intervention, quasi-experimental studies can help the field to move ahead; for example, investigating the effect of policy changes or differences in education or family and parenting support across the UK to identify what helps to improve children's health and wellbeing. Another priority is for future research to help to bridge gaps around the understanding of mental health and wellbeing, not only between different disciplines but also between professionals and young people themselves. Finally, most of the report used data that pre-date the COVID-19 pandemic. The 2020 follow-up[10] to the *Mental Health of Children and Young People in England, 2017* survey[2] showed a further rise in the prevalence of mental disorders, with one in six children aged 5–16 years now affected. This increase further emphasises the need to urgently address children's mental health and wellbeing in 2021.

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Perspectives of lived experience across continents: our reality and call for universal health coverage

Global Mental Health Peer Network

See **Comment** pages 3, 5, 8, and 9

The Global Action Plan,[1] signed by major global health agencies, provides a framework that guides collective action towards universal health coverage (UHC) and accelerates progress on the health-related Sustainable Development Goals.[2] However, according to WHO, the world remains a long way from meeting its 2030 targets. Additionally, the COVID-19 pandemic has highlighted how fragile our health systems are in the provision of quality and holistic care. The Global Mental Health Peer Network (GMHPN) aims to highlight the lived experiences of people in various world regions, showcasing that if true recovery is to be achieved, UHC must include the most vulnerable individuals among us and the uniqueness of diverse lived experiences.

For instance, in Africa, there is a shortage of public mental health-care services, and those that are available are costly to members, leaving families to use scarce resources to help their loved ones (CK). The absence of UHC makes it hard for poor communities or those without strong family support to access the help they need. GMHPN members from Cameroon (MAA), Botswana (SBJ), and Zimbabwe (PM) highlighted that they had no concrete help within their countries and continue to experience discrimination in their communities.

Members are often threatened with involuntary institutionalisation (PM), or find that mental health care and services are inaccessible and are left to rely on friends, family, and their religious communities to access some form of support and care. Such a situation was the case for members in Kenya and Ethiopia (CK and EM). Consistently, GMHPN members from across Africa feel the heavy burden of stigma in the community that compounds issues of access. These accounts show that people with a lived experience of mental health conditions are often left behind socially and economically. The aspiration of UHC must account for accessibility, affordability, and a model that is person centred. Such changes would allow for people

with mental health conditions in Africa to access much needed quality physical health and mental health care.

In Brazil, economic and housing vulnerability interact with continued unrest to complicate the realisation of UHC (KA). Additionally, the state of the Quilombolas (a group descended from African slaves) and Indigenous groups living in Rio de Janeiro State shows the urgent need to reduce the gap between academic literature and the actual needs of communities.[3] COVID-19 has further affected structural barriers, such as accessibility to health care, scarcity of safe water, and a reduction of traditional economic and agricultural practices. The collective stress and anxiety to survive in these conditions illustrates to Brazil's mental health advocates that UHC needs to actively consider equity and social contexts as central elements of mental health systems.[4] This account showcases how communities can be associated with severe mental health challenges.

A GMHPN representative from India (SA) highlighted that UHC alone is not sufficient, illustrated in the account of a woman aged 21 years with anxiety disorder who had trouble accessing care during a crisis period. Her parents attempted to get her help and called a peer support worker, looking for information about treatment options. The peer support worker had to inform the family that the psychiatric ward had been converted into a COVID-19 ward, leaving no nearby options accepting psychiatric patients. This account showcases that, even though India has been quoted as having an ambitious plan to achieve UHC, the system remains flawed in its inability to give adequate attention to peer support, recovery, and individual needs.[5]

It is evident that these themes occur across continents. One GMHPN representative's mother with severe treatment-resistant depression was admitted to a Romanian public psychiatric hospital during summer and autumn of 2020 (RMH). The representative's mother suffered an episode of loss of consciousness and fell while at the hospital, with subsequent trauma to the head and back, which is a medico-surgical emergency. An ambulance should have been called, as our representative knows from her practice as a Child and Adolescent Psychiatrist. However, not only did it take 5 days for her mother to be seen by a doctor (and even then, a physical exam was not done) but also, 12 days after the incident, an ambulance had still not been called. Our representative then took her mother from the hospital for further investigations. UHC alone will not change issues of poor policy implementation and equity concerns in Romania.

