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Regional strategy on mental health and substance abuse

World Health Organization
Regional Office for the Eastern Mediterranean

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1. Introduction

Mental health has a symbiotic relationship with general health and social determinants of health (*1*). 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 (*2*). At the same time, social disadvantage increases the risk for mental, neurological and substance use disorders in all societies, irrespective of the wealth of the country. Risk is triggered by exposure to adversity, such as bereavement, crime, violence, hunger, stress at work, poor parental health, natural disasters and unemployment. The disabling consequences of mental, neurological and substance use disorders create a vicious cycle that may perpetuate the disorder through loss of productivity and income, poor access to health care, social withdrawal, substance abuse and stigma. Thus mental health is closely linked with the Millennium Development Goals to eradicate extreme poverty and hunger, achieve universal education, promote gender equality, improve maternal health and enhance child survival and development.

Mental, neurological and substance use disorders are universal, affecting all social groups and all ages. At any given time about one person in every ten is suffering from a mental disorder, and about one in four families has a member with a mental disorder (*3*). Mental, neurological and substance use disorders place a heavy burden on the persons with the disorder, their families and the community. Mental and neurological disorders are responsible for 14% of all disability-adjusted life years lost due to disease and injury, worldwide and 12% in the Eastern Mediterranean Region (*4*). Despite the strong evidence that has accumulated to demonstrate that mental, neurological and substance use disorders are common and disabling, very few resources are invested in their care. Many countries spend less than 2% of their health budget on mental health. This is particularly evident in low-income and middle-income countries, where resources available to health care are also limited.

Mental health and substance use disorder programmes are not only concerned with treatment, but also aim to reduce the distress and burden of mental disorders and substance use disorders by prevention, and promotion of mental well-being. Yet the vast majority of mental health care resources are located in centralized institutions that are often heavily stigmatized, and inaccessible. Consequently the treatment gap (the proportion of people who require care but do not receive treatment) for mental, neurological and substance use disorders is more than 75% in many low-income and middle-income countries (*1*). Even those who do receive treatment often do not receive the most effective interventions and may be subject to inhumane treatment.

The World Health Report 2001 made ten recommendations to improve mental health systems and reduce the burden of mental disorders: 1) providing treatment in primary health care; 2) making psychotropic drugs available; 3) give care at the community level with community involvement; 4) educate the public; 5) involve communities, families and consumers; 6) establish national policies, programmes and legislation; 7) develop human resources; 8) link with other sectors; 9) monitor community mental health; and 10) support more research.

In 2008 the WHO 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 (*5*).

The Eastern Mediterranean Region is made up of 22 economically diverse countries, each with their own cultures and characteristics. Several countries in the Region continue to face the challenges of insecurity, war and humanitarian crisis. Within the Region, different countries have addressed different components of mental health and substance use care, according to their stage of development, related to their income and stability.

Considering the evidence which is elaborated upon in subsequent sections, recommendations of The World Health Report 2001, the launch of the mhGAP and regional resolutions, there is need for a coherent strategy for mental health that informs a coordinated and flexible plan of action to improve the mental health of the people of the Region. This is complemented by the regional strategic directions and actions for maternal, child and adolescent mental health care in the Eastern Mediterranean Region, which were adopted in 2010 (*6*). 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. Situation analysis

2.1 Burden and prevalence of mental, neurological and substance use disorders

Mental, neurological and substance use disorders account for 14% of all disability-adjusted life years (DALYs) lost due to disease and injury globally, and for 12.1% in the Region (*4*). Most of this burden is due to disability. Mental, neurological and substance use disorders account for 31.7% of years lived with disability in the world, and 27% in the Region. Depression alone is the leading cause of years lived with disability (Figure 1).

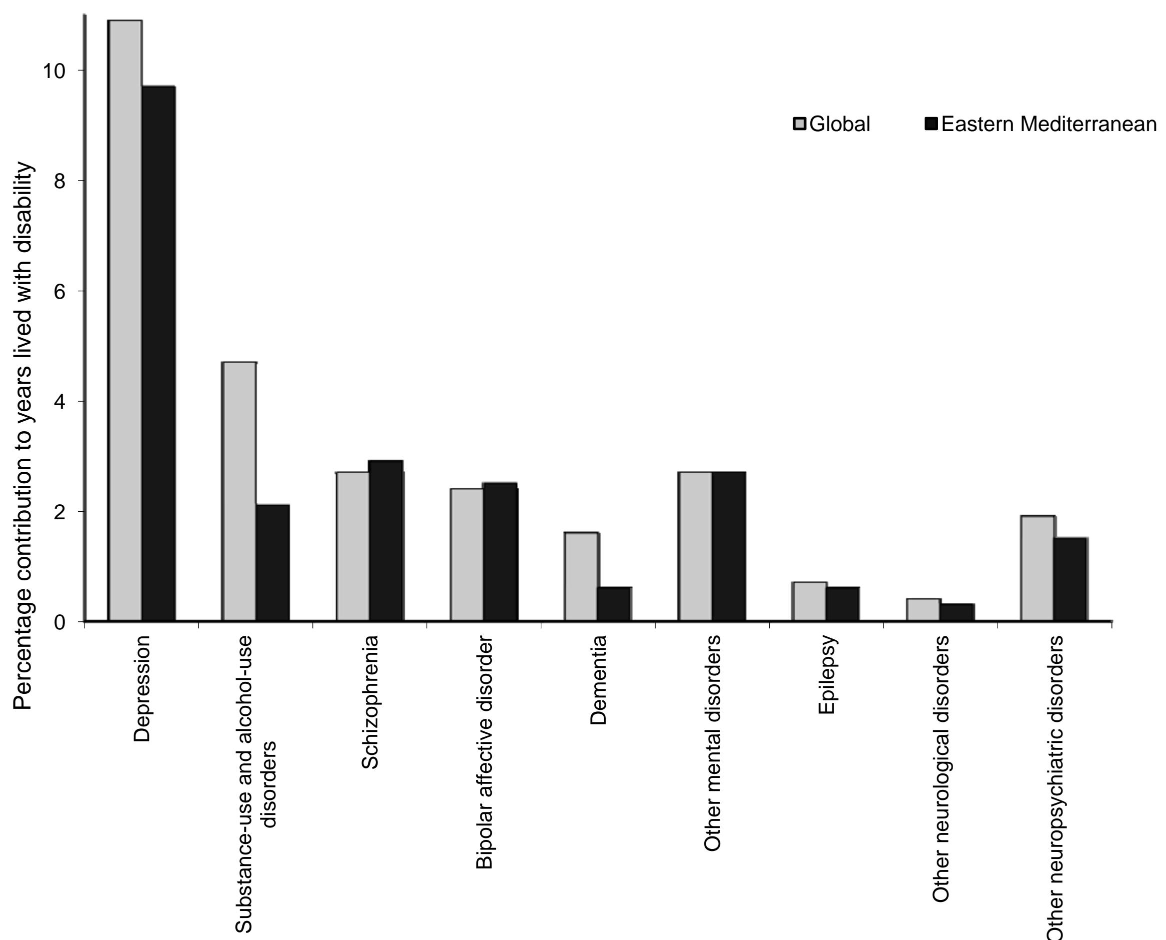

Figure 1. Contribution of mental, neurological and substance use disorders to years lived with disability worldwide and in the Eastern Mediterranean Region, 2004 estimates

(Data extracted from WHO website on disease and injury regional estimates for 2004, http://www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index.html)

Worldwide community-based studies estimate the lifetime prevalence of mental disorders in adults at 12.2%–48.6% and 12-month prevalence rates at 4.3%–26.4% (*1,7*). According to The World Health Report 2001, 20% of children and adolescents worldwide have disabling mental illness and approximately 50% of the mental disorders in adults begin before the age of 14 years (*8*). According to WHO estimates, more than 450 million people worldwide have mental, neurological and substance use disorders; 154 million people have depression and 25 million people have schizophrenia; 91 million people are affected by alcohol use disorders and 15 million by drug use disorders. As many as 50 million people have epilepsy and 24 million have Alzheimer disease and other dementias. Large-scale community surveys report rates of psychological distress between 15.6% and 35.5% in the Region (*9–12*), with higher rates in countries with complex emergency situations. The 12-month prevalence of mental disorders in the Region ranges between 11.0% and 40.1% (see Table 1) (*9,12–19*). Depression and anxiety disorders are the most frequent mental disorders, and rates in women are up to double those in men. Rates of mental disorder are significantly higher in countries with complex emergencies, for example: 37.4% of Iraqi schoolchildren were estimated to have mental disorders; 54.4% of boys and 46.5% of girls from Palestine were estimated to have emotional and behavioural disorders and 22.2% of schoolchildren in Afghanistan were estimated to have mental disorders.

Table 1. 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)(*9*)	Multi-cluster sample of household members aged 15 and above in Nangarhar province	Hopkins symptom checklist and Harvard trauma questionnaire	16.1% 21.9% 7.5%	58.4% 78.2% 31.9%	Depression 38.5% Anxiety 51.8% Post-traumatic stress disorder 20.1%
Islamic Republic of Iran (before 2004)(*10*)	Nationally representative sample of 31 014 aged 15 and above, selected by random cluster sampling	28-item version of the general health questionnaire	15.8%	29%	21%
Iraq (2006–2007)(*11*)	Nationally representative sample aged 18 and above: 9256 households completed SRQ	Self-reporting questionnaire (SRQ)	30.4%	40.4%	35.5%
United Arab Emirates (1996–1997)(*12*)	1394 participants aged 18 and above from sample of 1696 households in Al Ain	Self-reporting questionnaire			15.6% (11.8–19.5)
Assessment by diagnostic Interview					
Egypt (2003)(*13*)	Representative sample of 14 640 adults aged 18–64 in 5 regions	Mini international neuropsychiatric interview	10.6%	21.1%	16.9% (16.3–17.5)
Iraq (2006–2007)(*11*)	Representative sample aged 18+: 9256 households completed SRQ, 4332 individuals completed Composite international diagnostic interview	Self-reporting questionnaire 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 (2002–2003)(*14*)	Nationally representative sample of 2856 aged 18+,	Composite international diagnostic interview	–	–	16.9% 12-month
Morocco (2004–	Systematic nationally	Mini international	34.3%	48.5%	40.1% (depression

Country	Sample	Instrument	Male	Female	All
2005)(*15*)	representative randomized sample of 5498, aged 15 +	neuropsychiatric interview)			26.5%, anxiety 37%)
Pakistan (1995 and 1998)(*16,17*)	Rural village population aged 18+	Bradford somatic inventory followed by psychiatric assessment using ICD-10 research diagnostic criteria	25%	66%	–
	All of an urban population of 774, aged 18+		10%	25%	
United Arab Emirates (1989–1990)(*18*)	300 participants from random sample of 247 households in 7 districts of Dubai	Present state examination	–	–	22.6%
United Arab Emirates (1996–1997) (*12,19*)	1394 participants aged 18+ from sample of 1696 households in Al Ain	Composite international diagnostic interview	5.1% lifetime	11.4% lifetime	8.2% (6.7–9.7) lifetime

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 population (*20*). The few countries that have data on the prevalence of substance abuse 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. Epilepsy prevalence has been reported from 4 to 12 per 1000 population, with higher rates reported in young age groups and in rural populations (*21*). Many people with mental, neurological and substance use disorders often first seek care from primary health care, and the prevalence of mental disorders among primary health care attendees is high, ranging between 10% and 60%. About 15% of patients seen in primary care settings have medically unexplained symptoms coupled with psychological stress and help-seeking behaviour (*22–24*).

