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The path to global equity in mental health care in the context of COVID-19

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health governance for the benefit of all. Young people want a world in which everyone has the digital access, capacities, and skills to benefit from and meaningfully contribute to future digital health ecosystems.[7,8] Policy makers must build and expand resources and opportunities for young people to have agency over designing more equitable and sustainable health futures for all.[9,10] Youth will continue to stand at the forefront of health governance, extending the Commission's work beyond the report launch and shaping health futures for generations to come.

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The path to global equity in mental health care in the context of COVID-19

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The theme of the 2021 World Mental Health Day is "Mental Health in an Unequal World", highlighting unequal access to mental health care across the world. This situation has been further worsened by governmental and public responses to the COVID-19 pandemic. The response of many high-income countries (HICs) and institutions to the pandemic has been the reverse of equity, exemplified by inequitable access to COVID-19 vaccines and widening inequities in wealth.[1] A crucial consideration in this context is the imbalance in social and economic factors that shape onset and outcomes of mental health across communities and countries.[2] Looking through a lens of equity, some individuals and populations need greater—not equal—intensity of mental health promotion, prevention, and treatment efforts because of the constellation of adversities, social marginalisation, and burden of ill health they experience.

The growing inequity in systems of health and wealth has profound implications for a vision of mental health for all. Although pre-existing mental health inequities are being exacerbated by the COVID-19 pandemic in many settings, the data needed to call out inequity in the impacts of COVID-19 on mental health care are inequitably distributed, with scarce data available from refugee populations and low-income countries. As a group of clinicians, researchers, educators, and people with lived experience of mental illness, we call for services that are responsive to the different circumstances of individuals and communities rather than a system that offers the same, or equal, care for all. We propose that mental health in response to COVID-19 has to be framed around equity, particularly in relation to human rights and universal health coverage (UHC).

Future efforts to achieve equity in mental health should address the domains shown in the panel and

include four key actions. First, financial investment needs an equity focus on areas with the greatest exposure to risk factors of mental illness and the least access to mental health services. The UN movement for UHC, which complements the Sustainable Development Goals, captures this focus with its call for equitable distribution of health-care workers rather than a one-size-fits-all approach to health care. Sadly, we are far from global equity in financial investment for mental health services. Compared to other health conditions in low-income and middle-income countries (LMICs), mental disorders receive the least amount of philanthropic funding and account for only 0·5% of the total development assistance for health.[3] This under-resourcing of mental health care in LMICs has been compounded by the COVID-19 pandemic, as exemplified by the withdrawal of funding by some HICs for health programmes in LMICs.[4] As a result, there have been increasing treatment gaps for mental health care in the places where it is most needed that are expected to worsen during COVID-19 even as needs for these services increase.[5]

Second, growing social and economic inequities need to be tackled as global mental health threats, given that social determinants are core drivers of mental health and poor outcomes in people with mental health conditions.[6] Strategies should recognise the wide-ranging impact of COVID-19 on individual mental health and incorporate investment in all sectors that directly impact mental health, such as education, employment, and human rights protection. For example, anti-discrimination policies represent a multisectoral strategy that can yield economic and health improvements through housing, education, employment, civic participation, and responsive mental health care.[7] Such strategies are consistent with a syndemic framing.[8] Populations experiencing forced migration exemplify groups that should receive the increased mental health investment and support.[9]

Third, policy makers and practitioners need to prioritise people with mental illness likely to experience severe lifelong consequences if they are not adequately supported during the COVID-19 response. This includes the consequences of inequitable access to COVID-19 preventive actions and treatment for people with mental health conditions, which, when combined with differential exposure to economic impacts, might worsen their pre-existing risk of premature mortality.[10] Global efforts have largely focused on equalising access to mental health care through task-shared delivery of low-intensity mental health interventions integrated in primary and general health-care settings and community platforms.[11] Although this approach is more equitable than inaccessible, centralised, institution-dominated mental health services, a subgroup of people with severe mental illness have complex needs that cannot be met

***Panel:* Questions to guide effective global strategies for equity in mental health care in the COVID-19 pandemic and beyond**

Involvement of people with lived experience
How can people with lived experiences of mental health conditions be sustainably supported and mobilised to have a place at the table when determining how scarce mental health resources should be deployed to maximise rights and recovery?

Data collection in health care
How can we collect and integrate data on changes in social determinants of health so that health-care systems can preferentially respond to those with the highest risk and need?

Services
How do we implement services that flexibly respond to the intensity of a population's needs among those most severely affected by discriminatory COVID-19 responses and policies?

Care providers
How can mental health-care providers, including specialists and non-specialists, be leveraged in proportion to those populations in the greatest need of services?

Innovations
How do we devise innovative, accessible, and youth-friendly services for young people and their families to facilitate the pathway to obtain help when needed in settings with growing poverty, unstable housing, and limited technology access, partly resulting from government (in)actions related to COVID-19?

Policy
How do we explicitly incorporate equity objectives into global health policy activities and intersectoral programmes responding to COVID-19, to create alignment with the expansion of the definition of mental health to be more inclusive of mental wellbeing as an essential feature of development?

Cost-effectiveness
What will be the costs and benefits of an equity-based approach to mental health services responding to COVID-19, and how do we measure these to incorporate the social benefit and moral imperative to preferentially respond to the most vulnerable groups?

by non-specialists alone, including perinatal women with psychosis and people with comorbid substance misuse, forensic histories, or refractory illness.[12]

Fourth, advances in promotion, prevention, and intervention strategies should focus on low-resource settings. New interventions that can only be deployed in HICs are unlikely to yield a global reduction in the burden of mental ill health. Given the digital divide between HICs and LMICs and within all countries,[13] the growing attention to technological solutions in mental health care during the COVID-19 pandemic[14] risks widening disparities in health care in settings without access. Although there are examples of digital health initiatives across the globe during the COVID-19 pandemic that reduce rather than reinforce mental ill health, such as programmes for detection and treatment of depression, anxiety, and child and adolescent mental ill health in LMICs,[15] reliance on remote delivery and digital technology is most likely to disadvantage those living in poverty, families with unstable housing, and people with low technological literacy.[13]

Cutting across these four actions is the need to stand up against the stigma that leads to those people with lived experience of mental health conditions with the greatest needs for care being least likely to receive it. The voices of people with lived experience of mental ill health should be at the heart of determining the settings and strategies to prioritise equity during the COVID-19 response and in the post-pandemic recovery. Recovery from the pandemic will require us to calibrate a different value and belief structure that will require a whole-of-society and whole-of-person approach to human wellbeing, rather than strategies that limit health and wealth to those individuals and societies who already have them.

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