It is evident from these perspectives that we must aim higher than the prescribed targets and indicators of the Global Action Plan as we work towards the 2030 goal of achieving UHC. Reaching these metrics will not be the finish line. Countries must go beyond achieving UHC and demand that universal health systems are built on foundations of recovery that combine social justice and person-centred responses. At their core, these solutions must include the perspective of lived experience because this will allow us to reshape the health-care systems that have been historically Eurocentric in their mission.[6]

It is important to showcase the work of organisations such as Hacienda of Hope,[7] which describes itself as a safe alternative to emergency hospitalisation for individuals with mental health conditions living in a stressful life event or crisis. Peer guests can stay free of charge while they work on personal growth and wellness in a non-clinical environment, staffed by peers who all have a lived experience of mental health challenges and are able to relate, empathise, and offer hope. Advocacy for the perspective of lived experience within mental health systems is also showcased by the work of Mental Health America, which is the leading community-based non-profit organisation dedicated to addressing the needs of individuals living with mental illness and promoting the overall mental health of all. Mental Health America's national office and its over 200 affiliates and associates around the country work every day to protect the rights and dignity of individuals with lived experience, and ensure that peers and their voices are integrated into all areas of the organisation. Additionally, the organisation has shown a consistent emphasis towards supporting Black, Indigenous, and people of colour (BIPOC), and LGBTQ+ populations.

For more on **Mental Health America** see https://mhanational.org

Additionally, the Rio de Janeiro State Department of Health has been developing a qualification pilot project for reducing the mental health gap, which has the active presence of under-represented groups in policy-making discussions, and is represented in official publications.[8] This group is named Equity

Agents and has representatives from individuals with mental health conditions or severe mental illness, refugees, people living in favelas, BIPOC, homeless individuals, the Quilombola community, ex-prisoners, and the LGBTQ+ population.

It is vital that mental health systems worldwide consider the perspective of lived experience in its formulation and execution. Anything less does everyone a disservice.

KM reports presently working at Mental Health America. KA reports presently working at the State Department of Health, Rio De Janeiro. All other authors declare no competing interests.

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Decriminalising being Black with mental illness

See **Comment** pages 3, 5, 6, and 9

Mental illness should not be a death sentence. Being Black should not be a death sentence. Yet, in 2020 alone we have witnessed how these intersecting identities—Blackness and having a mental illness—have disproportionately led to the murder of Black people by police officers in the USA.[1] The deaths of George Floyd, Ahmaud Arbery, Rayshard Brooks, and Breonna Taylor focused international attention on excessive force used by police. These deaths sparked global protests, centring the Black Lives Matter movement and drawing attention to the grim reality that in the USA Black people are at an increased risk of death at the hands of the police.[1] The *Washington Post* database shows that Black people are killed by police at more than twice the rate of White people, despite constituting only 13% of the US population.[2]

Extraordinary risk lies at the nexus of mental illness, Black identity, and encounters with law enforcement. Police are more likely to kill Black people demonstrating signs of mental illness than White people with similar presentations.[1] The deaths of Natasha McKenna,[3] Daniel Prude,[4] and Walter Wallace Jr[5]—all killed by police or within police custody—were publicised examples revealing enduring trends. An intersectional approach to this deadly trifecta allows for systematic study of how interlocking social and power structures related to race and mental illness place Black people with mental illnesses at risk of criminalisation and harm.[6] Although widely used in sociology and public health, intersectionality has not been broadly applied in psychiatry. It is an applicable frame, as it presumes that the multiple effects of systems of power must be equally considered. Personally mediated racism (defined as the differential assumptions about the motives, intents, and abilities of others based on race),[7] stigma processes associated with mental illness, ethnicity, gender, and racialised diagnoses, wherein Black people receive different diagnoses—and consequently different care trajectories—from others with the same symptoms, inform this particular context of intersectionality.

Often overlooked are the consequences of mental illness criminalisation on communities that are exposed to violence or that engage with victims of traumatising incidents. Little research within the global Black