how best to uphold the rights of people with mental disorders in the context of UHC – such as the inclusion of person-centred, rights-based mental health care through the move away from institutional care to services delivered in the community where appropriate to do so. Most countries still lack a real political commitment to upholding people's right to good mental health, and lack the sustainable domestic financing (and catalytic international and national donor financing, where this is relevant) to create the change that is needed. Similarly, the UHC service coverage index, which tracks how global UHC is implemented, does not meaningfully include mental health.

This failure to act has been regularly documented in the WHO Mental Health Atlas reports, which are based on self-reporting by governments, and by independent reports such as The Lancet Commission on Global Mental Health and Sustainable Development. Indeed, the gap in coverage for some mental health conditions is in the range of 90% in some countries – and the gap is even larger if quality of care is taken into consideration. This is a serious failure in a world where every 40 seconds someone somewhere dies by suicide. Even where people with mental disorders are being treated, the nature of this treatment can violate their human rights, for instance through coercive and abusive treatment, according to regular reports from organisations such as Human Rights Watch.
The harsh reality is that the large majority of people are still confronted with a lack of access to rights-based, quality mental health care. Moreover, paying for mental health care can be financially ruinous to many individuals and families, and the need for financial protection is stark. Improvement is needed along all of the dimensions of the ‘UHC cube’.

The COVID-19 pandemic has made an already challenging situation worse – exacerbating both mental health needs and the gaps in mental health services. Persons with disabilities have been particularly affected. At the same time, funding for mental health globally has become increasingly threatened, as economies shrink, the fiscal field narrows, and available healthcare funds are diverted elsewhere.

THE NEED TO INTEGRATE MENTAL HEALTH IN UHC

If mental health is not integrated in UHC we put at risk both the quality of mental health outcomes, and the overall attainment of UHC. Indeed, without a mental health component, we cannot describe UHC as ‘universal health coverage’. There is no health without mental health.

This report defines the full integration of mental health in UHC as:

- including mental health care in all relevant aspects of health systems, such as health promotion, illness prevention, treatment and rehabilitation
- putting mental health care on a par with and – where relevant – accompanying physical health care
- ensuring mental health conditions are covered by population-wide financial protection measures.

Based on the data and policies of globally recognised authorities, Part I of this report makes three arguments to support the integration of mental health in UHC:

- **A health argument:** In a world where nearly 1 billion people live with a mental health or a substance use condition, there is a staggering – and growing – need to address mental health directly. Moreover, mental health and physical health are inextricably linked, and improving mental health cannot fail to improve other areas of health. To achieve truly universal health coverage, and save countless lives, mental health care must be included in UHC.

- **An economic argument:** Investment in mental health should be seen as just that – an investment for a future economic return and an opportunity to increase national prosperity. Integrating mental health into UHC is also highly cost-effective and can make health spending more efficient.

- **A rights argument:** The right to health, which UHC aims to uphold, includes the right to mental health. Integrating mental health care in health systems – if those systems provide rights-based services – could also be a way to ensure that the rights of people living with mental health conditions are recognised and protected.

Part II of this report discusses how the integration of mental health in UHC can be achieved. This builds on the numerous relevant technical documents that have been produced and on the many lessons learned by systems and organisations that have already undertaken this integration.

Moving towards UHC and the integration of mental health within it are, above all else, political choices. As such, we urge national and international decision-makers to spare no effort to ensure the complete integration of mental health in national UHC programmes.
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PART I

Why is it critical to integrate mental health in UHC?

Argument 1: There is no health without mental health

"If ever there was a time to invest in mental health, it’s now … We must take this opportu-
nity to build mental health services that are fit for the future: inclusive, community-based,
and affordable. Because, ultimately, there is no health without mental health"

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, 14 May 2020
ARGUMENT 1

There is no health without mental health

“If ever there was a time to invest in mental health, it’s now ... We must take this opportunity to build mental health services that are fit for the future: inclusive, community-based, and affordable. Because, ultimately, there is no health without mental health”

Dr Tedros Adhanom Ghebreyesus, WHO Director-General, 14 May 2020
It is widely recognised that mental health is a key component of overall health, and world and national leaders have increasingly adopted the slogan: “no health without mental health”.\textsuperscript{31} Unfortunately, this increasing recognition has not, by and large, translated into action and investment.

As a result, there is still a staggering, and growing, need to address mental health problems directly – one exacerbated and made more urgent by the COVID-19 pandemic.

Making mental health a mainstream element of existing health systems in a rights-based way, as part of the push towards UHC, is a golden opportunity to meet this need – especially at the level of primary and community-based care. It is at these levels where most of the contact between people and the healthcare system takes place, where most of the UHC effort is already focused, and therefore where delivering mental health services would have the most impact – both to directly address mental health conditions and, as a knock-on effect, to improve physical health.

Services are just one aspect of mental health provision. Integrating mental health into UHC must also include programmes to promote mental health and prevent mental health problems.

**INTEGRATING MENTAL HEALTH IN UHC: IMPROVING MENTAL HEALTH OUTCOMES**

With nearly 1 billion people around the world living with a mental health or a substance use condition, demand for mental health services is vast. At the same time, existing mental health systems almost universally fail to address the needs of their populations. To reverse this failure, rapid and decisive action and investment are needed to integrate mental health in UHC. This includes ensuring that adequate promotion and prevention schemes are put in place, and extending quality and affordable service coverage using a rights-based approach to everyone who seeks treatment.

While seeking treatment (and selecting the type of treatment) is and must always remain a choice, there are far too many barriers – such as availability and affordability – that people who need and want treatment have to overcome. As things stand, the treatment gap for mental health conditions is unacceptably large. Even in high-income settings, the gap in coverage for common conditions (e.g. depression and anxiety) can be higher than 50%, while in many low-income countries it can be as high as 90%.\textsuperscript{32}

When the availability of different types of intervention (e.g. psychosocial and pharmacological)\textsuperscript{33} or the quality of services are taken into account, the gap is even larger. According to a study of the treatment of major depressive disorder (MDD) across 21 countries, “[o]nly a minority of participants with MDD received minimally adequate treatment: 1 in 5 people in high-income and 1 in 27 in low-/lower-middle-income countries”.\textsuperscript{34} Even for severe disorders like schizophrenia, the treatment gap can be very large. A study has found, for example, that across 50 low- and middle-income countries, the median treatment gap was ~70%.\textsuperscript{35} Unfortunately, and despite strong recommendations from bodies such as the WHO and advocacy by lived experience advocates, mental health systems are often focused on costly in-patient care rather than community- and primary-level services, or promotion and prevention services.

The size of the mental health workforce also shows the extent of the gap in mental health provision. According to the WHO, the median number of mental health workers per 100,000
people is only 9 globally, and fewer than 2 per 100,000 people in low-income countries. Overall, “only 1% of the global health workforce provides mental health care”. There is an urgent need for greater task-shifting from doctors to nurses and to community-based health workers in order to deliver optimal mental health services for all.

The stigma and discrimination that is frequently directed at mental health professionals needs to change too, if more are to enter the field. Reports also suggest that mental health patients are frequently stigmatised by health professionals themselves – something that needs to be addressed through education.

While problems in mental health systems abound, the need for mental health care is staggering. Nearly 1 billion people around the world live with a mental health or a substance use condition. Globally, there are 264 million people with anxiety and 322 million with depression (often comorbidly). For many people, including young people, mental health conditions are life-threatening. Tragically, around 800,000 suicides take place every year – one death every 40 seconds; suicide is the second leading cause of death among young people aged 15-29.

Neurological conditions are another huge and growing source of demand for support. For instance, while in 2017 approximately 50 million people were believed to be living with dementia, projections suggest that by 2030 the number will reach 75 million.

Vulnerable populations (across all resource settings) are particularly prone to mental health conditions. This vulnerability is often defined by socioeconomic determinants like poverty and income inequality, a low standard of education, food insecurity, inappropriate housing, childhood adversity, violence, female gender, and minority ethnicity, amongst others. What is more, research has suggested that there is a complex bi-directional relationship between negative socioeconomic determinants and mental health conditions – with each tending to exacerbate the other. The modern world is also creating new triggers and vulnerabilities for mental health conditions, such as ‘climate anxiety’ and excessive internet use.

Conflict-affected populations have a particularly extreme prevalence of mental conditions – at any given point in time, an average of 22% of conflict-affected populations are affected by depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia. Moreover, as refugee situations are becoming increasingly protracted, different countries have taken different approaches on how much they can and are willing to integrate physical and mental health services for refugees into often resource-constrained national health systems.

The close relationship between mental health and people’s socioeconomic situation means the gap in mental health care provision may be a barrier to achieving the global development ambitions encapsulated in the Sustainable Development Goals. There is a clear link between vulnerability to poverty (including intergenerational transmission of poverty) and poor mental health. SDG target 5.2, the elimination of violence against women and girls, will also be more difficult to achieve without addressing the mental health gap, given the link between such violence and drug and alcohol use. There is also a link between maternal mental health and stunting in children (see p. 23), that relates to SDG target 2.2.

The fact that there is an overwhelming unmet need for mental health care, including in most high-income settings, despite its terrible burden on individuals, families and even
whole populations, should not come as a surprise. Governments around the world spend on average under 2% of their health budgets on mental health – a figure that tends to be larger for higher-income countries, though not always.\textsuperscript{50} In low-income countries, this translates to spending of only $0.20 on average per person per year.\textsuperscript{51} Much if this budget is typically spent on high-cost, low-quality in-patient care rather than community- and rights-based provision.

Similarly, less than 1% of global development assistance for health has been directed towards mental health.\textsuperscript{52} Research from 2016 puts this into perspective: it found that more is spent in coffee shops in the UK in just one week than is spent on mental health development assistance in low- and middle-income countries (LMICs) in a whole year.\textsuperscript{53} This spending has also tended to focus on emergency settings, with relatively little for longer term improvements in mental health systems.

Mental health conditions can cause severe disability, and even death; while good mental health can enable people to live a fulfilling life, as the case study below shows.

**KAMALA: A STORY OF HOPE BEYOND HOPE (NEPAL)**

Kamala has not had an easy life. When she was very young, Kamala was sold to people traffickers by her stepfather and was trafficked for three years. Eventually, when she was 9, Kamala was offered free food and accommodation to work as a cook, as long as she agreed to study at a convent, which she did.

She later went on to work as a tourist guide. One day, she was arrested and imprisoned after police found drugs in the bag she was carrying for a tourist. In prison, Kamala developed serious mental health problems. She became very violent, and ended up being chained. She received no treatment or medication. With nowhere to go and nobody to turn to when she came out of prison, Kamala became homeless. Eventually, however, a rescue centre run by an organisation called Koshish helped her find the right medication and counselling. She now has a stable job.

Kamala said: “After I realised I had a mental illness, I had no hope in my life. I became suicidal. But as of today, because I got timely help and treatment, I have reached a position where I can be a hope for others.”

