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Strategy for mental health and substance abuse in the Eastern Mediterranean Region 2012–2016

Mental health and its problems are a public health issue inextricably linked to quality of life, productivity and social capital. Mental, neurological and substance use disorders affect all social groups and ages, contributing to 14% and 12% of the burden of disease globally and regionally, respectively. Resolution WHA55.10 called on Member States to provide support to WHO's global action programme for mental health. The mhGAP programme calls for enhancement of political commitment and development of policy and legislative infrastructure. The Regional Committee in 2010 requested development of a comprehensive mental health strategy to guide the response of Member States, to promote mental health and to provide for integrated efforts for prevention, treatment and rehabilitation of persons with mental, neurological and substance use disorders. The regional strategy and actions proposed provide a foundation for the development of national strategies and action plans.

A draft resolution is attached for consideration by the Regional Committee.

Contents

Executive summary

Mental health and its problems are a public health issue inextricably linked to quality of life, productivity and social capital. Mental, neurological and substance use disorders are universal, affecting all social groups and ages, contributing to 14% and 12% of the burden of disease globally and regionally, respectively. World Health Assembly resolution WHA55.10 called on Member States to provide support to WHO's global action programme for mental health. This resulted in launch in 2008 of the mhGAP programme which calls for enhancement of political commitment and development of policy and legislative infrastructure. The discussions of the Regional Committee which led to resolution EM/RC57/R.3, adopted in 2010, were explicit in requesting development of a comprehensive mental health strategy to guide the response of Member States, to promote mental health and to provide for integrated efforts for prevention, treatment and rehabilitation of persons with mental, neurological and substance use disorders.

This paper provides a review of the epidemiological evidence highlighting the burden of mental, neurological and substance use disorders, followed by analysis of the response of mental health systems of Member States. In light of the review of burden and system response, challenges and opportunities are identified and the components of a regional strategy are elaborated to address the challenges and maximize the opportunities. The components of the regional strategy and actions proposed provide a foundation for the development of national strategies and action plans. The strategic components include strengthening leadership and governance of mental health systems, scaling up the integration of mental health into primary care, strengthening the specialist mental health service, prioritizing services for vulnerable persons, prevention of mental, neurological and substance use disorders and promotion of mental health, and enhancing local research for the generation of evidence and promoting its operationalization.

1. Introduction

Mental, neurological and substance use disorders are universal, affecting all social groups and ages. Mental, neurological and substance disorders are responsible for 14% and 12% of disability-adjusted life-years lost, globally and regionally, respectively (*1*). According to WHO more than 450 million people worldwide suffer from mental, neurological and substance use disorders, 154 million people suffer from depression and 25 million people from schizophrenia; 91 million people are affected by alcohol use disorders and 15 million by drug use disorders. As many as 50 million people suffer from epilepsy and 24 million from Alzheimer and other dementias. At any given time about one in four families has a member with a mental disorder (*2*).

Furthermore mental health has an intimate and symbiotic relationship with physical health and social determinants of health (*3*). Evidence is emerging that positive mental health is associated with good physical health, meaningful long-term relationships, a sense of belonging, good education, and being employed in a healthy working environment (*4*). However, social disadvantage increases the risk for mental, neurological and substance use disorders in all societies, irrespective of the wealth of the country. Thus, mental health is closely linked with the Millennium Development Goals to eradicate extreme poverty and hunger, achieve universal education, promote gender equity, improve maternal health, and enhance child survival and development (*5*).

In 2002 the WHO Executive Board, in resolution EB109.R8, called on Member States to adopt the recommendations of The World Health Report 2001, which serve as WHO's vision for the improvement of mental health systems to reduce the burden of mental disorders. The World Health Assembly, in resolution WHA55.10, urged Member States to reaffirm the provisions of the Executive Board resolution and called for strengthening of action to protect children from and in armed conflict and to provide support to WHO's global action programme for mental health.

Subsequently, in 2008, the WHO Director-General launched the mental health Gap Action Programme (mhGAP) as a priority programme aimed at effective and humane care for all people with mental, neurological and substance use disorders. The goal of this programme is to close the gap between what is urgently needed and what is available to reduce the burden of mental, neurological and substance use disorders worldwide (*6*).

