B5 | TRANSFORMING MENTAL HEALTHCARE GLOBALLY

Introduction

Mental health has historically been the Cinderella issue in global health. For decades, several assumptions have stymied action to respond to mental illnesses, in particular in non-European countries and populations. These assumptions included the notion that mental illnesses were entirely products of culture, and that psychiatry and psychology were products of European cultures and, therefore, of limited generalizability to the rest of the world. Indeed, some critiques argued that the use of diagnostic systems and interventions which had their origins in these disciplines to other contexts amounted to "psychiatric imperialism" (Patel 2014). The strong association of social disadvantage with poor mental health and the lack of a clear boundary between the normative human emotional response to such disadvantage and mental illnesses fueled the position that the only interventions which mattered were those which targeted upstream social determinants. On the other hand, health economists argued that mental illnesses lacked objective biomarkers and their assessment relied entirely on self-report, compared to mortality outcomes of infectious diseases and maternal and infant conditions which dominated global health priority lists. Furthermore, it was assumed that mental health problems were too expensive to treat, and so were relegated to being a luxury item in the basket of health goods for poor people and poor countries.

Global mental health, a discipline of global health which seeks to reduce disparities in the attainment of good mental health between and within populations, has been a powerful force to interrogate these assumptions (Patel and Prince 2010). A large body of science from diverse contexts has clearly shown that mental health problems are in fact universal health experiences with similar "core" features and responses to interventions, though cultural factors do greatly influence the way these illnesses are experienced, understood, and acted upon. Mental health is inseparable from one's personal life history, physical health, and socioeconomic conditions and context, and care for mental health problems must be tailored to these unique characteristics. Mental healthcare must, therefore, embrace a diversity of perspectives, experiences, and providers, and every community, irrespective of professional mental health resources, can offer at least basic mental healthcare. There is a growing recognition of the need for a rights-based approach which emphasizes the central role that people with the lived experience of mental illness must play in designing, delivering, and holding mental healthcare to account.

The COVID-19 pandemic has had a significant impact on the recognition of mental health as a critically important aspect of human health. In response, we have witnessed a flourishing of initiatives to address the mental health distress consequent to the unprecedented uncertainties and disruptions to daily life around the world (Kola et al. 2021). Importantly, this wave of suffering is occurring in the context of a global crisis of inadequate and inequitable access to quality mental health interventions which existed even before the pandemic. All countries of the world to varying extents were under-performing in terms of their mental healthcare, as reflected in low levels of coverage of quality care and little evidence of reducing the incidence of mental illness. The incidence of mental illness has also been increasing in certain contexts and demographic groups, for example amongst young people, a crisis whose causes are poorly understood. While the pandemic offers a historic opportunity to invest in mental healthcare globally, we will need to mobilize political will not only to enhance the meager sums spent on mental health but also to spend this money wisely, guided by principles of human rights and equity and a commitment to evidence-informed practices and community expectations. This chapter will propose what those investments should be, starting with setting the stage on the state of mental health in the global context, the barriers towards achieving parity and justice for people with mental health problems, and the impact of the pandemic. It then turns to a discussion of strategies which can address these limitations, emphasizing how mental health can be fully integrated within the framework of universal health coverage across dimensions from promotion and prevention to care and recovery.

Box B5.1: Defining mental health problems

Several terms are used, by specific scholarly disciplines, to describe the human experience of a mental health problem. This diversity of terminology is also reflected in the ways in which suffering associated with impairments of mental health is described. Mental illnesses or disorders, as defined by the diagnostic categories in the International Classification of Diseases (ICD), comprise a wide range of conditions across the life course, all of which share one core feature: the impairment of mental functions such as the way a person thinks, feels, and interacts with others. Apart from this shared feature, there is actually very little in common from an aetiological or therapeutic standpoint between autism and intellectual disability in childhood, mood, anxiety, psychotic, and substance abuse disorders which emerge in youth, and dementias which emerge in older age. Moreover, without exception, we do not have a clearly delineated aetiology or biomarker for any of these diverse conditions, and we rely entirely on self-reporting of inner states or observations of behavior to arrive at a "diagnosis." Thus, it is clear that the current diagnostic categories are dynamic, imperfect, and prone to considerable subjective and cultural variations between individuals and across contexts. An exemplar of the fluidity in defining mental health problems is homosexuality, which was considered a mental illness by biomedical classification systems right up to the 1970s. Another term, preferred by human rights advocates, is "psychosocial disability," which conveys the idea that the suffering associated with impairments of mental health are the result of social arrangements and discrimination rather than a biological process.

