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A Partnership for Transforming Mental Health Globally

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A partnership for transforming mental health globally



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The large and increasing burden of mental and substance use disorders, its association with social disadvantage and decreased economic output, and the substantial treatment gaps across country-income levels, are propelling mental health into the global spotlight. The inclusion of targets related to mental health and wellbeing in the UN's Sustainable Development Goals, as well as several national and global initiatives that formed during the past 5 years, signal an increasing momentum toward providing appropriate financing for global mental health. Drawing on the organisational and financial architecture of two successful global health scale-up efforts (the fight against HIV/AIDS and the improvement of maternal and child health) and the organisational models that have emerged to finance these and other global health initiatives, we propose a multi-sectoral and multi-organisational Partnership for Global Mental Health to serve two main functions. First is the mobilisation of funds, including raising, pooling, disbursing, and allocating. Second is stewardship, including supporting countries to use funds effectively, evaluate results, and hold stakeholders accountable. Such a partnership would necessarily involve stakeholders from the mental health field, civil society, donors, development agencies, and country-level stakeholders, organised into hubs responsible for financing, scale-up, and accountability.

The need to invest in global mental health

Mental and substance use disorders, suicide, and neurological disorders such as dementia affect more than a billion people annually, account for an estimated third of the global burden of disability, and result in 14% of global deaths.^{1,2} Despite this disease burden and its socioeconomic consequences being well established,³⁻⁶ the proportion of people with common mental disorders who receive minimally adequate care does not ever reach 1% in low-income countries, only 10% in relatively wealthy middle-income countries such as India and China, and 50% in most high-income countries.^{7,8} People with severe mental disorders often face violations of their fundamental human rights of dignity, freedom, and autonomy.

The evidence and experience base required to deliver and scale up effective interventions across socially, economically, and geographically diverse settings, notably through streamlining the content of interventions, using task-sharing models, and deploying select technological innovations, is robust.⁹⁻¹¹ Despite the emerging consensus on the need to improve global mental health outcomes and the evidence on how to do it, most countries are not prepared to scale up services on their own.¹² In fact, no country can claim to have solved the challenges posed by the population-level burden related to mental disorders: when it comes to mental health, "all countries are developing countries".¹³ WHO estimates that the median global spending by governments on mental health is below 2% of their health budgets, highlighting the striking imbalance between spending and burden and the need to mobilise national funding and global solidarity in a coordinated manner to support country-level efforts.¹⁴

The time is ripe for the constitution of an innovative, diverse, goal-oriented, and well-resourced Partnership for Global Mental Health that builds on the recommendations of the *Lancet* Commission on global mental health and sustainable development and the WHO high-level commission on non-communicable diseases.^{15,16} This

paper is part of an ongoing conversation in the global mental health field to address the structural barriers to scaling up mental health care. Diverse constituencies are involved in this discussion, including mental health leaders and providers, civil society advocates, donors, and decision makers. The challenge at this juncture is to delineate the concrete steps that need to be taken to leverage the collective experience of the global health field, in order to inform the process of pooling and allocating funds to improve global outcomes for mental health.

There are two aspects to this challenge. First, facing outwards, the global mental health field needs a partnership that offers a credible option for donors, investors, and countries for the strategic allocation and transparent management of their funds to maximise impact on health outcomes. Facing inwards, the growing flotilla of organisations needs to be integrated within an agreed framework of processes and goals. The *Lancet* Commission on global mental health and sustainable development highlights the fragmentation of constituencies and the usually ad-hoc nature of collaborations. Each multilateral organisation, non-governmental organisation, donor, and government pursues its own subset of priorities; this practice sometimes allows for punctual coordination but hinders sustained collaborations. The scarcity of formal mechanisms to negotiate differences causes stakeholders to periodically agree to disagree and move back to their own silos. This inconsistency is particularly problematic for mental health because the field is not dealing with a single disease (as in the case of the global HIV response) but with a constellation of disorders and health states across the life course that foster fragmentation of scopes, perspectives, and approaches. So, despite the plethora of existing organisations, the absence of a formal partnership focused specifically on global mental health has led to missing out on the astonishing growth in overall financing of global health, which is directed instead to health priorities with better developed governance

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mechanisms.^{17,18} The Sustainable Development Goals and the Universal Health Coverage agenda provide new impetus for the global mental health field, building on the World Health Report, the *Lancet* Commissions, and the WHO Mental Health Gap Action Programme and mental health action plan. To catalyse this momentum into actionable steps, a purposeful governance framework is needed. Established networks, such as the Movement for Global Mental Health and the Mental Health Innovations Networks, and emerging efforts such as the Global Campaign for Mental Health offer the foundations of a partnership and indicate that the time is ripe for establishing a multipolar and inclusive partnership to address the challenge of financing a global scale-up of mental health services. The question is how.

