EMRO Technical Publications Series 44

Mental health atlas 2014

Resources for mental health in the Eastern Mediterranean Region

World Health Organization
Regional Office for the Eastern Mediterranean

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Contents

Executive summary

The first assessment of available mental health resources in WHO Member States was carried out in 2001.[1] Updates were published for 2005 and 2011.[2,3] The *Mental health atlas 2014* provides up-to-date information on the availability of mental health services and resources across the Eastern Mediterranean Region. This information was obtained via a questionnaire sent to designated focal points in each WHO Member State.

Findings relating to key indicators can be used as a baseline against which to measure progress towards meeting the goals of the Comprehensive Mental Health Action Plan.[4] Comparisons have also been made with the rest of the world and earlier mental health atlas reports. The latest key findings are presented in the Box below.

Introduction

The WHO *Atlas of mental health resources* was first produced in 2001 and was updated in 2005 and 2011. It is an important resource on global information on mental health and a tool for developing and planning mental health services.

The Comprehensive Mental Health Action Plan 2013–2020 was adopted by the 66th World Health Assembly in May 2013. The action plan sets out goals and objectives to be achieved by 2020. In order to monitor progress in achieving these targets and to monitor other critical aspects of mental health system development, a set of core mental health indicators was developed (see Table 1). The core mental health indicators for the action plan were incorporated into the *Atlas*

Key findings

Regional reporting on core mental health indicators

- All 22 countries of the Region at least partially completed the atlas questionnaire, although many countries did not fully complete the sections on financing, workforce, service use and suicide.

Mental health governance

- 55% of countries of the Region have updated their mental health policies or plans in the past 5 years, but only 32% of countries of the Region have mental health policies that are fully compliant with international human rights instruments. 73% of countries of the Region have mental health legislation, but only 27% have mental health legislation that is fully compliant with international human rights instruments. Implementation of mental health legislation is weak. Persons with mental disorders and family members are rarely involved in the formulation and implementation of mental health policies, laws and services.

Financial and human resources for mental health

- Levels of public expenditures on mental health are not known for most countries of the Region, suggesting that specific budgets may not be set aside for mental health services. Spending is very low (less than US$ 2, per capita), and the majority of funding goes to inpatient care, especially mental hospitals.
- The median number of mental health workers in the countries of the Region is half that reported in the rest of the world, and there is extreme variation with greater density of mental health workers in health system group 1 countries.

Mental health service availability and uptake

- The median number of mental health beds per 100 000 population ranges from 1.7 in health system group 3 countries, through 6.4 in group 2 countries, up to 11.3 in group 1 countries. This compares with over 50 in high-income countries in the rest of the world; median rates of day care and outpatient facilities indicate they are relatively underdeveloped compared with the rest of the world.

Mental health promotion and prevention

- 41% of countries of the Region have at least two functioning mental health promotion and prevention programmes, a similar percentage to the rest of the world. Only 14% of countries of the Region have developed national suicide prevention strategies.

Mental health information

- 52% of countries of the Region regularly compile mental health–specific data covering at least the public sector. Vital reporting systems are poorly developed, and there are issues of underreporting of suicide. Less than 25% of countries were able to report on the number of suicides.

[1] *Atlas: mental health resources in the world 2001*. Geneva: WHO; 2001.

[2] *Mental health atlas 2005*. Geneva: WHO; 2005.

[3] *Mental health atlas 2011*. Geneva: WHO; 2011.

[4] *Mental health action plan 2013–2020*. Geneva: WHO; 2013.

2014. Between 2014 and 2020, a mental health atlas survey will be carried out every 2 years so that progress towards meeting the targets of the Action Plan can be monitored.

The WHO Regional Office for the Eastern Mediterranean has developed a framework for implementation of the action plan. The framework incorporated intermediate indicators to monitor progress towards the global goals and objectives. It is planned that these intermediate indicators will be incorporated into the *Mental health atlas* in the Eastern Mediterranean until 2020.

The Comprehensive Mental Health Action Plan 2013–2020 contains six indicators for assessing progress towards agreed objectives and targets (see Table 1). The WHO secretariat was requested to identify additional mental health indicators for Member States to report on (see Table 1, Service development indicators). Together, these form the core set of mental health indicators. The final set of

Table 1. Core mental health indicators, by action plan objective and target

Action plan objectives	Action plan targets	Action plan indicators	Service development indicators
Objective 1. To strengthen effective leadership and governance for mental health	Target 1.1. 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments (by 2020)	Existence of a national policy/ plan for mental health that is in line with international and regional human rights instruments	Financial resources. Government health expenditure on mental health Human resources. Number of mental health workers
	Target 1.2. 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by 2020)	Existence of a national law covering mental health that is in line with international and regional human rights instruments	Capacity-building. Number and proportion of primary care staff trained in mental health
Objective 2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings	Target 2. Service coverage for severe mental disorders will have increased by 20% (by 2020)	Number and proportion of persons with a severe mental disorder who received mental health care in the past year	Stakeholder involvement. Participation of associations of persons with mental disorders and family members in service planning and development Service availability. Number of mental health care facilities at different levels of service delivery
Objective 3. To implement strategies for promotion and prevention in mental health	Target 3.1. 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by 2020)	Functioning programmes of multisectoral mental health promotion and prevention in existence	Inpatient care. Number and proportion of admissions for severe mental disorders to inpatient mental health facilities that a) exceed one year and b) are involuntary
	Target 3.2. The rate of suicide in countries will be reduced by 10% (by 2020)	Number of suicides per year	Service continuity. Number of persons with a severe mental disorder discharged from a mental or general hospital in the past year who were followed up within one month by community-based health services Social support. Number of persons with a severe mental disorder who receive disability payments or income support
Objective 4. To strengthen information systems, evidence and research for mental health	Target 4. 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every 2 years through their national health and social information systems (by 2020)	Core set of mental health indicators routinely collected and reported every 2 years	

indicators used in *Atlas 2014* were formulated and agreed following consultation with the regions and field-testing.

Methods

The *Mental health atlas 2014* project was carried out in three stages. In the first stage, the questionnaire was developed in consultation with Member States and regional offices. The final questionnaire was translated into three official UN languages (French, Russian and Spanish), and a completion guide was prepared, which explained terminology and definitions to ensure standardized completion of the questionnaire. During the second stage the questionnaire was disseminated to a focal point, appointed by the ministry of health in each Member State. The focal point completed the questionnaire incorporating information provided by experts in the field and with guidance and support provided by staff at WHO headquarters and regional offices. In the third stage, the completed questionnaires were submitted and checked for inconsistencies or incomplete responses. Focal points were contacted again during clarification and checking of the responses to generate the highest quality data.

Table 2. Countries that completed the *Mental health atlas 2014* questionnaire

Afghanistan	Oman
Bahrain	Palestine
Djibouti	Pakistan
Egypt	Qatar
Iran (Islamic Republic of)	Saudi Arabia
Iraq	Somalia
Jordan	Sudan
Kuwait	Syrian Arab Republic
Lebanon	Tunisia
Libya	United Arab Emirates
Morocco	Yemen

All countries in the Eastern Mediterranean Region were invited to complete the *Mental health atlas 2014* (see Table 2).

Data were analysed for the Eastern Mediterranean Region, and comparisons made with global data, and where appropriate comparisons were made with data from *Mental health atlas 2011*. Rates per 100 000 population were calculated using UN population estimates for 2013. Monetary values where available were standardized to US$, base year 2014.

Within the Region comparisons were made based on the regional health system groups. The Regional Office for the Eastern Mediterranean has grouped countries based on broadly similar

Table 3. Regional health system groups

Group 1	Group 2	Group 3
Countries where socioeconomic development has progressed considerably over recent decades, supported by high income	Largely middle-income countries which have developed extensive public health service delivery infrastructure but face resource constraints	Countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability and other complex development challenges
Bahrain Kuwait Oman Qatar Saudi Arabia United Arab Emirates	Egypt, Iran (Islamic Republic of) Iraq Jordan Lebanon Libya Morocco Palestine Syrian Arab Republic Tunisia	Afghanistan Djibouti Pakistan Somalia Sudan Yemen

characteristics in terms of their population health outcomes, health system performance and level of health expenditure (see Table 3).

The data reported in this regional review differ in some respect from those in the global *Mental health atlas 2014*. This review includes data for Palestine, and some data excluded from the global report has been included in this report as it is of regional relevance.

Results

All 22 countries of the Region completed the *Mental health atlas 2014* questionnaire, compared with a response rate of 87% from the rest of the world. All countries of the Region reported on some indicators, such as those relating to mental health policy and law. However, for some items the country response rates were very low (e.g. six or fewer countries provided data), for example: mental health spending, service coverage, continuity of care, social support and suicide rates. It is not possible to make meaningful regional analyses with such limited data. Therefore, only a cursory summary of data on these items is included.

1. Mental health policy

The first objective of the Comprehensive Mental Health Action Plan is to strengthen leadership and governance for mental health. Leadership and governance are expressed through mental health policy, legislation and provision of resources. Mental health policy is a statement of the values, principles, objectives and areas for action to improve mental health. These may be stand-alone or may be integrated into other general health or disability policies or plans. For the purposes of the *Mental health atlas 2014*, a policy is considered valid only if it has been approved/published by the ministry of health or parliament.

Countries were asked about the presence of a stand-alone or integrated mental health policy and the year of its latest revision. Most countries (68%) have a stand-alone mental health policy (see Figure 1). Two countries (9%) have mental health integrated into other general health or disability policies or plans. Five countries (23%) do not have a mental health policy or plan.

Among countries with a stand-alone mental health policy, 12 (55% of all countries) were published or revised within the previous 5 years. The remaining three were all published within the past 12 years.

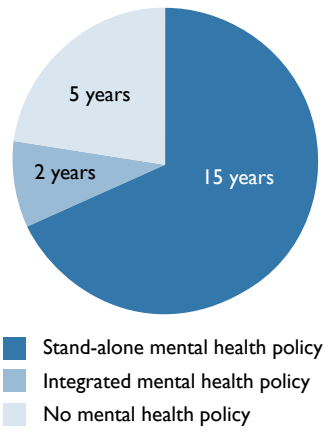


Figure 1. Number of countries with an approved/published mental health policy

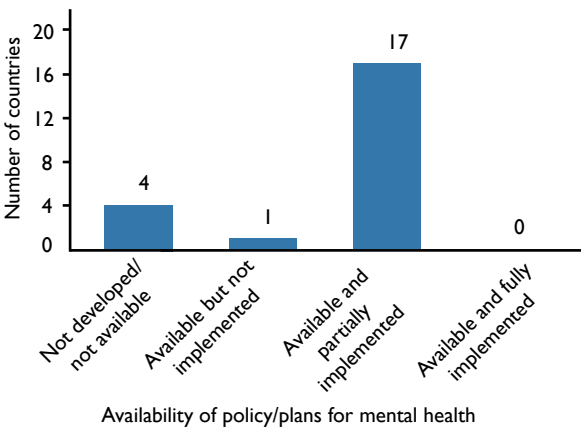


Figure 2. Current status of policy/plans for mental health

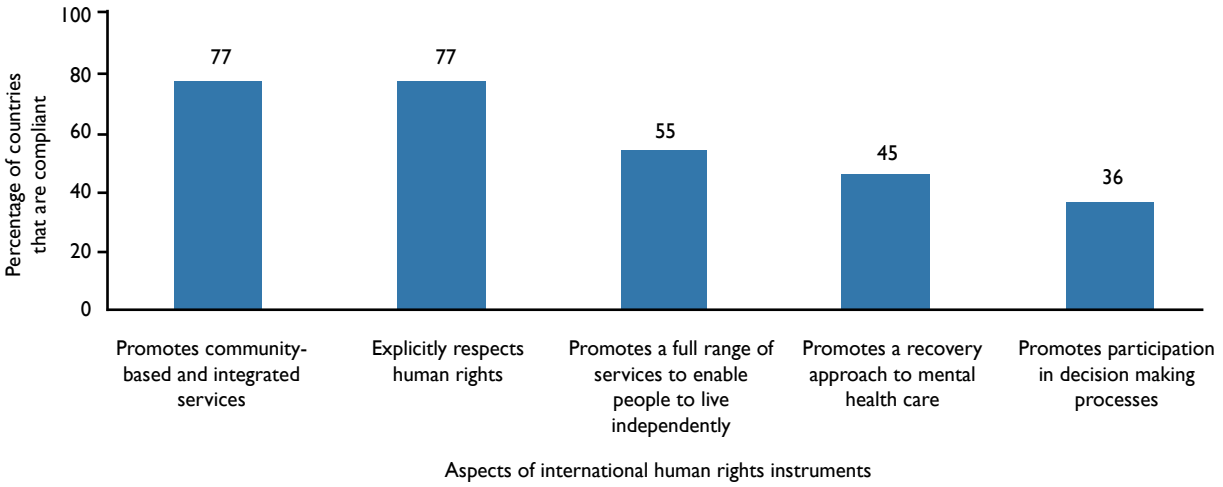


Figure 3. Compliance of mental health policy with human rights instruments (% of all countries in the Eastern Mediterranean Region)

Countries were asked to comment on the current status of implementation of a mental health policy (including both stand-alone and integrated policies). Most (77%) reported that a policy was available and partially implemented (see Figure 2). None was fully implemented. One had a policy available but not yet implemented, and four did not have an available mental health policy.

Countries were asked if their policies are compliant with international human rights instruments. Most countries' policies promote community-based and integrated services and explicitly respect human rights (see Figure 3). More than half promote a full range of services to enable people to live independently. However, less than half promote a recovery approach to mental health care and participation in decision-making processes.

Progress in presence of a mental health policy or plan between 2011 and 2014

Across the whole Eastern Mediterranean Region and within each health system group, there was little change in the percentage of countries with a stand-alone mental health policy between 2011 and 2014 (see Table 4). In 2014, 11 countries had a mental health policy or plan updated from 2011 onwards, five countries have updated policies/plans in line with all five items of the human rights instruments.

Table 4. Countries with stand-alone mental health policies in 2011 and 2014, by regional health system group

Group	Countries with mental health policy or plan (% of all reporting countries[a])	
	2011	2014
Eastern Mediterranean Region	16 (80%)	17 (77.3%)
Health system group 1	6 (100%)	5 (83.3%)
Health system group 2	7 (77.8%)	7 (70%)
Health system group 3	3 (60%)	4 (66.7%)

[a] The total number of countries reporting these data differed between 2011 and 2014, and hence the percentages for the 2 years have different denominators.