At the regional level, in 1997 all the Member States issued a joint statement at the 44th session of the Regional Committee for the Eastern Mediterranean to support their national mental health policies and programmes, coordinate with other social sectors, raise awareness and encourage and work with nongovernmental organizations to foster mental well-being. Subsequently, there have been resolutions on the subject of alcohol and substance abuse but the need for a regional mental health strategy was explicitly highlighted during the discussions on the regional strategic directions and actions for maternal, child and adolescent mental health care, which resulted in adoption of a resolution (EM/RC57/R.3) in 2010.

Considering the evidence which will be elaborated upon in subsequent sections, the recommendations of The World Health Report 2001, the launch of the mhGAP programme and the regional resolutions, there is need for a coherent strategy for mental health that will inform a coordinated and flexible plan of action to improve the mental health of the people of the Region. This will be complemented by the regional strategic directions and actions for maternal, child and adolescent mental health care adopted in 2010 (*7*). The aims of this strategy are to strengthen the integrated response of the health sector and other related sectors, through the implementation of evidence-based and achievable plans for the promotion of mental health and the prevention, treatment and rehabilitation of mental, neurological and substance use disorders, with respect for human rights and social protection.

2. Global and regional situation

2.1 Situation analysis

Worldwide community-based studies estimate the life-time prevalence of mental disorders in adults at 12.2%–48.6% and 12-month prevalence rates at 4.3%–26.4% (*6*,*8*) (Table 1). According to The World Health Report 2001, 10%–20% of children and adolescents worldwide suffer from one or more mental and behavioural disorders and approximately 50% of the mental disorders in adults begin before the age of 14 years (*9*). The global burden of mental, neurological and substance use disorders measured by years lived with disability (disability-adjusted life years, DALYs), accounts for 14% of the global burden of disease and 31.7% of the years lived with disability. The five major contributors to global burden of disability due to mental, neurological and substance use disorders are unipolar depression (11.8%), alcohol-use disorder (3.3%), schizophrenia (2.8%), depressive component of bipolar affective disorder (2.4%) and dementia (1.6%) (*2*).

Mental disorders also contribute to mortality. According to WHO estimates for 2005, neuropsychiatric disorders account for 1.2 million deaths every year and 1.4% of all the years of life lost. Every year, about 800 000 people commit suicide, 86% of whom are in low-income and middle-income countries Suicide is among the three leading causes of death among those aged 15–45 years and accounts for a quarter of all deaths in adolescent boys and up to three-quarters of all deaths in young women. A systematic review identified mental disorders as important proximal risk factors for suicide, in 91% of suicide completers. The prevalence of mental disorders in primary care settings among adults has been documented to range between 10% and 60% and an estimated 15% of patients seen in primary care settings have medically unexplained symptoms coupled with psychological stress and help-seeking behaviour (*3*).

Table 1. Twelve-month prevalence of mental disorders based on the report of the World Mental Health Survey (*7*)

Country	Percentage prevalence of any mental disorders (95% CI)
China (Beijing)	9.1 (6.0–12.1)
China (Shanghai)	4.3 (2.7–5.9)
Belgium	12.0 (9.6–14.3)
Colombia	17.8 (16.1–19.5)
France	18.4 (15.3–21.5)
Germany	9.1 (7.3–10.8)
Italy	8.2 (6.7–9.7)
Japan	8.8 (6.4–11.2)
Lebanon	16.9 (13.6–20.2)
Mexico	12.2 (10.5–13.8)
Netherlands	14.9 (12.2–17.6)
Nigeria	4.7 (3.6–5.8)
Spain	9.2 (7.8–10.6)
Ukraine	20.5 (17.7–23.2)
USA	26.4 (24.7–28)
Iraq	16.6 (13.7–19.5)