Mental disorders also contribute to mortality. According to WHO's 2005 estimates, neuropsychiatric disorders account for 1.2 million deaths every year and 1.4% of all years of life lost. Globally 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 15–45 year olds 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 (depression, schizophrenia and other psychoses, and alcohol use and substance use disorders) as important proximal risk factors for suicide, in 91% of suicide completers. The median suicide rate for the countries of the Region is 4.90 per 100 000 people (ranging from 0.56 to 17.17), compared with 6.55 for all countries of the world (*25*).

2.2 Cost-effective treatment

Research has shown that effective pharmacological and psychosocial treatments in low-income countries are available for depression (*26*), schizophrenia, epilepsy, alcohol and substance abuse (*3*). Randomized controlled trials in low-income countries have shown that treatment reduces by half the chance of relapse of schizophrenia after one year, with up to 77% being relapse free (*27*). More than half of people with epilepsy are seizure-free after one year of treatment. Both medication and brief physician-delivered interventions are 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. Despite this evidence, resources for mental health are grossly inadequate and provide only a fraction of what is required for the provision of basic mental health care (*27*). The median percentage of health spending allocated to mental health in the Region is 2% (*28*), 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, which is half of the global median spending. Both figures 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 (*29*). Community-based services delivering effective medication and psychosocial treatments for schizophrenia, bipolar disorder, depression, panic disorder and epilepsy can achieve the same beneficial effects as current treatments at half the current costs (see Table 2) (*30,31*).

Table 2. Cost-effectiveness of treatments for mental, neurological and substance use disorders in the Middle East and North Africa

Disorder and treatment	Cost-effectiveness (US$ per DALY saved)
Schizophrenia	
Current situation	11 400
Most cost-effective hospital-based service model: older (neuroleptic) antipsychotic drug plus psychosocial treatment	7 040
Community-based model: older (neuroleptic) antipsychotic drug alone	6 618
Community-based model: newer (atypical) antipsychotic drug alone	19 352
Most cost-effective community based service model: older (neuroleptic) antipsychotic drug plus psychosocial treatment	4 431
Bipolar disorder	
Current situation	7 668
Hospital-based model: older mood-stabilizing drug plus psychosocial treatment	6 036
Community-based model: older mood stabilizing drug (lithium)	4 068
Community-based model: newer mood stabilizing drug (valproate)	4 971
Community based model: older mood-stabilizing drug plus psychosocial treatment	3 823
Depression (treatment setting primary care)	
Current situation	2 905
Episodic treatment with older antidepressant drugs (tricyclic antidepressant)	1 039
Episodic treatment with newer antidepressant drug (SSRI)	1 516
Episodic psychosocial treatment	1 330
Maintenance psychosocial treatment plus older antidepressants	1 533
Panic disorder (treatment setting primary care)	
Current situation	1 208
Older antidepressant drugs (tricyclic antidepressant)	508
Newer antidepressant drugs (SSRI, generic)	747
Epilepsy	
Phenobarbital	165
Phenobarbital and lamotrigine	3 344
Phenobarbital and surgery	2 904

Source: *Disease control priorities related to mental, neurological, developmental and substance abuse disorders.* Geneva WHO, 2006.

2.3 Treatment gap

The mismatch between needs and resources leaves a large treatment gap of people who require care but do not receive treatment. The average treatment gaps based largely on data from America and Europe are 32% for schizophrenia, 50%–60% for depression and anxiety disorders, and 78% for alcohol abuse and dependence (*32*). A Lebanese study found a treatment gap of 70% for major depression (*17*), while in Iraq the overall treatment gap for mental disorders is 94% (*11*). The WHO-AIMS project found a treated prevalence rate for mental disorders of less than 1% in the Region (*28*), which is half that of the global comparison sample (*33*), and when placed against the global median prevalence rates (*34*) suggests an overall treatment gap of more than 90%. A systematic review of epilepsy treatment gap studies reported a gap of over 75% in low-income countries and over 50% in most middle-income countries (*35*). A population-based epidemiological epilepsy study in Pakistan showed an epilepsy treatment gap of 73% and 98% in rural and urban areas respectively (*36*).

2.4 Mental health systems response

In 2005, WHO launched the assessment instrument for mental health systems (WHO-AIMS) (*37*), comprising of a set of 156 input and process indicators addressing the domains of the ten recommendations of The World Health Report 2001. To date, 17 countries in the Region have completed the WHO-AIMS assessment.[1] The following sections are based on the WHO-AIMS assessment.

Governance. 12 (71%) countries have a contemporary mental health policy or plan; only four (24%) have mental health plans for emergency situations or natural disasters; and 12 (71%) have a formal link between the government mental health department and the department responsible for primary health care. A clear administrative structure is required to ensure that plans are implemented at provincial/governorate and district levels: 9 (53%) countries organize services by catchment areas; none of these are low-income countries. Eleven (65%) health departments publish a report on mental health data, but only four (24%) actually comment on it.

Legislation. Mental health legislation enacted in the past 20 years exists in five (29%) countries; 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. Twelve (71%) countries have a human rights review body although their activities are very limited; most countries reported conducting inspections in only 4% of their

[1] The WHO-AIMS report on mental health systems in the Eastern Mediterranean Region includes 14 countries/territories in the Region that completed WHO-AIMS between 2005 and 2009. Subsequently a further three countries in the Region have completed WHO-AIMS. Wherever possible data from all 17 countries/territories, 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, northwest Somalia, Sudan, Syrian Arab Republic and Tunisia). WHO-AIMS global comparison data are based on 42 countries (*33*).

mental health facilities. Only three (18%) countries have legislative provisions to protect people from mental, neurological and substance use disorders from discrimination in employment, and only two (12%) countries have legal provisions to facilitate employment.

Intersectoral linkages. Linkages are underdeveloped in many countries of the Region. 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 to put in place meaningful processes for rehabilitation of patients to the community.

Specialist mental health services. Mental hospital bed numbers increased in 13 (76%) countries of the Region in the five years before the WHO-AIMS project. Just under half of the mental health human resources in the Region are based in mental hospitals compared with one third in the global sample. Outpatient facilities are sparse: the Region has half the number of outpatient facilities (0.16 per 100 000) compared with a global sample (0.32 per 100 000). Only 1% of outpatient facilities in the Region provide follow-up community care compared with 18% in the global sample. In the seven countries where day treatment is available, it is offered to 2.8 people per 100 000 population compared with 6.3 in the global sample. Beds remain concentrated in the big cities (the median ratio of psychiatry beds in the largest city to all psychiatry beds in the country is 3.14), and more than half the countries report that rural users are substantially under-represented in their use of outpatient mental health services.

Integration into primary health care. Protocols to guide primary health care staff on assessment, treatment, referral and back-referral are present in some physician-based primary health care clinics in 13 (76%) countries, but in only three (18%) countries are these available in more than 80% of primary health clinics. The capacity of primary health clinicians to deliver integrated mental health care depends on their competence, but only 3% and 4% respectively of the total undergraduate training hours for doctors and nurses are devoted to mental health. In service mental health refresher training in the past year was given to a median of 2% of primary health doctors and 1% of nurses. Regarding ongoing support, supervision and referral: in only three (18%) countries do more than 50% of primary health doctors interact at least monthly with mental health services, and in only three (18%) countries do more than 80% of their primary health care centres make at least one referral each month.

Table 3. Resource allocation for mental health care in countries of the Region, by World Bank income group, 2010

World Bank income grouping	Countries	Median expenditure on health per capita (US$)	Median psychiatric beds per 10 000	Median psychiatrists per 100 000 population	Median psychiatric nurses per 100 000 population
Low	Afghanistan, Pakistan, Somalia, Sudan, Yemen	24	0.24	0.09	0.08
Lower middle	Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Morocco, Palestine, Syrian Arab Republic, Tunisia	84	0.96	0.80	0.50
Upper middle	Lebanon, Libyan Arab Jamahiriya, Oman, Saudi Arabia	380	1.10	1.25	5.15
High	Bahrain, Kuwait, Qatar, United Arab Emirates	772	2.35	3.25	16.80

Source: *Mental health atlas 2011.* Geneva, WHO, 2011.

Mental health workforce. There are 3.3 mental health professionals per 100 000 population in the countries that completed the WHO-AIMS, which is lower than the global average of 6.0. The size of the workforce varies between the countries of the Region, reflecting economic diversity (see Table 3). The competencies needed to practice in newly-developing community-oriented services are often not addressed in traditional training curricula. 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.

Availability of psychotropic medication. Almost all countries have essential psychotropic medicines in their medicine lists, and these are available in specialist mental health facilities in most countries. However, in countries with more outpatient and community units, up to 66% of community-based facilities do not have psychotropic medications available. All 17 countries have legislation that allows psychotropic medication to be prescribed by primary health care physicians, but only five (29%) supply more than 80% of their primary health care facilities with these medicines.

Family and service-user associations. Family and service-user associations are important advocates and allies in lobbying for service improvements, de-stigmatization and the human rights of people with mental, neurological and substance use disorders. They also help to empower their members. Service-user and family associations are poorly developed in the region. Ten countries have no service user associations, and 10 have no family associations. Where they do exist, they are small; the national memberships reported in WHO-AIMS ranged between 3 and 8 for user/consumer associations and between 4 and 500 for family associations.

Research. Globally only 6% of psychiatric publications come from low-income countries, which account for 85% of the world population. The Region is under-represented in research publications: of 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 five years, a median of 5% of published health research from the Region has been on mental health.

Alcohol and substance abuse services.[2] 79% (11/14) of countries have substance abuse drug policy or law. Detoxification for alcohol use disorders are provided on an inpatient and outpatient basis for medians of <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 a median of 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.

2.5 Values and principles

Mental well-being is fundamental to participation in civil, social and economic life, and for the exercise of human rights. People with mental, neurological and substance use disorders have the right to equal access to health services, employment, and education. Mental health care should be delivered and legislated to international standards of human rights, for example in the use of least restrictive care, informed consent to treatment, participation in research, regulation of involuntary admissions, the use of physical restraint and isolation, and confinement of mental disordered offenders. The values underpinning this strategy are those espoused in the World Health Report 2001.

Integration. Integrate mental health with general health care, and develop a community care approach to mental health to enhance psychological well-being of the population.

Participation and acceptability. Respond to people's expectations by engaging with service-users, family associations and being sensitive to cultural relativism, while protecting vulnerable sections of the population.

Availability, accessibility and equitability. Provide financial protection to people with mental, neurological and substance use disorders against the cost of ill-health by developing mental health care that is accessible to all people, and that has equity with general health services.

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

Evidence-based. Make use of the best available scientific evidence to develop services and provide interventions.

2.6 Challenges and opportunities

Mental health has a low political and public health profile (*38*). Lack of information and/or misinformation about mental health issues results in development of stereotypes. This translates into stigmatizing attitudes and discriminatory practices which contribute to mental health being accorded low priority in national developmental agendas and public health policies.

Lack of legislative provisions and weak implementation mechanisms contributing to human rights violations of individuals with mental ill health is an another challenge. Chronic under-resourcing; financial, logistic, organizational, infrastructural and human; is a major challenge which is further aggravated by inefficient allocation of scant available resources. Large mental hospitals, for example, are located near to large cities, cut off from the rest of medical care and society. This has also contributed to isolation and stigmatization of mental health services, staff and service-users. Institutional care has not only deskilled and robbed service-users of their sense of individuality, but it also constrains the skills and expectations of mental health staff, some of whom resist change. Furthermore the capacities of general health workers are limited, as are the public health skills of mental health leaders.