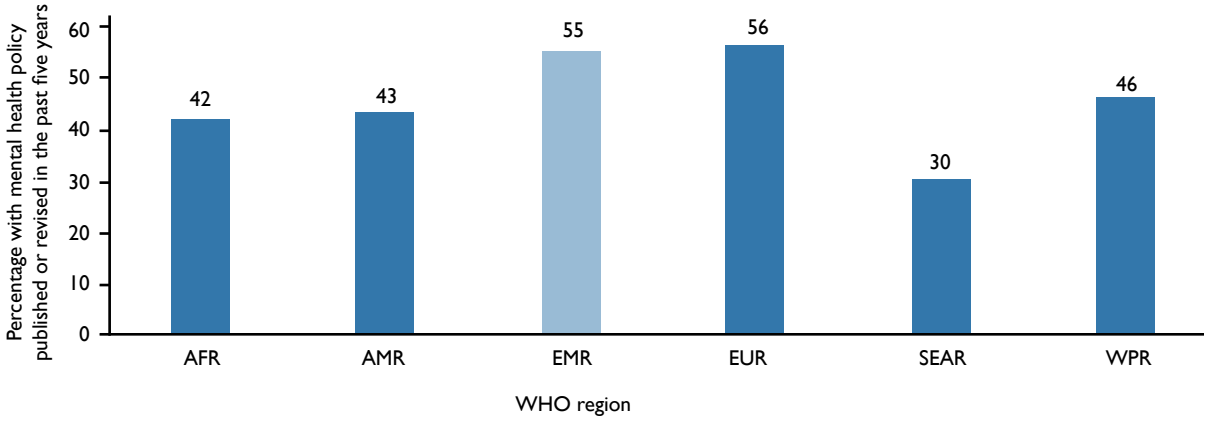


Figure 4. Percentage of countries in each WHO region that have published or revised their mental health policy in the past 5 years

Comparison of mental health policy in the Eastern Mediterranean Region with the rest of the world

Globally, 77% of countries have stand-alone mental health policies. The percentage of countries with stand-alone policies in the Eastern Mediterranean Region (68%) is lower than the global figure. The percentage of countries with mental health policies published or revised in the past 5 years in the Region (55%) is greater than the global rate of 47% and is among the highest reported by any WHO region[5] (see Figure 4).

The percentage of countries in which mental health policy is either fully or partially implemented in the Region (77%) is similar to the corresponding global figure of 76%, and the Eastern Mediterranean Region lies in the middle range of WHO regions (see Figure 5). However, when global comparisons are made

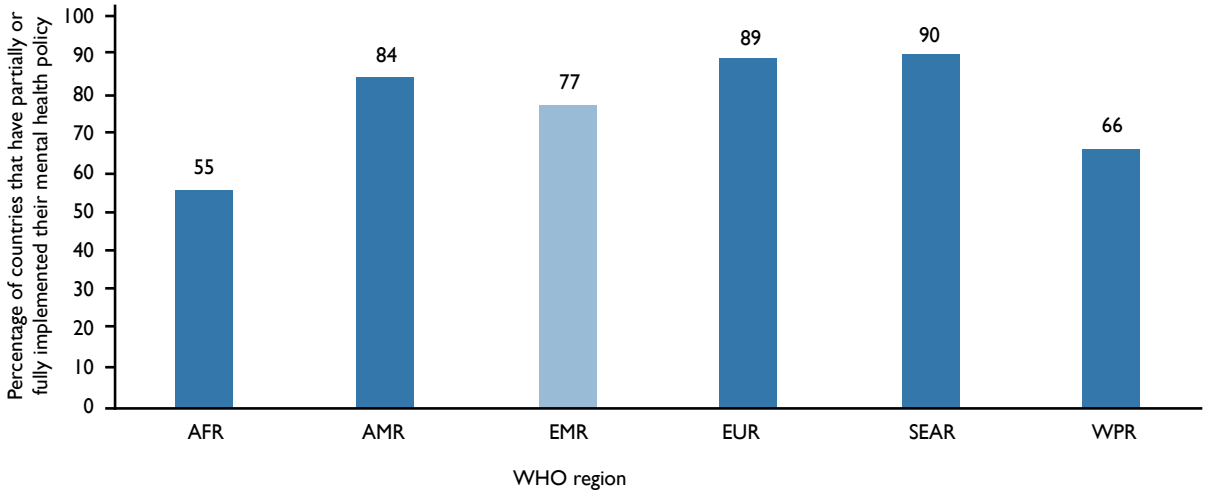


Figure 5. Percentage of countries in each WHO region that have partially or fully implemented their mental health policy

[5] The WHO regions are: Africa (AFR), Americas (AMR), South-East Asia (SEAR), Europe (EUR), Eastern Mediterranean (EMR) and Western Pacific (WPR).

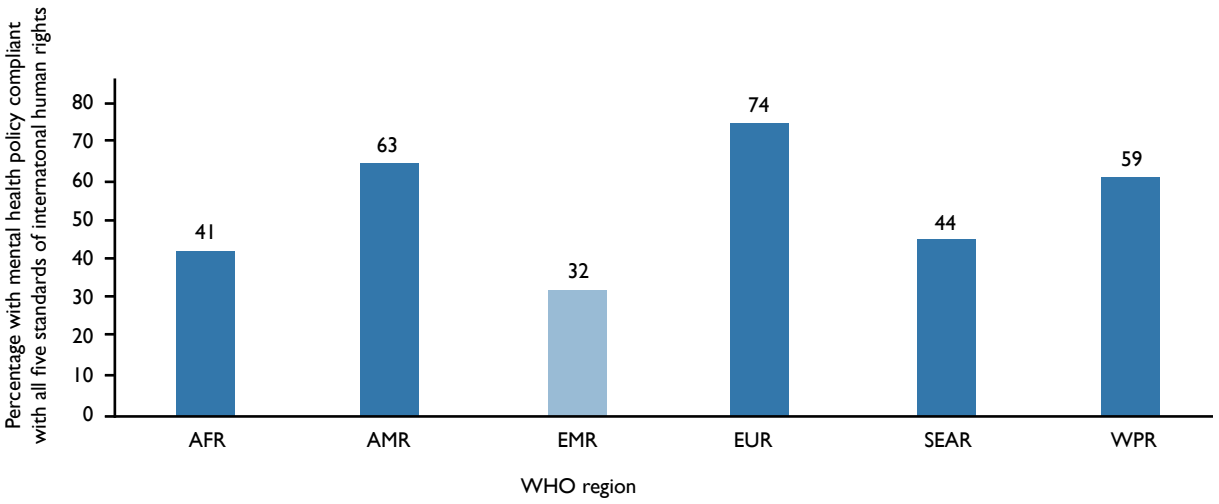


Figure 6. Percentage of countries in each WHO region that have mental health policies that are compliant with all five standards of international human rights

of full implementation rates, the Region has the lowest rate of 0% (compared with highs of 28% in the European Region and 30% in South-East Asian Region).

The Eastern Mediterranean Region compares less favourably with the rest of the world for compliance of mental health policies with international human rights: 45% of countries of the Region are compliant with more than three standards of international human rights, compared with 72% of all world countries. Seven (32%) countries of the Region are compliant with all five human rights standards, compared with 56% of all world countries (see Figure 6). Compared with other WHO regions, the Eastern Mediterranean Region has the lowest compliance with international human rights.

2. Mental health legislation

Mental health legislation is legislation specifically related to mental health that protects the civil and human rights of people with mental disorders and addresses treatment facilities, personnel, professional training and service structure. Mental health law may be stand-alone, or may be integrated into other general health or disability laws.

Countries were asked about the presence of stand-alone or integrated mental health legislation and the year of its latest revision. Most countries have a stand-alone mental health law (see Figure 7). Four countries have mental health integrated into other general health or disability laws. Five countries do not have a mental health law.

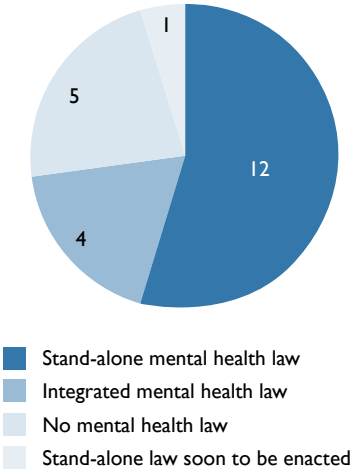


Figure 7. Number of countries with mental health legislation

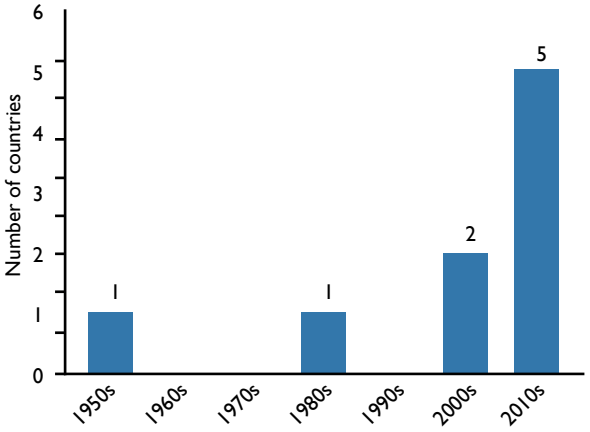


Figure 8. Decade that the mental health law was enacted

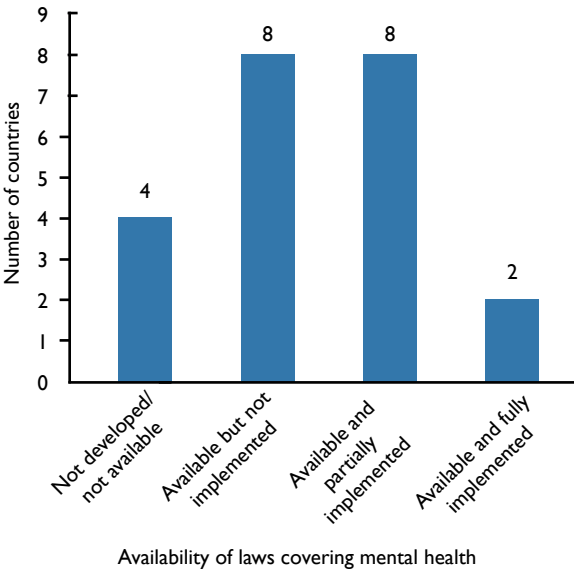


Figure 9. Status of the law covering mental health

Among countries with a stand-alone mental health law who provided data on year of enactment, five were enacted/revised within the past 5 years (see Figure 8). The remaining four were enacted more than 10 years ago, including one that dates back to 1959. One further country has stand-alone legislation that is about to be enacted.

Countries were asked to indicate the current status of implementation of their mental health legislation (including both stand-alone and integrated laws). Two (9%) reported that their mental health laws are fully implemented (see Figure 9). In 18% of countries of the Region, mental health legislation is not developed/ available and in a further 36% of countries it is available but not implemented.

59% of countries indicated that their mental health legislation is compliant with international human rights instruments in that they promote rights to exercise capacity and

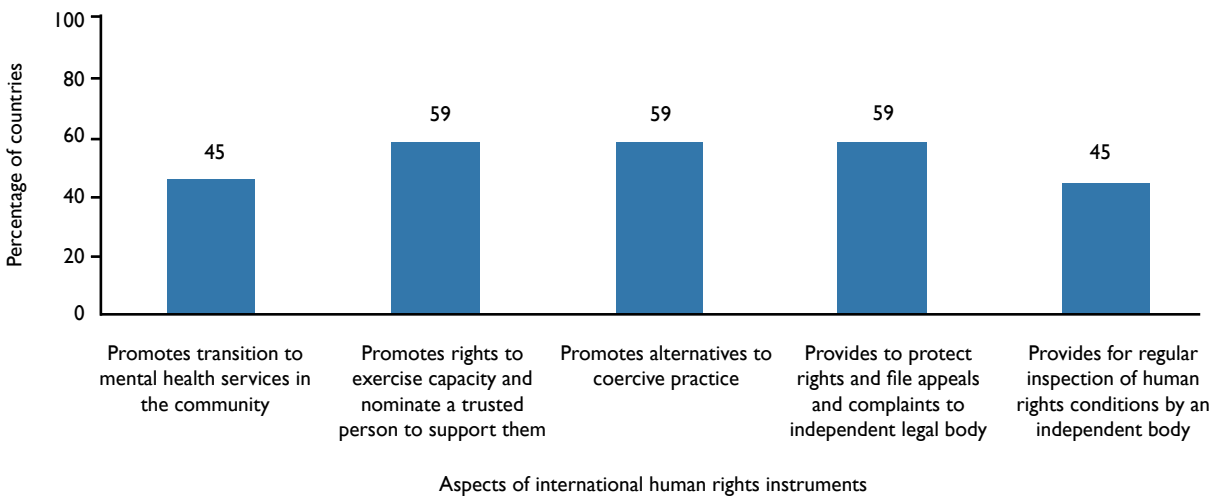


Figure 10. Compliance of mental health law with international human rights instruments (% of all countries of the Region)

Table 5. Countries of the Region with stand-alone mental health legislation in 2011 and 2014, by regional health system group

Group	Presence of stand-alone mental health legislation (% of all countries)	
	2011	2014
Eastern Mediterranean Region	11 (55%)	12 (54.5%)
Health system group 1	2 (33.3%)	2 (33.3%)
Health system group 2	7 (77.8%)	7 (70%)
Health system group 3	2 (40%)	2 (33.3%)

nominate a trusted person to support them; promote alternatives to coercive practice; and provide to protect rights and provide appeals and complaints to independent legal bodies (see Figure 10). Just under half of the countries in the Region indicated that their legislation promotes transition to mental health services in the community and provides for regular inspection of human rights conditions by an independent body.

Progress in the presence of stand-alone mental health legislation between 2011 and 2014

Across the whole Eastern Mediterranean Region and within each health system group, there was little change in the percentage of countries with stand-alone mental health legislation between 2011 and 2014 (see Table 5).

Six countries of the Region have developed or updated their mental health legislation between 2011 and 2014.

Comparison of mental health legislation in the Eastern Mediterranean Region with the rest of the world

Globally, 63% of countries have stand-alone mental health legislation. The percentage of countries with stand-alone legislation in the Eastern Mediterranean Region (55%) is slightly lower than the global figure. The percentage of countries with mental health legislation published or revised in the past 5 years in the Region (23%) is greater than the corresponding global rate of 18% and is the third highest among WHO regions (see Figure 11).