Unfortunately, millions of people around the world never get the care they need and want. While NGOs and charities are able to help some people, to ensure that this sort of support is sustainably available to everyone who wants it, governments urgently need to integrate mental health in UHC. This would ensure that mental health services are available as an intrinsic part of health systems, and no one falls through the gaps.

Source: adapted from the Museum of Lost and Found Potential, developed by the Speak Your Mind campaign (2019)

Kamala’s story shows that good mental health care and support can transform the lives of the most marginalised people, and have a positive impact on individuals and their communities. Mental health conditions should be considered to be of equal importance to physical conditions, and be treated as such. However, mental health systems have suffered...
from decades of neglect and under-investment, resulting in poor services and coverage. The inclusion of mental health in UHC using an approach that puts people’s human rights at the centre, especially in primary and community care, is critical to reverse this trend. This requires both integrating mental health in existing health systems, as well as expanding UHC coverage to those populations not currently included.

It would enable hundreds of millions of people living with mental health conditions to access quality and rights-based mental health services, perhaps for the first time, free of financial risk. For these people, this could be life-changing: an opportunity to live long, healthy, productive, and fulfilling lives. For the countries in which they live, it could help them accelerate their progress towards sustainable development.

INTEGRATION OF MENTAL HEALTH IN UHC: IMPROVING PHYSICAL HEALTH OUTCOMES

Mental and physical health are intimately connected. Integrating mental health in UHC will not only improve mental health outcomes but also support physical health care. It is a critical component of making UHC a success, and delivering holistic, person-centred care.

There is substantial evidence to suggest that when mental health services are integrated with physical health programmes, the combined physical and mental health treatment contributes to better overall health outcomes – translating directly to more lives saved, and a reduction in the impact of physical illness.
In relation to infectious diseases, integration of mental health interventions has been shown to reduce the incidence of HIV and TB (people living with mental health conditions are 4 times more likely to have HIV, people with depression have a 2.6-fold higher risk of contracting TB); support adherence to treatment; and stop onwards transmission (and, in the context of TB, the proliferation of drug resistance).

Integrating mental health care into UHC could also support the prevention and treatment of non-communicable diseases (NCDs), creating more effective health systems. The overarching link between mental health conditions and chronic physical conditions was confirmed in a study based on the World Mental Health surveys in 2016, which found that “most associations between 16 mental disorders and subsequent onset or diagnosis of 10 chronic physical conditions were statistically significant.”

Research has also shown that:

- “[c]linically diagnosed major depressive disorder was identified as the most important risk factor for developing CVD [cardiovascular disease]”
- depression reduces compliance with treatment, sometimes by as much as a factor of three, in diseases such as cancer, end-stage renal failure and rheumatoid arthritis
- addressing the consumption of alcohol and other substances could also help reduce unhealthy behaviours that contribute to the development of NCDs.

Mehnaz: TB and Mental Health Disorders (Pakistan)

After being married at 16, Mehnaz was subjected to physical abuse by her husband. At 19, Mehnaz was diagnosed with TB. By then, she had moved back in with her father. After nine months of treatment, she was declared cured. However, just 20 days later, she was re-diagnosed with drug-resistant TB. This was the result of her not taking care of herself properly due to her stressful and abusive relationship with her husband. She was also facing challenges from her own family: her father used to side with her abusive husband and would ask her to go back to living with him.

Her relationships made her feel that all men are bad. Mehnaz started to lose interest in people and the things she used to do. She sat in isolation, and would even go hungry, for long periods of time, and did not share her feelings with anyone else.

Mehnaz was then enrolled in a mental health counselling programme.

After only two sessions, Mehnaz’s father saw a notable improvement in her condition. He decided not to force her to go back to her husband unless and until her treatment was completed. This was a big step in Mehnaz’s life. The counsellor also dispelled their misconceptions about TB and helped Mehnaz to get back on her TB treatment. The programme helped Mehnaz become more sociable and begin to do simple tasks around the house. She even picked up a hobby – stitching. Most importantly, her relationship with her family improved.
Mehnaz now works in a garment factory as a quality checker. She is currently staying with her parents and her income helps support them. If not for the counselling, Mehnaz thinks she would never have returned to normal life.

With the right help and support, Mehnaz was able to overcome incredible odds, and be more likely to avoid a recurrence of TB. Governments must act to make sure the same kind of support becomes sustainably available to everyone who needs and wants it. They must integrate mental health in UHC to ensure that it is available as part of any aspect of the health system, including TB programmes.

Source: IRD, Pakistan

It is especially urgent to integrate mental health in primary- and community-level care, as well as within such priority programme areas as HIV, TB, maternal health and NCDs. However, it should be noted that for some people, for example people living with severe mental health conditions, it may be more appropriate to integrate physical health treatments within specialised mental health care.  

Mental health is not supplementary to health; it is integral to health. Using the image of the ‘UHC umbrella’, it is clear that the integration of health services, including mental health, is key to ensuring optimal outcomes for health systems as a whole, as well as to protection from the ‘clouds’ of negative social and environmental factors. At the same time, integration of mental health in UHC would ensure that mental health services are delivered in a way that does not cause financial hardship, and is ideally free at the point of delivery, requiring no out-of-pocket payment from service users.

HOW COVID-19 SHARPENS THE NEED TO INTEGRATE MENTAL HEALTH IN UHC

As the UN Secretary General wrote in his report on mental health and COVID-19,63 endorsed by 95 member states,64 COVID-19 has greatly sharpened the need for investment in mental health. The pandemic has increased mental health needs across the world, and put massive extra strain on health systems. To respond effectively to COVID-19, to create more effective health systems and to build back better after the crisis, it is ever more crucial to integrate mental health care in UHC.

At the time of writing, global COVID-19 continues to cause death and disruption worldwide.65 The pandemic has disproportionately affected the most vulnerable communities. For instance, in the UK, “[t]he mortality rates from COVID-19 in the most deprived areas were more than double the least deprived areas.”66 As a result, many people live in fear of infection,67 especially if they find themselves in situations where they cannot follow health and hygiene guidance as a result of their living conditions (e.g. due to overcrowding, or lack of access to soap and water).68

COVID-19 has also caused a sharp economic downturn. The World Bank has predicted that the number of people who will slide into extreme poverty (i.e. living on less than $1.90 per day) will increase by up to 150 million due to COVID-19 by 2021.69 At the same time, when a broader set of definitions is used (e.g. lack of basic shelter, child nutrition, clean water), the UN predicts that the number of people in poverty will rise by an even more staggering 240-490 million.70

The mental health impacts of this are stark, and already beginning to bite. For example, a study conducted in April 2020 suggested that the number of people in Ethiopia experiencing depressive symptoms tripled versus pre-COVID-19 levels.71 Similar findings have been reported in the US, where in late June 2020 40% of adults reported struggling with mental health or substance use.72 A US study also found that COVID-19 survivors are at increased risk of developing mental health conditions, even when compared with survivors of other acute conditions, such as influenza and other respiratory tract infections.73

The increase in mental health conditions has coincided with a reduction in services. The WHO found that mental health services were disrupted in 93% of the 130 countries that responded to their survey. A third of them reported “complete or partial disruption across at least 75% of specific MNS [mental, neurological and substance use]-related interventions/services”.74 There have also been reports, for example from South Africa, that public-sector pharmacies are running out of psychiatric medication.75

However, the most sobering evidence of the impact of COVID-19 has been the reports of increased deaths as a result of mental health conditions and substance use during the pandemic. For example, in India, by the summer of 2020, there was a 67% increase in the number of media reports of suicide when compared against the same period in 2019.76 In the US, deaths from drug overdoses are estimated to have risen by 13% in the first half of 2020 compared to the first half of 2019 (and in some states, the increase was over 30%).77

It is also important to recognise that COVID-19 has had a particularly severe mental health impact on people with existing vulnerabilities. For instance, an online survey in the UK found that people with pre-existing mental health conditions have been almost twice as likely to feel panic, and three times as likely to have suicidal thoughts compared with the general population.78 At the same time, people with substance-use conditions have seen a
significant reduction in their ability to access potentially life-saving services. The situation of people living with mental health conditions in some LMICs is also particularly difficult.

Women are another vulnerable group. In South Africa, a study of pregnant women in Cape Town during the national lockdown showed that the “risk of CMDs [common mental disorders] was almost three times more likely in women who were severely food insecure or who experienced psychological or sexual abuse”, and that the “strength of the association between key risk factors measured during the lockdown and psychological distress increased during the COVID-19 lockdown”.

Refugees and migrants are particularly at risk too. For example, a recent Scottish Refugee Council online survey found that about a third of the respondents (30% of women and 33% of men) categorised their recent mental health as poor or very poor. Similarly, children, healthcare workers, and many other groups have found themselves in particularly vulnerable situations.

Using the evidence from the SARS and MERS epidemics as an analogue, stress disorders associated with the pandemic in some COVID-19 survivors may persist for years. Economic recovery is also likely take years in some regions, with knock-on effects for people’s mental health. This all makes integrating mental health in UHC increasingly critical, so that all those who need and want mental health care can get it.

At the same time, COVID-19 has put significant strain on health services and disrupted some key health interventions (e.g. immunisation). This has created an urgent need for health systems to optimise their efficiency to catch up. As already discussed, health systems can only operate at optimal efficiency if they include mental health care. Addressing the mental health needs of people experiencing physical health conditions can help accelerate their recovery and reduce the chances of them developing such conditions in the first place – infectious diseases and NCDs are more prevalent and more difficult to treat among people with mental health conditions. Mental health care is also crucial for health workers – both for their wellbeing and their ability to perform their roles and keep the health system functioning.

When health funds are limited and the mental health of whole populations has been compromised by COVID-19, the integration of mental health in UHC is an effective and efficient response.

The comorbid relationship between mental and physical health also applies to COVID-19. Improved mental health correlates both with higher vaccination rates, and with increased compliance to epidemiological risk-avoidance protocols. For instance, a study conducted at the peak of the Ebola outbreak in West Africa in 2015 concluded that “higher scores on measures of PTSD symptoms and depression were associated with higher Ebola Virus Disease (EVD) risk behaviours, and symptoms of PTSD were associated with lower levels of EVD prevention behaviours”.

The same relationship between mental health conditions and higher risk of infection has been found in the context of COVID-19 as well. In the US, for example, analysis of about 60 million patient records found that a recent mental health diagnosis was strongly linked to a higher risk of a COVID-19 infection, even when controlling for age, gender, ethnicity and medical comorbidities. Moreover, when infected, a recent mental health diagnosis was linked to a higher rate of hospitalisation and a greater risk of death. Notably, the same
holds true for people living with substance-use disorders – patients with a diagnosis of such a disorder were more likely to contract COVID-19. The relationship between mental health and the risk of infection is another reason why integrating mental health in UHC, as well as progress on UHC itself, could be a key component of responding more effectively to COVID-19, and helping people become more resilient to subsequent pandemics or global health emergencies.

