and bipolar disorder[1,2], is included in SMD, as guidelines on its management are less medication-centric[9]. An overemphasis on pharmacological solutions has been a regrettable trend in response to mental health problems in LMICs[10].

Almost missing in the discussion is the fact that health care delivery in LMICs is dominated by primary health centres, with the bulk being provided by general physicians, nurses and ancillary health workers. Many recommendations based around coordination between mental and physical health care divisions sit uneasily against the reality of primary health centre based care in LMICs, where coordination may be required more in terms of referral between sub-primary, primary and specialist care rather than between specialists of different disciplines.

The proposed framework is not configured to assess whether more holistic and sustainable culturally appropriate interventions for LMICs could be useful. Instead, it mostly focuses on health strategies successfully used in North America and Europe, with emphasis on active engagement in surveillance, education and care. These strategies may or may not translate well to LMIC settings. The authors describe facilitators and barriers to application of recommendations and provide advice on how the recommendations can be put into practice, but do not assess resource implications for application of recommendations and monitoring in under-resourced settings.

Another issue relates to the responsibility and capacity of the state to provide adequate care for its citizens[11]. Persons with SMD tend to live in less safe neighbourhoods, have less access to healthy foods, and have less opportunities to be involved in healthy activities, which may contribute to poor lifestyle behaviours. The proposed framework for intervention largely shies away from comments on structural economic, political and social determinants of mortality in SMD. Rates of inequality and inequity within countries affect the distribution of health and welfare resources, so advances in medical science and health and social welfare sector responses by themselves cannot reduce mortality and morbidity. Moreover, the emphasis on chronic disease self-management and parity in service access, in the absence of structural correctives, may facilitate the erosion of traditional state-centred mechanisms of care and the will to care[11].

Finally, the proposed framework for intervention assumes that improved care for comorbid physical disorders would strengthen the overall response to SMD. However, it is possible that the focus on mortality rather than disability, in the resource strapped settings of LMICs, may draw attention away from the mental disorders in general and towards risk factors that are supposed to underlie both physical and mental illnesses.

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A policy implementer's perspective

We live in a time when we have a fair knowledge about what works for mental health, how best to deliver it, where best to fit the intervention and who should be doing it. Yet we are still far from achieving what we are committing ourselves to in the World Health Organization's Mental Health Action Plan 2013-2020[1].

When it comes to the framework proposed by Liu et al[2] to address the excess mortality in persons with severe mental disorders, it is clear that the authors are tackling all relevant levels with the aim of building up a holistic evidence-based approach to address the issue. Let me list, however, some crucial points.

The first point is an operational one, that can be summarized by the following questions: How does this framework link with local health systems at country level? What would be the cost and what is the best order of implementation of the different proposed interventions? Are there any best buys for countries that cannot fully implement? How does the framework rank in terms of priority with respect to other mental health interventions at country and global levels? Should some proposed interventions – especially policy level ones – be a prerequisite for other clinical ones? For example, should we consider launching tobacco cessation programmes for persons with severe mental disorders even if a country does not have policy regulations in line with the Framework Convention on Tobacco Control? These are the kind of over-arching questions that arise when considering the implementation of this framework.

The second point focuses more on the content of the framework and more explicitly on the groupings used for severe mental disorders and the integration of mental health into primary care.

The inclusion of moderate-to-severe depression within the "severe mental disorders" grouping might be problematic, as the course of that condition, the help-seeking behavior of the person, and the stigma around it are different from those related to schizophrenia. The inclusion of moderate-to-severe depression within the same framework as schizophrenia might be counter-productive for both

disorders, as the implications for service design and delivery seem to be – at least in our experience – different, for example at the primary care level.

Furthermore, when talking about the integration of mental health into primary care, it might be beneficial to allocate some attention to the way it is being done. Although implementation research is still ongoing, the Mental Health Gap Action Programme (mhGAP) Intervention Guide has been useful in training and supervising the primary care staff. However, to ensure the effective and sustainable integration of mental health within health systems, tools for the implementation and incorporation of the mhGAP within existing health systems are much needed. Such tools would help in the allocation of tasks/roles among different professionals at the primary care level, in the care packages and pathways for different disorders, in the health information system, and in the links of the primary care with specialized services.

A lot of attention is also needed for human resources. The tipping point in positive attitude change towards persons with mental disorders for many primary health care staff is often seen after they disclose a personal experience with mental health concerning themselves or a member of their family to an mhGAP supervisor and feel that the supervisor is able to listen and support. Addressing the mental health of the staff is a key action for integrating mental health into primary care and as such deserves closer attention.

A further factor to consider in order to enhance the integration of mental health into primary care is the use of innovations in domains such as management and information technology that have the potential to decrease cost and increase efficiency.

The third point highlights the importance of the context where persons with severe mental disorders live. Two main examples are prisons and humanitarian crisis. It might be a good idea if the framework delineated by Liu et al could include an item to highlight persons with severe mental disorders living in prisons as a vulnerable group in need of specific interventions. The same applies to persons with severe mental disorders living in humanitarian settings, where they are often either locked in big institutions or very disadvantaged in reaching the needed services, which in both cases will put them at a higher risk for premature death.

In summary, details pertaining to the implementation of the framework and to how it links to other mental health priorities are needed. This being said, this framework adds to the available tools and usefully highlights the importance of addressing the excess mortality in persons with severe mental disorders. In low-resource contexts – where mental health systems are under development with competing priorities – mental health disorder management, physical health treatment, screening for medical conditions, and stigma reduction interventions seem to be the components of the framework that would be easier and most important to consider, especially when the health system as a whole is fragmented or facing big challenges.

Finally, as mental health professionals and policy makers, we can learn a lot if we look to other disciplines and to emerging research in related fields, such as the newly published report "Insights for impact"[3]. This can help us increase the coherence of any model we propose with the bigger socio-political and technological world in which we live. Leveraging the knowledge we can gather on management innovations as well as latest evidence in human psychology and in mental health at the workplace, we can develop tailored interventions for health systems management and for the health workforce that would increase the engagement, well-being and efficiency of every health worker and of the system, helping them to achieve their goal of improving the health of the persons served.

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A service user's perspective

To address the alarming rate of excess mortality in persons with severe mental disorders (SMD), a multidimensional approach is the way to go, provided that communication and collaboration with the overall health system is effected and that it further extends to community-based, peer support and advocacy organizations which are providing psychosocial rehabilitation and support services.

Successful treatment of SMD does not merely rely on pharmaceutical intervention, but requires a holistic approach, one that specifically honors the entitlement of the rights of persons with mental disorders – the right to have access to quality health care services, have a good quality of life, enjoy life opportunities on an equal basis, and do so with dignity.

It is important to acknowledge the role that stigma plays in accessing health services and the severe neglect of mental health within the general health system. It is imperative that stigma reduction initiatives form an integrated component in all the suggested interventions and that mental health receive equal recognition as physical health.

Mental health services must provide a human rights focused approach that is perceived by persons with SMD as a means of care and support. Unfortunately, these services may present themselves as "punishment" in the sense of exposure to abusive attitudes and denying persons with SMD the right to participate in their treat-