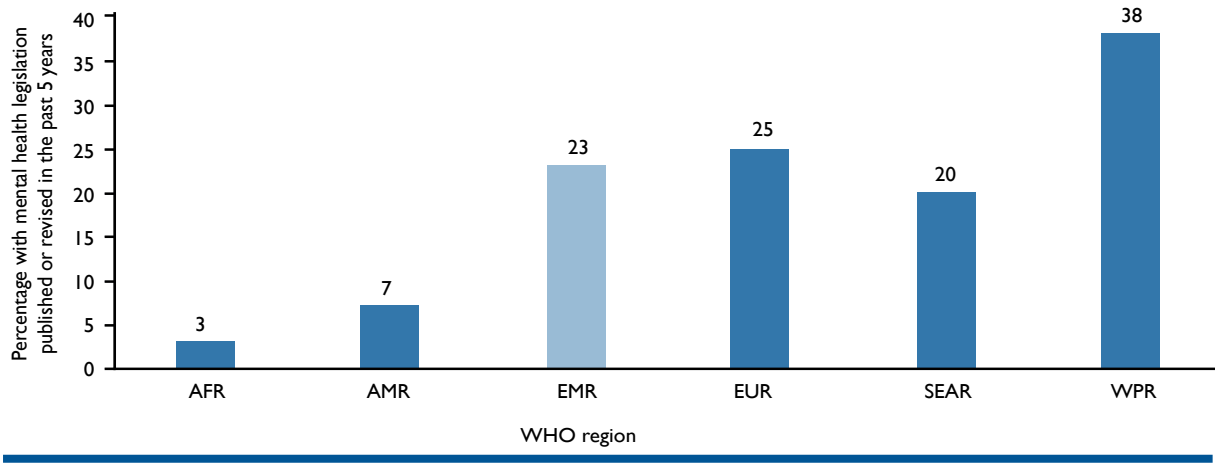


Figure 11. Percentage of countries in each WHO region that have passed or revised their mental health legislation in the past 5 years

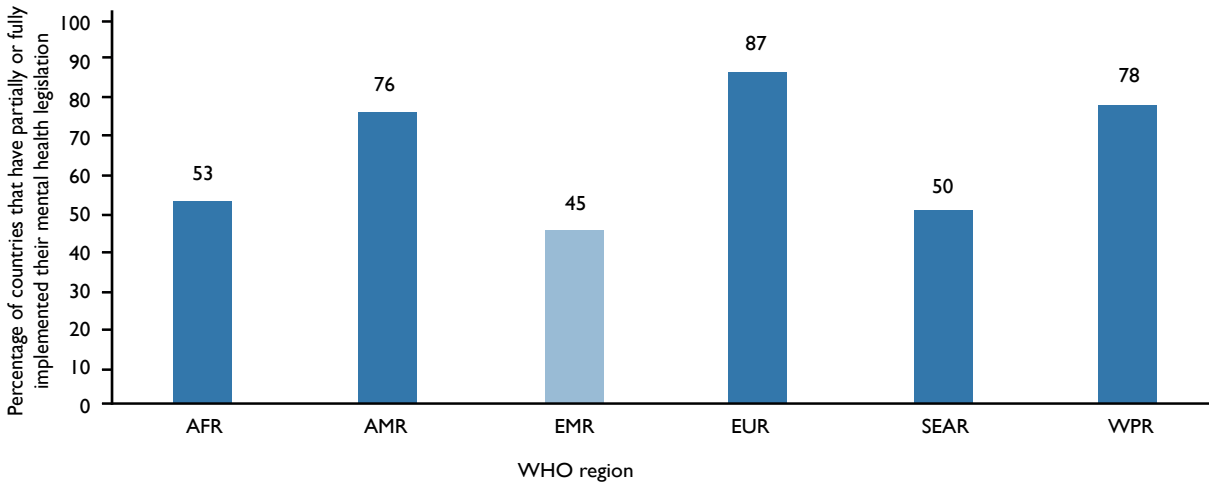


Figure 12. Percentage of countries in each WHO region that have partially or fully implemented mental health legislation

The percentage of countries in which mental health legislation is either fully or partially implemented in the Region (45%) is lower than the corresponding global figure of 69% and is lower than other WHO regions (see Figure 12).

Eleven or 55% of reporting countries of the Region are compliant with more than three standards of international human rights, compared with 61% of all world countries. Six or 25% of reporting countries of the Region are compliant with all five standards of international human rights, compared with 42% of all world countries. The Eastern Mediterranean Region ranks fifth (out of six regions) most compliant with international human rights (see Figure 13).

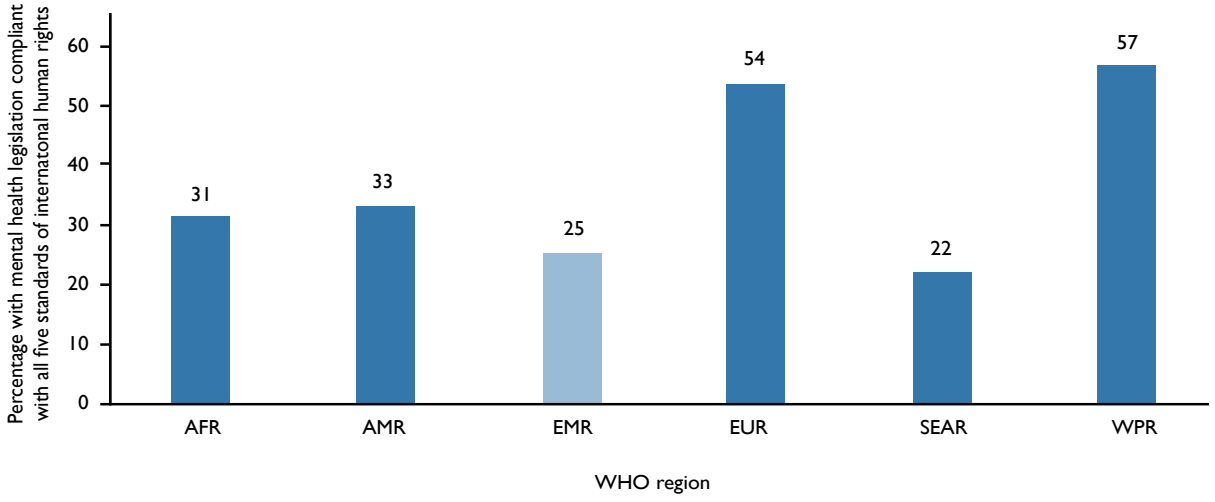


Figure 13. Percentage of reporting countries in each WHO region that have mental health legislation which is compliant with all five standards of international human rights

Box 1. Domains of involvement of associations of persons with mental disorders and family members in the formulation and implementation of mental health policies, laws and services

1. Information: ministry of health gathers and disseminates information about organizations of persons with mental and psychosocial disabilities and of families and carers.
2. Policy: ministry of health has developed and published a formal policy on the participation of persons with mental and psychosocial disabilities in the formulation and implementation of mental health policies, plans, legislation and services.
3. Early involvement: persons with mental and psychosocial disabilities, as well as families and carers, are involved from the beginning of the formulation and implementation of mental health policies and laws, and given adequate notice.
4. Participation: ministry of health systematically involves persons with mental and psychosocial disabilities in planning, policy, service development and evaluation: the majority of committees and subcommittees developing the above areas have representation from an organization of persons with mental and psychosocial disabilities or at least one person with a mental and psychosocial disability.
5. Resources: ministry of health reimburses costs of participation of persons with mental and psychosocial disabilities and provides resources to allow participation (physical location, transport, remuneration or reimbursement of expenses, interpreters, attendant carers and meeting support personnel).

3. Stakeholder involvement

Countries were asked to indicate the level of involvement of associations of persons with mental disorders and family members in the formulation and implementation of mental health policies, laws and services at a national level in the past 2 years. This was done on a three-point scale (not implemented; partially implemented; fully implemented) for five domains: information, policy, early involvement, participation and resources (see Box 1).

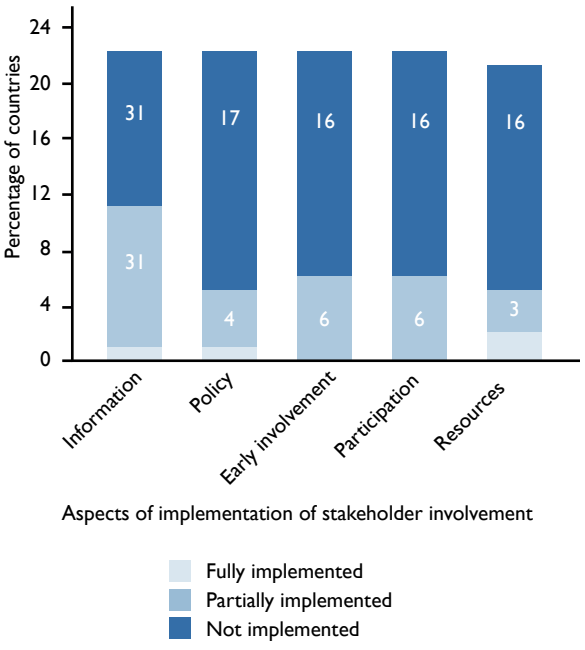


Figure 14. Implementation of stakeholder involvement

In all domains, most countries reported that measures are not implemented (see Figure 14). In about one-quarter of countries, measures were partially implemented. Full implementation was rarely reported; in only one country for the domains of information, policy and resources; and in no countries for early involvement and participation.

Comparison of stakeholder involvement in the Eastern Mediterranean Region with the rest of the world

Compared with the rest of the world, the Eastern Mediterranean Region has a lower level of involvement of associations of service users and their families, and this is evident for partial or full implementation in all five stakeholder involvement domains (see Figure 15). When compared with other WHO regions, the Eastern Mediterranean Region ranked fifth (of six regions) for the domain of policy, and ranked sixth (of six regions) for information, early involvement, participation and resources.

Stakeholder involvement is an aspect of mental health services that is particularly underdeveloped in almost all countries of the Region, and therefore there are opportunities to develop partnerships to catalyse and influence change in the planning and delivery of mental health services.

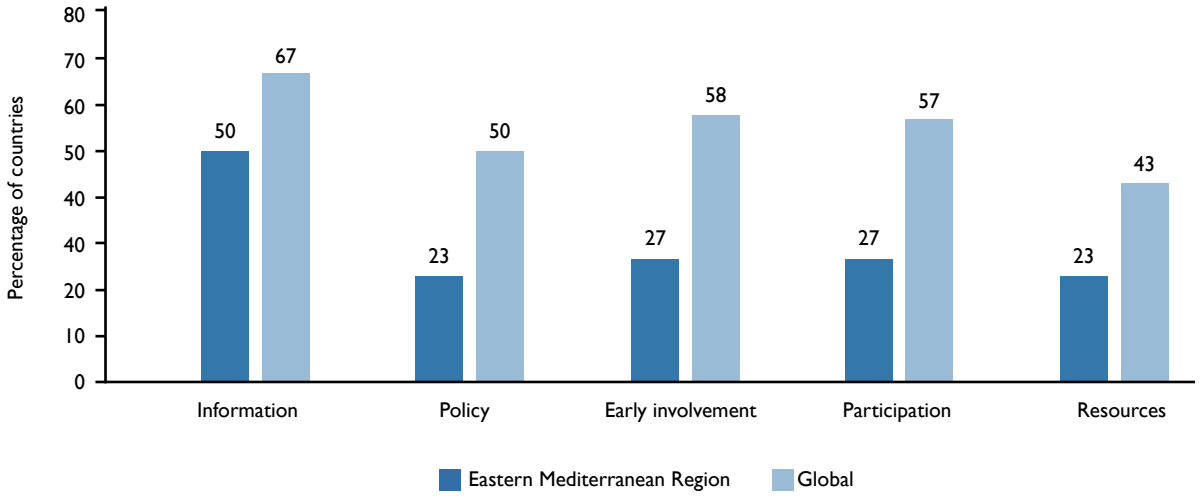


Figure 15. Comparison of the percentage of reporting countries in the Eastern Mediterranean Region and globally that have partially or fully implemented involvement of persons with mental disorders and family members in the formulation and implementation of mental health policies, laws and services at national level in the past 2 years

4. Government mental health spending

The government is the main source of mental health care and treatment funding in most countries in the Eastern Mediterranean Region (see Figure 16), which is similar to the sources of funding found in the rest of the world.

Less than half of the countries reported on the annual government spending on the various component settings of their mental health services (see Figure 17). Annual spending on mental hospitals was reported by six (27%) countries. Spending on other components was reported by fewer countries. That countries are unable to provide a breakdown of spending suggests that specific budgets may not be set aside for mental health services.

The small number of countries able to provide costing data limits the use of regional analysis for most components of the mental health system. However a tentative comparison of annual mental hospital spending shows considerable variation from less than one US cent per person in Pakistan, up to US$ 22 per person in Bahrain. A group 1 country (Qatar) has the highest per capita expenditure on mental hospitals among reporting countries, and a group 3 country (Pakistan) has the lowest expenditure.

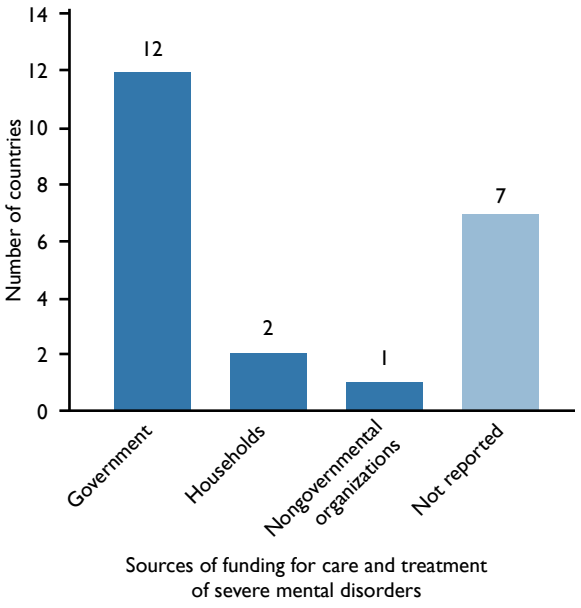


Figure 16. Main overall source of funds for care and treatment of severe mental disorders

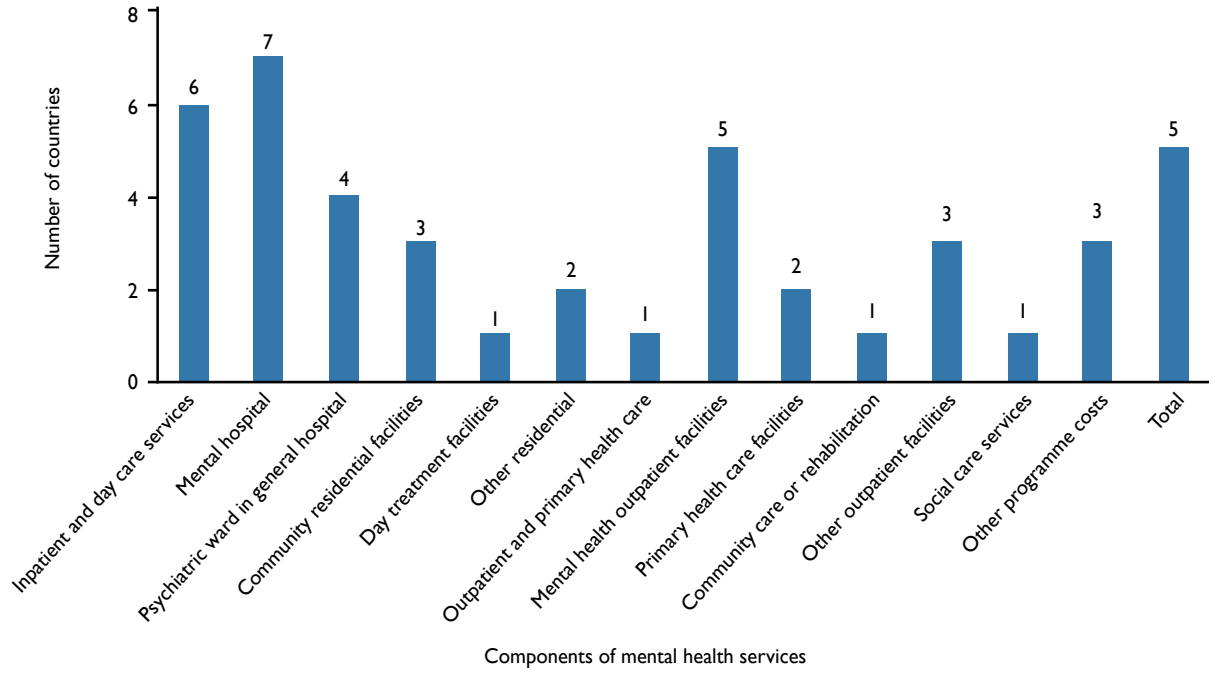


Figure 17. Number of countries reporting annual government spending on component mental health care settings

Comparison of government mental health spending in the Eastern Mediterranean Region with the rest of the world

The government (e.g. national health insurance or reimbursement schemes) is ranked as the main overall source of funds for care and treatment of severe mental disorders in 79% of world countries, compared with 80% of the reporting countries of the Region. The Eastern Mediterranean percentage is similar to those of the Americas Region and the Western Pacific Region, lower than those of the European Region and South-East Asian Region, but higher than that in the African Region (see Figure 18).