The paucity of public mental health research to provide the evidence to underpin operational planning and monitor implementation constitutes another major challenge in the region. 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 have been identified as the main obstacles to research in low-income and middle-income countries (*39*).

Nevertheless, there is growing recognition of the importance of positive mental health to society, productivity, security and social cohesion. Successful health promotional and public education programmes are already operating in many countries. Opportunities can be taken to develop partnerships and strengthen the mental health 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. Although evidence and mental health information in the Region are generally limited, it is very encouraging that almost all countries have participated in the WHO-AIMS project. This has provided evidence to underpin strategic planning and also gives a baseline against which to measure progress.

2.7 Strategic components

Strong, well-informed and sustained government-led commitment is fundamental to addressing the development and maintenance of the mental health system. This strategy calls for leadership, responsibility and accountability in the management and delivery of the suggested activities. The strategy acknowledges that not all countries are at the same stage of development or have the same resources, and therefore it is not expected that all suggested activities will be taken up in the same way in every country. Individual countries may decide to prioritize certain areas of the strategy according to the prevalence of disorders, relevant evidence, available resources, capacity of the mental health and primary care workforce and the circumstances of the country, and make realistic mental health plans aligned with the regional strategy.

There are also certain actions suggested in the regional strategy that are relevant for all countries. These include establishing or strengthening a mental health directorate or unit within the Ministry of Health for coordination, planning, monitoring and evaluation; building capacity to underpin integration into primary health care; strengthening mental health services, collaboration with other sectors and organizations for prevention of disorders and promotion of mental well-being; and promoting operational research. Likewise, all countries should plan to implement a range of activities to reduce stigma, and should collect data on mental health care and the capacity of the workforce to inform long-term planning.

Low-income countries that allocate proportionately less of their health budget to mental health will need to focus especially on harnessing the available resources to best effect by collaboration 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, and supported by comprehensive information and high quality research. Annex 1 provides a framework to guide countries in monitoring and evaluating implementation of the strategy according to their resources.

The aim of this strategy is to guide efforts by countries to deliver mental health services that will improve mental health and well-being for all the people of the

Eastern Mediterranean Region. It is an integrated set of activities that provide the framework and direction for countries to harmonize with their national mental health plans. It covers: 1) leadership and political commitment; 2) integration of mental health in primary health care services; 3) mental health services; 4) vulnerable groups of the population; 5) prevention and health promotion; and 6) information and research. Suggested activities for each of these strategic components are included.

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 an integrated mental health system as part of the general health system. Leadership is required to develop, regularly review and update policies, plans and legislation. Most countries in the Region have a mental health unit or directorate responsible for development, coordination, monitoring and evaluation of mental health strategies, policies, plans, legislation and service provision. However, most of these are inadequately staffed and resourced. Mental health legislation in countries needs to be promulgated and/or updated to ensure that the provisions of the United Nations Convention on the Rights of Disabled Persons are reflected to safeguard the rights of persons with mental disorders and disabilities. Furthermore, robust mechanisms for implementation also need to be in place.

Objectives

1. To establish and strengthen a mental health directorate or unit within the Ministry of Health of each country to develop resource, implement and monitor mental health and substance abuse strategy and plans aligned to the regional strategy.
2. To develop and review mental health legislation that meets the provisions of international standards and conventions.
3. To review existing mechanisms of mental health financing and suggest methods to move from direct out-of-pocket payment for health care to more equitable financing, such as prepayment and pooled payment methods.
4. To ensure effective and sustained intersectoral collaboration and coordination for mental health promotion.

Suggested activities

Regional level activities

1. Create a regional mental health advisory group to review and advise on implementation of the mental health strategy.

2. Enhance capacity to support countries in the design and review of their national strategies, policies, plans and legislation.
3. Collect relevant experience from within the Region and elsewhere, and disseminate guidance and lessons learned to the countries of the Region.
4. Develop tools to help with the formulation and review of strategies, policies, plans and legislation.

National level activities

All countries
1. Establish or strengthen a mental health directorate or unit within the Ministry of Health, and adequately resource it. 2. Establish or strengthen an intersectoral national mental health committee with clear membership and terms of reference. Technical subcommittees should be established for each of the strategic priorities identified by the national mental health committee. 3. Review existing health and social sector policies, strategies, plans and legislation to ensure that mental health is adequately represented in national development policies. 4. Coordinate mental health plans with health and social sector related workplans. Where they are absent or fall short of contemporary standards, priority should be given to their development or revision. 5. Develop a programme of review of existing mental health strategies, policies, plans and legislation, incorporating international human rights standards. 6. Review legislation on the supply and prescription of methadone. 7. Work towards mobilizing resources and ensuring that a fair proportion of the health budget is allocated to mental health. 8. Review financial barriers to accessing health care and work towards reducing reliance on direct payments and encouraging risk pooling, pre-payment approaches (*41–43*). 9. Establish and strengthen the mechanisms for functional integration of mental, neurological and substance use disorders into primary health care services at all levels, making such disorders part of the basic services package being offered in all health facilities at the service level.
Countries with low-level resources
1. Establish a system of regular human rights inspections of all mental health inpatient facilities every four years. 2. Promote the formation of service-user, family and advocacy associations to represent people with mental, neurological and substance use disorders and their

families.
Countries with mid-level resources
1. Establish and strengthen organizational structures at provincial/governorate and district levels to administer and monitor the delivery of the mental health plan to ensure that mental health services are provided equitably throughout the country. 2. Establish system of regular human rights inspections of all mental health inpatient facilities every three years. 3. Promote the formation of service-user, family and advocacy associations to represent people with mental, neurological and substance use disorders and their families. Set standards for service-user, family and advocacy representation on the committees responsible for planning, delivery and review of mental health services and activities.
Countries with high-level resources
1. Establish and strengthen organizational structures at provincial/governorate and district levels to administer and monitor delivery of the mental health plan to ensure that mental health services are provided equitably throughout the country. 2. Establish a system of regular human rights inspections of all mental health inpatient facilities every two years. 3. Promote the formation of service-user, family and advocacy associations to represent people with mental, neurological and substance use disorders and their families. Facilitate, encourage and support the involvement of service-user, family and advocacy associations interacting with mental health services. Set standards for service-user, family and advocacy representation on the committees responsible for planning, delivery and review of mental health services and activities.

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

Primary health care holds the possibility of comprehensive health care for the community. Dealing with mental, neurological and substance use disorders on an equal footing with other disorders in primary health care is less stigmatizing than mental hospital care, and facilitates holistic treatment of related physical and mental health problems (*24*). Many countries in the Region have achieved some degree of integration of mental health into primary health care, but in most countries these have limited coverage and generally only involve physician-based primary health care clinics. More efficient use of the available resources can be achieved by shifting specific tasks from highly qualified health workers to health workers that have received less training (*24,40,41*). 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. To facilitate this process, the WHO mhGAP programme provides guidance on interventions for priority mental, neurological and substance use disorders in non-specialized health settings with clear protocols for clinical decision making (*42*).

Objectives

1. To develop, strengthen and scale up comprehensive community-oriented mental health services through integration of mental health and substance abuse in the basic package of services being delivered in 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, using the mhGAP intervention guide and training material (*42*).

Suggested activities

Regional level activities

1. Support and cooperate technically with countries to facilitate identification of priority mental, neurological and substance use disorders, and development of intervention packages in line with the WHO mhGAP intervention guide.
2. Collect relevant experience from within the Region and elsewhere, and disseminate guidance and lessons learned to the countries of the Region.
3. 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.
4. Promote technical cooperation and exchange of experiences between countries of the Region in achieving functional integration of mental health into the primary health care service package.

National level activities

All countries
1. Carry out a systematic priority-setting exercise informed by clear decision-making criteria and put into place an essential package of mental health and substance abuse interventions for primary health care. 2. Identify the skill mix required at each service level, develop tasks and distribute tasks at each level, by task-shifting if necessary. 3. Carry out a review of medical, nursing, psychology and community health worker curricula and reformulate curricula to ensure they adequately address mental health and substance abuse to meet the needs of integrated community-oriented services. 4. Review and enhance refresher training in mental health, epilepsy and

alcohol/substance use for general health care professionals, including doctors, nurses and community health care providers.

5. Establish assessment, treatment and referral guidelines for priority disorders, including epilepsy (*47*), 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.
6. Establish assessment, treatment and referral guidelines for alcohol and substance use disorders (see mhGAP intervention guide, ASSIST guidelines and *Brief intervention for substance use: a manual for use in primary care*)(*42–44*).
7. Ensure robust support and supervision arrangements are in place to sustain mental health and substance abuse care in primary health care.
8. Establish referral and back-referral procedures between specialist mental health and substance abuse services and all primary health care clinics providing mental health and substance abuse care.
9. Establish a database of the mental health capacity of the primary health care workforce to inform planning for integration of mental health in primary health care.
10. Ensure essential psychotropic medicines, including medicines for the treatment of epilepsy, are reliably supplied to all primary health care facilities providing mental health care.
11. Incorporate mental, neurological and substance use indicators in the health management information system (HMIS):
    - Develop mental, neurological and substance use indicators for the HMIS;
    - Include mental, neurological and substance use indicators in the HMIS;
    - Make linkages between the information system of primary health care and the specialist mental health and substance abuse services; and
    - Report on mental, neurological and substance use indicators as part of the annual HMIS report.

Countries with low-level resources

1. Focus on a few key priority disorders, and aim to establish comprehensive integrated care in a manageable area. Start with a demonstration project with a commitment to scale up based on evaluation.

Countries with mid-level resources

1. Focus on priority disorders. Use evidence from existing demonstration project or start with a demonstration project with a commitment to scale up, based on evaluation, with the aim of establishing comprehensive integrated care to cover a manageable area.

Countries with high-level resources
1. Use evidence from existing demonstration project or start with a demonstration project with a commitment to scale up to comprehensive integrated care for all priority disorders to cover the entire population.

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

The move from institutional to community-based mental health care has been slow and uneven. Available resources are not used efficiently, with most being limited to centralized mental hospital facilities. Community-based models of care employing multidisciplinary approach needs to be fostered to ensure humane and cost effective care for mentally ill persons.

Objectives

1. To develop, strengthen and scale up comprehensive community-oriented mental health services through decentralization and establishment of 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 mental health workforce to deliver integrated community-oriented mental health care, by providing them with training consistent with their role in the mental health system.

Suggested activities

Regional level activities

1. Technically support countries to review, develop and deliver training packages for specialist mental health workers, in line with their redefined role in delivery of mental health services.
2. Review the postgraduate training programmes for mental health professionals and develop a framework to standardize the basic principles, content, methodology and setting of training.
3. Promote cooperation between countries by establishing a regional working group of experts from the countries of the Region and elsewhere to collaborate in the design and delivery of training packages.
4. Develop a Masters programme in public mental health with emphasis on leadership in collaboration with academic institutions at the regional and international level.