A body of literature on the governance of global health initiatives has emerged over the past decade, examining the mechanisms through which such initiatives succeed in achieving their stated goals and the factors that limit their impact.^{19–22} A purposeful governance framework is required because most global health challenges, particularly for mental health, are not the result of country-bound or sector-specific processes, but of a complex web of interactions between state stakeholders and non-state stakeholders, all of which are interdependent and share the power, responsibility, and consequences of decision making on public health.^{19,20} Drawing on this literature, we posit that a partnership of key stakeholders should coalesce under the banner of global mental health and leverage the optimal governance mechanisms identified during the past two decades to achieve outcome and procedural legitimacy. Considering the four major functions²³ of global health systems (producing public goods, managing global externalities, mobilising solidarity, and exercising stewardship) we argue that the key challenges that have been holding the field back are mobilising global solidarity and exercising stewardship to ensure this solidarity is translated into coordinated actions with demonstrable results. With respect to the other functions, the production of public mental health goods has blossomed in the past two decades, particularly in the form of evidence on the effectiveness and cost-effectiveness of scalable interventions and the emergence of global academic collaborations. Whereas other health fields are waiting for an innovation to be developed, we have the innovations but lack the funding and agreed priorities. As for managing global externalities, such as caring for the mental health of refugees and displaced populations, they are indeed fundamental global mental health challenges, and the multilateral agencies that care for these populations should be key stakeholders in the proposed partnership.

Global health success stories: curbing the AIDS epidemic and improving maternal and child health

Transformative advances in delivering health care for previously identified priorities have been achieved

through fund mobilisation and scale-up efforts. We draw on two highly successful endeavours, the fight against AIDS and the effort to improve maternal and child health outcomes, to consider the most appropriate model for a global mental health scale-up strategy and governance architecture.^{24,25} Although AIDS is a single disease with a clearly defined aetiology, it shares with mental disorders characteristics of stigma, human rights abuses, and a sluggish initial global response despite the evidence of transformative interventions. Through coordinated advocacy by a coalition of diverse stakeholders, the challenge of AIDS was met with unprecedented scientific, medical, political, and economic force within two decades of its emergence. Maternal and child health, which shares the complexity of determinants and heterogeneity of conditions characterising mental health, was neglected for decades until diverse stakeholders from multiple constituencies began to converge in what would ultimately become WHO's Partnership for Maternal, Newborn, and Child Health (PMNCH) in 2005, the UN's Every Woman Every Child (EWEC) strategy in 2010, and the World Bank's Global Financing Facility (GFF) in 2015. These three very different paths led to previously unimaginable global impacts. Both health domains were included in the Millennium Development Goals and the concerted action to address them has led to HIV infection becoming, in most regions, a chronic condition compatible with a healthy, fulfilling life, and to substantial reductions in maternal and under-5 mortality in all world regions. This is the scale of global impact we can, and must, achieve for mental health.

Important lessons can be learned from the governance models that made these two successful endeavours possible. We will focus first on three examples: the Global Fund to Fight AIDS, Tuberculosis, and Malaria, as a model for free-standing hybrid organisations; the PMNCH as a model of an organisation embedded in WHO; and the GFF as a model of a World Bank-embedded organisation. Finally, we will focus on a more recent case: the Coalition for Epidemic Preparedness Innovations, which combines elements from the previous three models with an innovative approach to autonomy and sustainability.

