المَجَلّةُ الصِّحِيّةُ لِشَرقِ المُتوَسِّطِ

EMHJ

Supplement on Mental Health

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**Eastern Mediterranean
Health Journal**

**La Revue de Santé de
la Méditerranée orientale**

Theme issue on Mental Health

Contents

Editorial

A new agenda for mental health in the Eastern Mediterranean Region

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Mental disorders are common and disabling. At any given time worldwide about 1 person in every 10 is suffering from a mental disorder, and about 1 in 4 families has a member with a mental disorder. Mental, neurological and substance use disorders combined account for a considerable proportion of the disease burden and as much as a fifth of years of life lived with disability. While effective pharmacological and psychosocial treatments are available and can be successfully applied in low-income countries, the vast majority of people with a mental disorder in these countries do not receive treatment (*1*). The treatment gap, of people who require care but do not receive it, has been estimated to range from 76% to 85%. This gap in provision of care can be attributed not only to lack of resources but also to inefficient allocation of available resources. Globally, most countries spend less than 2% of their health budget on mental health, which typically falls well short of the US$ 3–4 per capita needed for a selective package of cost-effective mental health interventions in low-income countries and the up to US$ 7–9 per capita needed in middle-income countries (*1,2*).

In the past 2 decades, the World Health Organization (WHO) has increasingly focused attention on action to improve mental health services and to reduce the burden of mental disorders. Key milestones have been the publication of the World Health Report 2001 (*3*), which for the first time was devoted to mental health; and the launch of the Mental Health Gap Action Programme (mhGAP) in 2008 (*4*), which aimed to improve effective and humane care for people with mental disorders and to close the wide gap between the treatment that is urgently needed and that which is actually available and delivered.

In May 2013, the World Health Assembly adopted the Global Mental Health Action Plan 2013–2020 (*1*), which is a commitment by all 194 Member States to take action to improve mental health. The 4 objectives of the plan are "to strengthen effective leadership and governance for mental health; to provide comprehensive, integrated and responsive mental health and social care services in community-based settings; to implement strategies for promotion and prevention in mental health; and to strengthen information systems, evidence and research for mental health." Each of these objectives is accompanied by actions for Member States, partners and the WHO Secretariat, with defined indicators and targets to be met by 2020.

The WHO Eastern Mediterranean Region (EMR) faces particular challenges in implementing the Global Mental Health Action Plan. It comprises 22 economically diverse countries, with their own cultures and characteristics. A substantial number of these countries have recently experienced insecurity, war and humanitarian crisis. In complex humanitarian situations, not only the rates of mental disorders tend to increase but there is attrition in the capacity of the health and social systems to respond to the increased needs and demands. WHO projects that about 1 in 6 people have a mental disorder after an acute major emergency. Close to 1 in 30 people will have a mental disorder so severe that it undermines their ability to function and survive a chaotic emergency environment (*5*).

With different countries in the Region being at different stages of development, including the development of their mental health systems, the Regional Office for the Eastern Mediterranean (EMRO) has devised a classification of countries into 3 groups that are similar in terms of their population health outcomes, health system performance and level of health expenditure (*6*). This facilitates more meaningful comparisons between countries as well as the formulation of recommendations appropriate to each country's current level of health system and socioeconomic development.

The Mental Health Atlas 2014 is designed to collect information to report on the agreed upon indicators and targets of the Global Mental Health Action Plan (*1*). The current iteration of the Atlas will provide data on the status of mental health services in countries of the EMR that will serve as a benchmark to monitor progress towards achieving the targets of the global plan. Preliminary analyses suggest that there is a pressing need to initiate and lead a process of change towards these objectives. For example, even though a substantial number of EMR countries have recently published mental health policies, more than half of these are not fully compliant with international human rights instruments and none are fully implemented. Several countries have outdated legislation about mental health, much of which does not conform

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with international human rights instruments. The involvement of associations of service users and their carers in the formulation and implementation of mental health policies, laws and services is markedly underdeveloped in the Region. Many countries continue to have institutionally-based mental health services, with the majority of staff located in mental hospitals. Across the Region, about two-thirds of mental health beds are in mental hospitals, and this proportion has not changed since the Mental Health Atlas 2011 (7). The mental health workforce is small, especially in the less developed countries, and this has also remained static in most EMR countries over the last 3 years. In some countries, such as some of those with humanitarian crises, the mental health workforce has been further depleted. Only a small minority of primary care staff have received recent training in mental health. One-quarter of countries in the Region have no national mental health or promotion programmes, and half the countries have 3 or fewer such programmes. There is also a scarcity of mental health information and limited research evidence with which to inform service planning or to monitor implementation.