National level activities

All countries
1. Decentralize and reorient mental health services by developing alternative community-based facilities such as mental health and substance abuse units in general hospitals, day care facilities, community-based outpatient services and community residential facilities.
2. Support the integration of mental health and substance abuse in primary health care by providing training, continuing support and referral/back referral.
3. Ensure the quality of care provided by mental hospitals by continuing training of mental hospital staff, maintenance of the physical environment and regular inspections.
4. Strengthen mental health and substance abuse capacity in secondary health care services and strengthen multidisciplinary teamwork, defining the roles of all members (including nurses, psychologists, social workers, occupational therapists).
5. In the light of revised professional roles, review and reformulate postgraduate and specialist training on mental health and substance abuse to ensure that training curricula are relevant to the community mental health care model and human rights.
6. Ensure that psychotropic medicines, including antipsychotic, antidepressant, mood stabilizing, anxiolytic, antiepileptic and opiate substitution medications, are on the essential medicines list and that these medicines are available at all specialist mental health facilities.
7. Involve service-user and family associations in the process of planning and implementing mental health and substance abuse services.
8. Reformulate the roles of specialist mental health and substance abuse professionals, for example the extent they will be involved in training, supervision, diagnosis, prescribing, or providing psychosocial interventions, and prepare plans for initial training, and systematic refresher training programmes for existing mental health staff, in relevant core competencies.
9. Set up in-service supervision or appraisal to support training and career development of specialist mental health staff.
Countries with low-level resources
1. Match the development of community-oriented services and workforce training to areas of integration into primary care.
Countries with mid-level resources
1. Match the development of community-oriented services and workforce training to areas of integration into primary care.
2. Convert mental hospitals to house medical and surgical wards in exchange for

mental health beds in general hospitals.
Countries with high-level resources
1. Scale up community-oriented services to cover the entire population. 2. Develop mental hospitals into centres of excellence in sub-specialty mental health services such as services for children and adolescents, the elderly and offenders with mental disorders.

Strategic component 4. Identify and prioritize vulnerable persons

This strategy is guided by the principle of provision of equitable treatment for people with mental, neurological and substance use disorders. However, some groups of people warrant particular attention because they are vulnerable or they require special care. There is an ethical imperative to provide more for those in greatest need. A particular priority is to address the needs of women, children and adolescents especially in complex emergency situations. Others include members of socially disadvantaged population groups, people with co-morbid physical illness, physical disability, street children and children in foster care, victims of abuse, offenders with mental disorders, and marginalized groups such as refugees, immigrants, displaced/abandoned/homeless people and people from ethnic minorities.

It is also important that treatment, promotion and preventive programmes are sensitive to gender-related issues and the needs of different life stages, particularly childhood and adolescence, young motherhood and old age. Early detection of alcohol and substance abuse among pregnant women and women of childbearing age is particularly important because of potential harmful effects on foetal development, and maternal depression has been shown to adversely affect the physical, emotional, psychological and intellectual development of children through into adulthood. Some priorities are relevant to all countries, while others are distributed unevenly. Individual countries should identify the priorities pertinent to their own circumstances.

Objectives

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

Suggested activities

Regional level activities

1. Support countries to implement the strategic directions and actions for maternal, child and adolescent mental health care as endorsed by the Regional Committee in resolution WHO-EM/RC57/R.3.
2. Prepare and publish the regional strategic directions and guidance for alcohol and substance abuse.
3. Coordinate regional preparedness and response plans for mental health and psychosocial support in emergency settings, develop a regional workforce of experts that can be rapidly deployed and apply assessment tools to inform response.

National level activities

All countries
1. Identify and prioritize vulnerable persons using clear decision-making criteria. 2. Implement the regional strategic directions and actions for maternal, child and adolescent mental health care (*6*). *The following list of national level activities is neither hierarchical nor prescriptive – individual countries will each decide their own priorities according to their own level and needs.* 3. Prepare an emergency preparedness plan for disaster or humanitarian crisis in collaboration with other agencies addressing inter-agency coordination, details of the mental health response, supply of medication, ensuring human rights are respected, maintaining care for people with severe mental disorders including inpatients in psychiatric units and mental hospitals, support for health staff, and preparing capacity of workforce by training of general health staff in psychological first-aid and psychosocial support skills (*45,46*). 4. Develop treatment services and programmes for mental health promotion and prevention that are appropriate to gender and the needs of different life stages, paying particular attention to children and adolescents, pregnant women and mothers of young children, and the elderly. 5. Assess and address the need for secondary care services to provide inpatient and/or outpatient interventions for alcohol and substance use disorders providing assessment, detoxification, maintenance therapy, substitution oriented treatment, and rehabilitation. 6. Target preventive programmes at groups at risk of suicide, and establish policies to reduce availability of methods of suicide. 7. Plan and implement how care will be coordinated where mental disorder occurs

jointly with physical illness. Mainstreaming of mental health care into general hospitals offers the opportunity to set up liaison psychiatry services, which also enhance the status of mental health with other health care professionals.

8. Develop treatment, promotion and preventive programmes that target groups that are socially disadvantaged, such as people in poverty and those who are the victims of abuse.
9. Ensure that people in marginalized groups such as refugees, immigrants and those from ethnic minorities have access to mental health services, and that such services are culturally sensitive and provide for different languages.
10. Assess the needs of offenders with mental disorders, and develop treatment services and programmes for mental health promotion and prevention in prison coordinated with prior/subsequent interventions.

Countries with low-level resources

1. Focus on at least one or two priorities matching with complementary partnerships in Annex 2.

Countries with mid-level resources

1. Aim to address two to four priorities, matching with complementary partnerships in Annex 2.

Countries with high-level resources

1. Aim to address all identified priorities, matching with complementary partnerships in Annex 2.

Strategic component 5. Intersectoral coordination and collaboration to promote mental health and prevent mental disorders

In order to promote and protect mental health, prevent mental disorders, and counter the stigma and discrimination associated with mental health and substance abuse, public education and advocacy should be strengthened using both top-down and bottom-up approaches, involving service user and family associations, and self-help groups. This may include media campaigns, especially addressing maternal and child health including parenting skills training, and integrating emotional and psychological health components into school health programmes. Productive partnerships are the cornerstone to effective implementation of comprehensive mental health plans. 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 increase awareness and reduce stigma about mental, neurological and substance use disorders and their treatment through development of partnerships and intersectoral collaboration.
2. To incorporate mental health and substance abuse components into other relevant programmes, such as health promotion programmes in schools, reproductive, child and adolescent health, AIDS and sexually transmitted diseases, and nutrition programmes.

Suggested activities

Regional level activities

1. Technically support countries to develop strategies for public education and mental health promotion, clearly outlining the distribution of tasks between different social sectors such as education, media, social security sectors, labour, municipalities, justice and law enforcement etc.
2. Collect relevant experience from within the Region and elsewhere, and disseminate guidance and lessons learned to the countries of the Region.
3. 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.
4. Collaborate with other United Nations agencies and nongovernmental organizations to incorporate mental health components into health and social sector programmes.

National level activities

All countries
1. Develop strategies for mental health promotion in mental health, public health, and other public policies. This requires high-level collaboration between the Ministry for Health and other government departments such as education, housing, employment and criminal justice. 2. Actively seek and engage in partnerships with nongovernmental organizations and programmes involved in prevention and health promotion within and outside the health sector (see Annex 2) 3. Develop information, education, and communication materials. 4. Establish a coordinating body to oversee public education and awareness campaigns on mental health and mental, neurological and substance use disorders. 5. Ensure there is wide access to information and public awareness programmes for

all parts of society on 1) mental health, 2) mental, neurological and substance use disorders, 3) the range of harm in the country arising from use of alcohol and drugs. Consider providing information about suicide.

6. Contribute to the development or adaptation of indicators of positive mental health that can be used in the Region.

Countries with low-level resources

1. Focus on partnerships likely to have the most sustained benefits (e.g. nutrition, maternal health care, education or legislation), or which address country priorities (e.g. harm reduction or emergency planning) (Annex 2).

Countries with mid-level resources

1. Develop a range of active partnerships within and outside the health sector to promote mental health, prevent mental, neurological and substance use disorders, and raise public awareness (Annex 2).

Countries with high-level resources

1. Develop a broad range of active partnerships within and outside the health sector to promote mental health, prevent mental, neurological and substance use disorders and raise public awareness (Annex 2).

Strategic component 6. Promote operational research

Research provides evidence to support policies and strategies, evaluate the effectiveness of current practice, assess innovations and generate new evidence, and inform training, service development and clinical practice. Mental health and substance abuse information and research is fundamental to increasing the visibility of mental health and substance abuse, and thus to attracting more resources and improving quality of care. It is therefore important to promote a research culture among all health care providers (e.g. in their basic and refresher training). Although information is being collected in some countries, it is rarely analysed or used as a tool for action.

Objectives

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

Suggested activities

Regional level activities

1. Support the development of an integrated system of databases across the Eastern Mediterranean region including information on mental health and substance abuse policies, strategies, services, and where possible promotion, prevention, treatment, care and recovery.
2. Work with countries towards an agreed database of mental health human resources that can be used in planning the optimal use of the workforce
3. Work with countries to agree priorities for research in mental health and substance abuse, drawing on existing international work in this area (*40,65*).
4. Develop a regional database of culturally validated research tools and instruments for mental health and substance abuse.
5. Develop new indicators where there are no internationally standardized measures, particularly in the areas of mental health promotion, prevention, treatment and recovery.
6. Develop a database of published mental health and substance abuse research.
7. Support the dissemination of good-quality evidence on mental health and substance abuse nationally and internationally.
8. Promote indexing of mental health journals in the Region.
9. Support periodic population-based mental health and substance abuse surveys, using standardized methodology across the Region.
10. Facilitate collaborative links between researchers in the Region and researchers outside the Region who have a strong track record of successful research bids and publications.
11. Support training in writing grant applications and papers for publication.

National level activities

All countries
1. Develop or strengthen national mental health information systems using internationally standardized and comparable indicators (e.g. WHO-AIMS) to monitor progress towards local, national and regional strategic goals to improve mental health and well-being. 2. Develop a database of mental health human resources and its capacity that can be used in planning the optimal use of the workforce. 3. Use indicator data and specially collected data to evaluate the impact of mental health and substance abuse plans, programmes and services.

4. Establish a national forum to identify mental health research priorities (*39,47*), 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 and substance abuse.
5. Facilitate cooperation between research institutions in mental health and substance abuse research.
6. Develop international collaborative research links within and outside the Region.
7. Involve service-user and family associations in research (i.e. in identifying research priorities, contributing to research planning and carrying out research, analysis and dissemination of findings).
8. Compile and analyse the country's existing mental health and substance abuse research in order to inform the evidence base for current service planning and to identify the next research priorities.

Countries with low-level resources

1. Monitor and evaluate new service developments.
2. Focus on operational research, i.e. situation analysis and pilot programmes.

Countries with mid-level resources

1. Study research problems specific to the Region and adapt or test research findings from high-income countries.

Countries with high-level resources

1. Undertake a broad range of research across all mental health research priority areas.

2.8 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 WHO Regional Committee for the Eastern Mediterranean, at which all Member States issued a joint statement promising support for mental health policies and programmes, coordination with other social sectors, raising awareness and encouraging working with nongovernmental organizations to foster mental well-being of people. 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 and to ensure that mental health legislation is reviewed and updated. During the next 5 years, the other five components of this strategy are to: scale up the integration of mental health into primary care; strengthen the mental health service; prioritize vulnerable persons; prevent mental, neurological and substance use disorders and promote mental health; and produce and use mental health information and research. The impact of complex emergency situations on mental health in the Region, especially of children and adolescents, requires that priority is given to emergency preparedness planning and delivery. In addition, each strategic component includes aspects to reduce stigma and discrimination associated with mental health and substance abuse, and in this respect there is particular emphasis on strengthening public education and advocacy though media campaigns and integrating emotional and psychological health components into school health programmes. Fundamental to achieving these objectives is capacity-building of all health personnel supported by specialist personnel and services, 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 time to act is now.