As in other parts of the world, mental, neurological and substance use disorders are common in the Eastern Mediterranean Region. Large scale community surveys carried out in the Region report rates of psychological distress between 15.6% and 35.5%, with higher rates in countries with complex emergency situations. The 12-month prevalence of mental disorders ranges between 11.0% and 40.1% (*10–20*) (see Table 2). Depression and anxiety disorders are the most frequent mental disorders, and rates in women are up to double those in men. Alcohol use disorder is almost exclusively found in men, among whom the prevalence ranges from 22 to 4726 per 100 000 population, with six countries having rates greater than 1000 per 100 000. The few countries that have data on the prevalence of substance misuse account for more than half the population of the Region; the median prevalence of drug use disorders is 3500 per 100 000 population, and 172 per 100 000 are injecting drug users (*21*). An estimated 4.7 million people in the Region suffer from epilepsy and its prevalence ranges from 0.4 to 2.1 per 100 000 population (*22*). Mental, neurological and substance use disorders account for 12% of the DALYs lost in the Region. Most of this burden is due to disability; mental, neurological and substance use disorders account for 27% of the years lived with disability in the Region (*1*). The median suicide rate for the countries of the Region is 4.9 per 100 000 population (range 0.56 – 17.17), compared with 6.55 per 100 000 for all countries of the world (*23*).

Rates of mental disorder are significantly higher in countries with complex emergencies. For example, 37.4% of Iraqi schoolchildren were estimated to be suffering from mental disorders; 54.4% of Palestinian boys and 46.5% of Palestinian girls were estimated to have emotional and behavioural disorders and 22.2% of Afghani schoolchildren were estimated to have mental disorders (*24–28*).

The average treatment gaps based largely on data from United States of America and Europe, are 32% for schizophrenia, 50%–60% for depression and anxiety disorders, and 78% for alcohol abuse and dependence (*29*). A Lebanese study found a treatment gap of 70% for major depression (*18*); while in Iraq the overall treatment gap for mental disorders was found to be 94% (*13*). The WHO-AIMS project found a treated prevalence rate for mental disorders of less than 1% in the Region (*30*), which is half that of the global comparison sample (*31*), and when placed against the global median prevalence rates (*7*), suggests an overall treatment gap of more than 90%.

Randomized controlled trials in low-income countries have shown that treatment halves the chance of relapse of schizophrenia after one year, with up to 77% being relapse-free (*23*). More than half of people with epilepsy are seizure-free after one year of treatment. Medication and brief physician-delivered interventions are both effective for alcohol abuse and can reduce alcohol consumption by 30% and up to 60% of people with substance abuse succeed in reducing their use (*9*,*23*).

Community-based services delivering effective medication and psychosocial treatments for schizophrenia, bipolar affective disorder, depression and panic disorder can achieve the same beneficial effects as current treatments at half the current costs (*32*,*33*) Despite this evidence, the median percentage of health spending allocated to mental health in the Region is just 2% (ranging from 0% to 4% in Member States of the Region) (*30*), which compares with 5%–10% required to match current comprehensive health care systems. A median of US$ 0.15 per person is spent on mental health, half the global median and both of which fall well short of the US$ 3–4 needed for a selective package of cost-effective mental health interventions in low-income countries and up to US$ 7–9 in middle-income countries (*34*). Furthermore the resources that are available are not used efficiently, with more than 50% of the financial and human resources being locked in institutional facilities compared with one third globally (*30*).

Table 2. Community-based surveys of the prevalence of mental disorders in countries of the Eastern Mediterranean region