In order to implement the Global Mental Health Action Plan within the Region, EMRO has developed a framework to operationalize the proposed actions by converting them into practical and concrete recommendations for intervention. The field of mental health is often seen as complex and unwieldy, and hence care has been taken to focus the framework on a limited number of priority strategic recommendations grouped under 4 domains mirroring the objectives of the global action plan. The principles guiding the development of the proposed regional framework are: evidence-informed; specific; parsimonious and relevant; and feasible and internally consistent. The framework also incorporates a set of SMART indicators [Specific–Measurable–Achievable –Relevant–Time-based] that will be used to monitor progress towards the global targets for 2020.

In order to inform and support the framework for implementation, EMRO has commissioned teams of international experts to develop evidence briefs on key components of mental health systems. The remit of these briefs is to review and summarize national and international evidence relevant to EMR countries, and to suggest strategic interventions for ministries of health that are affordable, cost-effective and feasible to bridge the treatment gap in countries of the EMR. These briefs, which are brought together in this theme issue of the *Eastern Mediterranean Health Journal* along with the framework for implementation, represent the current best evidence for mental health interventions for the Member States of the EMR.

The key recommendations include:

- reorientation of mental health services from institutional to community-based services;

- building the capacity of the mental health workforce to provide community-based integrated care;

- revision of mental health policies, plans and legislation conforming to international human rights instruments;

- assessment of national mental health resource needs and corresponding prioritization of budgetary allocations, taking care to protect people from the potentially catastrophic costs of mental disorder;

- implementation of specified "best buy" interventions within the mental health system and promotion and prevention programmes;

- review and decriminalization of the legal status of suicide and self-harm and establishment of suicide reporting at a national level;

- embedding mental health and psychosocial support in national emergency preparedness plans;

- routine collection and reporting on resources, service availability and coverage for priority mental disorders; and

- enhancing the capacity to carry out priority research to inform policy and service development.

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Comprehensive mental health action plan 2013–2020

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Introduction

Twenty years ago, a book was published entitled *World mental health: problems and priorities in low-income countries* (*1*). A few years later in 2001, the World Health Organization (WHO) devoted its World Health Report to *Mental health: new understanding, new hope* (*2*), and the Institute of Medicine in the United States of America brought out *Neurological, psychiatric, and developmental disorders: meeting the challenge in the developing world* (*3*). These publications were among the first to seize upon the finding that, due to their chronic course and disabling nature, mental, neurological and substance use disorders contribute very significantly to the global burden of disease. Each report also drew strong attention to the desperate situation in most low- and middle-income countries regarding the availability, quality and range of treatment services, and produced a series of recommendations for research and training, service provision and policy.

In a number of respects, much progress has been made since then. Awareness and acceptance of the value of mental health and the challenge posed by mental ill-health has continued to grow, both at the international level and in an increasing number of countries. New alliances and partnerships have been formed, including civil society organizations advocating for better rights and service access for persons with mental disorders and their families. In addition, the evidence base around what resources are available in countries

and which interventions are effective, feasible and affordable to implement in the context of low- and middle-income countries has improved dramatically (*4–7*).

In other respects, however, the situation now is not greatly different to how it was 20 years ago. There continues to be widespread stigma, discrimination and human rights violations against persons with mental disorders and psychosocial disabilities (*8*). Resources allocated to mental health remain extremely modest; the treatment gap is as large as ever (*5,9*).

This, then, was the backdrop against which a concerted new effort has taken place to put mental health higher on the health and development agenda of countries throughout the world. Culminating in the endorsement of the *Comprehensive mental health action plan 2013–2020* in May 2013 by the 194 Member States of WHO (*10*), this new effort now commits governments, as well as WHO and other partners, to taking defined actions across a number of areas of implementation. This article briefly sets out what these actions are, whose responsibility they are, and how they support the proposed regional framework to scale up action on mental health in the WHO Eastern Mediterranean Region.

Development of the plan

The process started with a proposal by a number of Member States to include an agenda item on mental health at

the Executive Board meeting of the WHO in January 2012; this was accepted and led to a Resolution, first at the Executive Board and subsequently at the World Health Assembly (WHA) of that year, on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. The WHA Resolution requested the Director-General, inter alia, to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.

So began an intensive period of drafting and consultation, not only with WHO Member States but also with nongovernmental organizations, WHO collaborating centres and other academic institutions. A 'zero' draft prepared by the WHO Secretariat in the summer of 2012 was made available for comment to all interested parties via a web consultation and was used for global and regional consultation meetings, including in the Eastern Mediterranean Region.