The global mental health crisis before the pandemic

Mental illnesses are leading causes of suffering in all countries of the world, affecting at least 10% of the global population at any given point in time. The relative burden, measured in terms of Disability Adjusted Life Years (DALYs), has been rising in all countries, driven by multiple factors including the falling burden of other health conditions, the failure to reduce the incidence of mental illness, and the rise in the proportion of the population entering the age of risk of onset, in particular the growing number and proportions of youth and of older adults (Patel et al. 2018). Suicide is a leading cause of death in young adults, and suicide rates amongst young people are rising in many countries in the past decade. At least half of the burden of mental illness in adulthood has fallen on adults younger than 24 years old. This is due to the interaction of unique neurodevelopmental processes occurring in adolescence and young adulthood with the dramatic psychosocial and biological transitions which occur during this relatively brief period of the life course, during which an individual makes the journey from being a child who is totally dependent on one's parents to becoming an independent adult who might be caring for children.

People with mental illness, particularly those living with psychotic disorders and substance use disorders, die much earlier than they should, mostly due to the poor quality of medical care for comorbid chronic diseases. The latter is one of the consequences of the pervasive levels of stigma and discrimination associated with mental illness, which leads to abuses of human rights including incarceration, torture, and denial of fundamental rights to dignity, freedom, and access to care (Patel and Farmer 2020). Indeed, the published estimates of the global burden of mental illness is actually much lower than their actual burden, thanks to the vagaries of how health conditions are categorized in the Global Burden of Disease models. For example, suicide and self-harm are not counted as mental health conditions, chronic pain syndromes which are often the result of mental health problems are entirely categorized as musculoskeletal disorders, and the significant contribution of severe mental illness to premature mortality is ignored. When these are taken into account, the actual disease burden for mental illness exceeds 30% of the global Years Lived with Disability and 13% of DALYs (Vigo, Thornicroft, and Atun 2016).

A rich body of epidemiological literature has clearly demonstrated the higher risk of mental illness in contexts in which individuals are exposed to adverse social determinants, notably those associated with poverty, gender disadvantage, and discrimination. Populations which are disproportionately affected by these determinants, for example low-income groups, women, sexual and ethnic minorities, refugees, and those in conflict settings, bear a higher burden of mental illness (Lund et al. 2018). The inter-generational transfer of poor mental health and social disadvantage are closely linked through their association with adverse childhood experiences, the most consistently demonstrated risk factor for mental illnesses. These early life adversities can be compounded by oppressive experiences and violence during adolescence. Young people and disadvantaged or marginalized groups also have less access to appropriate care and experience the double stigma attached to their group identity in addition to the mental health problem. The mechanisms through which social disadvantage and poor mental health are related are bi-directional: social disadvantage causes mental illness, for example by increasing exposure to more uncertainties and stressors in daily life or reduced opportunities for education; meanwhile, poorer mental health leads to social disadvantage, notably through reduced productivity at work, being discriminated in diverse sectors of society, and increased healthcare costs (Ridley et al. 2020).

Barriers to justice and equity

Despite strong evidence of the cost-effectiveness of a range of interventions for the prevention and care of mental illness (Patel et al. 2016), the vast majority of people in the world do not benefit from this knowledge. This is true even in wealthy countries, indicating that all countries can be considered "developing" when it comes to mental health. A vivid illustration of these "gaps" comes from a recent analysis of the World Mental Health Surveys, which found that while less than 5% of persons with depression in low- and middle-income countries (LMICs) receive adequate quality care, much wealthier countries are only reaching about a third of affected persons (Vigo et al. 2020). At least a part of this crisis can be attributed to the paltry spending on mental healthcare in most countries; indeed, no country in the world allocates resources for mental health proportionate to its burden of mental illness (Saxena, Sharan, and Saraceno 2003).

The discourse on the barriers to equitable access to mental healthcare has been dominated by two narratives: lack of mental health professionals and stigma attached to mental illness due to "non-scientific" views (Saraceno et al. 2007). Unsurprisingly, both perspectives are heavily promoted by mental health professionals and are underwritten by an unswerving faith in the biomedical model of mental illness. This model is enshrined in disease classification systems which lead to a focus on mental health specialist-led "treatment" of an individual's symptoms, dominated by a reliance on pharmacological agents. The inadequacy of this model to contribute to reducing the global burden of suffering of mental illness is evident from the large gaps in access to quality care and the lack of a reduction in the burden of mental illness in wealthy countries, which have most strongly embraced such a narrow, diagnosis-driven approach to mental healthcare. There are multiple reasons for this limited impact, ranging from the low demand for such mental healthcare to the inadequate recognition of the importance of psychosocial factors in both prevention and long-term recovery. Thus, even if we were able to mobilize more funds for mental health, as is desperately needed, the question that is most urgent to address at this juncture is how this money should be spent.