Country	Sample	Instrument	Male	Female	All
Assessment by screening questionnaire					
Afghanistan (2003) (*11*)	Multi-cluster sample of household members aged 15 years and above in Nangarhar province	Hopkins symptom checklist and Harvard trauma questionnaire		Depression	
			16.1%	58.4%	38.5%
				Anxiety	
			21.9%	78.2%	51.8%
				Post-traumatic stress disorder	
			7.5%	31.9%	20.1%
Islamic Republic of Iran (before 2004) (*12*)	Nationally representative sample of 31 014 people aged 15 years and above, selected by random cluster sampling	28-item version of the general health questionnaire (GHQ-28)	15.8%	29%	21%
Iraq (2006–7) (*13*)	Nationally representative sample aged 18 and above: 9256 households completed SRQ	Self-reporting questionnaire (SRQ)	30.4%	40.4%	35.5%
United Arab Emirates (1996–7)(*10*)	1394 participants aged 18 and above from sample of 1696 households in Al Ain	Self-reporting questionnaire (SRQ)			15.6% (11.8–19.5)
Assessment by diagnostic interview					
Egypt (2003) (*19*)	Representative sample of 14 640 adults aged 18–64 years in 5 regions	Mini international neuropsychiatric interview (MINI-Plus)	10.6%	21.1%	16.9% (16.3–17.5)
Iraq (2006-7) (*13*)	Representative sample 18+ years: 9256 households completed SRQ, 4332 individuals completed CIDI	SRQ followed by Composite international diagnostic interview (CIDI)	4.03% 30-day 8.8% 12-month 13.7% lifetime	10.3% 30-day 13.4% 12-month 19.5% lifetime	7.1% 30-day 11.1% 12-month 16.6% lifetime
Lebanon (2002-3) (*18*)	Nationally representative sample of 2856 people aged 18+ years	Composite international diagnostic interview (CIDI)	–	–	16.9% 12-month
Morocco (2004-5) (*20*)	Systematic nationally representative randomized sample of 5498 people, aged 15 + years	Mini international neuropsychiatric interview (MINI)	34.3%	48.5%	40.1% (depression 26.5%, anxiety 37%)
Pakistan (1995 and 1998) (*15,16*)	Rural village population aged 18+ years	Bradford somatic inventory followed by psychiatric assessment using ICD-10 research diagnostic criteria	25%	66%	–
	All of an urban population of 774, aged 18+ years		10%	25%	
United Arab Emirates (1989–90) (*14*)	300 participants from random sample of 247 households in 7 districts of Dubai	Present state examination	–	–	22.6%
United Arab Emirates (1996–7) (*10,17*)	1394 participants aged 18+ years from sample of 1696 households in Al Ain	Composite international diagnostic interview (CIDI)	5.1% lifetime	11.4% lifetime	8.2% (6.7–9.7) lifetime

2.2 Response of mental health systems in the Region

To date, 17 countries in the Eastern Mediterranean Region have completed the WHO-AIMS assessment[1] and 14 countries have participated in the ATLAS project regarding resources for prevention and treatment of substance use (*21*,*35*). The section below is based on the data collected during these exercises and provides a firm foundation of systematic data about mental health systems in the Region on which to build strategic plans.

Twelve (71%) countries in the Region have a contemporary mental health policy or plan. However only four (24%) have mental health plans for emergency situations or natural disasters. Eleven (65%) health departments publish a report on mental health data, but only four (24%) actually comment on it. Therefore, although information is being collected in some countries, it is rarely analysed or used as a tool for action. Five (29%) countries have relevantly recent legislation while four (24%) have legislation that is more than 20 years old and eight (47%) have no mental health legislation, leaving patients at risk of human rights violation.

Mental hospital bed numbers increased in 13 (76%) countries of the Region in the past 5 years, concentrated in or around the urban centres. The outpatient facilities are sparse (0.16 per 100 000 compared with a global median of 0.32 per 100 000) and only 1% of outpatient facilities in the Region provide follow-up community care compared with 18% in the global sample. In most countries in the Region, integration of mental health into primary health care is limited. Protocols to guide staff in assessment, treatment, referral and back-referral are available in more than 80% of primary health care clinics in only three (18%) countries. In-service mental health refresher training in the past year was given to a median of 2% of primary health care doctors and 1% of nurses. Only three (18%) countries report that more than 80% of their primary health care centres make at least one referral each month.

There are 3.3 mental health professionals per 100 000 population in the countries of the Region compared to a global average of 6.0. Only 3% and 4%, respectively, of the total undergraduate training hours for doctors and nurses are devoted to mental health. Although almost all countries have psychotropic drugs in their essential drug lists, up to 66% of community-based facilities do not have psychotropic medications available and only five (29%) supply more than 80% of their primary health care facilities with these drugs. Furthermore in most countries less than 20% of mental health staff received refresher training in the rational use of psychotropic drugs and psychosocial interventions in the previous year.