In the case of HIV, the Global Fund was created in 2002 for the unique purpose of pooling and disbursing US\$4 billion per year (more than double the annual budget of WHO) to curb a seemingly unstoppable pandemic. This model (referred to as a hybrid in the governance literature because of its combination of public and private approaches to key functional features)^{19,26} sought to achieve procedural legitimacy by delineating clear constituencies and a board representing each of them, including governments, donors, the private sector, non-profits, communities, and multilateral organisations. Outcome legitimacy rested on achieving optimal allocation, evaluation, and accountability, an iterative process of refining the allocation formulas, and

For more on the **Movement for Global Mental Health** see <http://www.globalmentalhealth.org/>

For more on the **Mental Health Innovations Networks** see <http://www.mhinnovation.net/>

For more on the **Global Campaign for Mental Health** see <http://gcfmh.org/>

For more information on **PMNCH** see <http://www.who.int/pmnch/en>

For more information on **EWEC** see <https://www.everywomaneverychild.org>

For more information on **GFF** see <https://www.globalfinancingfacility.org>

For more on the **Global Fund to Fight AIDS** see <https://www.theglobalfund.org/en>

improving mechanisms to weed out inefficient, mismanaged, or fraudulent organisations.

By contrast with this single freestanding hybrid, a constellation of interrelated organisations embedded in multilaterals emerged to steward the global effort to improve outcomes of maternal and child health. The PMNCH was created 3 years after the Global Fund, also to accelerate the pace towards the Millennium Development Goals but following a different model. PMNCH resulted from the merger of three pre-existing institutions comprising 80 members and is embedded in WHO. It raises approximately \$10 million per year to sustain stewardship efforts that it implements itself in collaboration with partners, which include governments, multilateral and hybrid organisations, and its current member organisations, which number more than 1000. It is governed by an inclusive and diverse board and has a secretariat staffed by WHO.

The GFF is a World Bank-based institution created to support interventions in maternal and child health by facilitating financing in a specific set of low-income countries. It provides only limited seed funding, and its main tools are the alignment of development assistance and government spending and the achievement of efficiency gains in government expenditures. It is governed by an investor group that includes countries, donors, non-governmental organisations, and multilateral organisations. Both the PMNCH and the GFF operate under the umbrella of the EWEC strategy, created by the UN, as a unified roadmap that seeks to streamline existing accountability mechanisms to ensure consistency across goals and indicators. The EWEC strategy (that includes six major UN agencies) seeks financial, policy, and service pledges through its website, which reports that \$45 billion in commitments have been disbursed by a multitude of institutions since 2010.

These three examples (Global Fund, PMNCH, and GFF) differ in two key aspects: whether they are freestanding or embedded organisations and whether their primary role is focused on fund mobilisation (including pooling, allocating, and disbursing) or on stewardship (including advocacy and technical guidance).¹⁹ With respect to the former, we argue that the ideal organisation for the global mental health field would need to have autonomy from pre-existing structures. Despite valid concerns about the concentration of power in a handful of major donors,²⁷ one of the advantages of the Global Fund is its intended procedural legitimacy, warranted by its diverse constituencies and the absence of one dominant partner, a feature that could be specifically strengthened in a new organisation. Its main disadvantage as a template for global mental health results from this very characteristic: a freestanding hybrid would involve substantial start-up and operating costs, probably beyond the means currently available for the field, leading to a high risk of failure. At the other end of this spectrum of autonomy are the fully embedded organisations that appear vulnerable to

the path dependency identified by their hosts in terms of goals and procedures. The GFF is a lean facilitation scheme focused on obtaining efficiency gains in a specific set of low-income countries, and the PMNCH has evolved into an ever-expanding constellation of partners, supported by many highly trained staff focused on setting a global agenda. Another important question is whether an organisation tasked directly with pooling and disbursing of funds (following the Global Fund model) or with advocacy, capacity building, and seeking pledges (following the PMNCH and EWEC strategy) would be preferable for the mental health field. We posit that actively pooling and disbursing funds is a preferable avenue; advocacy and capacity-building are already under the purview of WHO and seeking external pledges would risk reinforcing the fragmentation of the mental health field. Indeed, a pledge-seeking scheme (even if pledges are made under agreed goals) would at best lead to gradual improvements in the consistency of the disparate goals and methods currently pursued globally. However, such an incremental, piecemeal approach would be woefully inadequate to jump-start the processes in low-income countries where mental health services often need to be built from scratch, and in middle-income countries where funds currently captured by specialised hospitals and niche interventions need to be redirected to strengthen primary care and community services. Also, funders need to know that their solidarity will be spent in target countries and used directly to improve local outcomes, rather than funding multilateral entities.