Global mental health practitioners have robustly challenged these assumptions, and their findings are pointing to the need to reimagine the future of mental healthcare. Low-resource settings have offered an opportunity for some of the most transformative innovations to improve access to effective interventions for mental illness. These innovations almost universally deliver psychosocial therapies, a major departure from the dominating presence of psychotropic drugs, particularly in LMICs. Furthermore, these psychosocial interventions are typically simplified versions, comprising usually one or a few "elements" of complex psychological treatment packages, e.g., behavioral activation for depression, enabling elements to be learned and delivered by diverse providers with much greater ease (Singla et al. 2017). Innovators have also demonstrated the importance of interventions targeting adverse social determinants, e.g., enabling nurturing environments in early childhood, offering cash transfers for low-income populations, or promoting the school social environment for adolescent mental health (Shinde et al. 2018; Ridley et al. 2020), for the promotion of mental health and prevention of mental illness. In all these instances, human providers concerned with delivery are persons with no prior formal training in mental health. Typically, the providers are existing frontline providers such as community health workers or lay people engaged by the research or demonstration project. These innovations have shown that one does not require a psychiatric diagnosis to trigger care, greatly simplifying the dissemination of effective interventions, that these delivery models are highly acceptable to persons with mental illness, and that they demonstrate recovery rates comparable to specialist care models, and economic analyses find that these innovations are excellent value for money (Weobong et al. 2017).

A parallel strand of knowledge generation and advocacy has focused on demonstrating the central role that the long and dark history of institutional coercion, violence, incarceration, and systematic exclusion experienced by persons with severe mental illness (a group some advocates refer to as "persons with psychosocial disabilities") as the root cause of stigma associated with mental illness (Thornicroft 2006). A critical element of this effort is the engagement of and leadership by persons with the lived experience, as has been done with other marginalized groups such as persons with a disability (where the movement famously coined the slogan "nothing about us without us") and those living with HIV/AIDS. The Global Mental Health Peer Network is an example of a social movement led by persons with the lived experience of mental health problems (Box B5.2), demanding the right to be heard and respected, and to enjoy the same rights as any other person in every aspect of their lives, from education and employment to marriage and healthcare.

The singular policy landmark which has recognized the struggle for equality and justice in relation to mental health is the United Nations Convention on the Rights of Persons with Disabilities (CRPD) which requires:

> a paradigm shift from a medical model of disability to a social model that emphasizes overcoming the barriers to equality created by attitudes, laws, government policies, and the social, economic, and political environment. The approach adopted by the social model recognizes that people with psychosocial disabilities have the same right to take decisions and make choices as other people, particularly regarding treatment, and have the right to equal recognition before the law. (Sugiura et al. 2020)

A wide array of interventions have been identified to realize these rights, from legislations which prohibit or greatly limit involuntary treatment to supported

Box B5.2: The Global Mental Health Peer Network

The Global Mental Health Peer Network (GMHPN) emerged as an initiative of the Movement for Global Mental Health in 2018. The focus of its work has involved the building of a sustainable structure to develop global lived experience leadership and create a sophisticated communication platform where the lived experience community can share their views, opinions, perceptions, and experiences. The mission of the GMHPN is "strengthening the voices of persons with lived experience globally through empowerment and inspiring respect and acknowledgement of their experiences, views and opinions as valued and equal citizens of the world." The GMHPN's rich and diverse lived experience expertise currently represents over 30 countries with 67 global mental health lived experience leaders. The GMHPN aspires to have lived experience leadership from all countries in the world, which is expected to be instrumental in driving change and transformation in mental health. Access the latest Annual Report: https://www.gmhpn.org/uploads/1/2/0/2/120276896/gmhpn_annual_report_2019-2020_final.pdf.

decision-making enabling a person with a psychosocial disability to decide about care which respects their will and preference (Sugiura et al. 2020). The role of peers (other persons with psychosocial disabilities) in providing such support is often at the heart of these interventions. Yet, the fact remains that the vast majority of countries in the world continue to operate under legislation where coercion, involuntary treatment, and incarceration under inhumane conditions are all too frequent. This blot on the human rights landscape of global mental health is the single most important contributor to stigma attached to mental illness.

Another blind spot in global mental health has been the lack of attention to primary prevention despite the compelling cross-cultural evidence of the role of early life adversities, violence, and impoverishment on poor mental health and the evidence on the impact of interventions which target these determinants on improving mental health outcomes. A major reason for this is that most interventions fall well outside the health sector with little incentive for the mental health community to advocate for them. Unsurprisingly, mental health practitioners emphasize preventive interventions which target individuals, for example through curricular interventions to build social–emotional competencies in young people through teaching simplified versions of the psychological techniques used for the treatment of mood and anxiety disorders. While such interventions also have a role to play in the landscape of prevention, targeting upstream social determinants such as poverty, gender-based violence, early life adversities, quality education, and community social capital, all of which are Sustainable Development Goals (SDGs) in their own right, will likely have larger impacts on population mental health (Lund et al. 2018).

