WHO-EM/MNH/192/E

Summary report on the

Regional consultation on the development of the global mental health action plan

Cairo, Egypt
2–4 July 2012

World Health Organization
Regional Office for the Eastern Mediterranean

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Document WHO-EM/MNH/192/E/09.12/100

Contents

1. Introduction

In May 2012, the 65th World Health Assembly adopted a resolution (WHA65.4) on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. In the resolution, Member States requested the Director-General to develop a comprehensive mental health action plan based on an assessment of vulnerability and risks covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community. The action plan was to be developed in collaboration with Member States and as appropriate with international, regional and national nongovernmental organizations, international development partners and technical agency partners.'

The WHO Regional Office for the Eastern Mediterranean held a regional consultation on the development of the global mental health action plan on 2–4 July 2012 with participation of representatives from ministries of health (mental health departments), regional and international experts, some regional nongovernmental organizations and user associations. The objectives of the consultation were to:

- Review and discuss a background discussion paper on the vulnerabilities and risks for mental health;
- Review and discuss the discussion paper on a mental health action plan;
- Provide input towards the global mental health action plan including the development of a monitoring framework.

In a message to the consultation, Dr Ala Alwan, WHO Regional Director for the Eastern Mediterranean stressed the need for

strengthening the evidence base to advocate for placing mental health higher on social and developmental agendas of the countries, giving more focus to the plan with a small number of clearly stated actions guided by robust evidence and strengthening linkages with health systems to deliver the essential mental health packages.

Dr Saleh Al Hasnawi and Dr Hamad al Ghaferi were elected Co-Chairs, and Dr Richard Gater served as Rapporteur.

2. Summary of discussions on papers

- 40% of countries of the Region do not have mental health policies, 30% do not have plans, and 50% do not have funding.
- 65% of countries do not have current mental health legislation.
- Integration of mental health into primary care has been patchy.
- 66% of psychiatric beds are located in mental hospitals and 34% are located in community settings (compared with 57% and 43%, respectively, in the rest of the world).
- Outpatient facilities and contacts, psychiatric beds and admissions in general hospitals and community residential places per 100 000 population are low compared with the rest of the world.
- The mental health workforce includes a large percentage of other mental health workers compared with the rest of the world (64.4% compared with 5.1%); and relatively few other medical doctors (17.3% compared with 43.4%) and nurses (12.6% compared with 43.6%).
- A minority (<30%) of countries regularly collect and report data on interventions delivered in primary health care for people with mental disorders.
- Mental health is vulnerable to a wide range of risk factors at different levels: individual, social and economic circumstances,

and environmental factors; and at transition points in the life cycle. Certain groups in society are particularly vulnerable to mental health problems, such as households living in poverty, women, minority groups, and persons exposed to war or disaster.

- Persons with mental health problems are vulnerable to discrimination, human rights abuses, social exclusion, impoverishment, and premature mortality. Therefore there is value in protecting mental health and reducing risks by promoting a healthy start in life, supporting those at greatest risk and protecting human rights.
- Financial protection of people with mental disorder and their families is necessary to protect them from impoverishment. The plan should discourage out-of-pocket direct payments and encourage an alternative form of payment
- There is a need to strengthen economic and social development argument to advocate for placing mental health higher on social and developmental agendas of the countries. These should include interventions that yield quick results and for which there is robust evidence of a large effect size, so called “best buys”.
- Each of the cross-cutting principles mentioned in the action plan was strongly endorsed. However, there was concern that the cross-cutting principles are all generally applicable to all plans and none are specific to mental health. Participants questioned whether there is a cross-cutting principle that is unique to mental health.

3. Comments on the action plan

General comments

- Different countries in the Region, and elsewhere, are at different levels of development and one way to acknowledge and address this could be to include a stepped approach to actions; i.e. indicating the "best buy" actions appropriate to all countries, along with "good buys" that countries can implement according to their income as well as level of development.
- The Action Plan needs to highlight the actions for provision of services in countries with limited /degraded health systems especially in complex emergencies
- Enhance the Appendices especially add the Appendix on Implementation strategies and mechanisms with specified milestones and verifiable indicators to monitor progress.
- Compile a complete and fully referenced list of reference documents included in Appendix
- Adopt consistent and internationally accepted use of terms – e.g. reconsider use of terms like mental health conditions and mental disability.
- The plan should focus on a small number of objectives. For example, prevention and promotion; organization of services across health and social sectors; and information, evidence and research, and possibly governance and leadership.
- Under each of the revised objectives there should be a limited number of evidence based actions.
- Targets need to be revised in accordance with the suggested revisions to the structure and contents of each objective.