As health systems recover from the impact of COVID-19, and are adapted and reformed as a result of the crisis, it is critical that mental health is integrated in health systems at all levels – from the promotion of mental wellbeing and the prevention of mental health disorders, to treatment and rehabilitation.

**MOTHERS, CHILDREN AND YOUNG PEOPLE: AT THE HEART OF UHC**

Integrating mental health into the wider health system is critical for supporting mothers'/caregivers', children's and young people's mental health, as well as early childhood development. What we do now can shape the well-being of (at least) three generations: parents, their children, and their grandchildren.

Maternal, child and adolescent health has been a key area of focus for international development in general (e.g. through such mechanisms as the Global Financing Facility). This includes UHC and primary and community care. However, most international- and national-level effort has focused on physical health, without including mental health, despite its crucial importance to mothers/caregivers, children and young people.

Globally, 10-20% of children and adolescents experience mental health disorders, which can often have a protracted impact, affecting them throughout their lives. For vulnerable populations, this percentage can be much higher: 50-90% of children and adolescents living in conflict zones suffer from PTSD. Moreover, just as childhood and adolescence are crucial developmental stages, they are also the time when many mental health conditions start to be exhibited. Half of all mental health conditions start by the age of 14, and three-quarters by mid-20s.

As a result, mental health and substance-use conditions are responsible for 27% of the years lost due to disability in people aged 10-24 years around the world, and have been estimated to cause a 20% reduction in annual income later in life. Tragically, suicide is the second leading cause of death among 15-29 year olds worldwide.

The mental health of parents/caregivers can have an impact on both the physical and mental development of their children. Between 15-23% of children live with a parent with a mental health condition. Indeed, “[m]ental health problems among women who are pregnant or have recently given birth are among the most common causes of pregnancy-related morbidity”. This is especially true in lower-income countries, where the prevalence of both antepartum and postpartum depression can be approximately double what it is in high-income countries.

Research has analysed the impact of parent's/caregiver's mental health on the cognitive and emotional development of their children. For example, using the Avon Longitudinal Study of Parents and Children in the UK, postnatal depression in both mothers and fathers has been
separately associated with a raised risk of “behaviour disturbance” and “adverse emotional and behavioural outcomes” for children at 3.5 years of age. Moreover, in severe cases, difficult family or external circumstances can lead to toxic stress that can have “enduring effects on brain development and other organ systems”.

Parent’s/caregiver’s mental health conditions can also be starkly reflected in their children’s physical development. For instance, a Pakistani study found that children of mothers with prenatal depression had a relative risk of 2.4 of having an above-average number of diarrhoeal episodes per year. Maternal depression can also mean children have higher rates of respiratory disease, increased hospital admissions, and a lower likelihood of completing vaccination schedules. Finally, children of mothers with a common mental disorder were found to be three times more likely to be stunted.

The COVID-19 pandemic has exacerbated these challenges. Firstly, it has caused increased anxiety and uncertainty about the future for children. Lockdown has exposed more children to either experiencing or witnessing domestic abuse. At the same time, two-thirds of the 136 countries that responded to a UNICEF survey reported a disruption to services relating to violence against children (such as case management services, household visits to children and women at risk of abuse, and violence prevention programmes).

The pandemic has also exacerbated the rates of adult / parental anxiety and other mental health conditions, including for pregnant women. For example, it has been noted that the limitations placed on obstetric care by infection controls (e.g. quarantine and healthcare professionals wearing personal protective equipment) “may increase risk for birth-related posttraumatic stress disorder, especially for women with pre-existing trauma”.

Moreover, just as parents/caregivers are affected by the economic consequences of COVID-19, so are their children. According to the IMF and the UN, about half of all the people who will fall into extreme poverty as a result of COVID-19 (living on under $1.90 per day) are likely to be children. This is part of the acute stress caused by COVID-19, which for some children can “impair their cognitive development and trigger longer-term mental health challenges”. These negative impacts may stay with this generation of children for the rest of their life.

COVID-19 has also intensified already existing challenges in education. As the World Bank has reported, at the peak of the lockdown, 1.6 billion children were out of school; and conservative estimates suggest 7 million students may drop out of primary and secondary education altogether. Girls are more at risk of dropping than boys, leading to a growing risk of adolescent pregnancy, and with it a significantly higher risk of maternal mental health conditions (for instance, “pregnant adolescents are 2-9 times more likely to develop perinatal depression”). This not only impacts the health of the mother, but is a risk factor for worse physical, social, behavioural and cognitive outcomes for the child.

Finally, there is evidence that COVID-19 has increased suicidal ideation among young people. For example, a US study has suggested that nearly 25% of young adults (aged 18-24 years) contemplated suicide due to the pandemic. In lower-income settings, a similar picture emerges. For example, UNICEF reports that “[i]n Nepal, police reported a 40 per cent increase in suicides among girls, while a child helpline in Bangladesh intervened in six cases of potential suicide in a single week”.

"No Health without Mental Health": the Urgent Need for Mental Health Integration in Universal Health Coverage
Where maternal/caregiver, child and adolescent health and development is concerned, therefore, it is critical to integrate mental health in UHC. This integration is particularly urgent at primary and community healthcare level (including perinatal care, and in programmes such as parent coaching). This is where most of the contact between these groups and the health system already takes place, and where most of the UHC effort and reforms are already focused. It would help address their mental health conditions directly, and improve their physical health, for example, reducing stunting and increasing vaccination uptake. Integrating mental health in health systems could, in fact, revolutionise the delivery of care for mothers and children, and communities as a whole. This, in turn, would improve the world’s chances of successfully reaching the relevant SDG targets.

AYISHA: “THIS MATERNAL SADNESS IS TERRIBLE” (GHANA)

When she was pregnant with her first child, Ayisha experienced perinatal depression.

Her husband recalls: “I was scared. During her pregnancy, occasionally she could be so quiet and refuse to speak to anyone, but I used to think it was the pregnancy weighing on her. It was so serious after she delivered and that made me realise it was not a simple matter.”

Luckily, due to a timely screening during her last trimester, Ayisha was monitored through to her delivery and for several months afterwards. She received counselling, which (among other things) encouraged her to ensure that her child was immunised against childhood killer diseases. With the support of the community health and psychiatric nurses, who visited her regularly, she was also able to provide her baby with exclusive breastfeeding.

Ayisha has talked about her experience: “This maternal sadness is terrible. It was terrible for me. It looked like the world was no longer worth being in it. I thank God that my baby was not harmed. I didn't have the energy to attend to her as I needed to.” Ayisha wishes all women could have the same support she had.

Ayisha was one of the fortunate few. NGO BasicNeeds-Ghana and its partners were there to give her the support she needed. Through the Maternal Mental Health Project, funded by the UK’s Foreign, Commonwealth and Development Office (FCDO), BasicNeeds-Ghana and its partners have been able to train more than 1,000 midwives and community health nurses, and 250 community mental health staff.

While this is a step in the right direction, for a country the size of Ghana the job is far from done. BasicNeeds-Ghana said: “We are proud of the progress we have been able to make, with the support of the FCDO. However, for these services to become available to everyone who wants to get them, it is clear that increased government action and investment is required. Governments around the world – including Ghana – should integrate mental health in UHC, to ensure that everyone can have someone to turn to for their mental health needs.”

Source: BasicNeeds-Ghana
CONCLUSION

We have a long way to go on mental health: “When it comes to mental health, all countries are developing countries.” To date, the huge and growing need for quality and rights-based mental health care has gone largely unaddressed and unfunded – including for such key groups as mothers/caregivers and children. This has huge implications: mental health conditions are a critical source of death and disability in their own right, but they also often have a negative impact on physical health. The COVID-19 pandemic has only made the situation worse.

It is of paramount importance for the health – both mental and physical – of entire populations to ensure that mental health is rapidly integrated into health systems, including their promotion and prevention components. This involves providing sufficient and sustainable funding for mental health, and including it as part of the ‘build back better’ response to COVID-19.

While the integration of mental health is important for the entire healthcare system, it is especially crucial at primary and community health levels. This is where most of the contact between populations and the health system takes place, and has always been the cornerstone of UHC. This move could revolutionise mental health care delivery for entire populations, saving countless lives and significantly reducing ill health.

THIS IS OUR MESSAGE FOR ALL POLITICAL LEADERS: THE TIME TO ACT IS NOW.

One of IRD’s counselors is providing phone based counseling to her patients. Photo Credit: Shehzad Noorani
ARGUMENT 2
Mental health spending is an investment, not a cost
A psychiatrist outreach clinic in the Upper West Region of Ghana, facilitated by BasicNeeds-Ghana in collaboration with the Ghana Health Service. An outreach clinic provides mental health screening and diagnosis, treatment and referral in the community. It is a way of taking mental health treatment closer to the community and the service users.
It is widely recognised that health is a good investment. Indeed, this is the basis for the World Bank’s Human Capital Project, which argues that investment in people – including in their health – is a key component of building an increasingly prosperous and sustainable society. Investment in people pays off, “ensuring that people accumulate the health, knowledge and skills needed to realize their full potential and that they can put those skills to use across the economy”. In other words, spending on health should be seen precisely as an investment, an opportunity to increase national well-being and prosperity; and not as a cost.

Traditionally, this argument has been made about physical health. However, it is incomplete if it does not include mental health. Without integrating mental health in UHC, we will be failing to unlock the full productivity and economic potential of people living with mental health conditions and their carers. Moreover, as already discussed, integrating mental health in UHC is a simple and effective way of improving the efficiency of the health system as a whole. Indeed, mental health is so fundamental to sustainable development, that it can be argued that it should be added as a component of the Human Capital Index.

Given the difficult economic situation faced by most countries as a result of the COVID-19 pandemic, there is a risk that spending on mental health (and perhaps on health in general, outside of direct COVID-19 expenditure) will be deprioritised or even cut. However, this would be a false economy: investment in mental health (and health overall) must remain a top priority for policymakers, if they wish to promote long-term economic recovery and growth.

**HIGH COST-EFFECTIVENESS OF MENTAL HEALTH INTERVENTIONS**

Mental health interventions can be delivered in a highly cost-effective way; and, indeed, increasingly so as a result of COVID-19-driven innovation. This is another strong argument for integrating mental health in UHC at scale.

Mental health interventions can cost as little as 100 $Int per year of healthy life to deliver. This level of cost-effectiveness is in line with that of interventions in other areas of health, e.g. HIV and NCDs. This means that mental health can be integrated into health systems in a highly efficient way. This is especially true of primary and community care, as compared with less efficient institutional care.