In panel 1 we summarise advantages and lessons of the three models already described in this Personal View, alongside a fourth model, which draws on elements from the previous ones but also presents an innovation: an autonomous partnership with a secretariat housed not in a multilateral, but in an expert organisation. An example of this model is the Coalition for Epidemic Preparedness Innovations, a start-up partnership that emerged from the aftermath of the Ebola epidemic. A collaboration between academics and implementers analysed the global response to the epidemic and proposed an approach to improve it, and an interface with business and multilateral leaders during World Economic Forum meetings galvanised this collaboration into action through funding.²⁸ The Coalition received an endowment from the Bill & Melinda Gates Foundation, the Governments of India and Norway, and the World Economic Forum, which is held at the World Bank. It is governed by a diverse board that includes all stakeholders involved, and its secretariat is provided in an interim manner by the Norwegian Institute of Public Health. The secretariat received operational seed funding from Norway, India, and the Wellcome Trust, and its budget was approved by the board.

In this context, we posit that requisite organisational characteristics for governance include representation of diverse constituencies, autonomy from existing bureaucracies or specific vested interests, and

Panel 1: Strengths and lessons from existing organisational models for governance

World Bank—eg, the Global Financing Facility

World Bank leadership has shown a vision aligned with the prioritisation of mental health. The Bank would provide legitimacy as per the donor community and national authorities in most donor and recipient countries. Given the potential for path dependency in terms of procedures and goals resulting from being a World Bank agency, an optimal trade-off for a partnership would have to have the World Bank as a Hub leader providing its unique expertise in managing financial intermediary funds to the partnership (including holding, investing, disbursing funds, as well as issuing bonds and other instruments). The Bank plays a similar role for the Global Fund and the Coalition for Epidemic Preparedness Innovations (CEPI) by holding their trust funds.

WHO—eg, the Partnership for Maternal, Neonatal, and Child Health

A partnership with WHO would provide technical and ethical credibility. To some extent, a WHO-embedded group would be an incremental step from the status quo, in that the flotilla of global mental health organisations could coalesce around WHO’s mandate, gaining focus and coordination for agenda-setting. Similar risks of path dependency need to be considered in this case: the primary focus of a WHO agency would most likely be constrained to stewardship functions, rather than to fund mobilisation. Since advocacy, outcome monitoring, and capacity-building are already part of WHO’s mandate, it is unclear how another WHO-based office would contribute further. Instead, the partnership would benefit from having WHO as a key partner to lead the hub building advocacy and capacity.

Hybrid organisation—eg, the Global Fund to Fight AIDS, Tuberculosis and Malaria

A hybrid model would allow for plural governance by key public and private stakeholders, providing relative autonomy from specific stakeholders. Initial bureaucratic constraints and path dependency would be minimised and a favourable setting for innovative funding, development, implementation, and evaluation practices would be provided. Considering the large start-up and operational costs of free-standing hybrids, instead of creating another vertical disease-specific organisation, a feasible path for the global mental health field would be to retain an autonomous nature for the partnership, while gaining sustainability by relying on an expert organisation for start-up and logistical support.

Partnership hosted by an organisation or consortium with mental health expertise—eg, CEPI

A diverse decision-making board representing key constituencies including crucial economic and implementing stakeholders (see panel 3) would ensure plurality and process legitimacy and would also avert the perception of the partnership as oriented towards research rather than scale-up. An organisation with well established expertise in global mental health—an academic or scientific centre or consortium—could provide an optimal secretariat. It would be reliable, nimble, and versatile, with relatively low start-up costs. It would also be able to tap donors in a similar manner as CEPI.

sustainability. Achieving this combination of ingredients presents a singular challenge that none of the more traditional models seem to fully satisfy. A model similar to the Global Fund would be inclusive, diverse, and autonomous, but unlikely to be feasible or sustainable. An organisation fully embedded in a UN agency could set up a diverse governing board, but its structures, processes, and goals would be set by the hosting organisation. So, how can autonomy, plurality, and sustainability be achieved? How can the invaluable contribution of the UN and its agencies be leveraged without saddling them with the burden of further

expansion and the path dependency that these large multilateral bodies would impose on a fledgling organisation? The last model we presented, the autonomous partnership with logistical support by an expert organisation offers an adequate balance of autonomy and sustainability.

A partnership for global mental health

We propose an autonomous and inclusive Partnership for Global Mental Health, supported logistically by a secretariat provided by an expert organisation or consortium. Our proposal seeks to leverage the strengths of the governance models described above, while minimising predictable risks and threats to organisational legitimacy and sustainability.