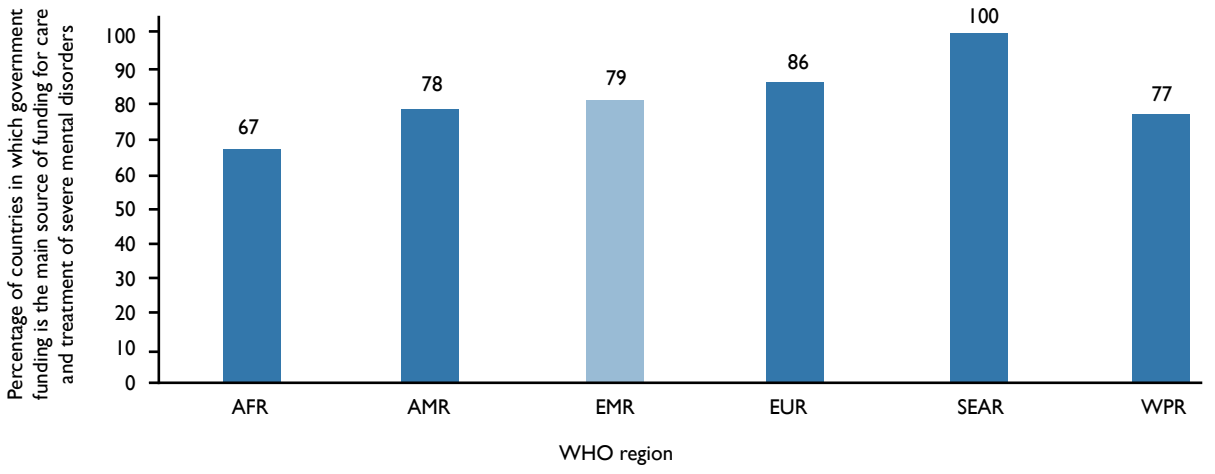


Figure 18. Percentage of reporting countries in which government funding is ranked the number one overall source of funds for care and treatment of severe mental disorders by WHO region

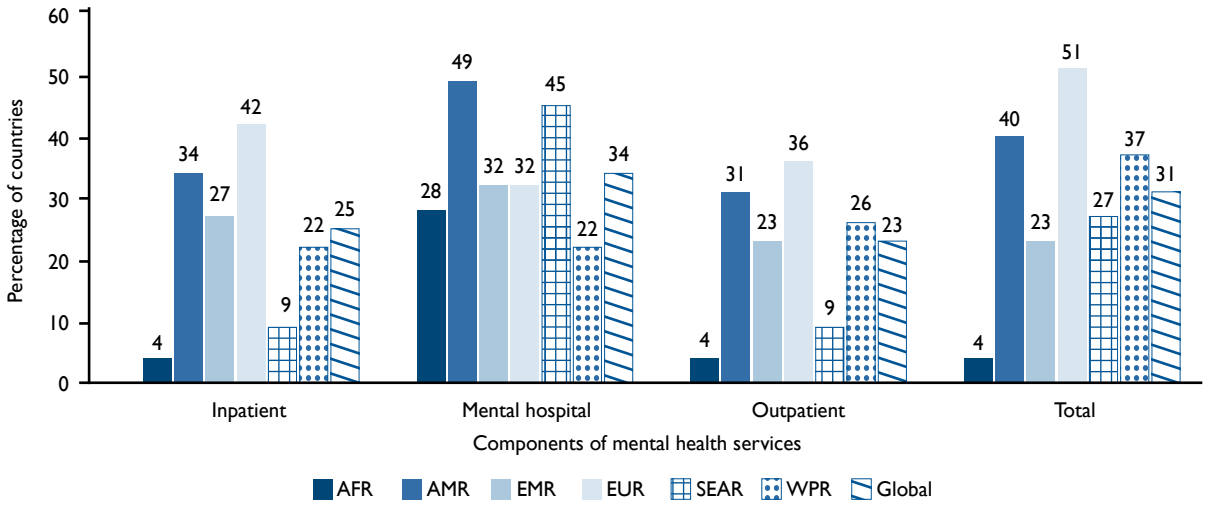


Figure 19. Percentage of countries in each WHO region and globally that provided per capita government mental health expenditure

23% of all countries of the Region provided government mental health spending per capita in the past year compared with 31% of countries globally (see Figure 19). For inpatient services, mental hospitals and outpatient services, the percentage of countries in the Eastern Mediterranean Region providing data was within 2 percentage points of the percentage of countries providing comparable data globally.

As noted above the government funding data available for the countries of the Region is based on a small number of countries, and therefore comparisons with other WHO regions has to be extremely cautious. The following four figures use the available data to provide a very rough indication of how the government funding of mental health services in the Eastern Mediterranean Region compares with the rest of the world.

The median government funding of mental health inpatient and day care services in reporting countries of the Region is US$

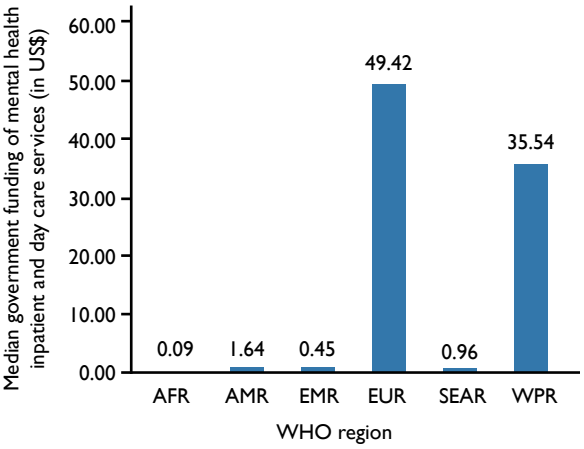


Figure 20. Median government funding of mental health inpatient and day care services in US$, by WHO region

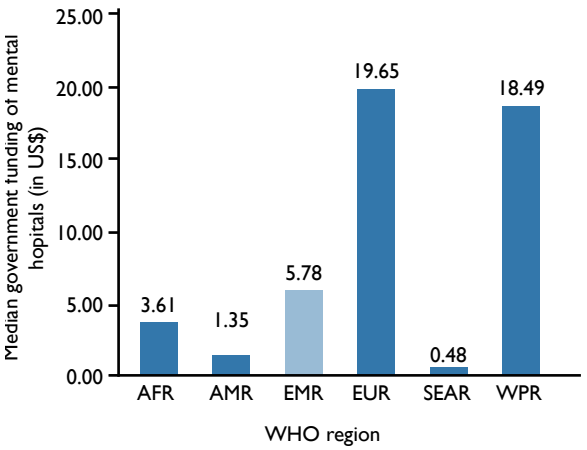


Figure 21. Median government funding of mental hospitals in US$, by WHO region

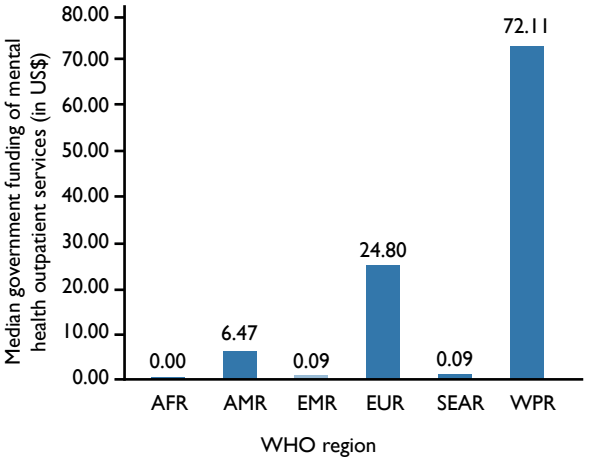


Figure 22. Median government funding of mental health outpatient services in US$, by WHO region

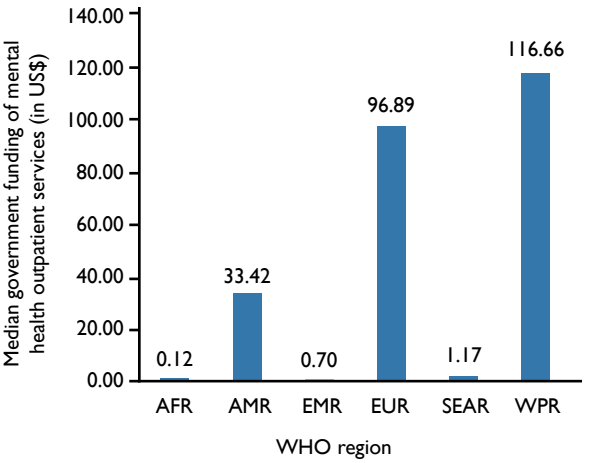


Figure 23. Median total government funding for mental health services in US$, by WHO region

0.45, which is very low in comparison with the global median of US$ 29.93. The Eastern Mediterranean Region ranks fifth of the six WHO regions for government spending on mental health inpatient and daycare services (see Figure 20).

The median government funding of mental hospitals in countries of the Region is US$ 5.78, which is half of the global median of US$ 11.02. The Eastern Mediterranean Region ranks third of the six WHO regions for government spending on mental hospitals (see Figure 21).

The median government funding of mental health outpatient services in reporting countries of the Region is US$ 0.09, which is very low in comparison with the global median of US$ 24.28. The Eastern Mediterranean Region ranks fourth of the six WHO regions for government spending on mental health outpatient services (see Figure 22).

The median total government funding for mental health services in reporting countries of the Region is US$ 0.70, which is very low in comparison with the global median of US$ 72.57. There is an apparently discrepancy that the reported figures for spending on mental hospitals exceed the amount reported for total mental health funding; this discrepancy has arisen because of poor response rates to the financing items in the Atlas questionnaire, and the group of countries that reported total government funding was different from the group of countries that reported on mental hospital spending. This emphasizes the caution required interpreting these financial data. The Eastern Mediterranean Region ranked fifth of the six WHO regions for total government spending on mental health services (see Figure 23).

5. Mental health workforce

Countries were asked to estimate the total numbers of mental health professionals working in each country by profession.

Across the Eastern Mediterranean Region, nurses (including both psychiatric nurses and general nurses working in mental health facilities) make up the largest professional group among the mental health workforce, followed by psychiatrists, psychologists and social workers (see Figure 24). There is approximately one psychiatrist for every four nurses, one psychologist for every six nurses and one social worker for every 16 nurses.

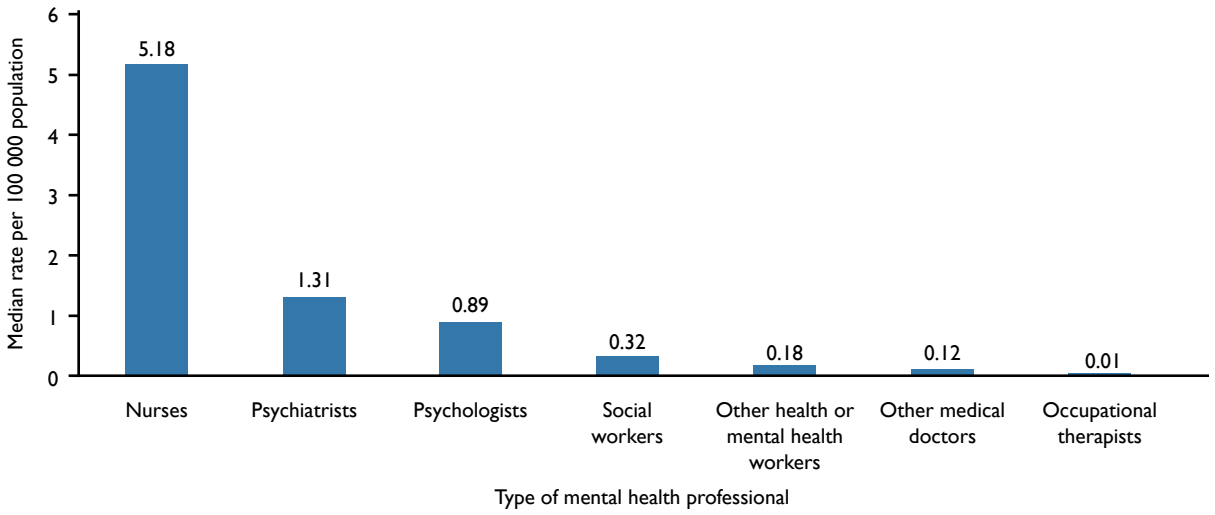


Figure 24. Median rate of health professionals per 100 000 population

Other health and mental health workers, other medical doctors and occupational therapists are relatively uncommon.