Moreover, the COVID-19 pandemic has contributed to an acceleration in innovative and efficient methods of delivering mental health care. It has intensified the challenges that health systems and individual providers face (e.g. not being able to give patients direct access to health professionals), and forced the mental health community come up with ways to overcome these difficulties – at pace. When it comes to mental health, this has created an “opportunity to build on what we know and advance progress in achieving the mental health objectives of universal health coverage”, both from an access and a cost perspective.
INNOVATION AND ADAPTATION: CONTINUING TO SERVE DURING THE PANDEMIC

Cape Mental Health, a South African non-profit organisation that provides day-care to adults and children with severe and profound learning disabilities, was able to move its in-person clubhouse-model services to a remote model within just 2-3 weeks. It adapted its programme to duplicate the “structured day that was usually delivered in the facility so that the carer and the parent could do it at home” (for instance, doing a song at the start). Staff providing remote support and guidance, and activities were adapted to suit a home setting, e.g. using fruit and vegetables to practice counting.134

ThriveGULU in Uganda used radio shows to disseminate accurate information on mental health issues. Furthermore, to ensure that mental health and psychosocial support messaging reached even the most disadvantaged service users, who may not have owned radios, ThriveGULU set up a van that was mounted with loudspeakers, and that played pre-recorded messages. This van was then driven around the villages.135

St. Patrick’s Mental Health, a provider of inpatient and outpatient mental health services to approximately 10% of the Irish population, was able to move 100% of its outpatient services online within just two and a half weeks. Remote care was also extended to some inpatients, as about 80 out of their 300 inpatients were set up with a home-care service. This new model of care has been so effective that St. Patrick’s plans to continue this scheme in the future, beyond COVID-19, offering a model of rapid de-institutionalisation that could inform approaches elsewhere.136

INTEGRATING MENTAL HEALTH IS A GOOD ECONOMIC INVESTMENT

The economic impact of poor mental health is too large to be ignored. Mental health care urgently needs to be scaled up and integrated into health systems to offset this impact and accelerate sustainable growth, especially in the context of COVID-19. Mental health can help improve productivity and ‘de-risk’ investments in other areas of health care (e.g. HIV, TB, maternal and child health).

Across 36 countries (representing 80% of the world's population), a staggering 12 billion productive days are lost each year due to depression and anxiety alone.137 Up to 20% of the world's working population is estimated to have a mental health condition at any given time.138 One study estimated that poor mental health cost the global economy $2.5 trillion in 2010 in reduced economic productivity and direct cost of care. This cost is projected to rise to $6 trillion by 2030.139 While this is disastrous on global and national levels, it also translates directly to impoverishment for individuals and families, sometimes across generations,140 as mental health conditions limit people's opportunity to work and earn an income.

The scale-up and integration of mental health into health systems is urgently needed to offset this economic loss. Extensive research has found that investing in mental health interventions for common mental health conditions, such as anxiety and depression, could deliver a return on investment of 3:1 in direct economic benefits, and 5:1 if the ‘value of health’ is included as well. These findings are compatible with, indeed rely on, the integration of mental health in UHC. For instance, the modelling assumed that all cases would be seen as part of outpatient and primary care, largely in ‘non-specialist health care settings by doctors, nurses and psychosocial care providers trained in the identification,
assessment, and management of depression and anxiety disorders”, in line with the WHO’s Mental Health Gap Action Programme (mhGAP) (see p. 51).

The same positive economic relationship holds true for more severe mental illness as well. For example, in the UK, a study on the integration of suicide prevention in primary care (based on awareness training of GPs, and subsequent referral for more specialist treatment) found that economic gains through directly avoided productivity losses (to say nothing of the saved lives themselves) were 20 times higher than the cost of the intervention.

Given the frequent comorbidities between mental and physical health, it is also likely that investment in mental health could ‘de-risk’ (and perhaps even magnify) the delivery of economic gains from other health programmes, e.g. in infectious diseases (such as TB and HIV), or in maternal and child health. When combined with mental health, the spending on other areas of health (and on UHC as a whole) will be in a position to deliver its full economic potential.

For instance, in a submission to the Global Fund to Fight AIDS, TB and Malaria's 2022-2027 strategy consultation, it has recently been argued that: “Integrating mental and substance use disorder treatment into HIV and TB platforms may synergistically increase [the economic] gains [from investment into HIV and TB health care] by reducing community transmission and drug resistance, as well as social and economic costs to individuals and households affected by these multimorbidities.” Fully integrating mental health into the Global Fund's 2022-2027 strategy could, therefore, substantially contribute to economic growth, as well as reduce HIV and TB transmission rates.

Moreover, integrating and mainstreaming mental health in UHC can also support the integration of mental health into the broader national development agenda, creating opportunities for intersectoral collaboration (e.g. with the education sector, or social services / violence prevention). For instance, a longitudinal study of stunted children in Jamaica showed that children who received even simple psychosocial stimulation (home visits promoting caregiver-infant play and verbal interaction) were three times more likely to have some college-level education, and earned 25% more than the control group of stunted children who did not have the home visits (and had earnings in line with the non-stunted comparison group).

Given the higher prevalence of mental health conditions during COVID-19, the return on investment of scaling-up mental health care is likely to be even larger than prior to the pandemic – both directly and through its effect on comorbidities. At the same time, in a situation where the global Human Development Index (a measure of progress in key dimensions of human activity, such as health and education) is projected to fall for the first time since its introduction in 1990, investment in mental health is a lever that countries around the world can scarcely afford to ignore.

**INTEGRATING MENTAL HEALTH INCREASES THE EFFICIENCY OF HEALTHCARE SYSTEMS**

Increasing investment in mental health, and integrating mental health in health systems, can be relatively low-hanging fruit in creating the conditions for the more efficient use of precious healthcare resources, both in terms of effective prevention, and cost-efficient delivery of care. Crucially, the more effective use of health resources in the context of UHC will translate into improved rates of coverage and financial protection.
As well as supporting economic growth in general, mental health integration can also promote more effective spending within health systems in particular. This is especially the case if spending on mental health is focused on de-institutionalisation in favour of mental health prevention and promotion activities in community settings.

Mental health conditions have been linked to a higher risk of developing physical health conditions, and therefore with potentially higher direct healthcare spending to treat those conditions. This is true across a large range of disease types (see Argument 1, p. 17 - 19). It follows that addressing mental health conditions can reduce the prevalence of physical conditions, and therefore the number of people who need to be treated for them, at a cost to the healthcare system. For example, screening and intervention for alcohol misuse as part of primary care in the UK has been shown to save more than twice as much money for the healthcare system as the intervention itself cost.\textsuperscript{147}

Moreover, addressing mental health conditions alongside physical health conditions can lead to a disproportionate reduction in the overall cost of care. A Canadian population-based study of nearly 1 million adults compared the healthcare costs of people living with and without mental health conditions. It found that: “3-year adjusted mean costs were $38,250 for those with a mental health disorder and $22,280 for those without a mental health disorder”; and that mental health conditions were “associated with higher rates of hospitalization and emergency department visits.”\textsuperscript{148} A number of studies have make a direct link between a mental health intervention and healthcare resource utilisation, finding that, in the case of diabetes, “effective depression treatment is associated with decreases in many types of health care costs”.\textsuperscript{149}

As well as saving money for the healthcare system, mental health interventions are highly cost-effective where other areas of public spending are concerned, such as for social services, education and the criminal justice system. For instance, school-based Social and Emotional Learning Programmes, evaluated in the UK, were found to successfully address the needs of particularly vulnerable children and deliver significant savings, mostly through reduction in crime.\textsuperscript{150}

The efficient use of resources, “doing more with the same”, is crucial in the context of UHC,\textsuperscript{151} as more effective use of health (and other public) resources may translate into improved rates of coverage and financial protection. Integrating mental health is relatively low-hanging fruit in achieving this goal. Given the added pressure on health systems and public finances due to COVID-19, integrating mental health in health systems must be a priority, to help ensure that available health resources are spent in a maximally effective way.

**GOOD MENTAL HEALTH AS A CORE COMPONENT OF HUMAN CAPITAL**

Human capital is “the knowledge, skills, and health that people accumulate over their lives, enabling them to realize their potential as productive members of society.”\textsuperscript{152} Progress in increasing human capital is tracked through the Human Capital Index, “an international metric that benchmarks key components of human capital across countries”. The Human Capital Index, which is at the core of the World Bank’s Human Capital Programme, has a number of components:\textsuperscript{153}

- Survival from birth to school age, measured using under-five mortality rates
- Expected years of quality-adjusted schooling
- Adult survival rates, defined as the fraction of 15-year-olds who survive until age 60
- The rate of stunting for children under five
Given the pivotal role that mental health plays in enabling people to live healthy lives and engage in work and education, it should be seen as a fundamental pillar of human capital. Indeed, it can be argued that it should be explicitly added as a fifth component of the Human Capital Index, or at least be explicitly addressed as a key enabler to the successful attainment of its four existing components (see the table below).

<table>
<thead>
<tr>
<th>HUMAN CAPITAL INDEX COMPONENT</th>
<th>EXAMPLE MENTAL HEALTH IMPACT ON COMPONENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-five mortality rate</td>
<td>Maternal (and caregiver) mental health can have an impact on the physical health of children, e.g. children of prenatally depressed mothers in Pakistan were found to have a relative risk of having a higher than average number of diarrhoeal episodes per year of 2.4; and children of depressed mothers are also at risk of higher rates of respiratory disease, hospital admission and reduced vaccination completion</td>
</tr>
<tr>
<td>Expected years of quality-adjusted schooling</td>
<td>Poor maternal (and caregiver) mental health can have an impact on the cognitive development of their children, as well as lead to a higher risk of emotional difficulties like ADHD and conduct disorder</td>
</tr>
<tr>
<td>% of 15-year-olds who survive until age 60</td>
<td>Mental health conditions are linked to worse physical health outcomes, across both infectious and non-communicable diseases. In addition, consumption of drugs and alcohol increases the risk of physical ill health</td>
</tr>
<tr>
<td>The rate of stunting for children under five</td>
<td>The mental health of mothers and caregivers can have an impact on whether their children are stunted. For example, children of mothers with a common mental disorder were found to be three times more likely to be stunted</td>
</tr>
</tbody>
</table>

**CONCLUSION**

Resources spent on mental health should not be seen as a cost. They are truly ‘human capital’ investments that can generate a direct return for the economy and for human development. They can improve the effectiveness of other health system spending, and help uphold the rights of everyone to good mental health. Moreover, many mental health interventions are already highly cost-efficient.

There is a strong economic case for investment in mental health. The time to invest is now.
ARGUMENT 3
Mental health, UHC and human rights
There are two mechanisms through which the integrating mental health in UHC is inextricably linked to human rights.

Firstly, in the context of UHC, the provision of quality, rights-based mental health care (to people who choose to access it) is a critical part of ensuring that their right to health care as a whole is met.

Secondly, integration of mental health in UHC creates a potential means for the protection of the rights of people with mental health conditions through reducing the opportunity for abuses of their human rights.\textsuperscript{155}

**UHC, MENTAL HEALTH AND THE RIGHT TO HEALTH**

Access to quality, affordable healthcare – including mental health care – is a right, not a privilege. Mental health must be integrated in UHC, if UHC is to achieve its goal of giving everyone the right to health.