Following revision and its approval by the Executive Board in January 2013, the final draft was submitted to and adopted by the WHA in May 2013.

Key elements of the plan

The *Comprehensive mental health action plan 2013–2020* is centred around 4 objectives, all of which are designed to serve the overall goal to 'promote

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mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders' (*10*). The objectives are:

- to strengthen effective leadership and governance for mental health;

- to provide comprehensive, integrated, responsive mental health and social care services in community-based settings;

- to implement strategies for the promotion and prevention in mental health;

- to strengthen information systems, evidence and research for mental health.

For each objective, a series of defined actions are identified for Member States, for international and national partners, and for the WHO Secretariat (Table 1). Relating to

governance and leadership, for example, proposed actions for Member States cover the development, strengthening and implementation of mental health policies, strategies, programmes, laws and regulations; resource planning; engagement and involvement with all relevant stakeholders; and empowerment of people with mental disorders and psychosocial disabilities.

For each action area, a set of implementation options are also provided, which reflects not only the diversity of current resources and opportunities among countries, but also the different ways by which key actions can be effectively accomplished. Looking across the Member States that comprise the Eastern Mediterranean Region, for example, there are enormous differences with respect to national income, resource availability and the state of the health care system, which is expected

to have an important influence on the precise set of actions that can actually be undertaken.

Monitoring implementation of the plan

Each of the 4 objectives is accompanied by 1 or 2 specific targets which provide the basis for measurable collective action and achievement by Member States towards global goals (see Table 1). Since the 6 targets and associated indicators represent only a subset of the information and reporting needs that Member States require to be able to adequately monitor their mental health policies and programmes, the WHO Secretariat was requested to prepare and propose a more complete set of indicators for Member States to use as the basis for routine data collection and

Table 1 Comprehensive mental health action plan 2013–2020: objectives and global targets

Objective	Action area	Key indicator	2020 target
Leadership and governance for mental health	• Policy and law • Resource planning • Stakeholder collaboration • Empowerment of persons with mental disorders and psychosocial disabilities	• Existence of a national policy/ plan for mental health that is in line with international human rights instruments	80% of countries
		• Existence of a national law covering mental health that is in line with international human rights instruments	50% of countries
Comprehensive, integrated and responsive services	• Service reorganization and expanded coverage • Integrated and responsive care • Mental health in emergencies • Human resource development • Addressing disparities	• Proportion of persons with a severe mental disorder who are using services	20% increase
Mental health promotion and prevention	• Mental health promotion and prevention • Suicide prevention	• Functioning programmes for multisectoral mental health promotion and prevention in existence	80% of countries
		• Number of suicide deaths per year per 100 000 population	10% decrease
Information, evidence and research	• Information systems • Evidence and research	• Core set of identified and agreed mental health indicators routinely collected and reported every 2 years	80% of countries

reporting to WHO. Additional indicators include:

- government health expenditure on mental health;

- number of mental health workers;

- number and proportion of primary care staff trained in mental health;

- extent of participation of associations of persons with mental disorders and family members in service planning and development;

- number of mental health care facilities at different levels of service delivery;

- number and proportion of admissions for severe mental disorders to inpatient mental health facilities that: a) exceed one year, and b) are involuntary;

- number of persons with a severe mental disorder discharged from a mental or general hospital in the last year who were followed up within one month by community-based health services;

- number of persons with a severe mental disorder who receive disability payments or income support.

Baseline data collection for this set of core mental health indicators has been undertaken via a revised 2014 version of the *Mental health atlas* (5). It is anticipated that the Atlas exercise will be repeated periodically, which will enable progress towards implementation of the plan as well as the monitoring of global targets.

Regional and national adaptation of the plan

Agreement on the overall structure and content of a global plan of action, with strong buy-in and consensus across stakeholders, is a vital step towards more coordinated and unified action towards improving mental health system access, quality and outcomes globally. Ultimately, however, policies are determined, resources are allocated and services are developed at the national level. It is, therefore, equally vital that such a global action plan be subject to a process of adaptation to prevailing local circumstances, standards and priorities.

This process has been facilitated by WHO through the development of regional action plans and implementation frameworks, which has enabled groupings of countries with shared cultural values to better reflect their own needs and preferences. Thus, in the Eastern Mediterranean Region, the initial consultation held at the drafting stage of development has been followed by a technical inter-country meeting at which regionally-focused objectives, implementation strategies and performance indicators could be reviewed, discussed and approved by national counterparts. The evidence briefs set out in this Mental Health Supplement were a direct input into these proceedings.