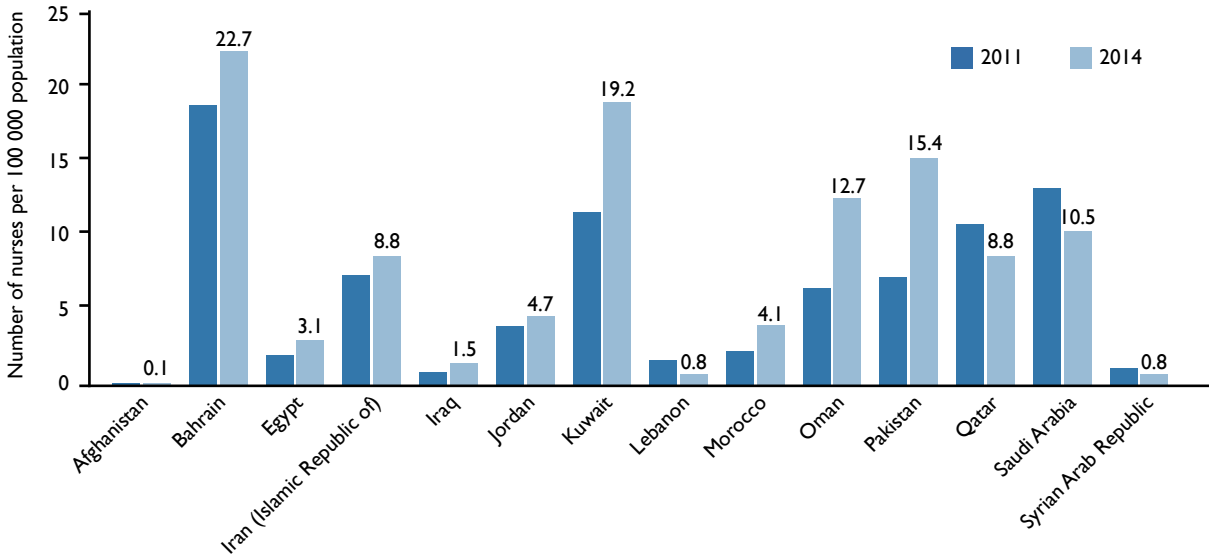
Comparing human resources in 2011 and 2014 (see Table 6) suggests that there have been increases in some specialist staff groups such as nurses, psychiatrists and psychologists; while occupational therapists, other medical doctors and other health or mental health workers have reduced in number across the Region as a whole.

The regional averages of the mental health workforce conceal specific changes in individual countries. For example, there have been substantial increases in the number of nurses working in mental health in Bahrain, Kuwait, Morocco, Oman and Pakistan; while the numbers of nurses per 100 000 population has decreased in Lebanon, Qatar, Saudi Arabia and Syrian Arab Republic (see Figure 25).

The nursing workforce is numerically stronger in health system group 1 countries compared with group 2 countries. Increases in the mental health nursing workforce between 2011 and 2014 are apparent in group 1 and group 2 (see Figure 26). Too few group 3 countries provided information to allow meaningful comparison.

Table 6. Median rate of health professionals per 100 000 population

Type of professional	2011	2014
Nurses (including both psychiatric nurses and general nurses working in mental health facilities)	3.3	5.18
Psychiatrists	0.86	1.31
Psychologists	0.41	0.89
Social workers	0.47	0.32
Other health or mental health workers working in mental health facilities	4.35	0.18
Other medical doctors not specializing in psychiatry	0.28	0.12
Occupational therapists	0.04	0.01



* Only countries with data for both 2011 and 2014 are included

Figure 25. Number of nurses per 100 000 population by country* in 2011 and 2014

Increased investment in the mental health workforce in group 1 countries between 2011 and 2014 is also reflected in the increase in numbers of psychiatrists (see Figure 27); but this is not seen in group 2 countries.

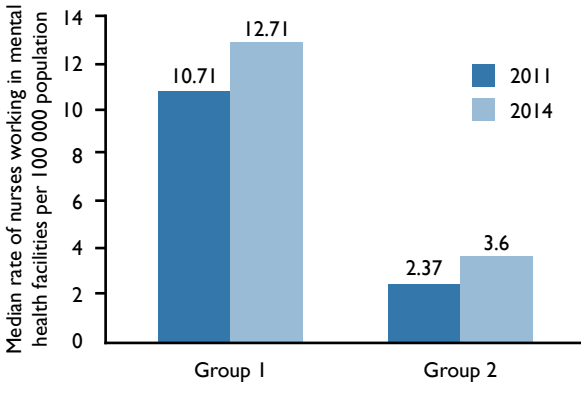


Figure 26. Median rate of nurses working in mental health facilities per 100 000 population in 2011 and 2014 by regional health system group

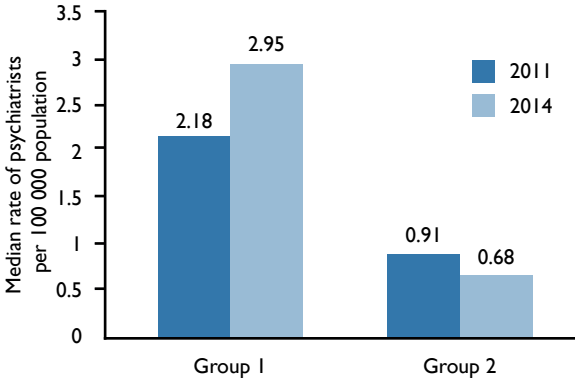


Figure 27. Median rate of psychiatrists per 100 000 population in 2011 and 2014 by regional health system group

Comparison of mental health workforce in the Eastern Mediterranean Region with the rest of the world

The average total mental health workforce in the Eastern Mediterranean Region is 14.6 per 100 000 population. This is less than half the comparable global rate of 33.8 per 100 000 population. The Eastern Mediterranean Region

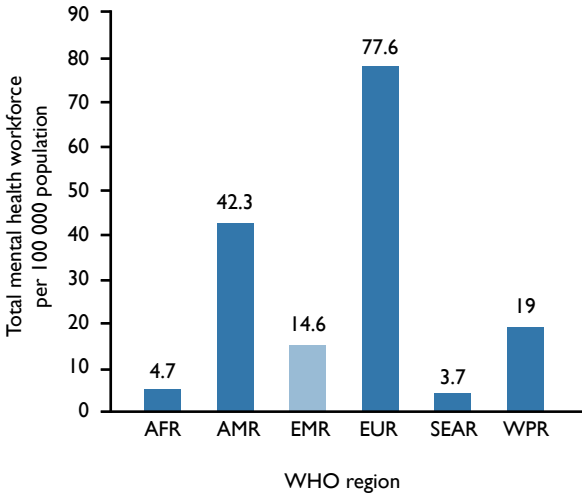


Figure 28. Total mental health workforce per 100 000 population by WHO region

is ranked fourth among the WHO regions for the size of its mental health workforce per 100 000 population (see Figure 28). There is a large difference in workforce between WHO regions from the lowest of 3.7 and 4.7 per 100 000 in the South-East Asia Region and the African Region respectively to the highest of 77.6 in the European Region.

Table 7 shows the average number of the various types of mental health staff per 100 000 population in each WHO region and globally and also indicates the rank of the Eastern Mediterranean Region compared with the other WHO regions. The figure quoted in the table is the mean within each region and is therefore different from the median figure quoted earlier in this section. Table 7 indicates that compared with the rest of the world, the Eastern Mediterranean Region has above the average number of other medical doctors working in mental health. The Eastern Mediterranean Region is just below the global average for other paid workers working in mental health. The number of nurses per 100 000 population in the Region is about half the global average, and slightly lower for psychiatrists. The Region has less than a quarter of the global average number of psychologists, social workers and occupational therapists per 100 000 population.

6. Mental health training in primary care

Primary care staff are the cornerstone of mental health care. The *Atlas 2014* questionnaire asked countries to report the numbers of primary care staff, by profession, who had been trained in mental health care for at least two days in the past 2 years. These numbers were divided by WHO estimates of the total workforce of doctors, nurses and community health workers in each country (the total workforce, not just the primary care workforce).

Twelve countries of the Region were able to provide data on training of doctors, and seven provided data on training for nurses and midwives (see Table 8).

Table 7. Average number of mental health staff per 100 000 population in each WHO region and globally

Mental health staff	AFR	AMR	EMR	EUR	SEAR	WPR	Global	EMR rank
Psychiatrists	0.3	3.5	1.7	10.5	0.7	1.6	4.2	3
Other medical doctors	0.2	1.6	4.7	5.1	0.4	1.4	2.4	2
Nurses	2.1	15.8	7.9	31.6	1.5	12.2	14.4	4
Psychologists	0.6	5.6	1.0	11.2	0.3	1.9	4.6	4
Social workers	0.1	9.0	0.7	2.8	0.1	1.2	2.9	4
Occupational therapists	0.3	0.8	0.2	3.2	0.1	0.6	1.1	5
Other paid workers	1.0	14.2	10.5	29.0	1.0	4.0	12.4	3

Table 8. Percentage of primary care staff trained in mental health at least 2 days in the past 2 years (by type of professional)

Primary care staff	Number of countries reporting	Median (%)	Range (%)
Doctors	12	2.7	0.3–29.2
Nurses and midwives	7	1.6	0.01–51.0

Overall, only a small minority of doctors (2.7%), and nurses and midwives (1.6%) had received training. There was a wide range between countries in the percentage of primary care staff receiving mental health training in the past 2 years. The countries in which the greatest percentage of both doctors and nurses and midwives had received training is in group 3.

In *Atlas 2014*, countries were asked to indicate the numbers and proportions of primary care staff trained in mental health for at least two days in the past 2 years. This question is substantially different from the question asked in *Atlas 2011*, which asked about the broad proportion of doctors and nurses who had received official in-service training on mental health within the past 5 years; therefore direct comparisons between the two atlases are not possible.

Comparison of mental health training in primary care in the Eastern Mediterranean Region with the rest of the world

The median percentage of primary care physicians globally who have received training in mental health for at least 2 days in the past 2 years is 2.1%, and the corresponding figure for nurses and midwives is 1.7%. The Eastern Mediterranean Region is therefore slightly above the global median for training of primary care physicians and slightly below the median for training of nurses and midwives. Compared with the other WHO regions, the Eastern Mediterranean Region ranks second for the training of physicians and fourth for the training of nurses and midwives (see Figure 29).

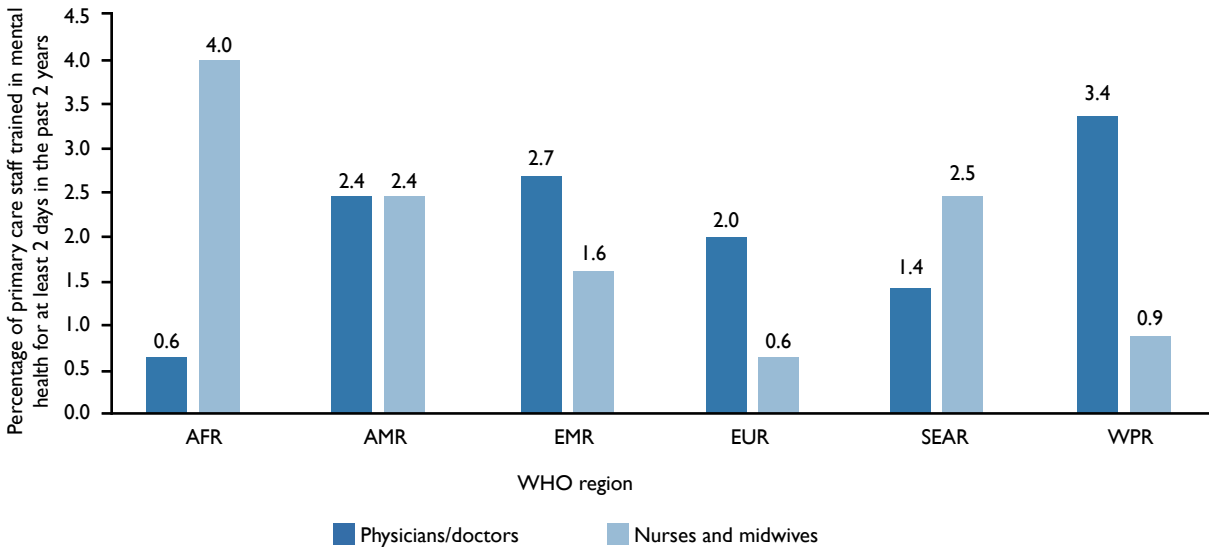


Figure 29. Percentage of primary care staff trained in mental health for at least 2 days in the past 2 years, by WHO region

7. Service availability

Residential facilities for persons with mental health problems are provided in mental hospitals, psychiatric wards in general hospitals and community residential facilities.

There is at least one mental hospital in each country of the Eastern Mediterranean Region, with the exception of Djibouti, where all the mental health beds are in psychiatric wards in a general hospital.[6] The average size of the mental hospitals varies between 14 beds (Lebanon) and 779 beds (Pakistan) with a median capacity of 220 beds. In 14 countries (82% of reporting countries) the size of the mental hospitals is between 100 and 620 beds.

There is at least one psychiatric ward in a general hospital in 14 countries in the Region. These are typically much smaller units than the mental hospitals, with average sizes ranging between three beds (Oman) and 60 beds (Djibouti) with a median capacity of 17 beds.

Five countries (23%) reported that they have mental health community residential facilities, and the numbers varied widely between one in Qatar and Tunisia; through seven in Lebanon, up to 93 in Islamic Republic of Iran and 344 in Pakistan. The average size of community residential facilities in countries varies between six and 124 beds with a median of 33 beds.

Eight countries (36%) reported that they have mental health day care or treatment facilities. Most of these countries have only one or two such facilities, but day treatment is more extensively developed in Islamic Republic of Iran, Tunisia and Pakistan, where there are 117, 48 and 14 day care facilities respectively. Islamic Republic of Iran also has the largest average capacity of day care facilities of 46 places. The median number of places in a day care facility across the countries of the Region which have them is ten.

[6] Somalia did not report on service availability.

Eighteen countries (82%) reported on the number of mental health outpatient facilities available in the country. The median number of patients seen in a mental health outpatient facility in the Region is 100 per week.

Availability of beds per 100 000 population

Throughout the Region there is a median of 6.1 psychiatric beds per 100 000 population. This rate varies between 0.8 and 19.8 per 100 000 with higher rates in group 1 countries (see Figure 30). The median number of all psychiatric beds per 100 000 population decreased from 7.0 in 2011 to 6.1 in 2014.

The median number of mental hospital beds per 100 000 population is 4.48 (range 0–19.5); and the median number of psychiatric beds in general hospitals per 100 000 population is 0.49 (0–6.8). The majority of countries in the Region do not have community residential facilities, but among the four that do, the median number of beds per 100 000 population is 1.2 (0.4–6.7).

Within the Region, 64.3% of psychiatric beds are located in mental hospitals and 35.7% are located in community settings: general hospitals (18.3%) and community residences

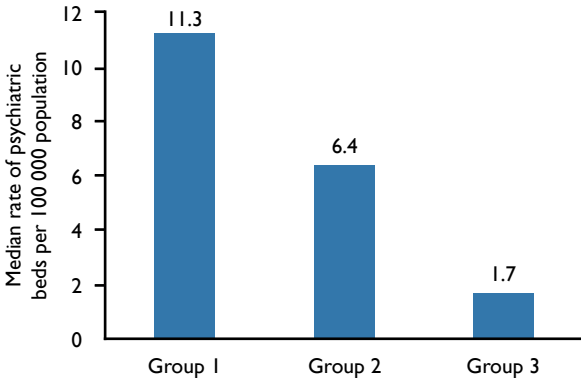


Figure 30. Median rate of psychiatric beds per 100 000 population by regional health system group

(17.4%). This distribution is almost unchanged from that found in 2011 (see Figure 31).

There remains a wide variation between countries in the extent to which their psychiatric beds are located in community settings, such as general hospital and community residential facilities (see Figure 32). In several countries the percentage of mental health beds that are in general hospitals and community residences fell between 2011 and 2014 (Jordan, Oman, Qatar, Saudi Arabia, Sudan, Syrian Arab Republic and Tunisia). Due to the small number of countries reporting, we cannot usefully compare beds available in community residential facilities in 2011 and 2014 at a regional level. At an individual country level, most have remained at a similar level, but in Pakistan (group 3) there has been a substantial development from zero in 2011 to 1.2 per 100 000 in 2014.