Global mental health in the shadow of the pandemic

The advent of the COVID-19 pandemic threatens to magnify the existing crisis through several pathways. There are now widespread reports of the increase in self-reported distress in populations around the world, in particular in contexts which have suffered high levels of coronavirus infection (Kola et al. 2021). The pandemic has confronted individuals with a range of stressors, from loss of loved ones to the unrelenting threat of infection, loss of livelihoods, uncertainty about when, if ever, life will return to a semblance of what people used to experience, the torrent of mixed messages about the science (real or fake) around the virus, and the lack of consensus on what the post-epidemic scenario might look like. It is not at all surprising, then, that experiences of anxiety, fearfulness, sleep problems, irritability, and feelings of hopelessness have become widespread. Much of this mental health distress can be understood as a normative stress response to extraordinary levels of uncertainty and disruption to daily life. The persistence of these stressors extending well into a second year and the emergence of enduring changes in society and everyday life that is coupled with a massive increase in adverse social determinants, from levels of absolute poverty to rising inequality and gender-based violence, may herald a potential new "epidemic" (pandemic) of mental illness.

Indeed, in the absence of any structural policies addressing these adverse social determinants, the increase in the average levels of distress in the population is a harbinger of a rise in the burden of clinically significant mental illness. "Deaths of despair" have been documented as the cause for the increased mortality and reduction in life expectancy in working-age white Americans following the economic recession in 2008 (Case and Deaton 2020). Suicide- and substance use- (the latter often even more discriminated against in healthcare than mental illness) related mortality accounted for most of these deaths. On this occasion, the pandemic threatens many, if not most, countries around the world. The threat is global and is likely to be far more persistent.

The pandemic has also amplified the social determinants which affect subgroups in the population disproportionately. Low-income groups such as the homeless and daily wage workers, already living precarious lives, have been especially badly hit with tens of millions of persons being acutely impoverished with catastrophic consequences for their well-being and that of their children, whose adverse childhood experiences are risk factors for poorer mental health years later in adulthood (Cash and Patel 2020). Women have found themselves locked in homes with violent partners and bear the triple burden of caring for young children and domestic chores alongside their professional commitments (see Chapter A2). Children and young people, who are the least affected by the virus, are the worst affected by the policies to contain the pandemic, notably the closure of educational institutions which some have estimated will ultimately lead to poorer health and social outcomes for an entire generation of young people (Christakis, Van Cleve, and Zimmerman 2020). The COVID-19 pandemic has illustrated, yet again, how people with mental health conditions are not only more vulnerable to acquire infections but also more likely to suffer worse consequences, including death, as a result (Wang, Xu, and Volkow 2021). In part, these adverse outcomes are the result of the impact of lockdowns on disrupting general and mental healthcare services.

While the pandemic has witnessed a flourishing of initiatives to address the rising tide of mental illness, most notably through telemedicine platforms (Kola et al. 2021), these suffer from the limitation that they rely heavily on mental health specialist providers who are very scarce in number and often unaffordable. This is compounded by the digital divide: digital literacy and adequate internet connectivity remains a distant goal for large swathes of the global population. Still, these initiatives are welcome for their demonstration of the feasibility of remote delivery and the value of psychological therapies, both of which should become cornerstones of efforts to reform mental healthcare systems after the pandemic recedes.

Box B5.3: Overcoming individual solutions for collective problems: a testimony from a community-oriented mental health service during the COVID-19 pandemic in Italy

In Italy, progressive funding cuts to the National Healthcare System, alongside the growing influence of private service providers, led to inadequate coverage of mental health needs. The answer to this shortage was sought in the free market with important consequences for social and health inequalities. Facing this situation, in 2013 a group of citizens, psychologists, and psychotherapists funded Sportello TiAscolto in Turin (northern Italy). This service today extends to the cities of Milan, Bolzano, Lecce, and Bologna and tries to respond to mental health needs through clinical and non-clinical practices.

The core values of Sportello TiAscolto are accessibility, sustainability, and political engagement. Providing accessible mental healthcare is one of our key goals, but not the only one. We aim to render more collaborative and politicized the practice of clinical psychology, which is usually viewed as a merely technical one. This is why we consider it important to engage in various forms of social and collective action.

Our clinical practice, for example, is made more accessible and sustainable through a system in which fees are negotiated based on patients' financial resources. Following a principle of mutualism, people are asked to give a contribution consistent with their economic possibilities; all fees are then evenly redistributed among therapists (and thus, indirectly, among patients). This serves the purpose of granting equal opportunities for clinical counselling and preventing economic-based discrimination. We give importance to sensitizing our patients about the meaning of our system of fee redistribution: by taking care of themselves, they also take care of fellow citizens of their community.