Conclusion

Adoption of the *Comprehensive Mental Health Action Plan 2013–2020* by the World Health Assembly in May 2013 provides the clearest example to date of an increasing commitment by governments to enhance the priority given to mental health within their health and public policy (10). The agreement by all countries – large and small, rich and poor, from all regions of the world – on a common vision for mental health along with objectives to reach defined targets within a specified time period represents an important step in a longer process to improve mental health across the world.

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From plan to framework: the process for developing the regional framework to scale up action on mental health in the Eastern Mediterranean Region

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Background

The comprehensive *Mental health action plan 2013–2020* was adopted by the World Health Assembly in May 2013 (*1*). This marked the start of a renewed global 7-year effort "to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders". The plan takes an evidence-based, multisectoral approach across the life course and follows the principles of universal health coverage, compliance with human rights and empowerment of persons with mental disorders. It presents a set of actions organized around the 4 objectives, each with 6 targets and indicators. A further 8 service development indicators were incorporated in line with data submitted in response to the questionnaire for the *Mental health atlas 2014*. These will be used to monitor progress in achieving the objectives of the comprehensive mental health action plan through biennial iterations of the *Atlas* until 2020.

Building on the experience gained from implementing the action plan for noncommunicable diseases, it was decided that there was a need to put the provisions of the comprehensive mental health action plan into operation. This would be achieved through the development of a regional framework identifying high impact, cost–effective, affordable, feasible strategic actions. These would be supported by a set of indicators to monitor the implementation of the plan.

This paper describes the process followed in the Eastern Mediterranean Region for the development of the regional framework for scaling up action on mental health (*2*) towards the implementation of the Comprehensive Mental Health Action Plan 2013–2020.

Preparatory phase

The preparatory phase involved progressing further with the concept and identifying the objectives, processes and key stakeholders required to develop the regional framework towards achieving the targets and objectives of the comprehensive mental health action plan. The key stakeholders identified were directors general of health and mental health focal points in the Member States, international and regional experts, experts from partner organizations, relevant staff from country offices, and staff from World Health Organization (WHO) headquarters and the Regional Office for the Eastern Mediterranean.

The specific objectives were to:

- develop an analysis of the mental health system resources and capacities in countries of the Region;

- develop policy briefs collating the best evidence and practices in specified areas; and

- draft a regional framework reflecting cost–effective, affordable, feasible strategic actions, supported by a set of indicators to monitor implementation.

The processes employed to achieve the objectives were detailed into activities with responsible actors, and time plans with deadlines were established for the steps required to attain the objectives (for example, see Table 1 for the analysis of the mental health system resources and capacities in the countries of the Region).

In order to develop policy briefs collating the best evidence and practices, a set of 9 topics were identified by blending the 6 building blocks for strengthening health systems (*3*) and the 4 objectives of the comprehensive mental health action plan. The topics included: mental health policy and strategic plan, legislation, investing in mental health, reorganization of services from institutional to community-based models of care, human resources, mental health and psychosocial support in humanitarian emergencies, promotion of mental health and prevention of mental disorders, mental health surveillance and information systems, and mental health research.

For each brief, 1 or 2 lead experts were identified, supported by teams of up to 8 contributors and up to 8 reviewers. In all, more than 40 international experts were invited to contribute to preparing or reviewing the evidence briefs. The policy briefs were structured according to a common template

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Table 1 Process for developing an analysis of the mental health system resources and capacities in the countries of the Eastern Mediterranean Region, 2014

Activity	Deadline
Development and finalization of methodology and tools for the Mental health atlas on national mental, neurological and substance use capacities and resources	31 March
Data collection	15 May
Clarification/validation	10 June
Data management and preliminary analysis	30 June
Organizing the information and developing the regional Mental health atlas and country profiles	07 August

with sections addressing the rationale, reviewing the relevant evidence, and making key recommendations for ministries of health in the countries of the Region. Although the evidence briefs were prepared to this standard template, they each had a style and character determined by their individual authors. In order to refine, harmonize and focus the evidence briefs, 2 of the authors (RG and KS) edited them into a standard format starting with a "Why? What? Who?" box and culminating in a clear set of recommendations that summarized the evidence for the strategic actions of the regional framework.

Countries were included in the teams involved in developing the briefs; in particular countries were invited to contribute descriptive case studies included with the briefs to highlight the programmes/interventions conforming to evidence-informed practices.