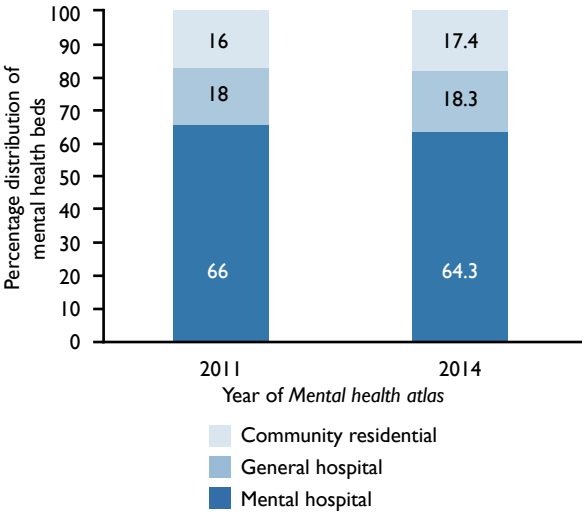


Figure 31. Distribution of mental health beds in the Eastern Mediterranean Region in 2011 and 2014

Availability of day care or treatment facilities per 100 000 population

In 2011, in the countries with day care facilities, there was a median of 0.005 day care facilities per 100 000 population. In 2014, the corresponding figure for the Region is still 0.005 day care facilities per 100 000, which indicates that day treatment remains relatively underdeveloped in the Region.

Availability of outpatient facilities per 100 000 population

Outpatient facilities comprise hospital outpatient departments, mental health

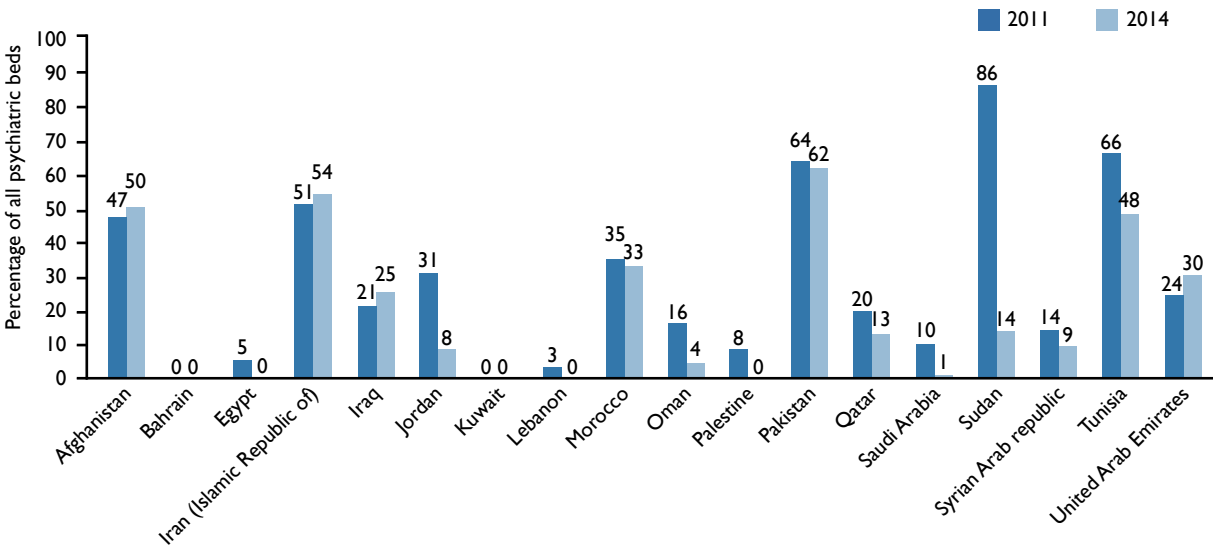


Figure 32. Percentage of all psychiatric beds that were in general hospital and community residences in 2011 and 2014 – countries shown are those with relevant data for both 2011 and 2014

outpatient clinics, community mental health centres and community-based mental health care facilities.

In 2011, there was a median of 0.28 outpatient facilities per 100 000 population in the countries of the Region, which was about half the global rate. In 2014, the corresponding figure for the Region was 0.15 outpatient facilities per 100 000, which is lower than in the previous *Atlas* survey.

The median number of outpatient visits per 100 000 has gone up from 279 per 100 000 in 2011 to 1275 per 100 000 in 2014. At first sight, this seems at odds with the minimal change in the number of facilities. However, some countries in the Region have reported that the capacity of their outpatient services was not fully used in 2011 but use has subsequently risen, thus greatly increasing the number of outpatient visits to a relatively stable number of outpatient facilities. A further possible explanation is that although 18 countries reported on the number of facilities in 2014, only 12 reported on the number of outpatient visits. Missing data on the number of visits may have biased the reported median number of outpatient visits per 100 000.

Comparison of service availability in the Eastern Mediterranean Region with the rest of the world

Compared with global rates, the Eastern Mediterranean Region has relatively low provision of psychiatric beds. The median number of mental hospital beds per 100 000 in the Region of 4.78 is lower than the global median of 6.5 per 100 000 and ranks third compared with other WHO regions (see Figure 33). The Region has fewer psychiatric beds in general hospitals (0.49 per 100 000 compared with 2.14 globally), and beds in community residential facilities (median of 0 per 100 000 compared with 0.15 globally), and ranks fifth and sixth respectively compared with other WHO regions.

There is a median of 0.02 day care places per 100 000 in the Eastern Mediterranean Region, which is lower than the global median of 0.01 per 100 000. However, the rate of 0.02 per 100 000 is equal or higher than other WHO regions except the European Region, which

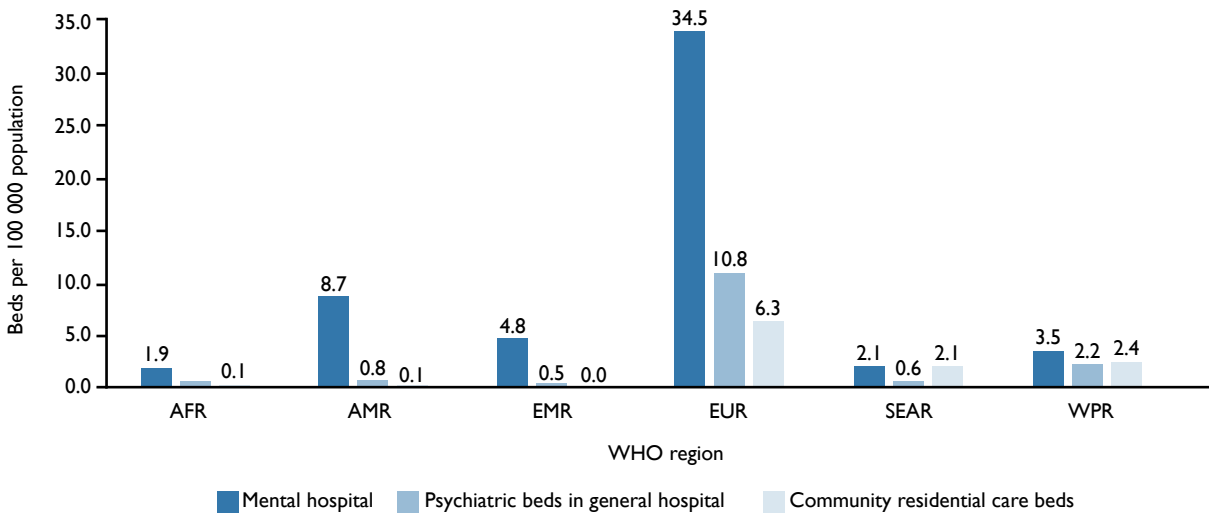


Figure 33. Psychiatric beds per 100 000 population in mental hospitals, general hospitals and community residential facilities, by WHO region

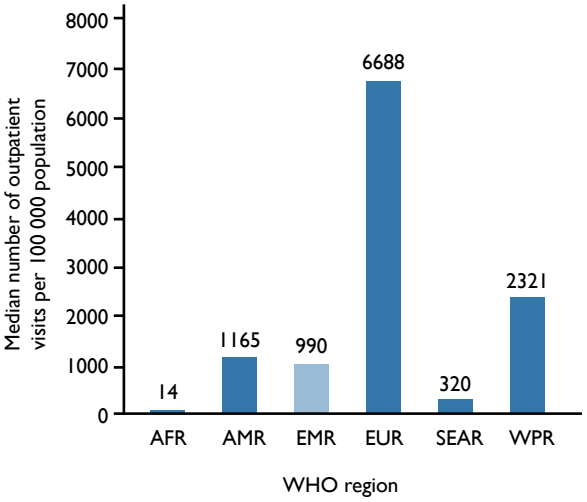


Figure 34. Median number of outpatient visits per 100 000 population, by WHO region

is the WHO region in which day treatment is most extensively developed.

The median rate of 990 outpatient visits per 100 000 population in the Region is similar to the global median of 1051 per 100 000, and ranks fourth when compared with other WHO regions (see Figure 34).

8. Service coverage for severe mental disorders

Coverage is a measure of the number of persons in need who receive care. The *Atlas 2014* collected information about coverage of all mental disorders and three forms of severe mental disorder: non-affective psychosis, bipolar affective disorder and moderate–severe depression. The sum of persons with severe mental disorders who received care in the previous year from inpatient and outpatient facilities has been divided by the whole population to give a reasonable estimate of treated prevalence.

From among the 22 Eastern Mediterranean Region countries that completed the Atlas questionnaire, relatively few were able to provide these data (see Table 9). For most settings, fewer than five countries provided data. Regional analysis of such limited data is not presented here. Cautious analysis of settings with data from five or more countries is presented - median values based on these small numbers of countries should be regarded only as a rough indication.

Table 9. Number of countries that provided information about the number of persons with mental disorders who received mental health care in the past year

Care setting	All mental disorders (common and severe)	Non-affective psychosis	Bipolar affective disorder	Moderate–severe depression
Inpatient and day care services				
Mental hospital	13	5	5	5
Psychiatric ward in a general hospital	9	4	4	4
Mental health community residential facility	5	3	3	3
Mental health day treatment facility	5	2	2	2
Other residential facility	3	1	1	1
Outpatient and primary health care services				
Mental health outpatient facility	8	4	4	4
Primary care facility / clinic	5	1	1	1
Other outpatient health facility or service (e.g. outreach service)	5	3	3	3
Social care services				
Community care or rehabilitation facility (e.g. day care centres)	2	2	2	2

Table 10. Median treated prevalence per 100 000 population for settings with responses from five or more countries of the Eastern Mediterranean Region

Care setting	Type of mental disorder	Number of countries	Median	Minimum	Maximum
Mental hospitals	All mental disorders	13	54	5	1151
	Non-affective psychosis	5	28	3	555
	Bipolar affective disorder	5	5	0.2	338
	Moderate–severe depression	5	26	0.2	259
Psychiatric wards in general hospitals	All mental disorders	9	29	0	1017
Mental health day treatment facilities	All mental disorders	5	6	0	9.5
Mental health outpatient facilities	All mental disorders	8	1158	37	3937

The median treated prevalence of all mental disorders in mental hospital is 54 per 100 000 population, and in psychiatric wards of general hospitals is 29 per 100 000 population (see Table 10). The treated prevalence of all mental disorders in mental health outpatient facilities (1158 per 100 000 population) is almost 14 times greater than in the two hospital settings combined. This indicates that from among every 14 patients seen as outpatients, one is likely to be admitted.

Among mental hospital treated patients, the treated prevalence of non-affective psychosis and moderate–severe depression are similar (28 and 26 per 100 000 respectively), and both are about five times more frequent than bipolar affective disorder (5 per 100 000).

9. Inpatient care

Length of stay

Ten countries provided data on length of stay in mental hospitals. In the majority of countries, lengths of stay are most often less than one year (see Figure 35). There are substantial percentages staying 1 to 5 years in Iraq, Syrian

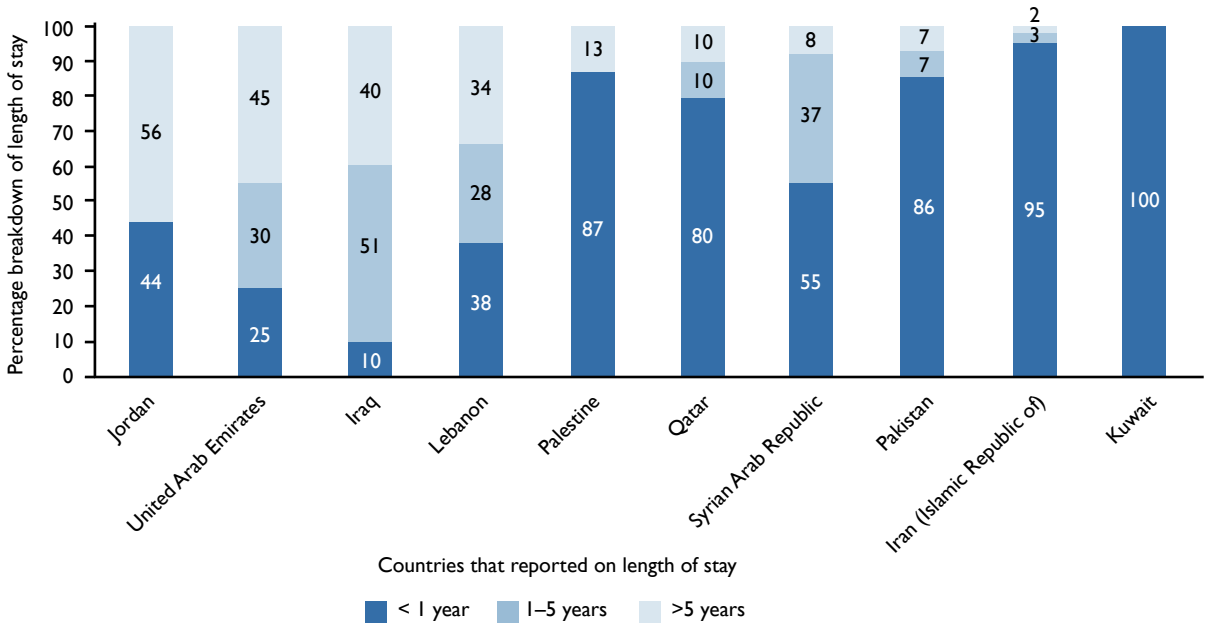


Figure 35. Percentage breakdown of length of stay for inpatients staying in mental hospitals on 31 December of the most recent year for which countries had data to report (most were 2013)

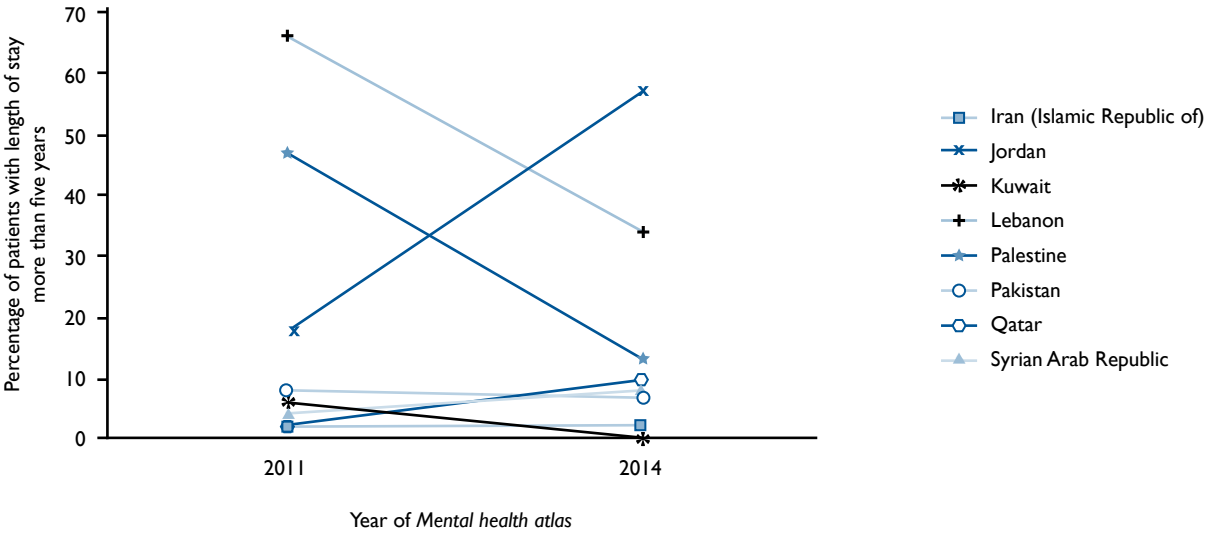


Figure 36. Percentage of patients with length of stay more than 5 years reported in the *Atlas 2011* and *Atlas 2014* surveys

Arab Republic, United Arab Emirates and Lebanon; and longer stays of more than 5 years occur most frequently in Jordan, United Arab Emirates, Iraq and Lebanon.