The partnership is envisioned as a well structured network of organisations with the following priority tasks: bringing together key and diverse constituencies and stakeholders; developing an array of financial instruments capable of attracting, pooling, and disbursing the necessary funds; setting geographic, thematic, and population group priorities; connecting delivery and expert organisations to design, build capacity for, implement, and evaluate the scale-up; and developing mechanisms to assess results and hold grantees accountable. Until now, the central limitation to global mental health services scale-up has been the mobilisation of funds commensurate to the need for such funds. However, the main funding sources and mechanisms capable of supporting such a process have already been identified thanks to other endeavours in global health and development (panel 2). Plus, the World Bank and other key economic stakeholders have shown an interest in “making mental health a global development priority”³ and have made concrete pledges to support this pursuit. Donors are increasingly willing to fund global mental health programmes, and there are new organisations formed with the sole goal of mobilising resources for mental health through advocacy (such as the Global Campaign for Mental Health). So, we believe now is a particularly opportune time for this proposal.

Key constituencies would include multilateral agencies, national governments, donors, development banks, universities and institutes with expertise in global mental health implementation, health service delivery organisations, and civil society organisations representing the voices of persons with lived experience. All would be represented at the governance drawing board, with the goal of achieving a collective commitment to actionable consensus (panel 3). The partnership’s board would be the decision-making body and it should be elected in a way that warrants procedural legitimacy by being truly representative of all partners. The experience of the Global Fund indicates that donors are willing to invest in credible organisations governed by diverse boards, especially when multilateral banks and private sector partners are also willing to invest and join the governance structure. The board would set priorities and decide allocation

Panel 2: Funding mechanisms and their objectives

Development assistance and philanthropy—integrating mental health components into other development priorities and packages

A key step forward would be achieved by requiring the inclusion of mental health components into development assistance for health packages, as well as mental health impact assessments for development packages in general (analogous to environmental impact assessments for infrastructure projects).²⁹ Another possible feature is implementing debt-for-mental-health swaps, through which donor countries swap payments by debt-distressed countries for local mental health investments.

Governments—investing in mental health directly and by strengthening health systems

High-income countries should increase funding for mental health, since this is a rational approach to control the costs of health systems and to increase workforce productivity. In low-income countries, overall government expenditure is low, health spending is even lower, and mental health funds are (near) nil.³⁰ Advocating for increased funding in this context would not be an effective strategy in and of itself. Instead, a call for governments to increase the fiscal space for mental health funding needs to be combined with an appeal to global solidarity. This strategy has been a game changer for the strengthening and improvement of the quality of health systems. Increasing fiscal space through so-called sin taxes is a well established government action to raise additional funds by taxing products that are harmful to the individual and costly to society, such as alcohol, tobacco, and other addictive substances.^{31–33} Also, solidarity levies on international travel in high-income countries or on luxury travel globally could be imposed. The resulting funds can be designated for strengthening of the health systems through diagonal interventions, such as integrating mental health services into primary care, maternal health care, and other community-based services.

Finance facilitation—developing strategic international finance-facilitation schemes

Seeking long-term pledges (eg, 15 years) of a fraction of what charities donate every year can provide predictability and help

secure the upfront funds required to progress through loans, while facilitating a strategic and sustainable long-term approach (eg, Education Financing Facility and the Immunization Financing Facility).

Social impact bonds—creating social financing schemes for selected mental, neurological, and substance use outcomes

This mechanism covers the upfront cost of scale-up through bonds that, on maturity, pay the investor an interest tied to the improved outcome. Its key components are well established social priorities, cost-effective interventions, ownership of cost, and impartial outcomes evaluation. Examples schemes are: supported employment for people with schizophrenia; countering isolation for the elderly, thus improving outcomes related to depression, dementia, and general health; inclusion of children with autism and developmental disabilities in the community; and treating parental substance use and improving parent–child attachment to keep families together and avoid out-of-home placement of children (from the Impact Bond Social Database by Social Finance UK).

Public-private partnerships—funding technological innovation to achieve universal coverage

Partnerships between governmental organisations, non-governmental organisations, and leaders in digital technologies can facilitate the development of integrated platforms for telemental health and e-mental health, as well as future versions of mental health care that will be made possible by artificial intelligence.