The concept of UHC, based as it is in the WHO Constitutions of 1948, is fundamentally rooted in human rights and equity: access to affordable health is a fundamental human right, not a privilege.\textsuperscript{156} At the same time, mental health is an inalienable part of the right to health. For instance, the International Covenant on Economic, Social and Cultural Rights (article 12.1) affirmed “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”.\textsuperscript{157}

UHC cannot fully meet its goal of promoting the right to health without the inclusion of mental health. In other words, if mental health is not integrated into UHC, national health systems will invariably discriminate against people living with mental health conditions. This was clearly recognised in the 2019 Political Declaration of the High-level Meeting on Universal Health Coverage, which explicitly confirmed the link between mental health and the right to health in the context of UHC. In that document, UN member states reaffirmed “the right of every human being, without distinction of any kind, to the enjoyment of the highest attainable standard of physical and mental health.”\textsuperscript{158}

At present, the right to mental health care is not being upheld. The clearest indications of this come from comparing the average mortality rates of people living with severe mental conditions and those without. For instance, people living with major depression and schizophrenia “have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended … and suicide”.\textsuperscript{159} Overall, people living with severe mental health conditions may die up to 20 years earlier than people without these conditions.\textsuperscript{160}

To meet this right and ensure the required level of coverage, therefore, it will be critical to include quality, rights-based mental health care within UHC service packages to ensure that services are available to those who need them and who want to access them. However, this is not just an issue of high-quality service coverage. It is also about creating an environment in which the risks of developing a mental health condition are minimised. Integrating mental health in UHC can be the first step towards establishing a cross-sectoral collaboration to address the socioeconomic determinants of mental health (see Argument 1, p. 15).

Furthermore, it is an issue of financial access, a key consideration for UHC. According to Human Rights Watch: “More than two-thirds of countries do not cover reimbursement for
mental health services in national health insurance schemes.” This forces people in need to spend large sums of money out-of-pocket. In Goa, for example, 15% of women with depression were found to spend more than 10% of their monthly household income on health – defined as ‘catastrophic health expenditure’. In Ethiopia, a study from 2017 identified poverty as the number one barrier to engagement with mental health care. To ensure that the right to health is met, UHC needs to provide quality, rights-based services while protecting service users from financial hardship, ideally through services that are free at the point of delivery, requiring no out-of-pocket payments from patients.

Once again, COVID-19 adds further urgency to these considerations. As well as interrupting the provision of mental health services, while increasing the need for them, the pandemic has triggered an economic downturn that will make it harder for people to pay for mental health care, and more likely to need it.

THE RIGHTS OF PEOPLE WITH MENTAL HEALTH CONDITIONS

As well as being critical to delivery of the holistic ‘right to health’, integrating mental health in UHC may also contribute to reducing the human rights abuses of people living with mental health conditions.

As The Lancet Commission on Global Mental Health and Sustainable Development emphasised, people living with mental health conditions can be among the most vulnerable in society. They can often endure extreme forms of human rights violations, such as chaining, which is commonly practiced. Even in their families and local communities, many people living with mental health conditions experience the complex and multifaceted burden of social rejection and abuse.

In addition, within many mental health systems, people can suffer abuses, such as incarceration, coercion and over-medicalisation. According to the WHO, adults with psychosocial and intellectual disabilities who live in institutions are “a highly marginalized, vulnerable group whose quality of life, human rights and reintegration in society are compromised by outdated, often inhumane institutional practices”. Unfortunately, it is typical for the lion's share of the already meagre national mental health budgets to be spent on this ineffective and inhumane form of care. For instance, in low- and middle-income countries, 80% of mental health budgets are spent on mental hospitals.

Both within institutions and communities, COVID-19 has further exacerbated the vulnerabilities of people living with mental health conditions. Mental health institutions are often not designed for infection control and can be overcrowded, putting the people in them at particular risk of infection. Validity International has collected evidence of rights abuses of people with disabilities during COVID-19 in multiple countries. These include poor care in institutions, lack of access to food, and discrimination in accessing basic, specialist and emergency health care.

In a similar vein, Human Rights Watch has recently reported that chaining has continued during the COVID-19 pandemic, significantly reducing the ability of those chained to protect themselves from infection. Finally, on an even more basic level, there have been reports that people living with mental health conditions, often deeply marginalised within their communities, have struggled to obtain food and other basic items during lockdowns.
A transition to high-quality, sufficiently funded, evidence-based, rights-based, community-based and universally accessible mental health care integrated into UHC would confer a number of benefits. For instance, as primary and community care are the focus of UHC, integrating mental health into UHC could catalyse the ‘de-institutionalisation’ of mental health. It would move mental health care away from the often ineffective, inhumane and costly tertiary institutions to services centred on the more effective and less costly primary and community mental health provision.\textsuperscript{174} Leveraging UHC to transition to this blueprint of service delivery will also be important to ensure that any further funding that is allocated to mental health is appropriately distributed, based on the de-centralised model of care.

Moreover, in conjunction with initiatives such as aligning national mental health legislation to international human rights covenants and running community outreach and education programmes, integration of mental health in UHC could reduce the opportunity for rights abuses. For example, it could replace chaining with high-quality evidence-based care, and help abolish so-called conversion therapy – a discredited and abusive practice of trying to change someone’s sexual orientation.\textsuperscript{175} It could also improve people’s perception of mental health conditions, for example by promoting the understanding that they are preventable, manageable and treatable.

The integration of mental health in UHC, if implemented according to a rights-based approach, would be a key stepping-stone towards realising the rights of people living with mental health conditions, in accordance with the Convention on the Rights of Persons with Disabilities (CRPD), including the right to health, the right to freedom from torture, the right to liberty and security of the person, and others rights.

To ensure that the integration of mental health in UHC can achieve these outcomes, it will be important to leverage such initiatives as the WHO’s Quality Rights Programme,\textsuperscript{176} the formal monitoring and accountability mechanisms of the CRPD,\textsuperscript{177} the efforts of NGOs like Human Rights Watch, the WHO Mental Health Atlas initiative,\textsuperscript{178} as well as any future outputs from the Countdown Global Mental Health 2030 project, “an independent, multistakeholder monitoring and accountability collaboration for mental health”.\textsuperscript{179}
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ENOCK MALOYA PHIRI: “I CAN FEEL FREE” (MALAWI)

“From time to time I would have an attack. Fear would just strike me, and I would take off running very fast. At that time, everyone was afraid of me. People would mock me shouting, ‘Crazy man! Crazy man!’ People would beat me. Some threw rocks at me. Others tied me up, saying I should be killed.”

Enock Maloya was 19 years old and thriving in 2013. Trained as a tailor by a development programme, he was married and had a good job in the city, working for a former cabinet minister. Then “some things started happening”. He lost his job, separated from his wife, and fled back to his home village.

“I never knew that a mentally ill person could get well. Because I have seen my friends who didn’t go to the hospital and sought help from traditional healers instead. Even now, they are still disturbed. Their illness hasn’t left them. But after I ran to the hospital, I got well. I feel fine and healthy and energetic in a good way. I take my medicine at the proper time, and yeah, that’s the way.”

Since his uncle convinced him to go to the hospital, Enock has been taking his medications and has benefited from regular visits from clinicians and community health workers. He has reunited with his wife and children and resumed his career as a tailor.

“People are nice to me now. They bring their clothes for me to sew sometimes. Kids can get close to me now. In the past, they would shout, ‘Enock is coming!’ and all the kids would hide indoors. Now, my relationship with the community is great. Now, they call, ‘Mr. Phiri, Mr. Phiri.’ Yeah, I am a happy person. I can feel free, yeah.”


CONCLUSION

In the words of recent commentators, it is a “moral outrage” and an “insult to our basic humanity” that most people living with mental health conditions are denied access to quality care and support. It is no less an outrage that the rights of people living with mental health conditions are ubiquitously abused. The mortality gap between people living with severe mental health conditions and people without mental health conditions is a “scandal ... that contravenes international conventions for the ‘right to health’”. This has never been in sharper relief than during the COVID-19 pandemic, where people living with disabilities have frequently been denied access to treatment and endured further erosion in their rights.

Urgent investment in mental health and the integration of mental health in health systems are sorely needed to reverse this injustice; and to ensure that UHC can live up to its promise of the right to health for all.

THE TIME TO ACT IS NOW, OR RISK FAILING THE VERY CONCEPT OF UHC AND LEAVING MANY MILLIONS EVEN FURTHER BEHIND.
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“No Health without Mental Health”: the Urgent Need for Mental Health Integration in Universal Health Coverage


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174 See, for example, Saxena, S., Thornicroft, G., Knapp, M., Whiteford, H. (2007), “Resources for mental health: scarcity, inequity, and inefficiency”, The Lancet. However, de-institutionalisation should happen only once alternative, functional community-based provision is in place. Note the Life Esidimeni tragedy, where the transfer of ~1,700 psychiatric patients out of an institution, but without proper community-based provision in its place, caused the deaths of at least 144 patients in South Africa

175 For more information, see Outright Action International (2020), Harmful Treatment: the global reach of so-called conversion therapy (New York: Outright Action International)

176 WHO, “WHO QualityRights initiative – improving quality, promoting human rights” webpage (accessed 05/10/2020); see also Part II below

177 See, for instance, OHCHR (2010), Monitoring the Convention on the Rights of Persons with Disabilities: guidance for human rights monitors, professional training series No. 17 (New York: UN)


PART II

How can the integration of mental health into UHC be achieved?
From intention to implementation: making scaled-up, integrated mental health care a reality

“Addressing mental health is central to achieving universal health coverage. It deserves our commitment”

Antonio Guterres, UN Secretary General, 10 Oct 2020
Given the many advantages of integrating mental health in UHC, as already outlined, it is clear that countries need to move from intention to implementation as quickly as possible. Returning to the analogy of the ‘UHC cube’, governments across all resource settings need to take steps to ensure that:

- mental health conditions are sufficiently and appropriately included within national UHC service packages
- high-quality rights-based services are accessible to everybody who needs and wants care
- they are provided in such a way that does not cause service users financial hardship.

This task will require a concerted effort and investment from service users, policymakers, funders, the expert and medical communities, civil society, lived experience advocates, and others. A number of challenges will need to be overcome, for example:

- a lack of mental health laws and policies aligned with human rights instruments
- stigma and exclusion, including stigma within the health system towards people living with mental health conditions
- an over-reliance on institutions and tertiary care centres, often providing poor-quality and not rights-based services
- a lack of trained staff to deliver the services, and a sub-optimally deployed workforce with poor retention rates
- a frequent lack of mental health data to support policy and funding decisions, especially in lower- and lower-middle-income countries
- an often challenging fiscal environment.