The regional framework was drafted as a set of strategic actions, accompanied by a set of indicators, and listing the WHO tools for monitoring and facilitating the implementation of the actions so as to realize the vision of the comprehensive mental health action plan. Over the past 3 decades there have been a number of local and regional initiatives to enhance mental health, yet the mental health atlases of 2005 and 2011 have shown that progress to improve mental health provision across the Region has been limited (*4–6*). Consequently, the formulation of the regional framework has been guided by principles that seek to ensure that its practical implementation can be successfully achieved within

the countries of the Eastern Mediterranean Region. In keeping with these guiding principles, the strategic actions and indicators are:

- *evidence-based:* evidence was used to identify "best buys" (*7*) which have the greatest health benefit, and are cost–effective and affordable, and for which scaling up is feasible, even in countries with limited resources;

- *clear and specific:* broad maxims and general vague advice were avoided;

- *economical:* the number of actions and indicators was kept to a minimum and they were expressed succinctly, avoiding over-complication and giving a clear message;

- *relevant and feasible:* for implementation in the countries of the Region;

- *consistent:* with meeting the goals and objectives of the comprehensive mental health action plan, and they were internally consistent with, and complemented, the other actions within the framework.

The indicators identified in the regional framework were in conformity with the core indicators of the comprehensive mental health action plan, but additional intermediate indicators were included to monitor the progress towards achieving the strategic actions identified in the regional framework.

In addition to the virtual consultations with international experts (described above), the WHO hosted a face-to-face consultation in Cairo in June 2014 between a select group of experts and WHO staff involved in the

process in order to refine the concept, evidence briefs and framework.

Engaging key stakeholders

At an early stage Member States and partner organizations were informed about the project and invited to comment and contribute to its development. Throughout the process Member States continued to participate and were encouraged to contribute to successive drafts of the policy briefs and framework. This was carried out by email and telephone, leading up to a face-to-face, high-level, inter-country meeting at the WHO Regional Office for the Eastern Mediterranean in Cairo, 15–17 September 2014. All Member States of the Region were invited to participate in this meeting to review, refine and confirm commitment to the regional framework.

Confirming agreement with stakeholders on the framework

The September 2014 meeting was attended by mental health focal points from Member States and a select group of international experts who had been closely involved in preparing the evidence briefs to guide the regional framework. The Regional Director urged delegates to produce a practical and realistic agenda for

action, focusing on high-impact issues that would be useful to policy-makers. Delegates reviewed the current situational analysis (8) and evidence briefs, and refined the regional framework through a series of presentations and workshops addressing each of the briefing paper topics [a report of the meeting is included in this theme issue(9)]. Accordingly, the regional framework was modified to make it more relevant and responsive to the issues and priorities raised by the Member States.

Next steps

The next steps were to finalize the regional framework by the end of 2014 by further virtual consultation, and to engage advocacy for its adoption at the highest political level in each country of the Region. Each country has agreed to work on prioritizing the strategic interventions identified in the regional framework and to monitor progress using the proposed set of indicators. The framework will be presented for

adoption at the Regional Committee Meeting for the WHO Eastern Mediterranean Region in October 2015.

The regional framework is an important step in the process of implementing the comprehensive mental health action plan, but finalization of the framework is not the end of the process. Implementation will be carefully monitored through future editions of the Mental health atlas and other reviews during the next 6 years, and the framework will continue to be reviewed and revised in the light of progress.

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Situational analysis: preliminary regional review of the Mental Health Atlas 2014

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تقييم الوضع الحالي: مراجعة إقليمية أولية لأطلس الصحة النفسية 2014

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الخلاصة: إن خطة العمل الشاملة لمنظمة الصحة العالمية في الأعوام 2013-2020 بشأن الصحة النفسية وضعت أهدافاً وغايات وافقت الدول الأعضاء على الوفاء بها بحلول عام 2020. ولتحديث أطلس الصحة النفسية لعام 2011 تم إدراج مؤشرات معينة من خطة عمل الصحة النفسية ومؤشرات إضافية خاصة بتغطية الخدمات في الاستبيان الخاص بأطلس عام 2014. إن هذه البيانات من شأنها أن تساعد على تحسين جمع المعلومات وعلى تركيز الجهود نحو تنفيذ "خطة عمل الصحة النفسية". تم ملء الاستبيان من قبل ضابط الاتصال الوطني للصحة النفسية في كل بلد. إن هذه المراجعة الأولية تسعى إلى دمج بيانات الاستجابة الأولية لاستبيان أطلس عام 2014 من قبل الدول الأعضاء في إقليم شرق المتوسط. ولقد تم تحليل البيانات الخاصة بهذه المراجعة لكامل الإقليم من قبل تجمعات للنظم الصحية ومن قبل كل بلد على حدة. وتتم مقارنة البيانات مع أطلس الصحة النفسية لعام 2011 – حيثما أمكن ذلك – لإعطاء منظور طولاني.