Annex 1. Framework for monitoring and evaluation of implementation of the regional strategy

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
Strategic component 1: Strengthen leadership and political commitment for mental health					
Regional					
1. Create a regional mental health advisory group to review and advise on implementation of the mental health strategy and plan.	Regional mental health advisory group with clear membership, terms of reference and regular meetings	No	Yes by 2012	Annual report	WHO
2. Enhance capacity for technical support.	Number of relevant staff at Regional Office	1	3	Annual report	WHO
3. Technically support countries in design and review of their national strategies, policies, plans, legislation and service delivery.	Percentage of countries supported in reviewing and/or finalizing: a) strategies/policies/plans b) legislation c) service delivery	NA	a) 100% by 2014 b) 80% by 2016	Annual report	WHO
4. Collect relevant experience from within the region and elsewhere, and disseminate guidance and lessons learned.	Number of guidelines developed and disseminated			Published reports	WHO
5. Develop tools to help with the formulation and review of strategies, policies, plans, legislation and service delivery.	Number of tools developed and disseminated to help with review of: a) strategies/policies/plans b) legislation c) service delivery			Publication of tools	WHO
National					
1. Establish a mental health directorate/unit within the Ministry of Health, and allocate adequate resources for it.	Percentage of countries with mental health directorate/unit within the Ministry of Health	NA	100% by 2013	Annual report	National Ministry of Health
2. Establish or strengthen an intersectoral national mental health committee involving primary health care.	WHO-AIMS 2.2.1.1-5: Percentage of countries with a national or regional 'mental health authority'	15/17 = 88%	100% by 2013	WHO-AIMS Survey	National Ministry of Health
3. Review existing health and social sector policies, strategies, plans and legislation to ensure that mental health is adequately represented in national development policies, and coordinate mental health plans with health and social sector related workplans.	WHO-AIMS 1.2.1: Percentage of countries with the latest version of the mental health plan in past 5 years (WHO-AIMS 1.2.2.1-11 = Yes)	12/17 = 71%	100% by 2014	WHO-AIMS Survey	National Mental Health Directorate
	WHO-AIMS 1.3.1: Percentage of countries with mental health legislation enacted within past 20 years (WHO-	5/17 = 29%	80% by 2016	WHO-AIMS Survey	National Mental Health Directorate

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
	AIMS 1.3.2.1-8 = Yes)				
4. Develop a programme of review of existing mental health strategies, policies, plans and legislation to address stigma and discrimination.	Percentage of countries with legislation to address stigma and discrimination in mental health.	NA	100% by 2016	Published legislation	National Mental Health Directorate
5. Review legislation on the supply and prescription of methadone.	Percentage of countries with legislated supply of methadone	2/22	50% by 2016	Published legislation	National Mental Health Directorate
6. Work towards mobilizing resources and ensuring fair and adequate resources for mental health.	Percentage of countries with identified mental health budget	11/17 = 65%	100% by 2014	Published health finances	National Mental Health Directorate
	WHO-AIMS 1.5.1: Mental health expenditure by the government health department	Refer to WHO-AIMS	Known by 2014	WHO-AIMS Survey	National Mental Health Directorate
7. Review financial barriers to accessing health care and work towards reducing reliance on direct payments and encouraging a risk-pooling, pre-payment approaches.	Percentage of countries with direct out-of-pocket payment representing 20% or less of health expenditure.	NA	80% by 2016	Published health finances	National Ministry of Health
	WHO-AIMS 1.5.3: Percentage of countries with all mental disorders covered by social insurance schemes	6/17 = 35%	80% by 2016	WHO-AIMS Survey	National Ministry of Health
	WHO-AIMS 1.5.4: Percentage of countries with free access to essential psychotropic medication	7/15 = 47%	80% by 2016	WHO-AIMS Survey	National Ministry of Health
8. Establish and strengthen the mechanisms for functional integration of mental, neurological and substance use disorders in primary health care services at all levels.	WHO-AIMS 5.2.5.1: Percentage of countries with formal collaborative programmes with primary health care/community health	12/17 = 71%	100% by 2014	WHO-AIMS Survey	National Ministry of Health and National Mental Health Directorate
9. Establish and strengthen organizational structures at provincial/governorate and district levels to administer and monitor delivery of the mental health plan.	WHO-AIMS 2.1.2: Percentage of countries with mental health services organized by catchment areas/service areas	9/17 = 53%	80% by 2016	WHO-AIMS Survey	National Mental Health Directorate
10. Establish a system of regular human rights inspections of all mental health inpatient facilities every two/three/four years.	WHO-AIMS 1.4.2: Percentage of countries carrying out biennial inspection of human rights in more than 80% of mental hospitals/facilities	4/16 = 14%	80% by 2016	WHO-AIMS Survey	National Mental Health Directorate
11. Promote the formation of service-user, family and advocacy associations to represent people with mental, neurological and substance use disorders and their families.	WHO-AIMS 4.4.1: Percentage of countries with user/consumer associations involvement in formulation of mental health policies, plans or legislation	3/17 = 18%	50% by 2016	WHO-AIMS Survey	National Mental Health Directorate

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
Facilitate, encourage and support the involvement of service-user, family and advocacy associations interacting with mental health services.	WHO-AIMS 4.4.2: Percentage of countries with family associations involvement in formulation of mental health policies, plans or legislation	4/17 = 24%	50% by 2016	WHO-AIMS Survey	National Mental Health Directorate
Strategic component 2: Scale up integration of mental health in primary health care					
Regional					
1. Support and cooperate technically with countries to facilitate identification of priority mental, neurological and substance use disorders, and development of intervention packages in line with the WHO mhGAP intervention guide.	Percentage of countries supported in finalizing: a) identification of priority disorders b) intervention packages	NA	a) 100% by 2014 b) 100% by 2016	Annual report	WHO
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.	Regional working group with clear membership and terms of reference	No	Y by 2013	List of members Terms of reference	WHO
3. Promote technical cooperation and exchange of experiences between countries of the Region in achieving functional integration of mental health in primary health care service package.	Number of: a) meetings held b) study tours organized	NA		Published reports	National Mental Health and Primary Care Directorates
National					
Low-level resources: Focus on a few key priority disorders, and aim to establish comprehensive integrated care in a manageable pilot area. ***Mid-level resources:*** Focus on priority disorders, and aim to establish comprehensive integrated care to cover manageable area. ***High-level resources:*** Scale up comprehensive integrated care for all priority disorders to cover entire population.					
1. Carry out a systematic priority setting exercise informed by decision-making criteria, and put in place an essential package of mental health and substance misuse interventions in primary health care.	Percentage of countries that have identified priority mental, neurological and substance use disorders and are carrying out a coordinated programme to address them in primary health care	NA	80% by 2016	Published national programme	National Mental Health and Primary Care Directorates
	Percentage of countries with functional integrated mental health as part of primary health care services	NA	80% by 2016	Published national programme	National Department of Health
	Percentage of countries with increase in treated prevalence of mental disorders in primary health care (requires inclusion of treated prevalence of mental, neurological and substance use disorders in primary health care in national minimum data set)	NA	10% by 2016	Annual national HMIS report	National Mental Health and Primary Care Directorates
	Percentage of countries with increase in psychosocial interventions in primary health care	NA	10% by 2016	Annual national HMIS report	National Mental Health and Primary Care Directorates

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
	(requires inclusion of this Indicator on national minimum data set)				
2. Identify the skill mix required at each service level, and develop and distribute tasks at each level.	Percentage of countries that have: a) reviewed needs b) published a policy/plan c) implemented the policy/plan	NA	a) 100% by 2014 b) 100% by 2015 c) 100% by 2016	Published national policy	National Mental Health and Primary Care Directorates
3. Carry out a review of medical, nursing, psychology and community health worker curricula and reformulate curricula to ensure they adequately address mental health and substance misuse, to meet the needs of integrated community-oriented services.	Percentage of countries that have reviewed and reformulated 50% of curricula of: a) doctors b) nurses c) psychologists d) community health workers	NA	a) 100% by 2016 b) 100% by 2016 c) 100% by 2016 d) 100% by 2016	Published reviews and curricula	National Mental Health Directorate and Undergraduate Education and Training Institutions
4. Review and enhance refresher training in mental health, epilepsy and alcohol/substance use for general health care professionals.	WHO-AIMS 3.1.2: Percentage of countries with refresher training programmes for a) >10% and b) >20% of primary health care doctors (at least 2 days in last years)	a) 3/17 = 18% b) 1/17 = 6%	a) 50% by 2015 b) 50% by 2016	WHO-AIMS survey	National Mental Health and Primary Care Directorates
5. Establish assessment, treatment and referral guidelines for priority disorders, including epilepsy, and ensure that intervention protocols are present in all primary health care clinics providing mental health care.	WHO-AIMS 3.1.3: Percentage of countries with assessment and treatment protocols in a) >50% and b) >80% of physician-based primary health care	a) 4/17 = 22% b) 3/17 = 18%	a) 80% by 2015 b) 80% by 2016	WHO-AIMS survey	National Mental Health and Primary Care Directorates
6. Establish assessment, treatment and referral guidelines for alcohol and substance use disorders.	Percentage of countries with assessment and treatment protocols for alcohol and substance use in (a) >50% and (b) >80% of physician-based primary health care	NA	(a) 100% by 2016 (b) 50% by 2016	Published guidelines or protocols	National Mental Health and Primary Care Directorates
7. Ensure robust support and supervision arrangements are in place to sustain mental health and epilepsy care in primary health care. 8. Establish referral and back-referral procedures between specialist mental health services and all primary health care clinics providing mental health care.	WHO-AIMS 3.1.4/5: Percentage of countries with at least monthly referral/interaction of >50% of primary health care doctors with mental health services	3/15 = 20%	50% by 2016	WHO-AIMS survey	National Mental Health and Primary Care Directorates National Mental Health and Primary Care Directorates
9. Establish a database of mental health capacity among the primary health care workforce to inform planning of integration of mental health in primary health care.	a) Functional database b) Percentage of health care providers including general practitioners, community health workers, nurses, multipurpose health workers trained on integrated mental health	NA	a) 100% by 2015 b) 50% by 2016	Annual report	National Mental Health and Primary Care Directorates
10. Ensure essential psychotropic medicines, including medicines for the treatment of epilepsy, are reliably supplied to all primary health care	WHO-AIMS 3.1.7: Percentage of countries with availability of medicines to primary health care patients in a) >50% and b) >80% of	a) 9/17 = 52% b) 7/17 = 41%	a) 80% by 2015 b) 80% by 2016	WHO-AIMS survey	National Mental Health and Primary Care Directorates