Fourteen (82%) countries have school-based activities to promote mental health and prevent mental disorders, although only two have more than 50% coverage and in eight it does not extend beyond 20% of schools. The absence of links with housing and employment undermines the possibility of putting in place meaningful processes for rehabilitation of patients to the community. Service user and family associations are poorly developed in the Region; 10 countries have no service user associations, and 10 have no family associations. Where they do exist, they are small; the national memberships reported ranged between 3 and 8 for user/consumer associations and between 4 and 500 for family associations. Globally, only 6% of psychiatric publications come from low-income countries which account for 85% of the world's

[1] The WHO-AIMS report on mental health systems in the Eastern Mediterranean Region includes 14 countries in the Region that completed WHO-AIMS between 2005 and 2009 (*30*). Since then, a further three countries in the Region have completed WHO-AIMS. Wherever possible, data from all 17 countries, representing 93% of the population in the Region, are considered in this strategy (Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Lebanon, Morocco, occupied Palestinian territory, Oman, Pakistan, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia). The WHO-AIMS global comparison data is based on 42 countries (*31*).

population. The Region is under-represented in research publications. Of the 11 000 intervention trials assessing treatment or prevention of schizophrenia, depression, developmental disorders or alcohol-use disorder, only 1.8% were from north Africa and the Middle East. In the past 5 years, a median of 5% of published health research from the Region has been on mental health (*30*).

With regard to alcohol and substance abuse services,[2] 79% (11/14) of countries have a substance abuse drug policy or law. Detoxification for alcohol use disorders is provided on an inpatient and outpatient basis for <10% and 10–50% of the population, respectively. Two countries have some residential rehabilitation for alcohol use disorders. Inpatient detoxification for substance use disorders covers an estimated 50% of the population, while outpatient provision has a lower coverage (detoxification <10%; abstinence-oriented treatment <10%) and outpatient substitution maintenance therapy is available in only one country. Community-based needle exchange programmes are present in 36% (5/14) of countries (*21*).

3. Challenges and opportunities

Mental health has a low political and public health profile. The stigma attached to mental health cuts across all aspects of mental health care and leads to rampant discrimination, impacting on service development, delivery and utilization. Mental health has suffered chronic under-funding and consequently there is a paucity of specialist mental health staff and services. Furthermore, the meagre resources have been centralized in large mental hospitals near to large cities, cut off from the rest of medical care and society, which has contributed to the isolation and stigmatization of the service, its staff and its service-users. The skills of the limited workforce are another barrier to integration of mental health into general health care, because the mental health skills of general health workers are limited, as are the public health skills of mental health leaders. The human rights of people with mental disorder have been neglected in many countries of the Region and they have been allowed to suffer inhumane treatment and discrimination. Institutional care has not only deskilled and robbed service-users of their sense of individuality, but also constrains the skills and expectations of mental health staff, some of whom resist change.

Nevertheless, there is growing recognition of the importance of positive mental health to society, productivity, security and social cohesion. Successful health promotion and public education programmes are already operating in many countries. Opportunities can be taken to develop partnerships and strengthen the mental health promotion and prevention components of these programmes.

Evidence is accumulating on how limited resources can be used more cost-effectively. Countries are already in the process of adopting more efficient models of mental health care by reorienting mental health services to a more community-based approach involving primary health care. Therefore, even if there is no additional funding, there is the opportunity to reach more people by more cost-effective use of the limited resources available. Many countries already have examples of successful interventions to develop community services, integrate mental health into primary health care, and provide for the needs of priority groups. Some countries have successfully scaled these up to cover most of their population.

The main perceived obstacles to research in low-income and middle-income countries are inadequate funding, shortage of trained staff, difficulties in training due to poor institutional infrastructure; constraints on research time due to service and teaching commitments, absence of a strong research ‘culture’, and weak peer networks and collaborations (*36*). Although there has generally been a paucity of evidence and mental health information in the Region, it is very

[2] Alcohol and substance abuse services data are based on the 14 countries with relevant data in the WHO ATLAS – project on resources for treatment and prevention of substance use disorders.

encouraging that almost all countries have participated in the WHO-AIMS project. This has provided evidence to underpin the strategic planning and a baseline against which to measure progress.