Corporate investment—directing social responsibility expenditures toward mental health improvements for communities and the work force

Mental health in the workplace is already acknowledged as a key priority by most large corporations, given its impact on productivity and liability implications, so investing in in-house programmes that target mental wellbeing is common practice in some countries.³⁴ With effective advocacy, investing in mental health initiatives for surrounding communities and consumers could become an attractive option for corporate responsibility.

For more on **Social Finance UK** see <https://sibdatabase.socialfinance.org.uk/>

autonomously, while relying on, for instance, the World Bank for financial services (providing credibility for funders or investors), and on WHO agencies and community stakeholders for stewardship, capacity building, and accountability. The diverse constituencies represented in the board would thus converge in hubs with specific key functions and goals. For example, a funding hub, led by donors and development agencies, could facilitate the process of mobilising and holding funds. A stewardship hub, led by WHO, could support countries in developing resources and preparing national plans. An implementation hub, led by expert organisations, could build capacity for the actual scale-up and evaluation

of results. An accountability hub, led by civil society organisations, could enhance transparency. Such a network of hubs would facilitate a balanced integration of expertise and interests, leveraging the experience of organisations with demonstrable capacity, while also engaging key stakeholders across hubs (particularly civil society organisations including people with lived experience) to promote transparency and accountability.

The secretariat, which would provide logistical support to the partnership's governing board, should achieve an optimal combination of technical expertise and credibility within a sustainable and nimble operating framework, with few bureaucratic constraints and path dependencies.

Panel 3: Key stakeholders in the prospective Partnership for Global Mental Health

Financial stakeholders

In order to make a credible case that funds will follow recommendations, major donors, and development banks will need to be involved in the governance structure, demanding transparency and accountability

Governments

Both high-income and low-income countries have a crucial role to play in the development of scale-up strategies, particularly in how to coordinate efforts that leverage global solidarity, while bolstering national ownership and sustainability, and in striking the optimal balance between direct investments in mental health and health system strengthening, which will be country-specific (see panel 2 for details)

Multilateral organisations

UN, WHO, UNICEF, United Nations High Commissioner for Refugees, and other organisations that represent national governments and focus on general or specific populations concerned with mental health issues (eg, refugees, displaced people, or populations affected by conflict) are also necessary partners

Expert organisations

Scientific or academic centres with expertise in global mental health, initiatives concerned with advocating for and mobilising funds for the cause, and professional associations can contribute and pool their first-hand experience from fundraising to establish local partnerships

Health delivery organisations

Governmental or non-governmental organisations concerned with the delivery of mental health care within routine health-care services will provide the expertise needed for local service delivery

Civil society stakeholders

People with lived experience with mental disorders would be the paramount stakeholder, in line with the principle “nothing about us without us”

This role could be played by a centre or consortium with demonstrable expertise in global health implementation and management and capacity to provide support to the partnership, without the overwhelming structure and cost of multilaterals or brand-new initiatives. Such an arrangement can offer sustainable logistical and technical support for the start-up phase independently of short-term funding cycles, until the partnership is well established to sustain operating costs.

Conclusion

A partnership such as the one we propose will face challenges and threats that must be anticipated and mitigated, including: how to ensure a decision-making

process that is based on genuine participation, avoid the emergence of dominant partners, regulate interactions, and manage conflict between stakeholders; how to balance centralisation and distribution of control to combine responsiveness and efficiency optimally; and how to develop effective accountability structures. To address these challenges, our model builds on the experience and strengths of existing organisations, while avoiding some of the risks inherent in fully embedded initiatives and free-standing hybrids. The partnership would ensure legitimate decision making through: a board representing the diverse constituencies; clearly defined and transparent decision-making procedures to avoid dominance of particular interests; and reliance on existing resources and capacities for secretariat functions. We believe that the time is right for this approach to harness and catalyse the growing momentum towards applying the large body of scientific evidence to achieve a global scale-up of effective mental health interventions. Reducing the large care gap and redressing the serious human rights abuses experienced by people with mental and substance use disorders offers a unique opportunity to serve a high moral imperative and advance the world's goals for sustainable development.

Contributors

DVV and AK developed the initial idea and the first draft, including the panels. VP provided extensive comments, together with DVV and AK, to the first and subsequent drafts. AB, GR, and SS provided extensive comments to subsequent drafts. DB and WY provided extensive comments on all aspects related to health economics and financing.

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AB reports future book royalties from Routledge Taylor & Francis Group, outside the submitted work. All other authors declare no competing interests.

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