Eight countries provided length of stay data for both *Atlas 2011* and *Atlas 2014*. The changes in percentage of patients with lengths of stay greater than 5 years are shown in Figure 36. In Lebanon, Palestine and Kuwait the percentage of patients with length of stay greater than 5 years fell between 2011 and 2014. In Islamic Republic of Iran and Pakistan it has remained low and constant. In Qatar and Jordan the percentage of patients staying more than 5 years has increased.

Figure 37 shows a similar graph for length of stay more than 1 year. The percentage of patients staying more than 1 year has fallen in

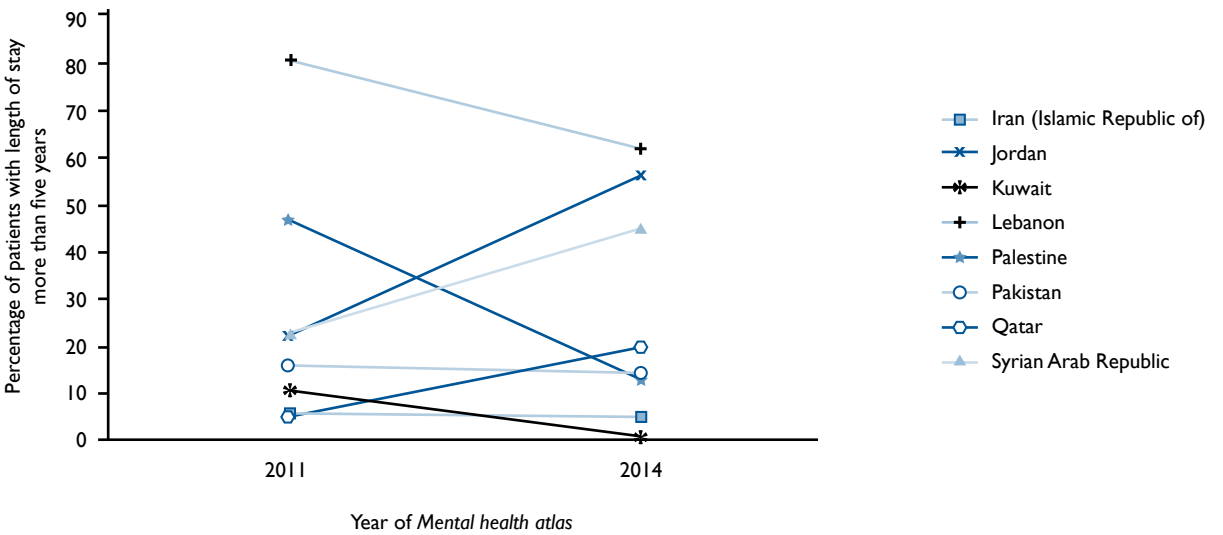


Figure 37. Percentage of patients with length of stay more than 1 year reported in the *Atlas 2011* and *Atlas 2014* surveys

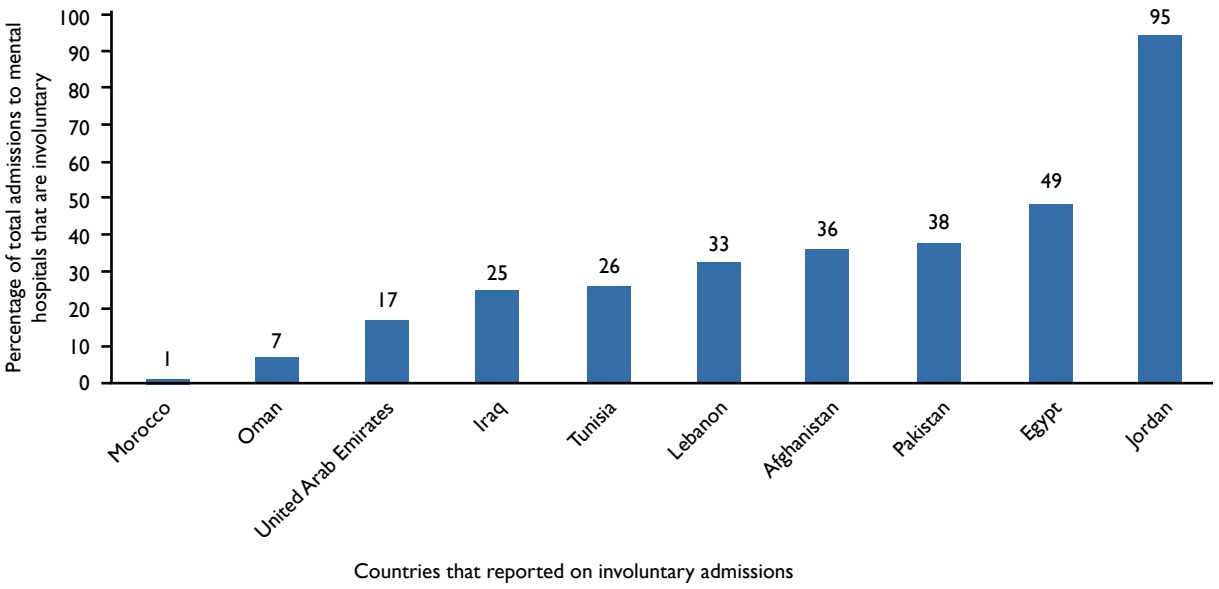


Figure 38. Percentage of total admissions to mental hospitals that are involuntary

Lebanon, Palestine and Kuwait. It is low and slightly reduced in Islamic Republic of Iran and Pakistan. In Jordan, Qatar and Syrian Arab Republic the percentage of patients with length of stay more than 1 year increased between 2011 and 2014.

Involuntary admissions

Ten countries provided data on involuntary admissions to mental hospitals. A median of 26% of admissions across the region are involuntary, with a range from 1% to 95% (see Figure 38).

The number of countries providing data on general hospitals and community residential facilities is very small. Four countries provided data on involuntary admissions to general hospitals (Djibouti 71%; Lebanon 60%; Pakistan 2%; United Arab Emirates 4%). One country, Pakistan, provided data on involuntary admissions to community residential facilities (34%).

Globally, 11.6% of all admissions were involuntary, suggesting that the percentage of admissions that are involuntary in the Eastern Mediterranean Region is higher than the global average.

Table 11. Percentage of discharged patients who were followed up within 1 month

Country	Percentage of patients discharged from hospital who had a follow-up visit within 1 month	
	Mental hospital	General hospital
Afghanistan	1	59
Djibouti	Not applicable	92
Jordan	55	74
Palestine	100	Not applicable
Pakistan	54	42
United Arab Emirates	85	100

Table 12. Persons with mental disorders who received social support in the past year

Country	Number of persons with mental disorders who received social support in the past year per 100 000 population	
	Monetary support	Non-monetary support
Bahrain	300	Unknown
Djibouti	17	Unknown
Iraq	4	Unknown
Pakistan	0.1	36
United Arab Emirates	1.3	0.02

10. Continuity of care after discharge

Six countries provided data about the number of persons who had a follow-up visit within 1 month of discharge from mental hospital and from psychiatric wards in general hospitals (see Table 11).

11. Social support

Countries were asked to report on the number of persons who had received social support, such as disability payments, income support or forms of non-monetary support, such as housing support, access to employment and educational assistance. Only five countries of the Region provided data on the number of persons with mental disorders who received social support in the past year (see Table 12).

12. Mental health promotion and prevention

The third objective of the Comprehensive Mental Health Action Plan concerns the implementation of strategies for promotion and prevention in mental health. National mental health promotion and prevention programmes exist in 10 (45%) countries in the Eastern Mediterranean Region (see Figure 39).

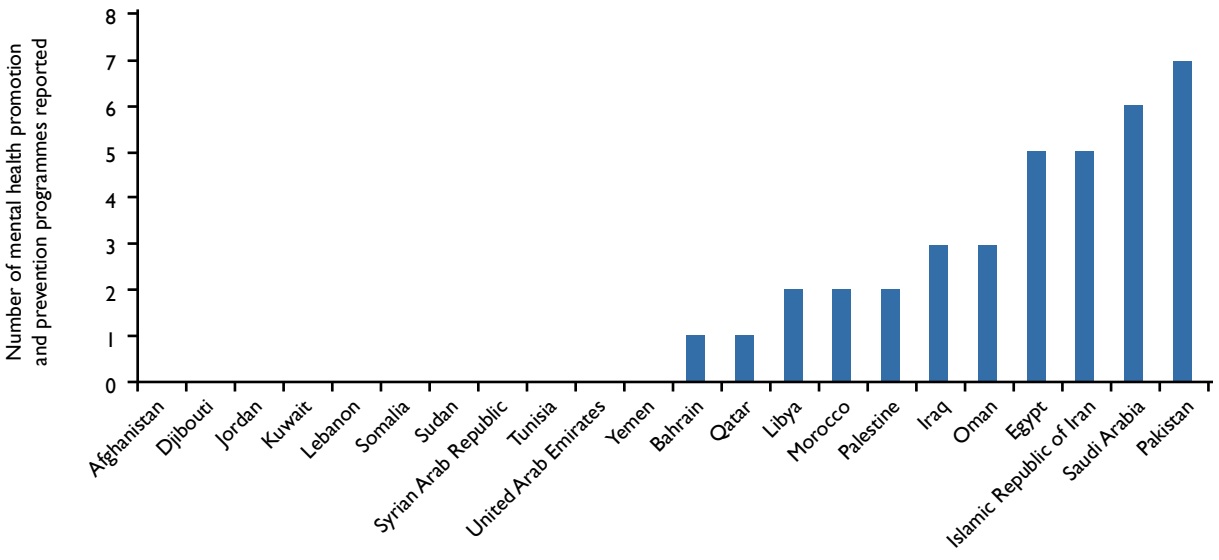


Figure 39. Number of mental health promotion and prevention programmes reported by countries

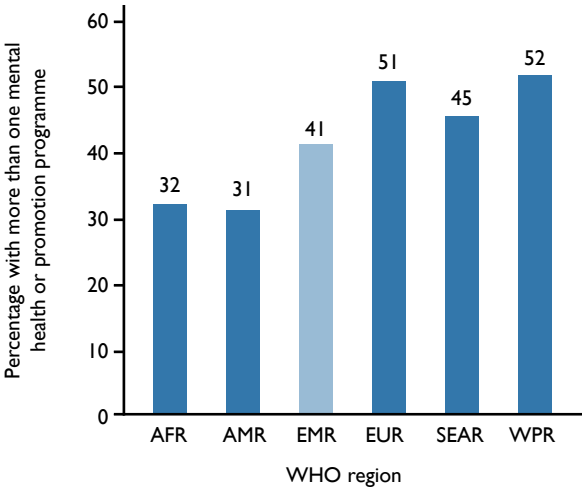


Figure 40. Percentage of countries in each WHO region with more than one mental health prevention and promotion programme

Comparison of mental health promotion and prevention in the Eastern Mediterranean Region with the rest of the world

Globally, 41% of countries have mental health promotion and prevention programmes, which is the same percentage as in the Eastern Mediterranean Region. The Region is correspondingly positioned in mid-range for percentage of countries with more than one prevention and promotion programme when compared with the other WHO regions (see Figure 40).

13. Suicide prevention

Globally, suicide was the cause of 804 000 deaths in 2012.[7] Suicide prevention is a priority, and Target 3.2 of the Comprehensive Mental Health Action Plan aims for a 10% reduction in suicides by 2020. The *Atlas 2014* asked countries to report on suicide rates and on their suicide prevention strategies.

Three countries in the Eastern Mediterranean Region reported that they have developed national suicide prevention strategies: Islamic Republic of Iran, Palestine and Tunisia.

[7] *Preventing suicide: a global imperative.*

Table 13. Crude suicide rates

Country	Crude suicide rate per 100 000 per year
Bahrain	1.6
Iran (Islamic Republic of)	2.5
Palestine	0.7
Pakistan	4.4
Tunisia	0.4

In many countries throughout the world, vital registration systems are poorly developed and consequently there are issues of underreporting of suicide. Five countries reported the number of suicide deaths (see Table 13). All of these rates are lower than the global, age-standardized suicide rate of 11.4 per 100 000 population.

14. Core mental health indicator set

Specific reports on mental health activities have been produced in half of the countries in the Eastern Mediterranean Region in the past 5 years (see Table 14). Most other countries in the Region have reported mental health activities in general health statistics. Two countries have not compiled a mental health report in the past 2 years, and one country did not submit a response to this item.

Comparison of reporting of core mental health indicator set in the Eastern Mediterranean Region with the rest of the world

The Eastern Mediterranean Region compares favourably with other regions for reporting of mental health data (see Figure 41). The Region ranks second for specific mental health reports for public and private sectors, and for public sector only. A smaller percentage of countries of the Region have not compiled mental health data in the past 2 years than in all but one other WHO region.