4. Regional strategy for mental health and substance abuse 2012–2016

4.1 Vision and rationale

The vision of this strategy is to guide efforts by the Member States to deliver mental health services that improve mental health and well-being for all the people of the Region. The strategy, while being regional in scope acknowledges that the priorities for mental health and mental, neurological and substance use disorders for each country differ according to the prevalence of the various disorders, the evidence for effective interventions relevant to the country, the available resources, the capacity of the mental health and primary care workforce, and the circumstances of the country. However, in light of the commonality of the most of the challenges identified above it is possible to have a consensus on the strategic options at the regional level to provide the necessary direction to the entire spectrum of stakeholders.

It is not expected that every suggested activity under the broad strategic options will be followed in the same way in every country. Countries should make realistic choices when harmonizing their strategies and plans to address their own priorities according to their own resources. However, all countries should establish or strengthen a mental health directorate/ unit within the Ministry of Health, extend the integration of mental health into primary health care, implement a range of activities to reduce stigma, and collect data on mental health care and the capacity of the workforce to inform long-term planning, and coordinate all interventions carried out by other sectors with impact on mental health. Low-income countries that allocate proportionately less of their health budget to mental health have relatively limited capacity to carry forward mental health plans, and they will have to harness their resources to best effect by: strengthening leadership, governance and information collection; utilizing collaborative links in prevention and health promotion; and laying the foundations of integration of mental health into general health care. High-income countries have the resources to implement most of the suggested activities for integration of community-based services for the entire population, with provision to meet the needs of vulnerable persons, supported by comprehensive information systems and quality research.

A detailed document further elaborating on the necessarily summarized strategic options and actions outlined below has been developed along with an implementation and monitoring framework to support the Member States.

4.2 Components of the strategy

1. Strengthen leadership and political commitment for mental health
2. Scale up integration of mental health into primary health care
3. Strengthen secondary and tertiary care mental health services
4. Identify and prioritize vulnerable persons
5. Promote intersectoral collaboration for public mental health literacy, promotion of positive mental health, and prevention of mental, neurological and substance use disorders
6. Enhance the production of and operationalization of research

Strategic component 1. Strengthen leadership and political commitment for mental health

Strong, well-informed and sustained government-led commitment is crucial to addressing the development and maintenance of mental health care as part of the current health system. Leadership is required to establish regular review and updating of policies, plans and legislation, and to ensure that human rights are respected.

Objectives

1. To establish or strengthen a mental health directorate/unit within the Ministry of Health of each country to formulate, resource, implement and monitor mental health care, prevention and promotion.
2. To ensure that national mental health plans, aligned with this regional strategy, are in place, implemented, reviewed and meeting international standards.
3. To ensure that mental health legislation is contemporary and meets international human rights standards.

Selected suggested activities

Regional level activities

1. Create a regional mental health advisory group to review and advise on implementation of the mental health strategy and plan.
2. Develop tools to help with the review and formulation of policies, plans, capacity building interventions and legislation.

National level activities

1. Establish/strengthen a mental health directorate/unit within the Ministry of Health.
2. Review existing mental health and social sector policies, strategies, plans and legislation to ensure they are up-to-date and meet with national and international standards.
3. Work towards mobilizing resources and ensuring fair and adequate resources for mental health.

Strategic component 2: Scale up integration of mental health in primary health care

Most people with mental, neurological and substance use disorder often first seek care from primary health care, and the prevalence of mental disorders among primary health care attendees is high. Dealing with mental, neurological and substance use disorders on an equal footing with other disorders within primary health care is less stigmatizing than is mental hospital care, and facilitates holistic treatment of related physical and mental health problems. More efficient use of the available resources can be achieved by shifting specific tasks from highly qualified health workers to health workers who have received less training. Therefore, mental health systems need to work with primary health care to increase the capacity of the primary health care system to delivery an integrated package of care by training, support and supervision.