However, the good news is that we can benefit from many years of relevant programmatic, technical and operational work by the WHO, the World Bank, the voluntary and academic sectors, and many other organisations and individuals across different resource settings. We can also learn from countries and communities that have already sought to scale-up mental health services as a part of UHC, and how they were able to overcome the challenges described.

Moreover, the global movement for mental health has generated significant momentum in recent years, and the trend has continued during COVID-19. There is growing interest among the general public in mental health – Google searches on the issue of ‘mental health’ have been increasing by about 10% per year over the past three years. Similarly, there was unprecedented public engagement with World Mental Health Day in October 2020: the official World Mental Health Day campaign hashtag (#MoveForMentalHealth) generated ~19,000 social media posts and had a reach of over 94 million, within the space of just 36 hours. In addition, ‘Mental Health for All’ has been an official Gates Foundation Accelerator since 2019. This momentum should be used as a springboard to advance the integration of mental health in UHC and the strengthening of health systems.

To support this aim, this section will:

- bring together key programmatic documents on the scale-up and integration of mental health in UHC
- suggest what an approach to integrating mental health in UHC could look like across different resource settings
- estimate how much such a scale-up and integration could cost
- give examples of health systems that have taken successful steps on this journey.
It is, unfortunately, outside of the scope of this section to discuss approaches to the implementation of UHC itself. To find out more about this, please refer to resources such as the WHO *World Health Report 2010* on health systems financing, the WHO handbook *Strategizing national health in the 21st century*, the World Bank *High-Performing Health Financing Universal Health Coverage* report from 2019, the 2018 World Bank report *Delivering Quality Health Services: A Global Imperative for Universal Health Coverage*, and the 2016 World Bank publication *UHC in Africa: A Framework for Action*, among many others. A number of key publications also track UHC’s overall progress, including by the WHO and the World Bank, and recent publication by UHC2030.

**KEY PROGRAMMATIC DOCUMENTS ON SCALING-UP AND INTEGRATING MENTAL HEALTH IN UHC**

Significant work has been done in recent years by the WHO, the World Bank, and other organisations and individuals on how to integrate mental health in health systems. We are in a position now to leverage this knowledge to take rapid action.

The key global framework for the scale-up of mental health within the context of UHC is the WHO’s *Mental Health Action Plan 2013-2020*. This document, created in consultation with and ratified by member states, sets high-level global goals and suggests concrete activities to achieve them. Originally ratified for the period of 2013-2020, the Action Plan is being extended until 2030 (with updates being made to Appendices 1 and 2) – a reflection of the critical importance and continuing relevance of this document.

The Action Plan incorporates UHC as a cross-cutting principle, and focuses on four key objectives, which include setting up “comprehensive, integrated and responsive mental health and social care services in community-based settings”, as well as the implementation of “strategies for promotion and prevention in mental health”.

Achieving these objectives relies on building genuine political commitment for mental health integration in UHC, and mobilising domestic and international catalytic donor financing.

A powerful visual representation of the Action Plan’s objectives is the WHO’s service mix pyramid. In the pyramid – which illustrates the optimal mix of services for mental health care delivery – self-care, informal community care and primary care services predominate, with fewer services delivered in hospitals and specialist facilities. This approach is closely aligned with the focus of UHC on community-based health services and primary care, as exemplified by the ‘UHC umbrella’ (see Argument 1, p. 19).
In addition to the Action Plan, the WHO provides a number of other key documents to support specific aspects of scaling-up mental health provision (see the table below).

<table>
<thead>
<tr>
<th>DOCUMENT NAME</th>
<th>DOCUMENT DESCRIPTION</th>
</tr>
</thead>
</table>
| The Mental Health Gap Action Programme (mhGAP)          | • A technical set of documents (including operations and training manuals, implementation guides, and other resources) to support the scale-up of mental health provision, especially in low- and middle-resource settings.  
  • mhGAP can be used as a “capacity building tool for a range of health professionals and para professionals” in mental health, given the critical shortages of a qualified mental health workforce around the world |
| Draft menu of cost-effective interventions for mental health | • A working document, based on the WHO-CHOICE methodology, assessing the indicative value for money of a range of key interventions.  
  • Currently in draft form, for inclusion in the updated WHO Mental Health Action Plan 2013-2020-2030 in 2021 |
| QualityRights                                           | • A toolkit based on the CRPD to help improve adherence to human rights in mental health and social care facilities.  
  • The toolkit provides guidance on the rights and quality standards that need to be in place in mental health and social care institutions, how to assess these, and how to act on the basis of the assessment (including to help improve accountability to service users) |
A key programme that will generate substantial relevant learning, and one that deserves special mention, is the WHO’s catalytic Special Initiative for Mental Health (2019-2023), launched in 2019. This initiative aims to provide $60 million of catalytic funding and technical support across 12 selected countries over five years, to scale up the integration of mental health in UHC and extend quality interventions and services to 100 million additional people. This initiative is designed to “enable WHO to support governments to lead substantial scale up of care for mental health conditions”, catalysing local resources and support for mental health.

The World Bank has also produced a number of programmatic documents on the need for and the approaches to scaling up and integrating mental health within health systems (see the table below).

<table>
<thead>
<tr>
<th>DOCUMENT NAME</th>
<th>DOCUMENT DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of the Shadows: Making Mental Health a Global Development Priority</td>
<td>A 2016 report that made the case for making mental health a global development priority, and suggested a number of ways to integrate mental health care in existing platforms, as well as potential mechanisms to fund this</td>
</tr>
<tr>
<td>Moving the Needle: Mental Health Stories from Around the World</td>
<td>A 2018 report that collated a list of technical assessments and operational guidelines for integrating mental health in community-based healthcare, and provided a deep-dive on how mental health scale-up could be financed</td>
</tr>
<tr>
<td>Harnessing Technology to Address the Global Mental Health Crisis: An Introductory Brief</td>
<td>A 2019 study that outlined how technology can “garner new insights, build efficiencies, and scale support in responding to the mental health challenges unfolding in a wide array of communities and contexts”</td>
</tr>
<tr>
<td>Healing Minds, Changing Lives: A Movement for Community-based Mental Health Care in Peru</td>
<td>A 2018 report that described the implementation in 2013-2016 of a programme to integrate mental health into the Peruvian health system, including specific successes and challenges</td>
</tr>
</tbody>
</table>
Within the context of COVID-19, a key document that sets out what should be done on mental health is the UN Policy Brief on COVID-19 and the Need for Action on Mental Health. The brief makes three recommendations:

- Apply a whole-of-society approach to promote, protect and care for mental health.
- Ensure widespread availability of emergency mental health and psychosocial support.
- Support recovery from COVID-19 by building mental health services for the future.

The last recommendation in particular is key for integrating mental health in UHC. It encompasses actions such as setting up “affordable community-based services that are effective and protective of people’s human rights as part of any national COVID-19 recovery plan”, including mental health in “health care benefit packages and insurance schemes to ensure essential mental health needs are covered”, and involving people with lived experience in the “strengthening of mental health services.” The importance of integrating mental health in COVID-19 UHC response plans is echoed in the UN Policy Brief on COVID-19 and Universal Health Coverage.

Lastly, a significant amount of translational research on scaling up mental health provision and integrating mental health in health systems has been conducted – and experience codified – within the academic and mental health community at the global, regional, and country levels, and in response to the COVID-19 pandemic. The ‘PRogramme for Improving Mental health carE’ (PRIME), which ran between 2011 and 2019, and worked on integrating mental health into primary care in Ethiopia, India, Nepal, South Africa and Uganda, is one example of such efforts. Emerald, a mental health systems research project in Ethiopia, India, Nepal, Nigeria, South Africa and Uganda, is another. This body of knowledge has been further bolstered by the direct experience of multiple organisations in the field, which can be explored on platforms such as the Mental Health Innovation Network and includes learning and experience gained from dealing with the challenges of COVID-19. A more holistic approach to mental health is, furthermore, being called for by mental health funders, such as the Wellcome Trust.
In addition to all these sources, the global community is able to learn from the successes and challenges of countries that have already gone some way towards integrating mental health in UHC. (See p. 60 - 63 for the detailed case studies of Peru and Pakistan, for example.)

Of course, there is still room for additional insight and research. However, like never before, we are in a position to build from and leverage this substantial body of work, information, learning and experience to move towards swift action on integrating mental health in health systems.

AN EXAMPLE SHORT-LIST OF APPROACHES FOR INTEGRATING MENTAL HEALTH IN UHC

Based on the key documents and frameworks already listed, this section provides an example shortlist of priority activities that would be required – across all resource settings – to integrate mental health in UHC.

It is critical that the local context drives the selection and adaptation of strategies, approaches and interventions discussed in the documents and frameworks listed on pp. 50 - 53.

However, as an illustrative example of what integrating mental health care in UHC might look like, this section describes a set of potential priority activities across low-, medium- and high-resource settings, structured around the four objectives of the WHO Action Plan. Depending on the local context, some of these activities will be more urgent in light of the COVID-19 pandemic.

It is important to note that, just as mental health is a complex, cross-sectoral issue, so the successful implementation of a programme of activity like the one presented below will also require strong cross-sectoral collaboration. It will need to go beyond health – and public health – systems, and towards a whole-of-society and whole-of-government approach. It will also need to strictly uphold the human rights of people living with mental health conditions and their families.
**Strengthen effective leadership and governance for mental health**

