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In the context of mental healthcare, all
mental health coverage?
Why have countries failed to achieve universal
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How can mental health interventions be
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90%.4 Quality gaps (a measure of the effec-
tiveness of the coverage) are even larger. Across all income categories, countries invest tiny fractions of their healthcare budgets on mental health, disproportionately less than the burden of mental disorders.3 This results in an inadequate number of mental health professionals per capita, a massive shortage of community based men-
tal healthcare, and the persistence of badly run large mental hospitals.

These barriers to supply are compounded
by barriers to demand, related to stigma and the discrepancies between biomedical framing of mental health problems and the conceptualisation of emotional distress in the community. Barriers to demand are one of the reasons for the large gaps in coverage observed in well resourced contexts, where universal supply of mental healthcare interventions has been largely attained—such as in the UK with its diverse mental healthcare programmes including community based mental healthcare teams and the Improving Access to Psychological Therapies programme. Further, national averages hide enormous inequities within countries, both geographic and societal—indigenous, minority, rural, and socially and economically disadvantaged communities have much poorer access to quality care. A particularly egregious example is people with severe mental disorders experiencing a loss of up to half their life expectancy relative to the general population,6 being more likely to experience homelessness and marginalisation, and being denied the basic rights to freedom and dignity through incarceration in hospitals or prisons.7

Since the Alma Ata declaration in 1978, the means of improving access to mental healthcare has been to integrate it with primary healthcare. But after four decades of trying, we know that achieving such integration at scale will require nothing short of a wholesale re-engineering of the healthcare system. At the heart of the challenge is the architecture of primary healthcare in most countries, which is simply not fit for the integration of mental disorders (or any chronic condition).8 Historically, primary healthcare was for acute or episodic medical events—from cuts to colds, extending to childbirth and the management of acute infections such as malaria and diarrhoea. Anything more complex (involving long term care or requiring a person centred approach to care, beyond a reductionist biomedical diagnosis) was either ignored or passed to secondary care. Attempts to integrate mental health have failed because they have not tackled these fundamental barriers; instead, they have tried to replicate secondary care in primary care—for example, by posting psychiatrists in primary healthcare centres,9 10 a strategy that is neither scalable nor necessary.

How can mental healthcare be integrated into
primary care?
A key element of the field of global men-
tal health is the design and evaluation of
innovative strategies for integrating cost
effective pharmacological and psycho-
social interventions in primary health-
care.11 11 The evidence from this work, from
a range of contexts including high income
countries, is showing the way to integra-
tion.1 A theme across this evidence is the
placement of non-specialised providers
(including peers, community health work-
ers, and nurses) in primary healthcare and
community settings to perform diverse roles
such as coordinating collaborative care12; educating and mobilising the community to increase demand for care13; supporting families and patients to tackle proximal social determinants of mental health; and delivering empirically supported psycho-
logical and social interventions.14

The growing recognition that binary
models of diagnosis of mental disorders do
not capture the dimensional distribution
of symptoms, distress, and disability of
mental health problems in the population
has important implications for treatment
planning. A “one size fits all” approach
does not work. Instead, we need a
staged approach whereby interventions

mental disorders are the lead-
ing contributor to the global
burden of years lived with
disability.1 The burden and
cost of untreated mental dis-
orders is immense for individuals, families,
communities, and ultimately the world.2
A key strategy to tackling this burden is
universal coverage of cost effective inter-
ventions for mental disorders,3 one target
of the sustainable development goals. We
analyse key questions related to this goal: why have countries failed to achieve univer-
al health coverage for mental disorders?
How can mental health interventions be
integrated in primary healthcare, the foun-
dational platform of delivery of universal
health coverage? What are the lessons for
integrating other chronic conditions into
primary healthcare?

It is estimated that across the full range of chronic conditions, including mental disorders, costs are one target
of the sustainable development goals. We
analyse key questions related to this goal: why have countries failed to achieve universal
health coverage for mental disorders?
How can mental health interventions be
integrated in primary healthcare, the foun-
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• All countries have failed to achieve
universal health coverage for mental
disorders, owing to barriers related to
budget and stigma
• The architecture of primary health-
care in most countries is simply not fit
for the integration of mental disorders
(or any chronic condition)
• Integration can be achieved using an
approach that is person centred, col-
laborative, compassionate, engaged
with the community, and that
includes long term planning
• These principles could be applied
across the full range of chronic con-
ditions

KEY MESSAGES
are delivered based on both symptom severity and the effect of these symptoms on distress and disability.\textsuperscript{15} This aligns with the notion that most care targeting relatively mild, early, or transient stages of mental distress can be delivered through self care and by non-specialist providers with appropriate skills. This facilitates quicker recovery for those people while simultaneously identifying those who might need more intensive interventions for referral to specialised providers. This approach, which reduces the emphasis on biomedical diagnoses, is also more likely to be acceptable to the wider population and to be less stigmatising.