Objectives

1. To develop, strengthen and scale up comprehensive community-oriented mental health services through integration with primary health care.
2. To enhance the capacity of primary health care workers at all levels to provide integrated mental health care for priority mental, neurological and substance use disorders.

Selected suggested activities

Regional level activities

1. Cooperate technically with countries to facilitate identification of priority disorders, and development of intervention packages in line with the WHO mhGAP intervention guide.
2. Establish a regional working group of experts from the countries of the Region and elsewhere to collaborate in the design and delivery of training packages.

National level activities

1. Carry out a systematic priority-setting exercise informed by decision-making criteria and put in place essential interventions package for inclusion in primary health care.
2. Establish assessment, treatment and referral guidelines for priority disorders, including epilepsy and ensure that intervention protocols to guide primary health care staff on assessment, treatment, referral and back-referral are present in all primary health care clinics providing mental health care.
3. Ensure robust support and supervision arrangements are in place to sustain mental health and epilepsy care in primary health care.
4. Ensure essential psychotropic drugs, including drugs for the treatment of epilepsy, are reliably supplied to all primary health care facilities providing mental health care.
5. Incorporate mental health indicators in the health management information system.

Strategic component 3: Strengthen secondary and tertiary care mental health services

Objectives

1. To establish community facilities, such as inpatient units in general hospitals, community outpatient clinics and day care facilities, with clear referral processes and support for primary health care.
2. To strengthen the capacity of the specialist mental health workforce to deliver integrated community-oriented mental health care, by training consistent with their role in the mental health system.

Selected suggested activities

Regional level activities

1. Support countries to enhance the capacity of the specialist mental health system and personnel to deliver community-based care and to support primary health care.

National level activities

1. Decentralize and reorient mental health services by developing alternative community-based facilities.
2. Reformulate the roles of specialist mental health professionals and set up in-service supervision or appraisal to support training and career development of specialist mental health staff.

Strategic component 4: Identify and prioritize vulnerable persons

This strategy document is guided by the principle of provision of equitable treatment for people with mental, neurological and substance use disorders. However, some groups of people are marginalized and vulnerable, for example those living in countries/areas affected by disaster, war or civil conflict, widows, substance dependants, etc., have greater mental health needs, suffer

more serious consequences or require special care. There is an ethical imperative to provide more for those in greatest need.

Objectives

1. To identify vulnerable persons and ensure that appropriate mental health services are made available to them.
2. To collaborate with other social sectors for mental health promotion and prevention of mental disorders among vulnerable persons.

Selected suggested activities

Regional level activities

1. Publish and distribute the regional strategic directions and actions for maternal, child and adolescent mental health care.
2. Prepare and publish the regional strategic directions and guidance for alcohol and substance misuse in the Eastern Mediterranean Region.
3. Coordinate and develop regional preparedness and response plans for mental health and psychosocial support in emergency settings with a regional workforce of experts that can be rapidly deployed.
4. Support Member States in developing/contextualizing policies, strategies, instruments and interventions for provision of mental health and psychosocial support for countries affected by disaster, war and civil conflict.

National level activities

1. Develop and implement the plans for provision of mental health services for mothers and children and initiate suicide prevention programmes for adolescents.
2. Prepare and implement emergency preparedness plans for disaster or humanitarian crisis in collaboration with all stakeholders.
3. Develop services to provide inpatient and/or outpatient interventions for alcohol and substance use disorders.

Strategic component 5: Promote intersectoral collaboration for public mental health literacy, promotion of positive mental health, and prevention of mental, neurological and substance use disorders

Given the size of the treatment gap and the paucity of mental health and primary care resources available, collaboration with existing prevention and health promotion programmes to include mental health components may be the most effective way for some countries to reduce the burden of mental, neurological and substance use disorders and enhance positive mental health.

Objectives

1. To reduce ignorance and stigma about mental, neurological and substance use disorders and their treatment through development of partnerships and intersectoral collaboration.
2. To incorporate mental health and epilepsy components into other health and social sector programmes.