ABSTRACT The WHO comprehensive Mental Health Action Plan 2013–2020 established goals and objectives that Member States have agreed to meet by 2020. To update the Atlas of Mental Health 2011, specific indicators from the Mental Health Action Plan and additional indicators on service coverage were incorporated into the questionnaire for the Atlas 2014. The data will help facilitate improvement in information gathering and focus efforts towards implementation of the Mental Health Action Plan. The questionnaire was completed by the national mental health focal point of each country. This preliminary review seeks to consolidate data from the initial response to the Atlas 2014 questionnaire by Member States in the Eastern Mediterranean Region. Data for this review were analysed for the whole Region, by health systems groupings and by individual countries. Where possible, data are compared with the Mental Health Atlas 2011 to give a longitudinal perspective.

État des lieux : examen régional préliminaire de l'Atlas de la santé mentale 2014

RÉSUMÉ Le Plan d'action exhaustif de l'OMS pour la santé mentale sur la période de 2013-2020 a déterminé des cibles et des objectifs que les États Membres ont accepté d'atteindre d'ici 2020. Pour actualiser l'Atlas de la santé mentale de 2011, des indicateurs spécifiques du Plan d'action pour la santé mentale ainsi que des indicateurs supplémentaires concernant la couverture des services ont été intégrés au questionnaire pour l'Atlas 2014. Les données permettront de favoriser l'amélioration du recueil d'informations et de concentrer les efforts sur la mise en application du Plan d'action pour la santé mentale. Le questionnaire a été complété par le point focal national pour la santé mentale dans chaque pays. Cet examen préliminaire visait à consolider les données provenant de la réponse initiale au questionnaire pour l'Atlas 2014 par les États Membres dans la Région de la Méditerranée orientale. Les données pour cet examen ont été analysées pour toute la Région, par groupes de systèmes de santé et par pays. Dans la mesure du possible, les données ont été comparées à celles de l'Atlas de la santé mentale de 2011 pour apporter une perspective longitudinale.

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Introduction

The World Health Organization (WHO) recognizes the increasing burden of mental disorders globally and the huge gap between the need for treatment and the provision of mental health care. Following consultation with representatives of Member States, civil society and international partners, the comprehensive Mental Health Action Plan 2013–2020 was adopted at the World Health Assembly in May 2013. The action plan sets out objectives with specific targets to be achieved by 2020 (*1*).

The results of a global exercise in mapping of mental health resources in the form of the WHO Atlas of Mental Health was first published in 2001 and updated in 2005 and 2011 (*2*). The targets and key indicators of the comprehensive Mental Health Action Plan have been incorporated into the latest version of the Atlas 2014 to help focus the planning, development and monitoring of mental health services.

This preliminary regional review is based on the initial responses to the Mental Health Atlas 2014 questionnaire from Member States of the Eastern Mediterranean Region (EMR). This is a step in the ongoing project to gather, clarify and analyse the data from Member States, and as such it is not the definitive report.

Methods

The Mental Health Atlas 2014 questionnaire was developed by WHO to include specific indicators as identified by the comprehensive Mental Health Action Plan. The WHO Secretariat was also requested to identify additional indicators to expand on the data collected on mental health services provision. The 14 groups of indicators in the Mental Health Atlas are shown in Table 1, organized according to the objectives of the action plan.

The Regional Office for the Eastern Mediterranean (EMRO) collaborated with the responsible ministries of Member States of the EMR to appoint a local contact for completing the Atlas questionnaire. Once the questionnaire had been completed and submitted back to EMRO, there was a continuing process to clarify incomplete or inconsistent answers with the local contact.

Data were analysed on a regional basis and by individual countries and, where possible, they were also organized according to health system groups, which is a classification of countries into 3 groups based on population health outcomes, health system performances and health expenditure. The latest data were compared with the results from the Mental Health Atlas 2011 when corresponding data were available.

Results

All 22 Member States of the EMR completed the Atlas 2014 questionnaire. However, there were specific questions for which the country response rates were very low (e.g. with 6 or fewer countries providing data) which renders analysis at the regional level unreliable in some cases.

Mental health policy

A useful indicator of leadership and governance is the presence and degree of implementation of an updated national mental health policy and information about whether the policy is in line with human rights instruments.

The majority of EMR countries have a stand-alone mental health policy that has been updated in the past 10 years (Figure 1). However, where present, the mental health policies are only partially implemented.