Table 14. Availability of mental health activity reporting in the past 2 years

Availability/status of mental health reporting	Number of countries	%
No mental health data have been compiled in a report for policy, planning or management purposes in the past 2 years	2	10%
Mental health data have been compiled for general health statistics in the past 2 years, but not in a specific mental health report	8	38%
A specific report focusing on mental health activities in the public sector only has been published by the health department or any other responsible government unit in the past 2 years	8	38%
A specific report focusing on mental health activities in the public and private sectors has been published by the health department or any other responsible government unit in the past 2 years	3	14%

Discussion

All 22 countries in the Eastern Mediterranean Region submitted data for the *Mental health atlas 2014*. Items such as policy, legislation and stakeholder involvement were answered comprehensively by all countries. However, other items, particularly those pertaining to finances, service use and suicide, were answered by only a minority of countries. This has severely constrained the scope of analysis of the Regional review, but also illustrates of significant issues relating to budgetary and service planning and information systems, which will be discussed further.

The *Atlas* survey has highlighted the scope for development of leadership and governance in mental health, and this is indicated by the total absence of fully implemented mental health policies and near total absence of fully implemented mental health legislation. Compared with other WHO regions, the Eastern Mediterranean Region has been the most active in recently publishing and reviewing mental health policies and plans. However, where present, mental health

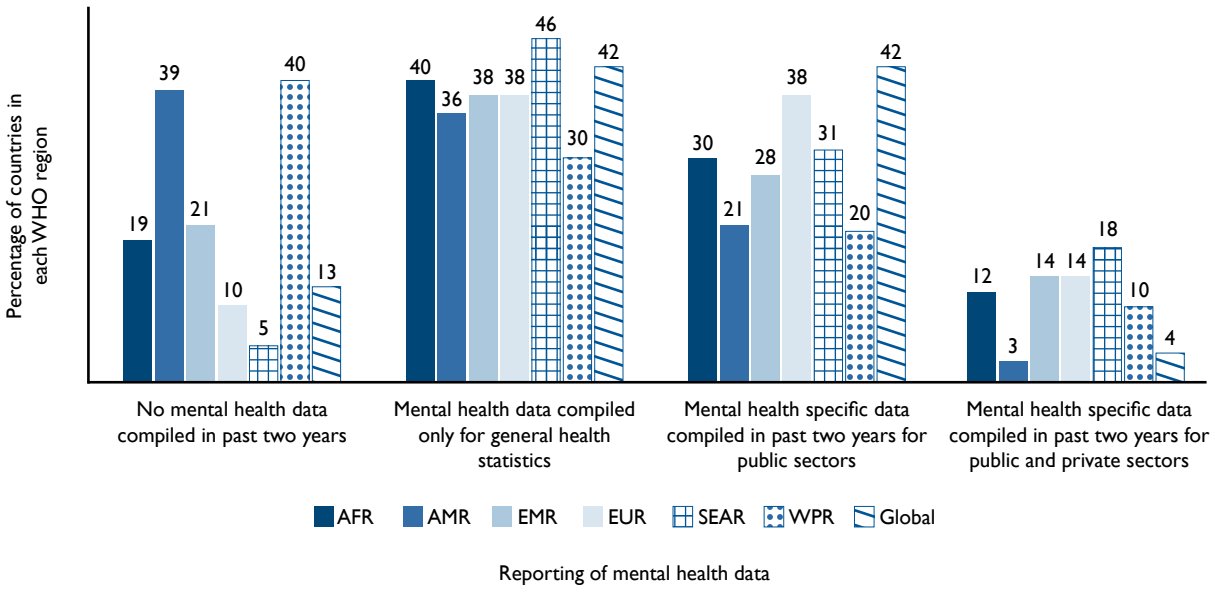


Figure 41. Reporting of mental health data in the past 2 years, by WHO region

policies are only partially implemented and many require revision to bring them in line with internationally agreed human rights instruments. The lack of effective policies and governance providing a framework for development has also affected stakeholder involvement, which is very underdeveloped in the Region. The strengthening of leadership and governance in the Region with involvement of stakeholders would be important steps in influencing and catalysing the development of mental health resources in order to address the increasing burden of mental illness.

The *Atlas 2014* survey also shows that the majority of countries could not provide specific data on mental health spending, and this suggests a lack of a specific budget for mental health. In the absence of a current specific mental health budget it is difficult to formulate a clear framework for mental health resources development. Clarification of budgets and budgetary planning linked with development is a clear opportunity for a focused strengthening of mental health leadership and governance.

The overall trend in the Region of increasing specialist mental health staff, such as nurses, psychiatrists and psychologists, is encouraging. However, the mental health workforce has decreased in some countries. The fall in psychiatrists per 100 000 in group 2 countries, compared with an increase in group 1 countries, suggests that sociopolitical and economic factors may be a factor influencing the availability and mobility of mental health resources within the Region. Key factors to consider in mental health workforce planning are the retention and attraction of skilled mental health professionals.

Alongside consideration of the specialist mental health workforce, the general health workforce is accessible to far greater numbers of people with common mental health problems. The ability of primary care to respond and provide cost-effective interventions for mental health problems can be strengthened by mental health training for primary care staff. The *Atlas 2014* findings indicate that only a small minority of primary care staff (2.7% of physicians and 1.6% of nurses and midwives) have received at least 2 days of training in mental health in the past 2 years. These figures are similar to the global medians. This is therefore an area of potential development to address the goals of the Comprehensive Mental Health Action Plan.

There is a large variation of mental health facilities in countries across the Region, which is at least in part associated with the availability of resources and political stability (for example: progressively fewer psychiatric beds per 100 000 population comparing group 1 to group 2 and group 3 countries, and fewer nurses and psychiatrists per 100 000 population in group 2 than group 1 countries). Nevertheless there are examples of countries with relatively meagre resources or that are dealing with crises or political unrest where meaningful progress towards the goals of the Comprehensive Mental Health Action Plan have already been made, for example: increased availability of psychiatric beds in community residential facilities in Pakistan; mental health promotion and prevention programmes in Djibouti and Pakistan; and reduced length of inpatient stays in Palestine.

Compared with other WHO regions, the Eastern Mediterranean Region has relatively low levels of psychiatric beds, particularly in general hospitals and community residential facilities, and the distribution of psychiatric beds between mental hospitals, general hospitals and community residential facilities in the Region has not changed between 2011 and 2014, which at first sight suggests that there may be inertia in the provision of inpatient services. However, the median total number of psychiatric beds per 100 000

population fell between 2011 and 2014, and there has also been a reduction in the median number of outpatient facilities per 100 000 population. These trends may represent the lack of sustainable policies for maintaining mental health infrastructure or possibly even disinvesting in mental health infrastructure. Unfortunately financial data are not available to confirm or refute this hypothesis. However, another possible explanation for this trend is that there is more focused use of current resources and thus restructuring of current infrastructure to create fewer but more efficient units to provide for mental health care. This has some support in that there has been a more than four-fold increase in the median number of outpatient visits in 2014 as compared to 2011. The increase in outpatient visits may also be partially explained if care has shifted from to the community following the reduction in psychiatric inpatient beds. This may represent changes in cultural attitudes and possibly destigmatization of mental disorders, which will have a long-term impact on healthcare consumption behaviour. Careful consideration may need to be taken to ensure that current policies that influence development of mental health infrastructure will be in line with meeting the demand for mental health consumption. Further research may also be beneficial into the cultural changes that have increased the consumption of mental health outpatient services to better help inform changes to existing policies and help with longer-term mental health resource development planning.

There is a large range in the numbers of national mental health promotion and prevention programmes, and unlike the treatment services, this appears to be irrespective of a country's development or wealth as represented by the health system grouping. This suggests that there is capacity for promotion and prevention programmes in all countries. Yet more than half of countries in the Region have not yet started to address mental health promotion and prevention programmes, and for those countries this represents an important opportunity.

Although almost all countries reported that they have captured and reported on mental health data over the past 2 years, this regional analysis indicates that there are significant and widespread gaps in the data collection and highlights that current information systems may not be in-line with target indicators of the Comprehensive Mental Health Action Plan and *Mental health atlas*. The failure of many countries to report on service coverage, length of hospital stay, follow-up of patients after discharge from inpatient care and provision of social support in the community not only highlights the need for improved information systems, but also suggests a lack of leadership and governance structures with service user and carer participation for the transition of care to community settings. Suicide is poorly reported across the Region, and the majority of countries do not have any suicide prevention strategies in place. This presents an important opportunity for the development of prevention strategies respecting the social, religious and cultural aspects of suicide and suicide reporting in the countries of the Region.

Baseline comparison with the targets of the Comprehensive Mental Health Action Plan 2015–20

The *Mental health atlas 2014* was revised from previous versions of the Atlas to focus on the targets and indicators identified in the Comprehensive Mental Health Action Plan. In the final section of this review, the extent to which the Eastern Mediterranean Region measures up in 2014 against the six global targets for 2020 is examined.

Global Target 1.1. 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by 2020). Although 55% of countries of the Region have updated their mental health policies in the past 5 years, many are not compliant with some or all international human rights instruments. In 2014, seven countries of the Region, or 32%, are compliant with all five of the five measured components of human rights and therefore meet the Action Plan target; although no country of the Region claims that these policies are as yet fully implemented. If this target is to be achieved in the Region, policies need to be updated in line with human rights instruments in at least 11 more countries by 2020; and strong leadership is required to ensure that these policies are properly resourced and implemented.

Global Target 1.2. 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by 2020). 73% of countries of the Region have mental health legislation (either stand-alone or integrated into other legislation), but as with policy this is often not compliant with some or all international human rights instruments. In 2014, six countries of the Region, or 27%, are compliant with all five measured components of human rights instruments and therefore meet the Action Plan target; although none of these country states that these laws are fully implemented (five of the six state the legislation is available but not implemented, one states it is available and partially implemented). If this target is to be achieved in the Region, mental health legislation in line with human rights instruments needs to be updated and enacted in five more countries of the Region, along with appropriate governance to ensure that mental health laws are implemented in all countries.

Global Target 2. Service coverage for severe mental disorders will have increased by 20% (by 2020). In order to monitor and assess this indicator a current baseline of service coverage needs to be established. Our current information does not properly establish this baseline. First, the denominator for calculating coverage is the total population at risk, rather than the total population in need. Secondly, the reporting of numbers of people with severe mental disorders treated is available only for 13 countries at the level of the mental hospital and nine at general hospital and eight at mental health outpatient levels. If the treated prevalence in mental health outpatient facilities, currently at the level of 1158 per 100 000 population (based on eight countries) is to increase by 20% by 2020, then the target is 1390 per 100 000 population.

Global Target 3.1. 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by 2020). According to responses to *Atlas 2014*, nine or 41% of countries of the Region have two or more functioning programmes. Among the other 13 countries, only two have one programme, the remaining 11 have no functioning national promotion or prevention programmes. To meet the target by 2020, the nine countries with two or more programmes must continue to have eligible programmes, and a further nine countries of the Region must establish two or more national promotion or prevention programmes.

Global Target 3.2. The rate of suicide in countries will be reduced by 10% (by 2020). This target requires a current baseline against which to measure progress in 2020. Only five countries (23%) reported rates of suicide in the *Mental health atlas 2014* survey, with a median of 1.6 suicides per 100 000 per year. A reduction by 10% suggests a target of less

than 1.44 suicides per 100 000 per year. However the currently reported rates may underestimate the true suicide rate due to possible underreporting for social, religious and cultural reasons. There is an urgent need to work towards establishing accurate suicide reporting in countries of the Region.

Global Target 4. 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every 2 years through their national health and social information systems (by 2020). Although 19 countries of the Region have produced reports on mental health data (either dedicated reports or reports on mental health in general health statistics), it is clear from the responses to the Atlas questionnaire that the extent of mental health information is limited in most countries of the Region. Only one country reported on all the indicators, and for several sections that country reported from a region rather than the whole country. With the regional framework for implementation of the Comprehensive Mental Health Action Plan, the Regional Office for the Eastern Mediterranean has provided a core set of indicators that countries can incorporate into their health management and other information systems or collect by periodic surveys in order to monitor progress towards the targets of the Action Plan.

The current status of the Region in relation to the 2020 targets of the Comprehensive Mental Health Action Plan is summarized in Table 15. With each biennial Atlas survey the percentage progress towards achieving the 2020 target should increase towards 100% by 2020.

In order to progress from the current situation to achieve the global targets and goals of the Comprehensive Mental Health Action Plan, the Region needs to commit to early and sustained mental health development over

Table 15. Extent to which the global targets of the Comprehensive Mental Health Action Plan have been met at baseline in 2014

Targets set out in the Comprehensive Mental Health Action Plan (2013–2020) to be achieved by 2020	Status of Eastern Mediterranean Region in *Atlas 2014*	Percentage progress towards achieving the 2020 target
Policy: 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments.	Seven or 32% of countries have contemporary mental health policies compliant with international human rights instruments	40%
Legislation: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments.	Six or 27% of countries contemporary mental health legislation compliant with international human rights instruments	54%
Coverage: service coverage for severe mental disorders will have increased by 20%.	Treated prevalence in mental health outpatient facilities, of 1158 per 100 000 population	*Atlas 2014* establishes baseline
3.1. Prevention and promotion: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes.	Nine or 41% of countries have two or more functioning programmes	51%
3.2. Suicide: the rate of suicide In countries will be reduced by 10%.	Median of 1.6 suicides per 100 000 per year based on five reporting countries.	*Atlas 2014* establishes baseline, but this is inadequate due to low response rate and underreporting.
Information: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every 2 years through their national health and social Information systems.	One or 5% of countries reported on all the indicators in *Atlas 2014*,	6%

the next 6 years. The Eastern Mediterranean regional framework for scaling up action on mental health[8] along with its accompanying briefing documents and resources provides guidance on how this can be achieved. Success will depend on prompt establishment of strong leadership for mental health in each country empowered with sufficient information and effective governance of resources to plan and deliver. Key partnerships need to be forged, none more important than service user and carer participation. The mental health atlas survey, with Region-specific modifications and interim indicators, will be repeated every 2 years to assist in monitoring progress. WHO will also provide technical advice and support to countries as they work towards implementation of the regional framework. Countries who succeed in achieving these targets will be making a major contribution to their populations in achieving the overall goal of the Comprehensive Mental Health Action Plan to "promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders".

[8] *WHO Regional Committee for the Eastern Mediterranean resolution EM/RC62/R.5 scaling up mental health care: a framework for action*. Cairo: WHO Regional Office for the Eastern Mediterranean; 2015 *(http://applications.emro.who.int/docs/RC62_Resolutions_2015_R5_16582_EN.pdf?ua=1, accessed 4 February 2016)*.

Mental disorders have a profound effect on individuals, their families and society. The Mental health atlas 2014 provides up-to-date information on the availability of mental health services and resources across the WHO Eastern Mediterranean Region. This is the first time that all the countries of the Region have participated and contributed to this exercise. The results provide an invaluable resource that will assist stakeholders to identify gaps in current provision and inform decisions around increasing resources to scale up services for mental health, and support the monitoring of progress towards global and regional targets.

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