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
facilities providing mental health care.	physician-based primary health care facilities				
	Percentage of countries with increase in prescription of psychotropic medication in primary health care (requires inclusion of this Indicator on national minimum data set)	NA	Increase of 10% over previous year	Annual national HMIS report	National Mental Health and Primary Care Directorates, and Health Management Information System
11. Incorporate mental, neurological and substance use indicators in the HMIS: a. Develop indicators for HMIS b. Include them in HMIS c. Establish linkages between the information system of primary health care and the specialist mental health services d. Report on mental, neurological and substance use indicators as part of the annual HMIS report.	Percentage of countries with: a) Mental health indicators developed for the HMIS b) Mental health indicators included in HMIS c) Linkages present between the information system of primary health care and the specialist mental health services. d) Mental health indicators reported in an annual HMIS report.	NA	a) 100% by 2016 b) 50% by 2016 c) 50% by 2016 d) 50% by 2016	Annual national HMIS report	National Mental Health Directorate and Health Management Information System
Strategic component 3: Strengthen secondary and tertiary care mental health services					
Regional					
1. Technically support countries to review, develop and deliver training packages for specialist mental health workers.	Percentage of countries supported in the a) development , and b) delivery of training packages	NA	a) 100% by 2015 b) 100% by 2016	Annual report	WHO
2. Collate and review the training programmes of mental health professionals, to reach agreement on the basic principles, content, methodology and setting of training.	a) Commissioned review b) Regional meeting to consider commissioned review and agree basic principles of training c) Published report	No	a) Y by 2013 b) Y by 2014 c)Y by 2015	Published report of meeting	WHO
3. Promote cooperation between countries of the region by establishing a regional working group of experts from the countries of the Region and elsewhere to collaborate in the design and delivery of training packages.	Regional working group with clear membership and terms of reference	No	Y by 2013	Annual report List of members Terms of reference	WHO
4. Develop a Masters degree programme in public mental health with emphasis on leadership in collaboration with academic institutions at the regional and international level.	Students enrolled on functioning MSc in public mental health	No	Y by 2016	Annual report	WHO in collaboration with regional and international academic institutions
National					
Low-level resources: Match the development of community-oriented services and workforce training to areas of integration into primary care. ***Mid-level resources:*** Match the development of community-oriented services and workforce training to areas of integration into primary care. ***High-level resources:*** Scale-up community-oriented services to cover entire population.					
1. Decentralize and reorient mental health services by developing alternative community-based facilities such as mental health units in general hospitals, day	Percentage of countries with a programme for the organization and development of community mental health services including	NA	100% by 2015	Published programme	National Mental Health Directorate

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
facilities, community-based outpatient services, and community residential facilities.	specialist mental health services				
	Percentage of countries that have identified priority mental, neurological and substance use disorders and are carrying out a coordinated programme to address them at different levels	NA	100% by 2015	Published programme and annual report	National Mental Health Directorate
	WHO-AIMS 1.5.2: Expenditure on mental hospitals – percentage of countries whose expenditure on mental hospitals is <50% of total money spent on mental health services	4/11 = 36%	70% by 2016. Aim to reduce by 10% if baseline >50%.	WHO-AIMS survey	National Mental Health Directorate
	Percentage of countries with community-based psychiatric inpatient units in more than 50% of general hospitals	NA	100% by 2016	Survey	National Mental Health Directorate
	Percentage of countries with psychiatric outpatient units associated with more than 50% of general hospitals	NA	100% by 2016	Survey	National Mental Health Directorate
	Percentage of countries with day treatment facilities associated with more than 50% of general hospitals	NA	100% by 2016	Survey	National Mental Health Directorate
	Percentage of countries with ratio of outpatient care to inpatients care >1 (Lund Flischer Index)[66]	5/8 = 63%	100% by 2016	WHO-AIMS Survey	National Mental Health Directorate
2. Support the integration of mental health in primary health care by providing training, continuing support and referral/back referral.	WHO-AIMS 3.1.4/5: Percentage of countries with >50% of primary health care doctors having referral/interaction with mental health services	Refer to WHO-AIMS	100% by 2016	WHO-AIMS survey	National Mental Health Directorate
3. Ensure that high quality care is provided by mental hospitals by continuing training of mental hospital staff, upkeep of the physical environment and regular inspections.	Percentage of countries with: a) specific indicators for continuing training (see 8 and 9 below) b) inspection policy c) regular inspection implemented (2–4 yearly dependent on resources)	a) NA b) NA c) NA	a) see below b) 100% by 2014 c) 100% by 2016	Published inspection policy. Annual report	National Mental Health Directorate
4. Strengthen mental health capacity in secondary health care services and strengthen multidisciplinary teamwork, defining the roles of all the members (including nurses, psychologists, social workers, occupational therapists). In the light of revised professional roles, review and reformulate postgraduate and specialist training for mental health to ensure that training curricula are relevant to the community mental health care	Percentage of countries that have reviewed and reformulated 50% of postgraduate curricula of: a) psychiatrists b) other doctors c) psychologist, social worker or occupational therapist d) other health or mental health workers	NA	100% by 2016	Survey	National Mental Health Directorate and Postgraduate Education and Training Institutions

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
model and human rights.					
5. Ensure that psychotropic medicines, including antipsychotic, antidepressant, mood stabilizing, anxiolytic and antiepileptic medications are on the essential medicines list, and that these medicines are available at all mental health facilities.	WHO-AIMS 2.10.1: Percentage of countries with availability of medicines in mental hospitals all through the year	14/16 = 88%	100% by 2014	WHO-AIMS survey	National Mental Health Directorate
	WHO-AIMS 2.10.2: Percentage of countries with availability of medicines in community-based psychiatric inpatient units all through the year	9/15 = 60%	100% by 2014	WHO-AIMS survey	National Mental Health Directorate
	WHO-AIMS 2.10.3: Percentage of countries with availability of medicines in mental health outpatient clinics all through the year	8/17 = 47%	100% by 2014	WHO-AIMS survey	National Mental Health Directorate
6. Involve service-user and family associations in the process of planning and implementing mental health services.	Percentage of countries with interaction of >20% of mental health services with user/consumer associations	1/17 = 6%	50% by 2016	Survey	National, Provincial and District Mental Health Directorate(s)/ Committee(s)
	Percentage of countries with interaction of >20% of mental health services with family associations	0/17 = 0%	50% by 2016	Survey	National, Provincial and District Mental Health Directorate(s)/ Committee(s)
7. Reformulate the roles of specialist mental health professionals, for example the extent they will be involved in training, supervision, diagnosis, prescribing, or providing psychosocial interventions, and prepare plans for initial training, and systematic refresher training programmes for existing mental health staff, in relevant core competencies.	Percentage of countries with published policy on roles of specialist mental health professionals	NA	100% by 2014	Published policy	National Mental Health Directorate
	WHO-AIMS 4.2.2.1-4: Percentage of countries with refresher training for 20% or more of mental health staff on the rational use of psychotropic medicines in the past year	Psy[3] 6/17=35% OD 5/16=31% Nur 3/17=18% HW 2/17=12%	50% by 2015 80% by 2016	WHO-AIMS survey	National Mental Health Directorate and Postgraduate Education and Training Institutions
	WHO-AIMS 4.2.3.1-5: Percentage of countries with refresher training for 20% or more of mental health staff in psychosocial interventions in the past year	Psy 3/17=18% OD 5/15=33% Nur 2/17=12% PSO =7/15=47% HW 2/17=12%	50% by 2015 80% by 2016	WHO-AIMS survey	National Mental Health Directorate and Postgraduate Education and Training Institutions
	Percentage of countries with training plans for community-based roles: a) leadership b) rehabilitation and recovery c) communication skills d) support and supervision skills e) training skills	NA	100% by 2015	Published plans	National Mental Health Directorate and Postgraduate Education and Training Institutions
8. Set up in-service supervision or appraisal to support training and career development of specialist mental health staff.	a) Supervision and/or appraisal policy b) Implementation for >50% of mental health staff	NA	a) 2013 b) 80% by 2015 c) 80% by 2016	Published policy Annual report	National, Provincial and District Mental Health Directorate(s)/ Committee(s)

[3] Psy = Psychiatrist; OD = Other doctor; Nur = Nurse; PSO = Psychologist, social worker or occupational therapist; HW = Other health or mental health worker

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
	c) Implementation for >90% of mental health staff				
Strategic component 4: Identify and prioritize vulnerable persons					
Regional					
1. Support countries to implement the regional strategic directions and actions for maternal, child and adolescent mental health care.	Number of countries supported in implementing the regional strategic directions and actions for maternal, child and adolescent mental health care	NA	100% by 2013	Annual report	WHO
2. Prepare and publish Regional strategic directions and guidance for alcohol and substance misuse in the Eastern Mediterranean Region.	Regional strategic directions and guidance for substance misuse published	No	Yes by 2013	Published Strategy	WHO
3. Coordinate regional preparedness and response plans for mental health and psychosocial support in emergency settings; develop a Regional workforce of experts that can be rapidly deployed; and apply assessment tools to inform response.	Number of states supported in reviewing and/or finalizing preparedness and response plans for mental health and psychosocial support in emergency settings Regional workforce exists with: a) membership b) agreed terms of reference	No	Yes by 2012	Annual report List of members and Terms of reference	WHO
National					
Low-level resources: Focus on at least one or two priorities matching with complementary partnerships. ***Mid-level resources:*** Aim to address two to four priorities, matching with complementary partnerships. ***High-level resources:*** Aim to address all identified priorities, matching with complementary partnerships.					
1. Identify and prioritize vulnerable persons using decision-making criteria.	Percentage of countries with a formal agreement identifying vulnerable persons and their priority.	NA	100% by 2014	Published report	National Mental Health Directorate
2. Implement the regional strategic directions and actions for maternal, child and adolescent mental health care.	The strategy for maternal, child and adolescent mental health care has its own actions, indicators and time-frames	NA	See strategy for maternal, child and adolescent mental health care	See strategy for maternal, child and adolescent mental health care	See strategy for maternal, child and adolescent mental health care
3. Prepare an emergency preparedness plan for disaster or humanitarian crisis in collaboration with other agencies addressing inter-agency coordination, details of the mental health response, supply of medication, ensuring human rights are respected, maintaining care for people with severe mental disorders including inpatients in psychiatric units and mental hospitals, support for health staff, and preparing capacity of workforce by training of general health staff in psychological first-aid and psychosocial support skills.	WHO-AIMS 1.2.4: Percentage of countries with a disaster/emergency preparedness plan for mental health, reviewed within the past 5 years	NA	100% by 2014	Published plan and WHO-AIMS survey	National Mental Health Directorate
	Percentage of countries that have implemented activities to fulfil the requirements of the disaster/emergency preparedness plan	NA	100% by 2015	Annual report	

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
4. Develop treatment services and programmes for mental health promotion and prevention that are appropriate to gender and the needs of different life stages, paying particular attention to children and adolescents, pregnant women and mothers of young children, and the elderly.	Percentage of countries that are implementing a formally agreed mental health programme specifically addressing children and adolescents	NA	100% by 2016	Published programme and annual report	National Mental Health Directorate
	Percentage of countries that are implementing a formally agreed programme for maternal mental health	NA	100% by 2016	Published programme and annual report	National Mental Health Directorate
	Percentage of countries that are implementing a formally agreed mental health programme for the elderly	NA		Published programme and annual report	National Mental Health Directorate
5. Assess and address the need for secondary care services to provide inpatient and/or outpatient interventions for alcohol and substance use disorders providing assessment, detoxification, maintenance therapy, substitution oriented treatment, and rehabilitation.	Percentage of countries that are implementing a formally agreed programme for alcohol and substance use	NA	100% by 2016	Published programme and annual report	National Mental Health Directorate
6. Target preventive programmes at groups at risk of suicide, and establish policies to reduce availability of methods of suicide.	Percentage of countries that have implemented a programme for the prevention of suicide	NA	If priority, Y by 2016	Published programme and annual report	National Mental Health Directorate
	Median suicide rate for the countries of the Region	4.9 per 100 000 population	Reduced	Annual report	
7. Plan and implement how care will be coordinated where mental disorder occurs jointly with physical illness.	Percentage of countries that are implementing a formally agreed programme for mental disorder occurring jointly with physical illness	NA	100% by 2016	Published plan and annual report	Department of Health and National Mental Health Directorate
8. Develop treatment, promotion and preventive programmes that target groups that are socially disadvantaged, such as people in poverty and those who are the victims of abuse.	Percentage of countries that have implemented a programme for socially disadvantaged persons	NA	If priority, Y by 2016	Published programme and annual report	National Mental Health Directorate
9. Ensure that people in marginalized groups such as refugees, immigrants and those from ethnic minorities have access to mental health services, and that services are culturally sensitive and provide for different languages.	Percentage of countries that have implemented a programme for marginalized persons	NA	If priority, Y by 2016	Published programme and annual report	National Mental Health Directorate
10. Assess the needs of offenders with mental disorders, and develop treatment services and programmes for mental health promotion and prevention in prison coordinated with prior/subsequent interventions.	Percentage of countries that have implemented a programme for offenders with mental disorders	NA	If priority, Y by 2016	Published programme and annual report	National Mental Health Directorate