<table>
<thead>
<tr>
<th>WHO ACTION PLAN OBJECTIVES</th>
<th>ALL RESOURCE SETTINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Include people with lived experience, their families and other stakeholder groups</strong> (e.g. young people) in the development of all approaches and plans, and their implementation and monitoring</td>
<td></td>
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<tr>
<td><strong>Ensure there is an appropriate legal and policy basis for mental health, e.g. laws / policies are in line with human rights instruments and protect (or even increase) mental health financing, especially given other pressures on health budgets; policy is cross-sectoral where needed (e.g. links with social services, employment and education sectors), and explicitly addresses the needs of vulnerable populations; even within a country, policies may need to be adapted to regions based on local context</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Build a whole-of-government consensus</strong> on the importance of mental health, including, where possible, at the highest level of government (e.g. President or Prime Minister)</td>
<td></td>
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<tr>
<td><strong>Fully integrate mental health services in UHC reforms and planning</strong>, ensuring that mental health is a fundamental part of the process. In the shorter term, ensure that mental health is integrated into priority health and other social programmes nationally (e.g. MNCH, NCDs, HIV)</td>
<td></td>
</tr>
<tr>
<td><strong>Include an adequate range of mental health services and approaches (pharmacological and non-pharmacological) in national basic packages</strong> of essential services; ensure that mental health medicines are included in the basic medicines lists</td>
<td></td>
</tr>
<tr>
<td><strong>Include mental health services / medicines within the financial protection mechanisms of the health system</strong> (e.g. national insurance schemes) for all, inclusive of delivery in both specialised and non-specialised settings; no user fees should be charged for essential mental health services, wherever they are delivered. To ensure sustainability and in-country ownership, resources should be raised and investment made domestically, where possible</td>
<td></td>
</tr>
<tr>
<td><strong>Develop a national specialist mental health workforce</strong>, e.g. make mental health more prominent on university curricula, create a career progression for mental health professionals within the health service, improve staff retention, and <strong>scale up the training of general health staff and other relevant professions</strong> (e.g. teachers, police, social workers) in mental health clinical and non-clinical skills (e.g. communication), and emotional coping skills for the workforce itself</td>
<td></td>
</tr>
<tr>
<td>WHO ACTION PLAN OBJECTIVES</td>
<td>LOW-RESOURCE SETTINGS WITH FEW MENTAL HEALTH RESOURCES AND INFRASTRUCTURE</td>
</tr>
<tr>
<td>---------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Provide comprehensive,</strong></td>
<td><strong>Enable primary care to identify common mental</strong></td>
</tr>
<tr>
<td><strong>integrated and</strong></td>
<td><strong>disorders and deploy basic evidence-based</strong></td>
</tr>
<tr>
<td><strong>responsive mental</strong></td>
<td><strong>psychosocial interventions in an integrat-</strong></td>
</tr>
<tr>
<td><strong>health and social care</strong></td>
<td><strong>ed way with other treatment (e.g. using task-</strong></td>
</tr>
<tr>
<td><strong>services in</strong></td>
<td><strong>shifting and the mhGAP approach, with face-</strong></td>
</tr>
<tr>
<td><strong>community-based</strong></td>
<td><strong>to-face or digital supervision); and to</strong></td>
</tr>
<tr>
<td><strong>settings</strong></td>
<td><strong>identify / refer severe cases to secondary</strong></td>
</tr>
<tr>
<td></td>
<td><strong>care (general hospitals). This can be further</strong></td>
</tr>
<tr>
<td></td>
<td><strong>enabled by use of peer support workers, as well</strong></td>
</tr>
<tr>
<td></td>
<td><strong>as peer supervision to ensure the high quality</strong></td>
</tr>
<tr>
<td></td>
<td><strong>of interventions is maintained</strong></td>
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<tr>
<td></td>
<td><strong>Enable secondary care to train, support and</strong></td>
</tr>
<tr>
<td></td>
<td><strong>supervise primary care delivery of mental health</strong></td>
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<tr>
<td></td>
<td><strong>services; treat people with more severe mental</strong></td>
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<tr>
<td></td>
<td><strong>health problems in an integrated way with other</strong></td>
</tr>
<tr>
<td></td>
<td><strong>treatment in outpatient and inpatient</strong></td>
</tr>
<tr>
<td></td>
<td><strong>facilities; and refer to tertiary care (specialist services)</strong> where appropriate</td>
</tr>
<tr>
<td></td>
<td><strong>Initiate scale-down of specialist care, e.g. through</strong></td>
</tr>
<tr>
<td></td>
<td><strong>closure of some long-stay institutions in favour</strong></td>
</tr>
<tr>
<td></td>
<td><strong>of community settings, and movement of mental health</strong></td>
</tr>
<tr>
<td></td>
<td><strong>inpatient services to general hospitals.</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Before scale-down, ensure safe and viable</strong></td>
</tr>
</tbody>
</table>
|                           | **alternatives fully in place.**  

227 Improve quality of remaining psychiatric hospitals |                                                                                                                 |                                                                                                   |
<table>
<thead>
<tr>
<th></th>
<th>Implement strategies for promotion and prevention in mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Establish means of licensing all practitioners</strong> treating people with mental disorders, including non-formal care facilities</td>
<td><strong>Implement coordinated programmes in communities and workplaces on mental health promotion, stigma reduction, encouragement of help-seeking behaviours and demand for mental health services, and self-help, including focus on specific vulnerable groups</strong> (though taking care not to increase demand before increasing supply)</td>
</tr>
<tr>
<td>Leverage digital technologies, where appropriate, to improve service reach and efficiency (being mindful of limitations, e.g. data privacy, potential lack of access to internet and data for poorest populations)</td>
<td>Improve quality and accessibility of suicide prevention and drug and alcohol use prevention programmes (e.g. opioid substitution therapy)</td>
</tr>
<tr>
<td></td>
<td>Create a range of independent and supported accommodation for people with long-term mental disorders</td>
</tr>
<tr>
<td><strong>Implement evidence-based and culturally relevant programmes in communities and workplaces to promote understanding of mental health, reduce stigma, increase help-seeking behaviours and encourage demand for mental health care and services, and enable self-care</strong> (though taking care not to increase demand before increasing supply)</td>
<td><strong>Implement intensive and tailored programmes in communities and workplaces on mental health promotion, stigma reduction, encouragement of help-seeking behaviours and demand for mental health services, and self-help</strong> (though taking care not to increase demand before increasing supply)</td>
</tr>
<tr>
<td>Set up peer-support networks to provide encouragement and a sense of belonging, build empowerment and resilience, and share expertise</td>
<td>Put in place intensive suicide prevention programmes (e.g. reduce access to means of self-harm, hotlines, media training) and alcohol and drug use prevention programmes</td>
</tr>
<tr>
<td>Put in place suicide prevention programmes and policies (e.g. reduce access to pesticides), and alcohol and drug use prevention programmes and policies (e.g. reduce access to alcohol)</td>
<td>Create a full range of independent and supported accommodation for people with long-term mental disorders</td>
</tr>
</tbody>
</table>
### Strengthen information systems, evidence and research for mental health

<table>
<thead>
<tr>
<th>Strengthen information systems, evidence and research for mental health</th>
<th>Run antenatal, early childhood, school (e.g. life-skills training), and parenting / parent coaching interventions, and bolster other relevant intersectoral / intergovernmental areas for collaboration (e.g. with the justice system)</th>
<th>Put in place community-based rehabilitation tailored for people with psychosocial disabilities</th>
<th>Put in place a range of evidence-based services in community platforms, e.g. schools, colleges and workplaces</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify key mental health indicators that can be tracked to support decision-making and funding allocations, ensure increased accountability, and enable comparison over time and between countries.</td>
<td>Integrate mental health into community-based rehabilitation and inclusive development programmes</td>
<td>Identify additional indicators on access and use of mental health services and stigma perceptions</td>
<td>Establish linked health information systems to allow data triangulation from different sources</td>
</tr>
<tr>
<td>Pilot and scale interventions to manage mental health using community-based approaches (psychosocial and pharmacological)</td>
<td>Put in place programmes to support the mental health of caregivers of people with mental health conditions (e.g. dementia)</td>
<td>Conduct more resource-intensive research (larger studies, cross-linking databases, use of social media analytics)</td>
<td>Put in place machine learning and AI analytics across datasets to develop real-time risk profiles</td>
</tr>
<tr>
<td>Implement systems to monitor, track and maintain service quality</td>
<td>Wherever possible, address socioeconomic determinants of poor mental health, e.g. implementing poverty alleviation measures, improving housing conditions, ensuring that children and parents have safe (green) spaces to play and exercise</td>
<td>Wherever possible, address socioeconomic determinants of poor mental health, e.g. implementing poverty alleviation measures, improving housing conditions, ensuring that children and parents have safe (green) spaces to play and exercise.</td>
<td>Put in place community-based rehabilitation tailored for people with psychosocial disabilities</td>
</tr>
</tbody>
</table>

THE COST OF SCALING UP MENTAL HEALTH CARE

Increasing expenditure on mental health to just 5-10% of total government health spending would increase coverage by 40-80% in low- and middle-income countries. To ensure sustainability, it is best for this funding to come from domestic sources; though, in some cases, catalytic national and international donor financing may be needed.

Although the exact cost of the integration of mental health in health systems would depend on the specific country, setting and approach taken,\textsuperscript{228} The Lancet Commission for Global Mental Health and Sustainable Development has suggested that countries should be aiming to commit at least 5-10% of their health spending to mental health, depending on the resource level of each country (5% for lower-income countries, and 10% for higher-income countries).\textsuperscript{229} Although still relatively modest, this would represent a substantial growth in resources committed to mental health (\~2x growth for HICs, and \~10x growth for LICs).\textsuperscript{230} This underlines the fact that, across all resource settings (including high-income), mental health is still significantly underfunded.\textsuperscript{231} Moreover, as the Peru example on p. 60 shows, to be maximally effective these funds would need to be directed towards high quality, rights-based services, mainly provided at community level.

If investment is gradually scaled up to these levels by 2030, recent work commissioned by United for Global Mental Health from Deakin University (using the WHO OneHealth Tool) has suggested that this would substantially increase treatment coverage. For five major conditions, coverage would be expanded to 55-100% depending on resource setting and condition (based on an investment of 5% of the health budget in low-income settings, 7.5% in middle-income settings, and 10% in high-income settings).\textsuperscript{232} This would amount to between 40% and 80% more coverage see the table below. Further investment would be needed to achieve greater levels of coverage.

<table>
<thead>
<tr>
<th>Change in coverage by 2030, by resource setting, as a result of increase in investment</th>
<th>Low income</th>
<th>Lower-middle income</th>
<th>Upper-middle income</th>
<th>High income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety disorders</td>
<td>10% 89%</td>
<td>14% 55%</td>
<td>22% 78%</td>
<td>37% 85%</td>
</tr>
<tr>
<td>Depression</td>
<td>10% 89%</td>
<td>14% 55%</td>
<td>22% 78%</td>
<td>37% 85%</td>
</tr>
<tr>
<td>Psychosis</td>
<td>11% 90%</td>
<td>31% 72%</td>
<td>37% 93%</td>
<td>51% 99%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>10% 89%</td>
<td>14% 55%</td>
<td>22% 78%</td>
<td>37% 85%</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>25% 100%</td>
<td>35% 76%</td>
<td>45% 100%</td>
<td>90% 100%</td>
</tr>
<tr>
<td>% increase in treatment coverage by 2030</td>
<td>79%</td>
<td>41%</td>
<td>56%</td>
<td>48%</td>
</tr>
</tbody>
</table>

It is important that the financing comes primarily from domestic funds to ensure that health systems are set up to be sustainable, are fully 'owned' by the countries and citizens themselves,\textsuperscript{233} and to enable a more efficient pooling of resources. Some countries have already had marked successes in financing the integration of mental health in health systems, through domestic budgetary allocations combined with reforms in the approach to service delivery. These countries include Brazil, Sri Lanka, Ethiopia and, as the case study below describes, Peru.
CASE STUDY: REFORMING THE MENTAL HEALTH SYSTEM IN PERU

In 2012, about 20% of Peruvians were living with a mental health condition, including 10% of children. As is often the case, the most vulnerable Peruvians were also the most severely affected: in one region (heavily affected by political violence in the late 20th century), the lifetime prevalence of mental conditions was estimated to be as high as 50% of all inhabitants.