The exponential growth of digital health innovations—spanning guided self care, training and supervision of frontline workers, remote consultations by specialist providers, and remote monitoring of mental health—offers a transformative opportunity to bypass historical structural barriers to enabling task sharing and collaborative care.\textsuperscript{16} Several examples of innovative programmes and projects can be found in the Mental Health Innovation Network (www.mhinnovation.net) and the Lancet Commission on Global Mental Health and Sustainable Development.\textsuperscript{17}

We have identified five key elements needed to integrate mental health in primary care, which we refer to as the “5C approach” (box 1). Although these elements were derived from innovations seeking to attain universal coverage of mental healthcare, they can be applied to the full range of chronic conditions.

Three key points need to be emphasised. First, integration must cover the full range of mental disorders, in particular ensuring that people with severely disabling conditions—such as schizophrenia, alcohol and drug dependence, and dementia—are not left behind as they are less likely to seek care, less likely to use digital technology, and more likely to experience discrimination, isolation, and premature mortality. Second, coverage must be equity sensitive, recognising that subgroups in the population that experience higher levels of deprivation or exclusion, such as poor people, refugees or ethnic, religious, or sexual minorities, bear a disproportionate burden of mental disorders. Third, integration must emphasise quality of care for both the mental disorder (for example, to abolish coercive, harmful, and abusive practices) and co-existing physical health conditions, which are major contributors to premature mortality.

**What are the lessons for integrating chronic conditions?**
Mental healthcare has led the development of care strategies for health conditions characterised by a chronic, episodic, or relapsing course. At the heart of these innovations is the transition of delivery of long term care from institutions to the community, with the goal of decreasing disabilities, optimising quality of life, slowing disease progression, and minimising the risk of relapse. Interventions have focused on “recovery” by going beyond the specific symptoms of the disorder to tackle impairments in daily life and experiences prioritised by the patient—the hallmark of person centred care.

Mental health programmes have championed the integration of pharmacological with psychological and social interventions, referred to as the biopsychosocial approach to care; the engagement of family members (where culturally appropriate and agreed with the patient) to support recovery and tackling the needs of caregivers; and intersectoral interventions to promote the inclusion of people with mental disabilities and to promote mental health. Examples of innovative delivery strategies include using non-specialist providers, including peers, to deliver psychosocial interventions,\textsuperscript{16} using digital platforms to support guided self care and training and supervision of providers,\textsuperscript{16} and using collaborative care with case managers to manage multiple morbidities.\textsuperscript{12, 18} Engaging civil society to increase the demand for care, to tackle stigma and discrimination, and to design, deliver, and hold services accountable has helped reduce barriers to demand while also empowering people with lived experience.

Despite robust evidence from pilot studies and trials, little progress has been made in scaling up these strategies in most countries.\textsuperscript{19} Major barriers that remain include financing of non-specialist providers to deliver psychosocial interventions; implementing scalable approaches to training, supervision, support, and quality assurance; and institutionalising collaborative and coordinated care. The goal of improving the recognition of mental disorders and delivery of mental health interventions in primary care remains a distant one for most of the world.

This focus on implementation science is at the heart of the work of the PRIME consortium\textsuperscript{10} (sponsored by the UK Department for International Development) and the National Institute of Mental Health’s research partnerships for scaling up mental health interventions in low and middle income countries (https://www.nimh.nih.gov/about/organization/cgmhr/scaleuphubs/index.shtml). The goal is to show how routine healthcare systems can fully integrate the strategies that have proved effective for the management of mental disorders. A key strategy is integration of care with other chronic conditions. Mental disorders (including substance use disorders), for example, worsen the outcomes of cardiovascular and metabolic disorders, which are major contributors to the premature mortality of people with severe mental disorders.\textsuperscript{18} The synergies between non-communicable diseases and mental health problems are recognised in inclusion of mental health in the scope of the World Health Organization’s independent high level commission and the United Nations’ high level meeting on non-communicable diseases.

**Conclusions**
As the global health community reflects on the role of primary healthcare in this 40th anniversary of the historic Alma Ata declaration, we reaffirm the view that pri-
mary healthcare must be the foundation of the architecture of universal health coverage to realise the goals of reducing the unmet need for mental healthcare globally. Achieving this, however, will require fundamental re-engineering of the way that primary healthcare is conceptualised, organised, and delivered, and this, in turn, will need the full engagement and support of all actors in universal healthcare, not least people who are affected by mental disorders. The rising burden of mental disorders, in all countries, requires immediate and dramatic actions, informed by the rich body of evidence on delivery innovations from diverse contexts. Failure to do so will mean failure to achieve universal health coverage—universal refers not just to coverage of the population but also coverage of the full range of its health needs, and health should be considered comprehensively, to include mental health and social wellbeing alongside physical health.

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