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
Strategic component 5: Intersectoral coordination and collaboration to promote mental health and prevent mental disorders					
Regional					
1. Support technically countries to develop strategies for public education and mental health promotion clearly outlining the distribution of tasks between different social sectors.	Percentage of countries that are implementing a promotional component in their national mental health plan	13/17 = 76%	100% by 2016	National mental health plans	WHO and National Mental Health Directorates
2. Collect relevant experience from within the region and elsewhere, and disseminate guidance and lessons learned to the countries of the Region.	a) Commissioned review b) Regional meeting to consider commissioned review and agree guidance c) Published report	No	a) Y by 2013 b) Y by 2014 c) Y by 2015	Annual report Published report of meeting	WHO
3. 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.	Agreed set of indicators of positive mental health that can be used throughout the Region	No	Y by 2015	Published set of indicators	WHO
4. Collaborate with other United Nations agencies and nongovernmental organizations to incorporate mental health components into health and social sector programmes.	Percentage of countries promoting national or provincial public education and awareness campaigns on mental health through a) government agencies, b) nongovernmental organizations, c) professional associations, d) private trusts and foundations, and e) international agencies	NA	(a–e) each 50% by 2014, 80% by 2016	Survey (biennial)	WHO and National Mental Health Directorates
	Percentage of countries with specific national or provincial education and awareness campaigns on mental health targeting a) general population, b) children, c) adolescents, d) women, e) trauma survivors, f) ethnic groups, and g) other vulnerable or minority groups	NA	(a–g) each 50% by 2014, 80% by 2016	Survey (biennial)	WHO and National Mental Health Directorates
	Percentage of countries with specific national or provincial education and awareness campaigns on mental health targeting a) health care providers, b) complementary/alternative/ traditional sector, c) teachers, d) social services staff, e) leaders and politicians, and f) other professional groups linked to the health sector	NA	(a–f) each 50% by 2014, 80% by 2016	Survey (biennial)	WHO and National Mental Health Directorates
	Percentage of countries with formal collaborative programmes with the education sector	11/17 = 65%	100% by 2014	Published national collaborative programmes	WHO and National Mental Health Directorates
	Percentage of countries promotion and prevention activities in more than 50% of primary and secondary schools	2/17 = 12%	100% by 2016		WHO and National Mental Health Directorates

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
National					
Low-level resources: Focus on partnerships likely to have most sustained benefits (e.g. nutrition, maternal health care, education or legislation), or which address country priorities (e.g. harm reduction or emergency planning). ***Mid-level resources:*** Develop a range of active partnerships within and outside the health sector to promote mental health, prevent mental, neurological and substance use disorders, and raise public awareness. ***High-level resources:*** Develop a broad range of active partnerships within and outside the health sector to promote mental health, prevent mental, neurological and substance use disorders and raise public awareness.					
1. Develop strategies for mental health promotion in mental health, public health, and other public policies.	WHO-AIMS 1.2.2.7: Contents of mental health plan include advocacy and promotion	Refer to WHO-AIMS	Y by 2016	WHO-AIMS survey	National Mental Health Directorate, Ministry of Health and other relevant government departments.
2. Actively seek and engage in partnerships with programmes involved in prevention and health promotion, nongovernmental organizations, and those within and outside the health sector.	WHO-AIMS 5.1.3: Populations targeted by specific education and awareness campaigns on mental health	Refer to WHO-AIMS	Y to all by 2016	WHO-AIMS survey	Coordinating body to oversee public education and awareness campaigns on mental health and mental, neurological and substance use disorders
	WHO-AIMS 5.1.4: Professional groups targeted by specific education and awareness campaigns on mental health	Refer to WHO-AIMS	Y to all by 2016	WHO-AIMS survey	
	WHO-AIMS 5.2.5.7: Formal collaborative programmes with education	Refer to WHO-AIMS	Y by 2014	WHO-AIMS survey	
	WHO-AIMS 5.3.3: Promotion and prevention activities in primary and secondary schools	Refer to WHO-AIMS	>50% (D or E) by 2016	WHO-AIMS survey	
3. Establish a coordinating body to oversee public education and awareness campaigns on mental health and mental, neurological and substance use disorders.	WHO-AIMS 5.1.1: Percentage of countries with a coordinating body for public education and awareness campaigns on mental health	Refer to WHO-AIMS	100% by 2014	WHO-AIMS survey	National Mental Health Directorate
4. Ensure there is wide access to information and public awareness programmes for all parts of society about: 1) mental health; 2) mental, neurological and substance use disorders; 3) the range of harm in the country arising from use of alcohol and drugs; and 4) consider information about suicide.	WHO-AIMS 5.1.2: Agencies promoting public education and awareness campaigns on mental health	Refer to WHO-AIMS		WHO-AIMS survey	Coordinating body to oversee public education and awareness campaigns on mental health and mental, neurological and substance use disorders
5. Contribute to the development or adaptation of indicators of positive mental health that can be used in the Region.	As regional Item 5.3 (above)	No	Y by 2015	Published set of indicators	National Mental Health Directorate and Coordinating body to oversee public education and awareness campaigns on mental health and MNS disorders
6. Develop information, education, and communication materials.	Number of published materials	NA		Published material	National Mental Health Directorate, Ministry of Health and other relevant government departments.

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
Regional					
1. Support the development of an integrated system of databases including information on mental health policies, strategies, services, and where possible promotion, prevention, treatment, care and recovery.	Regional report on mental health systems published, based on WHO-AIMS	NA	Y by 2011	Published report on the WHO-AIMS survey	WHO and National Mental Health Directorates
2. Work with countries towards an agreed database of mental health human resources and its capacity that can be used in planning the optimal use of the workforce	Number of states supported in finalizing database of mental health human resources and its capacity	No	50% by 2015, 80% by 2016	Annual report	WHO and National Mental Health Directorates
3. Work with countries to agree priorities for research in mental health, drawing on existing international work in this area.	a) Commissioned review b) Regional meeting to consider commissioned review and agree research priorities c) Published report	No	a) Y by 2013 b) Y by 2014 c) Y by 2015	Annual report Published report of meeting	WHO and National Mental Health Directorates
4. Develop a regional database of validated instruments.	Functioning database of validated instrument	No			WHO
5. Develop new indicators where there are no internationally standardized measures, particularly in the areas of mental health promotion, prevention, treatment and recovery.	a) Commissioned review b) Regional meeting to consider commissioned review and agree indicators c) Published report	No	a) Y by 2014 b) Y by 2015 c) Y by 2016	Annual report Published report of meeting	WHO
6. Develop a database of published mental health research.	Functioning database of published mental health research	No			WHO
7. Support the dissemination of good-quality evidence on mental health nationally and internationally.	Number of WHO supported regional publications and meetings disseminating research evidence Annual number of mental health publications as identified on PubMed	NA	Annual increase of 5%	Annual report	WHO
8. Promote indexing of mental health journals from the Region.		No			WHO
9. Support periodic population-based mental health surveys, using standardized methodology.	Number of population-based mental health surveys (over 5-year period)		As appropriate	Published report	WHO and National Mental Health Directorates
10. Facilitate collaborative links between researchers in the Region and researchers outside the Region who have a strong track record of successful research bids and publications.	Annual number of: a) research meetings b) study tours c) funded collaborative research studies	NA		Annual report	WHO
11. Support master classes in writing grant applications and papers for publication.	Number master classes held and number of researchers who have attended a master class	NA		Annual report	WHO
National					

Suggested activity	Indicator	Baseline	Target	Verification mechanism	Responsible body
Low-level resources: Monitor and evaluate new service developments; and focus on operational research, i.e. situation analysis and pilot programmes.					
Mid-level resources: Research problems specific to the Region and adapting or testing research findings from high-income countries.					
High-level resources: Undertake a broad range of research across all research priority areas.					
1. Develop or strengthen national mental health information systems using internationally standardized and comparable indicators (e.g. WHO-AIMS) to monitor progress towards local, national and regional strategic goals to improve mental health and well-being.	Percentage of countries that have assessed their mental health systems using WHO-AIMS	17/22 = 77%	100% by 2013	WHO-AIMS survey	National Mental Health Directorate and Health Management Information System
	Percentage of countries that have reassessed their mental health systems using WHO-AIMS	0/22 = 0%	77% by 2016	WHO-AIMS survey	National Mental Health Directorate and Health Management Information System
2. Develop a database of mental health human resources and its capacity that can be used in planning the optimal use of the workforce.	As regional item 6.4 (above)	NA	50% by 2015 80% by 2016	Annual report	National, Provincial and District Mental Health Directorate(s)/ Committee(s)
3. Use indicator data and specially collected data to evaluate the impact of mental health plans, programmes and services.	WHO-AIMS 6.1.6: Percentage of countries that publish a report on mental health services by the government health department in last year, with comments on the data	4/17 = 24%	80% by 2016	WHO-AIMS survey	National, Provincial and District Mental Health Directorate(s)/ Committee(s)
4. Establish 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.	Percentage of countries with national mental health research priorities identified and supported through a national policy/plan	NA	Y by 2015	National policy or plan	National Mental Health Directorate and Research Institutions
5. Facilitate cooperation between research institutions in mental health research.	Average annual number of mental health publications on the country over the past five years as identified on PubMed (can be calculated from denominator of WHO-AIMS 6.2.2)	Refer to WHO-AIMS	Increase by 2016	WHO-AIMS survey	National Mental Health Directorate and Research Institutions
6. Develop international collaborative research links within and outside the Region.	WHO-AIMS 6.2.2: Proportion of health research that is on mental health	Refer to WHO-AIMS	Increase by 2016	WHO-AIMS survey	WHO, National Mental Health Directorate and Research Institutions
7. Involve service-user and family associations in research	Percentage of countries with (a) user/consumer associations, and (b) family associations, involvement in research	NA	a) 50% by 2016 b) 50% by 2016	Survey	National Mental Health Directorate and Research Institutions
8. Compile and analyse the country's existing mental health research– to inform the evidence base for current service planning and to identify the next research priorities.	a) Commissioned survey and review b) National meeting to consider commissioned review and agree research priorities c) Published report	No	a) Y by 2013 b) Y by 2014 c) Y by 2015	Survey and review Published report	National Mental Health Directorate and Research Institutions

Annex 2. Areas for collaboration with partners involved in prevention and health promotion

Maternal health care

- To promote child development: develop and offer effective programmes for parenting support and education starting during and after pregnancy. Consider parenting skills training programmes, early child education and socialization, and pre-school education. Programmes can be adapted from available packages such as the Care for Child Development Intervention Package developed by WHO and UNICEF.
- To reduce risk of premature birth, low birth weight, perinatal mortality and neurological and cognitive developmental problems: consider educational programmes for pregnant women addressing use of tobacco, alcohol and substances in pregnancy,
- To reduce risk of premature birth, low birth weight, reduce child abuse and reduce subsequent substance abuse: consider educational and supportive psychosocial interventions for socially disadvantaged young women during pregnancy and early infancy, enhancing social support, improving parenting skills, facilitating child-parent interactions and reducing smoking.