We believe that mental health problems which people experience on an individual level must be addressed also from a collective and political point of view to affect the structural and social causes of distress. Since health only exists in the interaction between people and their real-life contexts, no clinical practice is devoid of political implications. Diagnoses are therefore handled with a critical eye. As we explore our patients' individual experiences, we encourage them to think how their personal story is connected to and shaped by the social, economic, and cultural structures that represent limits and opportunities for people's well-being. In order to prevent excessive psychologization, we evaluate with our clients their real-life situations to assess the cases in which an external, rather than internal, course of action would be more effective.

As an organization, we are involved in a variety of actions that aim to actualize our political engagement. These follow three main directions:

- Participation in and promotion of local and national networks.
- Work with disadvantaged social groups (including homeless people, migrants, refugees, and asylum seekers).
- Promotion of a culture of health rooted in the understanding of its broader determinants.

In promoting a culture of health, we oppose over-medicalization and profit-driven logics through awareness-raising campaigns, events, and trainings. A working group is developing a model to evaluate our experience and make it replicable.

Participation is key for our project. Throughout the years, local partners and community actors have become increasingly engaged in the organization's principles and goals. We've had the opportunity to share our model with like-minded colleagues willing to start similar projects. With the use of questionnaires, we have collected feedback and suggestions from our patients and used them as a tool for evaluation and planning. Former patients and students of our training courses propose joint projects with us, and sometimes have founded partner organizations. Sprouting in different territories, we have strengthened our capability to act and respond as a network and to engage in political dialogue.

We feel that the approach is working towards the goal of making mental health more accessible, participative, collective, and politically informed, grounded in a communitarian dimension. However, the COVID-19 pandemic confronted us with the persistence with which our society in a time of crisis seeks and resorts to isolated individually based responses to collective health. Since 2020, we have been experiencing a troubling situation related to the COVID-19 crisis, which we collectively perceive to be a problem. The pandemic is having a differential impact on different social groups; such differences are heavily related to social inequalities and the "starting condition" from which each individual faces the situation, apart from any pre-existing mental health conditions. Nonetheless, individual narratives and needs of care show a remarkable alignment on a socially shared and collectively relevant matter.

Despite these premises and the bases of our approach, we observed a tendency for people during an acute crisis creating socially shared distress (such as the pandemic) to seek individual help as the privileged avenue for coping and sense-making. This preference comes at the expenses of more collective forms of action and mutual care. At the same time, we noticed our own tendency – as a group of mental health professionals – to favor initiatives aimed at broadening access to individual psychosocial support. Effective as it may be on the individual situation, we are aware of how this can lead to fragmented responses to a widespread social emergency.

We think it is a significant social symptom that, in such a time of collective crisis and socially shared distress, people in northern Italy mainly sought professional, medically defined individual care, which was promptly provided by mental health professionals, including ourselves. Still, our double vantage point as psychotherapists and politically involved citizens has allowed us to gather invaluable, if sometimes discomforting, information to direct future actions. We witnessed, for example, rage, resentment, and mistrust against society or one another; fear, anxieties, the loss of safety and confidence in the future; loneliness, sadness, and isolation; amidst overcrowded apartments and increased levels of domestic violence.

On the brighter side, many people addressed this crisis as a chance of renewal and change, making key decisions to set their lives on new tracks: moving to another town, leaving a dead-end career, restoring long lost friendships, resuming political commitment. Altogether, we observed the need to mend healthier social bonds in contrast with a worrying disintegration of the links of our society. In this scenario, only active citizen participation can contribute to fairer life contexts. In professional healthcare, raising political awareness and engaging with communities become critical actions to promote widespread health.

Re-imagining mental health: from categories to people

To recap: there was a global mental health crisis even before the pandemic, and countries which spent much more on mental healthcare, but within narrow biomedical and specialist models of care, have not witnessed a reduction in the burden of mental health-related suffering in the population as one might have expected. This contrasts sharply with "physical" health outcomes where there is at least some correlation between healthcare spending and investing in prevention and a reduced burden of disease. The pandemic provides an opportunity to reimagine mental healthcare everywhere, at the heart of which is an explicit recognition of the need to embrace diversity, from the wide variations in how mental illness is experienced by individuals and across contexts, to the ways in which it can be addressed. The 2018 Lancet Commission on Global Mental Health usefully laid down three key principles for re-framing mental health (Patel et al. 2018).