With regards to compliance with human rights instruments, most countries'

Table 1 Questionnaire for the Mental Health Atlas 2014 in the Eastern Mediterranean Region: target indicators organized by Mental Health Action Plan (*3*) objectives

Action plan objective	Indicators included in questionnaire
Leadership and governance	• Mental health policy • Mental health legislation
Comprehensive, integrated and responsive mental health and social care services	• Stakeholder involvement • Mental health spending • Mental health workforce • Mental health training in primary care • Service availability and utilization • Service coverage • Inpatient care • Continuity of care after discharge • Social support
Promotion and prevention	• Mental health promotion and prevention • Suicide rate
Information systems	• Core mental health indicator set
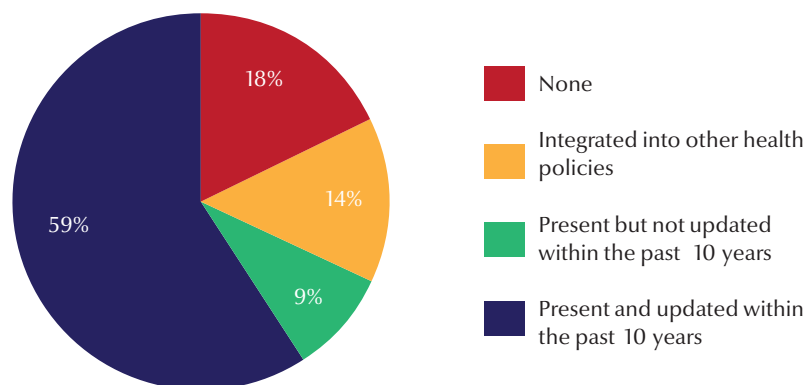
Figure 1 Percentage of Eastern Mediterranean Region countries with a mental health policy (Source: Mental Health Atlas 2014)

policies promote community-based and integrated services (85%) and explicitly respect human rights (81%). More than half promote a full range of services for independent living (62%). Half of the policies promote a recovery approach (50%) and less than half promote participation in decision-making processes (43%).

Mental health legislation

A similar but distinct indicator of leadership and governance is the presence of contemporary national mental health legislation, its degree of implementation and whether it is in line with international human rights instruments.

Half of the EMR countries (50%) have stand-alone mental health legislation. However, among these almost half were revised more than 10 years ago; 6 countries have mental health legislation integrated into other legislation; and 5 countries do not have mental health legislation, although one of these is pending ratification. Of the countries with stand-alone and updated mental health legislation, none of them have fully implemented the legislation and only 1 country has partially implemented their mental health legislation, with the remaining countries having legislation available but not implemented (Figure 2).

With regards to compliance with human rights instruments, most EMR countries' legislation promotes rights to exercise capacity and nominate a trusted person to support the patient (65%), promotes alternatives to

coercive practice (67%) and provides for protection of patients' rights to file appeals/complaints to independent bodies (65%). In half of the countries, legislation promotes the transition to mental health services in the community (50%) and regular inspection of human rights conditions by an independent body (50%).

Stakeholder involvement

Persons with mental disorders and their families are useful crucial sources of information, collaboration and lobbying in relation to the needs of those with mental disorders. The Atlas questionnaire enquired about the degree of stakeholder involvement over the past 2 years in developing national policies in the domains of information, policy, early family involvement, stakeholder participation and resources (Figure 3). Half of EMR countries have at least partial implementation for information, but for the other 4 domains most EMR countries reported that measures of stakeholder involvement are not implemented. In about one-quarter of countries, measures were partially implemented. Full implementation was rarely reported.