Specific comments

- In the Vision: In the last line only say “highest possible level of health” rather than physical and mental health
- In the Goal: add “prevention of disorders”

Objective 1

1. Broaden the scope of objective 1 to "strengthening leadership and governance" adding development of policies and legislations as activities focusing on integration of mental health component in all health and social sector policies and plans as well as having Mental health and psychosocial support as part of emergency preparedness plans.

Objective 2

2. Reorganize the structure of this objective using the health systems framework (6 pillars of health systems), and how they can be strengthened to deliver mental health care.
3. Under each pillar, suggest a limited number of actions (1–2).
4. There is need for implementation strategies and mechanisms for the suggested action. Most of the current actions can be reflected in the section on implementation strategies.
5. Redraft title of this objective by adding “comprehensive” and “quality” and removing “community-based” and rephrase to “mental health care”.
6. Rephrase the key principles taking care not to give blanket endorsement to native/indigenous healers.
7. Highlight the need for intersectoral action between health and social services to ensure continuity of care and recovery.
8. Mention “restructure or downsize mental hospitals” rather than “replace mental hospitals with a network of community mental health services.”

9. Bullet 7: emphasize the need for addressing “psychosocial skills” while discussing the importance of diverse needs of vulnerable groups
10. When discussing informal mental health care, training and support needs, distinguish between health services personnel with other persons involved in providing care.
11. Mention mhGAP-IG, especially in integration into primary health care.
12. Highlight the need for a stronger evidence base on savings and mortality/morbidity gains by integrating mental health into primary health care and restructuring of institutions.

Objective 3

13. “Support for development of organizations of people with mental health conditions and their families” does not need to be a discrete objective. This is an action to achieve all the objectives of the action plan and should be reflected as such.

Objective 4

14. There is a need to strengthen the evidence base for prevention and promotion strategies. These should focus on equity, effectiveness, cost-effectiveness and affordability.
15. Specify population and individual level prevention and promotion interventions.
16. Reconsider the framework for prevention and promotion. Using the Universal, Selected, and Indicated interventions framework. Within each of these domains limited evidence-informed actions need to be recommended.
17. For the implementation of these interventions, consider mechanisms /strategies specifically for: settings (schools, health facilities, etc), specific population groups (e.g. women subject to

violence), specific disorders (substance use, suicide and psychosis etc) and determinants of mental health.

18. Consider adding the following implementation strategies for prevention and promotion:
    - Multisectoral action with specified roles of sectors and coordination and reporting mechanisms (rather than vertical, build linkages).
    - Building partnerships within health sector (e.g. nutrition, vaccination, mother and child) and other stakeholders especially in media and education sectors.
    - Supporting the development of user and family associations is an action to achieve this and other objectives.

Objective 5

Introductory text

19. Change the title “To strengthen information, evidence and research system for improved planning, delivery and evaluation of the mental health services.”

20. In the list of 4 minimum indicators, clarify what is meant by social/economic outcomes.

Actions by Member States

21. Bullets 1 and 2: Harmonize the two bullet points into one point.
22. Bullet 3: Consider rephrasing “establish an active surveillance system to monitor complete and attempted suicide”.
23. Bullet 4: Rephrase to read: “Ensure that national population-based surveys capture...” removing “demographic and health surveys” and define the terms “key information, including risk factors and disabilities”.
24. Bullet 7: “Strengthen national, regional and global cooperation...”.

25. Bullet 8: “Compile, report and utilize information and evidence...”, and remove “research data”
26. Include user involvement in research within objective 5.
27. Include an Appendix on global minimum data set of basic indicators, periodicity.

Actions by WHO

28. Bullet 1: Harmonize bullet 1 with changes to Country Actions; add “and core minimum data set”
29. Bullet 2: Add “Health and other information systems”
30. Bullet 3: Specify tools that already exist, such as WHO-AIMS and Atlas.
31. Bullet 4: Add the Role of WHO research collaborating centres
32. Bullet 5: Remove “global” from agenda, and add in subsequent line “global and regional networks for research collaboration”
33. Bullet 6: Edit to be congruent to last action for countries add “facilitate utilization in policy and practice”
34. Add an action about development of a standard module with core mandatory indicators and additional optional indicators that can be included in national health information systems and population-based surveys with metadata files for each indicator.
35. Add action on development of guidelines on conducting qualitative research, and ethical guidelines on conducting good research.

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