First, we need to move beyond the narrow diagnosis-driven approach to classifying and labeling mental illness, an approach which may work well for infectious diseases and be desirable for a psychiatry which seeks to be recognized as a legitimate discipline of medicine. But this approach is neither supported by decades of basic and epidemiological science, nor acceptable to communities globally. Given the dominating influence of this approach on research and practice for half a century, it is obvious that we will need to incrementally modify it to embrace the multi-dimensional nature of mental health and iteratively refine the approach to assessment and treatment planning. Indeed, the first steps in this direction have been taken by the latest classification of mental illness in the ICD-11. Ultimately, the goal may well be a multi-dimensional approach which could be applied at two levels to any individual to characterize specific mental health functions and experiences, such as mood, cognitive abilities, and impulsivity: first, at the higher level from overall well-being at the one end to psychosocial disability at the other and, second, at a more granular, neuro-scientifically aligned level. Practically speaking, this would entail assessing mental health across a number of discrete domains of psychological function and addressing impairments in specific domains in a person-centered way. We might no longer try to pigeon-hole the diverse presentations of mental health problems and individuals into superficially homogenous diagnostic categories and then apply a standardized treatment package or algorithm, as if one size fits all the persons who are given the same diagnosis (as one might do, for example, for malaria).

Second, we need to reject once and for all the debate about whether mental health is determined by nurture or nature. The Lancet Commission proposed a convergent approach to understanding mental health (and mental illness) which recognizes the interaction of genetic factors, early and contemporary life experiences, and biological systems (ranging from neurodevelopmental processes to the gut microbiome). Importantly, each of these domains includes both risk and protective factors and, given the enormous heterogeneity in a population in even just one of these domains, the sum of the permutations of factors across all domains is potentially infinite. This is yet another reason why the artificial applications of categories of diagnoses fails to recognize the unique causal pathways for mental illness deeply embedded in the personal life story of each individual. Moreover, the convergent approach especially emphasizes the role of environmental determinants (social, economic, and physical), particularly in the first two decades of life when the brain is most plastic and responsive to environmental influences. This approach recognizes the critical importance of nurturing environments at home, in schools, in neighborhoods, in society, and, increasingly, in the digital space in promoting mental health and preventing mental illness.

Third, we need to reframe mental health through the lens of human rights. At least three specific kinds of rights are particularly relevant to transforming mental health globally. The first is the right to be protected from known harms which adversely affect mental health, in particular adversities in childhood, violence through the life course, facing any form of discrimination, and the damaging effects on mental health on living in conditions of poverty. Second is the right to receive care, on par with any other health condition and regardless of the ability to pay for a mental health condition. Third, and most important of all, is the right to the freedom to choose what type of care, if any, a person wishes to receive, without any coercion or fear. This right is aligned with the CRPD's vision of equality for persons with psychosocial disability on all matters, including the right to refuse treatment for a health condition. This latter right is the most contentious of all, as some argue that the capacity to fully understand and consent to healthcare interventions can itself be seriously compromised by a mental illness and, if this right is to be realized in spirit and letter, there is a risk that this may even lead to further deterioration of a person's mental health. The intent to commit suicide by a person who is severely depressed is an example of such a "hard case" which eludes consensus between the differing views on the interpretation of this article of the CRPD (Mahomed, Stein, and Patel 2018).

Implementing these lofty principles will require partnerships between a wide range of stakeholders, in particular frontline workers and care providers, ranging from peer support workers and community health workers to nurses, traditional healers, and midwives, who share the characteristics of not having had professional mental health training and living in the communities that they serve. The engagement of family members or significant others to support the recovery process is often a key strategy. The evidence clearly demonstrates that many, perhaps the majority, of people affected by mental illness can be effectively helped to recovery by appropriately trained and supervised frontline workers (Singla et al. 2017), yet there remains virtually 0% coverage of such an approach globally. Key barriers to improving the coverage of this transformative mental healthcare model include the lack of commercial and vested interests to promote psychological treatments, in contrast to the strong corporate lobbying power of Big Pharma. It is therefore essential that we build a robust movement for the right to access quality care that emphasizes psychosocial interventions and demands concerted action by governments and donors to support approaches to scaling up. Scaling up will also require a dramatically different approach to the traditional strategy of expert-led workshops and supervision, which are inherently non-scalable but also tether the innovation forever to "experts" who are often scarce and costly in the first place. Recent innovations seeking to scale up these approaches demonstrate the acceptability and effectiveness of digital training in the delivery of psychological treatments and of peer supervision for quality assurance (Singla et al. 2014; Muke et al. 2020). This range of innovations, when combined and scaled up, can transform access to one of the most effective interventions in medicine. This is exactly the goal of the EMPOWER platform which seeks to use a range of digital tools to enable frontline providers to learn, deliver, and master psychosocial interventions.