Primary care

- To reduce suicide: ensure intervention for depression in primary care, including prescription of antidepressant medicines.
- To reduce epilepsy: ensure good antenatal and perinatal care, vaccination against and appropriate treatment of neuroinfections, and interventions to decrease head trauma.
- To reduce the onset of dementia: ensure antihypertensive treatment for elderly people with high systolic blood pressure.
- To reduce stress and depression in caregivers of people with chronic illness: consider psycho-educational interventions informing caregivers about the ill-person's disease, resources and services available for them, and training in how to deal with illness-related problems.

Elderly care

- To increase life-satisfaction and well-being, reduce psychological distress and depressive symptoms, lower blood pressure and reduce falls: consider physical exercise interventions for the elderly population.

Harm reduction

- To prevent spread of bloodborne viruses by outreach programmes; to prevent the start of intravenous drug use; and to encourage those who are injecting to quit or use a safer method of drug use: establish counselling programmes to reduce unsafe injecting and unsafe sexual practices, drug maintenance treatment and needle exchange programmes.

Education

- To promote positive mental health and primary prevention of mental, neurological and substance use disorders: integrate life-skills education and mental health components within health promoting schools initiatives.
- To improve cognitive development and educational outcome, and reduce behavioural problems: consider preschool programmes teaching reading, health screening, and social play for low-birth-weight children and children of socially disadvantaged families.

Nutrition

- To enhance cognitive development, improve educational outcomes and reduce risk of mental, neurological and substance use disorder: improve the nutrition of socioeconomically disadvantaged children through food supplementation, growth monitoring and psychosocial care.

Legislation

- To reduce suicide: reduce access to the means of committing suicide by detoxifying domestic gas and car exhaust fumes, establishing safety precautions on high buildings and bridges and restricting availability of painkillers, sedatives, pesticides and other toxins.
- To reduce harm from tobacco and alcohol:
  - consider restricting access to tobacco and alcohol by taxation, minimum legal age, limiting hours of sale, restrictions on use of tobacco and alcohol in public places and workplaces combined with total ban on all advertising.
  - introduce and enforce limits on alcohol and drugs for drivers, with lower limits for young drivers and professional drivers, supported by testing and suspension of driving license.

– regulate marketing of alcohol, especially where it targets young people (content, volume, sponsorship, use of social media). Although alcohol use disorders are not common in many countries of the Region at present, advertising may target new potential markets.

Employment

- To enhance mental health and job satisfaction: work towards healthier workplaces through assessment and management of risk and stress of tasks, increasing social support and participation in work-related decision-making, and implementing reasonable hours, work patterns and exercise.
- To improve the chance of re-employment for the unemployed and those with mental illness: consider multifaceted programmes to enhance job-searching skills and motivation, ability to cope with setbacks and social support.

Housing

- To improve self-reported physical health and mental health: improve the housing of socio-economically disadvantaged people and people with mental illness.

Community

- To counter stigma and discrimination: promote community-based interventions such as public awareness campaigns, involving primary care staff, and community facilitators such as teachers, religious and community leaders and the media.
- To reduce the harm from alcohol and drugs, mobilize communities to develop and support alcohol and drug-free environments especially for young people.

Media

- To collaborate with the media and provide the media with timely high quality information: agree on reporting guidelines and develop media communication and public relations skills or resources within the mental health team.
- To reduce the duration of untreated psychosis: consider media campaign to increase mental health literacy and encourage early care seeking and involve the media in suicide prevention programmes.

Personal finance

- To alleviate some of the stress of poverty and to improve psychological well-being: consider implementing poverty alleviation programmes.

Inter-agency planning for emergency situations

- To prevent mental disorder in conflict, disaster and humanitarian emergency situations: develop mental health and psychosocial support programmes, guided by IASC guidelines (45).

Complementary/alternative/traditional/healers sector

- To improve collaboration with traditional healers: enhance early identification of mental, neurological and substance use disorders and reduce delays in pathways to care.

User associations, self help groups and family associations

- To empower the users of mental health services: promote the development of consumer associations, self-help groups and family associations in countries.

References

1. Prince M et al. Global mental health 1: no health without mental health. *Lancet*, 2007, 370:859–77.
2. Deacon L et al. *North-west mental wellbeing survey 2009*. Liverpool, North West Public Health Observatory, 2010.
3. *The World Health Report 2001*. Mental Health: New understanding, new hope. Geneva, World Health Organization, 2001.
4. *Disease and injury regional estimates for 2004*: Geneva, World Health Organization. http://www.who.int/healthinfo/global_burden_disease/estimates_regional/en/index.html
5. *Mental Health Gap Action Programme: scaling up care for mental, neurological and substance use disorders*. Geneva, World Health Organization, 2008.
6. *Maternal, child and adolescent mental health: Challenges and strategic directions for the Eastern Mediterranean Region*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2010. (Document No WHO-EM/MNH/190/E)
7. Lehtinen V et al. The intrinsic value of mental health. In: Herrman H, Saxena S, Moodie R, eds. *Promoting mental health: concepts, emerging evidence, practice*. Geneva, World Health Organization, 2005.
8. Patel V et al. Social determinants of mental disorders. In: Blas E, Sivasankara Kurup A, eds. *Priority public health conditions: from learning to action on social determinants of health*. Geneva, World Health Organization, Forthcoming.
9. Scholte WF et al. Mental health symptoms following war and repression in eastern Afghanistan. *Journal of the American Medical Association*, 2004, 292, 585–93.
10. Noorbala AA et al. Mental health survey of the adult population in Iran. *The British Journal of Psychiatry*, 2004, 184:70–3.
11. *Iraq Mental Health Survey 2006/7*. World Health Organization, 2009.
12. Abou-Saleh MT, Ghubash R, Daradkeh TK. Al Ain community psychiatric survey. I. Prevalence and socio-demographic correlates. *Social Psychiatry and Psychiatric Epidemiology*, 2001, 36:20–8.
13. Ghanem M et al. National survey of prevalence of mental disorders in Egypt: preliminary survey. *Eastern Mediterranean Health Journal*, 2009, 15, 1:65–75.
14. Karam EG et al Prevalence and treatment of mental disorders in Lebanon: a national epidemiological survey. *Lancet*, 2006, 367:1000–6.

15. Kadri N et al. Moroccan national study on prevalence of mental disorders: a community-based epidemiological study. *Acta Psychiatrica Scandinavia*, 2010, 121:71–4.

16. Mumford DB et al. Stress and psychiatric disorder in rural Punjab. A community survey. *The British Journal of Psychiatry*, 1997, 170:473–8.

17. Mumford DB et al. Stress and psychiatric disorder in urban Rawalpindi. Community survey. *The British Journal of Psychiatry*, 2000. 177:557–62.

18. Gubash R, Hamdi E, Bebbington P. The Dubai community psychiatric survey: I. Prevalence and socio-demographic correlates. *Social Psychiatry and Psychiatric Epidemiology*, 1992, 27, 53–61.

19. Daradkeh TK, Ghubash R, Abou-Saleh MT. Al Ain community survey of psychiatric morbidity II. Sex differences in the prevalence of depressive disorders. *Journal of Affective Disorders*, 2002, 72, 167–76.

20. *ATLAS on substance use (2010): resources for treatment and prevention of substance use disorders*. Geneva, World Health Organization, 2010.

21. *Epilepsy in WHO Eastern Mediterranean Region: bridging the gap*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2010.

22. Ustun TB, Sartorius N. *Mental illness in general health care: an international study*. New York, John Wiley, 1995.

23. Gater R et al. The pathways to psychiatric care: a cross-cultural study. *Psychological Medicine*, 1991, 21:761–74.

24. WHO and World Organization of Family Doctors (Wonca). *Integrating mental health into primary care: a global perspective*. Geneva, World Health Organization, 2008.

25. Jacob KS et al. Global mental health 4: mental health systems in countries: where are we now. *Lancet*, 2007, 370:1061–77.

26. Patel V et al. Global Mental Health 3: Treatment and prevention of mental disorders in low-income and middle-income countries. *Lancet*, 2007, 370:991–1005.

27. Saxena S et al. Global mental health 2. resources for mental health: scarcity, inequity and inefficiency. *Lancet*, 2007, 370:878–9.

28. *Mental health systems in the Eastern Mediterranean Region: Report based on the WHO assessment instrument for mental health systems*. Cairo, WHO Regional Office for the Eastern Mediterranean, 2010 (EMRO Technical Publications Series No 37).

29. Hyman S et al. Mental disorders. In: Jamison DT et al, eds. *Disease control priorities related to mental, neurological, developmental and substance abuse disorders,* second edition (DCP2) Oxford University Press and the World Bank, 2006: 1–20.

30. *Dollars, DALYs and decisions: economic aspects of the mental health system*. Geneva, World Health Organization, 2006.
31. Chandra V et al. Neurological disorders. In Jamison DT et al, eds. *Disease control priorities related to mental, neurological, developmental and substance abuse disorders*, second edition (DCP2). Oxford University Press and the World Bank, 2006: 21–37.
32. Kohn R et al. The treatment gap in mental health care. *Bulletin of the World Health Organization*, 2004, 82:858–66.
33. *Mental health systems in selected low- and middle-income countries: a WHO-AIMS cross-national analysis*. Geneva, World Health Organization, 2009.
34. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization World Mental Health Surveys. *Journal of the American Medical Association*, 2004, 291, 2581–90.
35. Meyer AC et al. Global disparities in the epilepsy treatment gap: a systematic review. *Bulletin of the World Health Organization*, 2010, 88:260–6.
36. Aziz et al. Epilepsy in Pakistan: a population-based epidemiologic study. *Epilepsia*, 1994, 35(5):950–8.
37. *World Health Organization: Assessment instrument for mental health systems, WHO-AIMS Version 2.2*. Geneva, World Health Organization, 2005.
38. Saraceno B et al. Global mental health 5, barriers to improvement in mental health services in low-income and middle income countries. *Lancet*, 2007, 370:1164–74.
39. *Challenges and priorities for global mental health research in low- and middle-income countries: symposium report*. London, The Academy of Medical Sciences, 2008.
40. Lewin SA et al. Lay health workers in primary and community health care. *Cochrane database systems review*, 2005, (1):CD004015.
41. *Task shifting: rational redistribution of tasks among health workforce teams. Global recommendations and guidelines*. Geneva, World Health Organization, 2008. Available at http://www.who.int/healthsystems/TTR-TaskShifting.pdf
42. *mhGAP Intervention guide for mental , neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010.
43. *The alcohol, smoking and substance involvement screening test (ASSIST): guidelines for use in primary care*. Geneva, World Health Organization, 2003.
44. *Brief intervention for substance use: a manual for use in primary care*. Geneva, World Health Organization, 2003.
45. *IASC Guidelines on mental health and psychosocial support in emergency settings*. Geneva, Inter Agency Standing Committee, 2007.

46. Van Ommeren, Saxena S, Saraceno B. Mental and social health during and after acute emergencies: emerging consensus? *Bulletin of the World Health Organization*, 2005, 83:71–7.

47. Global mental health 6. Scale up services for mental disorders: a call for action. *Lancet*, 2007, 370:1241–52.

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 12% of the burden of disease in the WHO Eastern Mediterranean Region. Such disorders place a heavy burden on the persons with the disorder, their families and the community. Yet despite the accumulation of strong evidence showing that mental, neurological and substance use disorders are common and disabling, very few resources are invested in their care. The regional strategy on mental health and substance abuse aims at strengthening 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. The strategy and actions proposed, which were endorsed by the WHO Regional Committee for the Eastern Mediterranean in 2011, provide a foundation for the development of national strategies and action plans.