At the same time, investment levels in mental health were disproportionately small compared with the need for care. In 2011, just 0.27% of the health budget was committed to mental health, 98% of which was spent on tertiary institutions. There was also a severe lack of human resources to provide care, with only 700 psychiatrists working in the whole of Peru (0.57 per 100,000 inhabitants); of these, 85% were concentrated in Lima. Moreover, there was little financial protection for mental health conditions, as patients had to pay for mental health services out-of-pocket or through their own insurance.

It was a situation that meant more than 85% of people who needed mental health services received no care in 2012. As a result, neuropsychiatric conditions accounted for approximately one sixth of all disability-adjusted life years lost in Peru, and accounted for the greatest economic cost to the country of all chronic diseases.

An important step towards reform was the passing of Law 29889: the “General Health Law guaranteeing the rights of people with mental health problems”. This “explicitly guarantees the availability of programs and services for mental healthcare country-wide, including interventions related to the promotion, prevention, recovery and rehabilitation of every citizen at every level of the healthcare system”. Following this, a number of key developments to enable the scale-up of mental health in Peru, and its integration in UHC.

Firstly, mental health services were integrated into the Seguro Integral de Salud (SIS), the publicly-funded health insurance designed to cover the most vulnerable Peruvians. Importantly, integration included an adjustment of the reimbursement rate for mental health services to a level that was seen as viable by providers – a critical step in ensuring that Peruvians covered by SIS could access mental health services in practice.

Secondly, in 2014, a stable, long-term source of domestic financing for mental health was put in place through a 10-year budget specifically committed to the scale-up of community-based mental health, and linked to achieving specific results (prior to that, mental health was financed from the NCD budget). Moreover, this funding has grown over time, from $25 million to over $100 million.

Thirdly, mental health service provision started on a journey of transformation from a hospital-based to a decentralised model, resulting in closer integration between mental health provision and the health system through:

- training primary care clinicians to detect and offer basic treatment for common mental health conditions (using WHO's mhGAP)
- the opening of over 150 community mental health centres (CMHCs), with approximately 50 more planned, to provide more specialised mental health services, and as referral and supervision points for primary healthcare
- the opening of 24 short hospitalisation services for mental health in general hospitals
- the creation of 11 sheltered homes (with 30 more planned) to support patient recovery

These reforms have led to a marked improvement in how mental health care is delivered in Peru. Care coverage for people with mental health conditions increased to over 25% by 2018 (still a long way from target, but a significant improvement from the starting point).
The new model of care is also highly cost-effective. According to the World Bank, the average cost of an outpatient consultation in a specialised hospital setting was $58.96, five times more than the cost for the same intervention in a CMHC ($11.58). The same is true for in-patient care. The average bed-day cost in a specialised facility was $90.86, while the daily cost of residential treatment at a halfway house was $28.48, more than three times less.

Of course, a lot remains to be done: further scaling the model and the investment in mental health (to reach 10% of the overall health budget); integrating mental health across all public policies; promoting citizen participation in the development of the sector; and ensuring effective and rights-based implementation of the policies into day-to-day practice.

For instance, interviews with key stakeholders from service user organisations show that while mental health services are now integrated in the SIS, a significant amount of paperwork and procedure is required not only to obtain insurance for mental health conditions, but also to make an appointment for services. With no guidance on how to navigate the process, this is a substantial barrier to those who need access to care. Moreover, the quality of services is often poor. Users highlight a significant focus on the biomedical approach to mental health as opposed to a more holistic, psychosocial model. Users also note instances of maltreatment of patients by health workers. Across the board, action is needed to tackle stigma towards mental disorders. Finally, citizen participation in mental health sector development “is still incipient”, and can be more of a formality, rather than true involvement or consultation. There is thus still a great need for user voices to be heard in Peru, which could be attained through establishing a central coordinating mechanism to support mental health associations.

It is important to acknowledge that Peru has made important initial steps in mainstreaming mental health, with already impressive results. It is essential that it continues its journey towards an inclusive, rights-based approach to mental health, improving the quality of services and making a true effort to promote and protect the rights of people with psychosocial disabilities.

At the same time, some countries will need to rely on catalytic national and international donor funding, at least in the early stages of integrating mental health in UHC. To this end, the Global Financing Facility, the Global Fund, and other international and national donors should aim to integrate mental health into their coordinated health system financing efforts. These should emphasise improving the quality of services using a rights-based community level approach.

The case study from Pakistan, below, is an example of integration through catalytic donor funding.
PART II

CASE STUDY: INTEGRATING MENTAL HEALTH CARE IN PRIMARY CARE IN PAKISTAN

Pakistan has a treatment gap of about 90%, even for common mental disorders. Only a handful of institutions and professionals provide appropriate treatment: recent estimates suggest that there are only about 500 psychiatrists in Pakistan, or about one psychiatrist per 400,000 people.\textsuperscript{258} In 2017, the government spent only 0.4% of its health budget on mental health.\textsuperscript{259}

By contrast, the need is high. Studies estimate the prevalence of depression among pregnant Pakistani women ranges from between 36% to 40%,\textsuperscript{260} while anxiety among pregnant women has been found to be as high as 49%.\textsuperscript{261} At the same time, stigma and lack of awareness make it harder for people to seek mental health services.

To improve the situation, Interactive Research and Development (IRD) Pakistan, with the funding and support of Grand Challenges Canada and the Government of Canada, established and successfully scaled the Pursukoon Zindagi, or ‘Peaceful Life’, programme. The programme is designed to provide brief psychological treatment or referral using a task-shifting approach (training ‘lay counsellors’), while being fully integrated in the delivery of routine health services and existing patient-care cycles.

The programme began as a community-based mental health pilot in 2014 in three resource-constrained settings in Karachi. Since 2018 it has been integrated within the primary care networks of major providers there, as well as within specific disease programmes (diabetes, TB, HIV, COPD/lung health, etc.). At the time of writing, the programme is operating in 20 primary care centres, and 80 lay counsellors have been trained and deployed.\textsuperscript{262} These counsellors conduct screening for depression and anxiety, offer basic counselling treatment and customised treatment-adherence counselling, and refer more severe cases to a psychologist.

As well as focussing on ‘supply’, the programme is taking steps to build the ‘demand’ for mental health services in the communities they serve. For example, it engages key community members to ensure buy-in, and conducts focused dialogues to reduce stigma and increase awareness of mental health conditions and services.

The results of the programme are impressive. Since 2018, over 100,000 people have been screened (of whom two thirds were female). Of these, over 5,000 presented with symptoms of depression and anxiety, and nearly 4,000 have been enrolled for further treatment.\textsuperscript{263}

The programme is also highly appreciated by the patients. In the words of one patient: “I had been experiencing mental distress for the past three months. I was losing interest in day-to-day activities and not enjoying my life at all. Then I met the mental health team from IRD and attended a mental health awareness session, which helped me learn that I am under a lot of mental stress, for which I eventually sought out counselling. Now I feel fresh and actively participate in my day-to-day routine. I also advocate about mental health in my community.”

During the COVID-19 outbreak in Pakistan, moreover, the programme was able to pivot in an agile way to respond to the pandemic by setting up:\textsuperscript{264}

- a proactive mental health support and treatment-adherence counselling helpline to patients tested for COVID-19 and quarantined, supporting 22,000 people to date
- a reactive helpline for the general population to access free counselling services, supporting over 800 people
- partnerships with eight healthcare organisations, providing more than 800 frontline health workers with mental health support.
Thanks to the hard work and success of organisations such as Interactive Research and Development (IRD) and funders like Grand Challenges Canada, as well as other activists and advocates, the importance of mental health and its integration in health systems is beginning to get traction in Pakistan.

As Dr Zafar Mirza, the Former State Minister of Health of Pakistan, recently put it: “Investments in mental health should be commensurate with the direct and indirect burden of mental health conditions.” This is reflected in the launch in 2019 of the President’s Programme to Promote Mental Health of Pakistanis (focused on women’s and young people’s mental health), and in the recent decision to pilot mental health as a core part of UHC within the public health systems. Moreover, according to Dr Safi Malik, the Director General, National Health Services Regulation and Coordination: “We have … now finalised the first-level care facility packages for achieving Universal Health Coverage across the country. One of the most important components of that is mental health.” This will be rolled out in 12 districts initially, but subsequently expanded.

It is critical that the scaling and continued integration of mental health in health systems continues, with sustainable funding provided by the government, so that these critical services are available universally across the country.

### CONCLUSION

A lot of work has been done to create comprehensive frameworks and guidelines for the scale-up and integration of mental health in health systems: the good news is, we are now in a position where we know what to do. We can move quickly because we do not need to re-invent the wheel.

We therefore have a real opportunity to make substantial progress on integrating mental health in UHC. With concerted commitment and action on existing frameworks and initiatives (e.g. the WHO Mental Health Action Plan, or the WHO Special Initiative for Mental Health), it is no longer a dream, but an attainable reality.

**THE TIME FOR ACTION IS NOW.**
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“No Health without Mental Health”: the Urgent Need for Mental Health Integration in Universal Health Coverage


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231 Worth noting also is the relatively low overall level of spend for healthcare (in the region
of 4-6% for low- and middle-income countries). This is in contrast to such agreements as the Abuja Declaration (2001), whereby the African Union countries committed to spend at least 15% of their budgets on the health sector.

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267 United for Global Mental Health (2020), “March for Mental Health: Pakistan” (online video project for World Mental Health Day) (accessed 09/10/2020)
Ten years ahead of the SDG deadline, the goal of attaining UHC for all is still a long way off. About half of the world's population is still not covered by essential health services. At the same time, 100 million people are pushed into extreme poverty every year through healthcare expenses, and over 930 million spend at least 10% of their household budgets on healthcare.

Looking forward, estimates from 2019 suggested that, at the historic pace of change, about a third of the world's people “will remain underserved by 2030”. COVID-19 has further increased the level of uncertainty. According to the 2020 Goalkeepers report, the level of UHC coverage in 2030 could, in the most pessimistic scenario, even decrease in comparison to 2019.

Mental health is an inalienable part of health. Despite the complexity of mental health, its integration in UHC is a relatively low-hanging fruit for increasing the effectiveness and comprehensiveness of health systems, and a desperately needed boost to meet the goal of UHC by 2030. It is deeply worrying that in the past some countries have excluded aspects of mental health from UHC.

There is, moreover, an urgent need to make progress on mental health, in and of itself. Every 40 seconds (or about as long as it takes someone to read to this point in this Conclusion) someone somewhere dies by suicide. By the time the reader finishes reading this Conclusion, another 40 seconds will have elapsed.

We therefore call for the following actions to be taken as a matter of urgency:

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<td>International and national funders</td>
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As the world grapples with the impact of COVID-19 and designs the future of healthcare, we need the global community to come together now and commit its political will towards action and investment in mental health.

**THERE IS NO HEALTH WITHOUT MENTAL HEALTH.**
**THE TIME TO ACT IS NOW.**
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