That said, one size does not fit all for mental healthcare (nor for any non-communicable health condition). There will always be persons who need more specialized care including medications, which can be transformative (think of generic antipsychotic drugs for schizophrenia, antidepressant medication

Box B5.4: Building the frontline workforce to deliver mental healthcare

The evidence of the effectiveness of frontline worker-delivered brief psychosocial interventions offers the most promising opportunity to transform mental healthcare globally. A major barrier towards scaling up this evidence is the historic reliance on expert-led, in-person, workshop-based training and supervision. EMPOWER is a program which is building an innovative digital platform comprising a suite of tools for non-specialist health workers to learn, master, and deliver psychological interventions for a wide range of mental health problems.

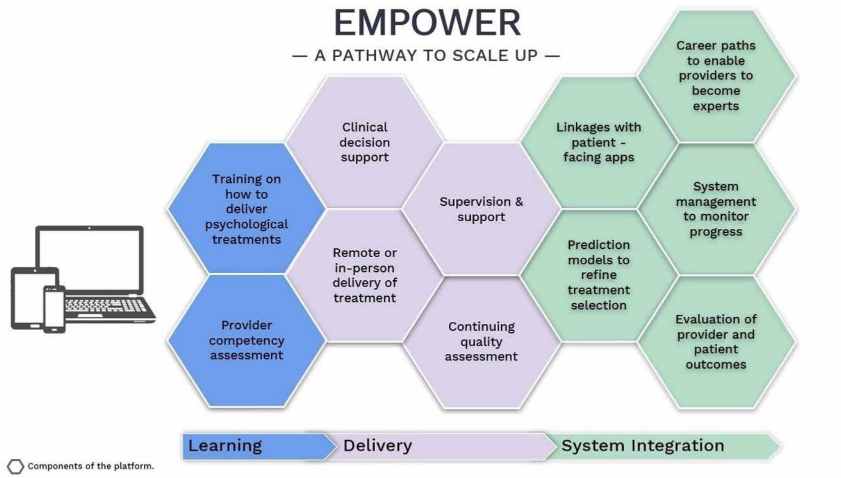

Figure B5.1 The elements of the EMPOWER platform.

Source: Figure by Vikram Patel; Vikram Patel, "EMPOWER: A Digital Solution for Learning, Mastering, and Delivering Quality-Assured Psychological Treatments." Powerpoint, Department of Global Health and Social Medicine, Harvard Medical School.

At the time of writing this chapter, the program is completing a randomized controlled trial comparing two versions of digital training of India's Accredited Social Health Activists (ASHAs) to deliver the Healthy Activity Program for depression, with orthodox in-person training (Muke et al. 2020). The scripts for the training are being adapted for the US context (making this a rare example of an intervention developed in the Global South being adapted for use in a wealthy country) for initial roll-out in Texas in 2021. Designing and testing the digital tools for supervision and quality assurance will begin in India in 2021, as will the addition of new curricula for problem-solving for adolescents and early child development.

For more information, please consult: www.empower.care.

for severe depression, lithium for bipolar disorder, and methylphenidate for childhood hyperactivity as outstanding examples), and brief hospital stays for acute exacerbations. Even the much-maligned electroconvulsive therapy has an important role when used judiciously for persons with severe and potentially life-threatening depression. Thus, collaborative care, involving a close partnership between primary and community care providers with mental health specialists working in tandem to help the person realize their desired outcomes (the hallmark of person-centered care) in a coordinated, seamless manner, would comprise the best evidence-informed delivery model. This is, of course, the same delivery model for all chronic conditions, and offers the opportunity to integrate the care of physical and mental health concerns, bridging a chasm which has historic roots in the evolution of modern medicine. The integration of mental and physical healthcare is, perhaps, the central vision of universal health coverage.

A key task now is to translate this evidence to unleash the power of communities, through empowering people to inform the process of scale-up of evidence-informed interventions, acquire skills to deliver these interventions, mobilize political will and resources for scaling up and enabling access to specialized mental health services for those who need such care, and hold mental health services accountable. This effort should especially focus on empowering

Box B5.5: The "5C" approach to integrating mental health in universal health coverage