Selected suggested activities

Regional level activities

1. Cooperate technically with countries to develop strategies for public education and mental health promotion.
2. Collate evidence, tools and indicators on assessment of positive mental health and work towards agreeing a set of indicators that can be used in the Region.
3. Collaborate with other United Nations agencies and stakeholders to incorporate mental health components into health and social sector programmes.

National level activities

1. Develop intersectoral strategies for mental health promotion and prevention of mental disorders.
2. Develop and disseminate information, education, and communication materials.
3. Develop or adapt indicators of positive mental health that can be used nationally.
4. Actively promote formation and involvement of families and user associations.

Strategic component 6: Enhance the production of and operationalization of research

Mental health information and research is fundamental to generating evidence to guide policies and interventions, and thus to attracting more resources and improving quality of care.

Objectives

1. To strengthen mental health operational research, appropriate to each country's needs and resources.
2. To make comparable comprehensive assessments of each country's mental health system and its capacity, in order to monitor progress and inform planning.
3. To collect, analyse and report on agreed mental health indicators that are incorporated into the health information system.

Selected suggested activities

Regional level activities

1. Work with countries to agree priorities for research in mental health, drawing on existing international work in this area.
2. Support capacity-building for undertaking mental health research in the countries of the Region.
3. Facilitate collaborative links between researchers in the Region and researchers outside the Region who have a strong track record of successful research proposals and publications.

National level activities

1. Establish a national forum to identify mental health research priorities, and to lobby for support for these priorities, and/or establish and fund a national body to identify and support priority research in mental health.
2. Develop international collaborative research links within and outside the Region.
3. Compile and analyse the country's existing mental health research (e.g. epidemiological, services, biology/genetics, policy/programmes/economic, psychosocial and pharmacological interventions) in order to inform the evidence base for current service planning and to identify the next research priorities.

5. Conclusions

Over the past three decades, there have been repeated attempts to integrate and mainstream mental health. These have been addressed in country reports, intercountry meetings and training modules. These efforts were reinforced in 1997 at the 44th session of the Regional Committee and in 2010 in the discussion for adoption of the regional strategic directions for maternal, child and adolescent mental health. However, as the situation analysis shows, integration is patchy and uneven, funding is inadequate, resources remain centralized in mental hospitals located near big cities, and stigma is widespread. That is why it is so important for this strategy to reinvigorate efforts to improve the mental health of the peoples of the Region by calling on governments to strengthen leadership and governance of their mental health systems. During the next 5 years the five key options identified in this strategy are to scale up the integration of mental health into primary care, to strengthen the mental health service, to prioritize vulnerable persons, to prevent mental, neurological and substance use disorders and promote mental health, and to produce and use mental health information and research. Each strategic component suggests actions to reduce stigma. Fundamental to achieving these objectives is capacity-building, through recruitment, training and continuing development of the primary health care and specialist mental health workforce, and through linking in partnership with other agencies in the health and social sector. The Regional Office will continue to provide technical support to Member States to enhance their capacity to develop and strengthen the delivery of mental health services in an integrated manner, based on best available evidence.

6. Recommendations to Member States

1. Endorse the strategy for mental health and substance abuse in the Eastern Mediterranean Region 2012–2016;
2. Review and update national health policies, strategies and plans in line with the regional strategy to ensure that mental health and substance abuse are identified as a priority public health issue with commensurate allocation of resources;
3. Set up a national multidisciplinary mechanism with the involvement of concerned ministries and relevant sectors, with the Ministry of Health taking the lead, in order to coordinate, plan and monitor the implementation of the national mental health and substance abuse strategies/plans of action with commensurate resource allocations;
4. Integrate mental health and substance abuse services within the existing health systems including primary health care;
5. Strengthen the secondary and tertiary level mental health and substance abuse services to provide training, referral and supervisory support to the primary health care system;
6. Promote intersectoral collaboration to enhance mental health literacy; to minimize stigma and discrimination faced by persons suffering from mental disorders; prevent mental disorders and promote mental health particularly focusing on the vulnerable sections of the society;
7. Promote applied research and build up the capacity to undertake research in the area of mental health and substance abuse.

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