- *Person-centered* – focusing on what matters to the patient rather than what is the matter with the patient, which translates into attending to functional needs, multiple morbidities, and social suffering and to the empowerment of the person to harness their personal and community resources to enable recovery with dignity.
- *Continuing or long-term planning* – recognizing that "cures" are rare and the goal of care is to optimize the quality of life and health.
- *Community platform of delivery* – engagement with families and the broader community to tackle stigma, adherence, and other barriers to the uptake of effective care.
- *Collaborative care* – with seamless coordination by community health workers or case managers of primary care and specialist providers to ensure high coverage of quality care and early "stepping up" of the intensity of care when needed.
- *Compassionate stance* – instills hope, a key ingredient for patient engagement, motivates health-promoting behaviors, and harnesses the placebo effect (which has a robust neuroscientific basis).[1]

persons with the lived experience of mental illness. They must not face exclusion or discrimination in any sector of society, notably education, employment, and civil rights. Their engagement is also critical for addressing the pervasive stigma and discrimination associated with mental illness, for social contact with persons with the lived experience is the most effective strategy to address this enormous barrier to inclusion and parity (Thornicroft et al. 2016). The recognition of the inseparable association of mental health with social determinants demands actions at the structural level, for example cash transfers to alleviate acute indebtedness and supporting low-income families to offer nurturing environments to young children, as well as ensuring that the care of persons with mental illness addresses social determinants simultaneously with their clinical symptoms (Lund et al. 2018). This is a key strategy to improve long-term recovery rates, which remain stubbornly low for many affected persons.

Governments need to build leadership across the health system for implementing interventions for the promotion of good mental health, for the prevention and care for mental illness, and for the recognition of and coordination between sectors spanning diverse ministries. Beyond health, other key sectors which must be party to this collective stewardship are those concerned with education, disability, finance, and labor. Such inter-sectoral action has been the hallmark of psychosocial programming in contexts affected by conflict (Inter-Agency Standing Committee 2007), which led to the shift from the earlier dominating focus of clinical interventions for post-traumatic stress disorder (PTSD) to recognizing the need for a broader, community-oriented emphasis on social determinants, basic needs, and mental health. Established policies which reduce harm to mental health and promote well-being must be implemented across these sectors, for example, policies which address bullying or workplace harassment, establish parity with physical health in employee assistance programs, offer training for learning effective stress management techniques, provide cash transfers for low-income groups, or promote healthy school environments for all children. The challenge inherent in coordinating actions across such diverse sectors and ministries may be addressed by vesting the responsibility of stewardship for mental health to an inter-sectoral group drawn from all relevant ministries. Similarly, the approach towards accountability must monitor a range of indicators which span from the upstream determinants of mental health to the effective coverage of evidence-informed interventions and social inclusion of persons with mental illness (Saxena et al. 2019).

Mental health professionals play a central role in this reimagined mental healthcare system, but their contribution will need to go beyond clinical interventions and include providing support to collaborative care models, participating in capacity-building and quality assurance efforts, offering referral pathways for patients who need their expertise, and joining hands with diverse groups to address structural barriers in one voice. The foremost barrier is the sustained under-investment in mental health at both national and global levels (Gilbert et al. 2015), a dismal situation which is likely to be worsened thanks to the diversion of health funds towards the pandemic and the downturn of the economy which reduces resources for the social and development sectors. This happened earlier in the late 1990s when it appeared that mental health would finally be recognized as a priority by the world's leading development agencies, thanks to the publication of the first Global Burden of Disease report which identified a number of mental illnesses amongst the leading contributors. But mental health then was left entirely off the table in the Millennium Development Goals of 2000. Fifteen years later, mental health found its rightful place in the SDGs. And now, with the pandemic still sweeping the world, mental health risks are being shoved back into the shadows. The engagement of and leadership by persons with the lived experience in such movements will be a critically important strategy to successfully addressing these barriers.

Conclusion

Mental illnesses were already a leading cause of suffering and the most neglected health issue globally before the pandemic. The pandemic will, through worsening the social determinants of mental health, compound this crisis. Still, the pandemic also presents a unique and historic opportunity to reimagine mental healthcare, for its mental health impacts have been widely documented and recognized and the inability of the existing mental healthcare system to respond to these populations-wide impacts have also been fully exposed. This may well represent an opportune moment to mobilize the political will, resources, and community demand for scaling up the science which demonstrates the need to embrace the diversity of experiences and interventions to address this crisis. Political will is needed not only to contribute materially but also to support the engagement of a more diverse workforce to deliver mental health interventions and to empower persons with the lived experience to hold services accountable.

In the spirit of the Sustainable Development Goals, the moral imperative for mental healthcare is to leave no one behind by implementing evidence-informed community delivered programs for the care and prevention of mental illness, embedded in a universal health coverage and empowerment framework. Investing in such a reformed mental health system can enable individuals to regain hope for the future and the necessary cognitive and emotional capabilities to be effective in their work and personal lives and to participate meaningfully in one's social world. Collectively, it can help to build stronger, more cohesive communities, improving their capacities to confront not only the pandemic but also the economic and ecological crises that loom in our post-pandemic future. Ultimately, we need to recognize and celebrate mental health as a fundamental, universal human quality, an indivisible part of health important to all people in all countries, and for which care should be regarded as a global public good.

Note

1 From Patel and Saxena 2019.

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