Mental health spending

The financial resources allocated to mental health services are critical for the development of integrated and
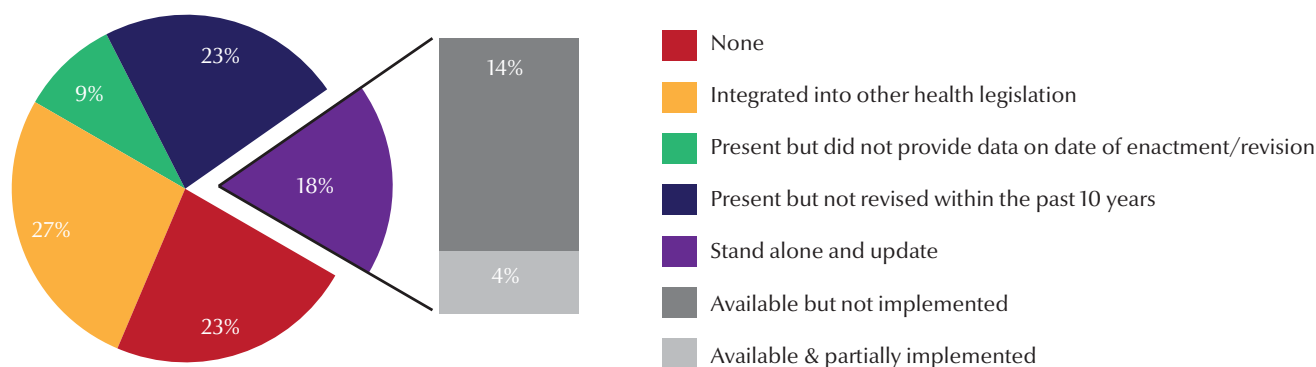
Figure 2 Percentage of Eastern Mediterranean Region countries with stand-alone and updated mental health legislation (Source: Mental Health Atlas 2014)
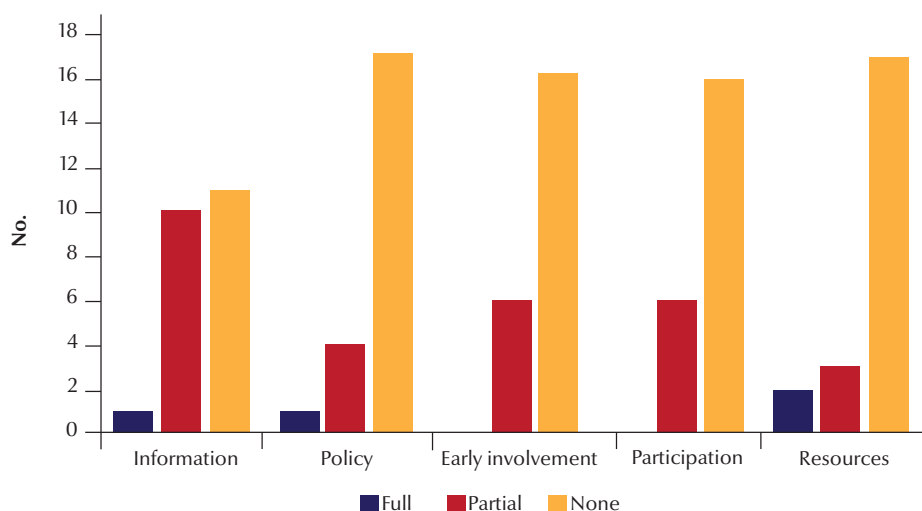
Figure 3 Number of Eastern Mediterranean Region countries reporting on the degree of implementation of stakeholder involvement in development of national policies in different domains (Source: Mental Health Atlas 2014)

comprehensive mental health services. The Atlas questionnaire asked about the main source of funding in countries and how the mental health budget is allocated to the different components of mental health services, ranging from mental health hospitals to community-based outpatient facilities to social services.

In most countries of the Region the government is the main source of funding (77%). In the remaining countries, the main source of funding is households (2 countries), non-government organizations (1 country) or unknown (2 countries did not report).

With regards to the allocation of the budget to the different components of mental health services, 9 countries in the Region provided data on their annual spending dedicated to mental health hospitals. Less than 1 in 5 provided data on a specified budget allocated to the other components of mental health services (Figure 4).

Of the 9 countries that provided data on their spending on mental health hospitals, the group 1 countries (Bahrain and Qatar) have the highest per capita expenditure. The 2 countries with the lowest per capita expenditure have households and nongovernmental

organizations as their main source of funding, while for the 7 other countries the government is the main source of funding.

Mental health workforce

The provision of mental health services is dependent on the availability of human resources in the form of trained mental health professionals per 100 000 population. There are corresponding data on human resources from the Mental Health Atlas 2011 which allow for a comparison with 2014 (Table 2).

In the latest data, nurses make up the largest professional group in the mental health workforce, followed by other health or mental health workers. There is typically 1 psychologist and psychiatrist for every 5 nurses. Although medical doctors not specializing in psychiatry are relatively uncommon throughout the Region, the upper limit of the range indicates that a small number of countries employ a large number of non-psychiatrist medical doctors. Social workers and occupational therapists are relatively uncommon.

Although there has been an increase in the median number of mental health nurses per 100 000 population as a whole, there is actually a reduction in

the median of nurses in group 3 countries in 2014 when compared with 2011. Group 1 countries show the highest increase of their nursing workforce, while group 2 countries show a smaller increase. From 2011 to 2014, there was also an increase in the median number of psychiatrists in group 1 countries but a decrease in group 2 and 3 countries.

Mental health training in primary care

Mental health training in primary care is a useful indicator of the accessibility of mental health care to the population as well as the degree of integration of mental health care into general health care. The Atlas questionnaire collected data on mental health training of at least 2 days duration over the past 2 years for a range of community health-care professionals.

Only half the EMR countries provided data on the proportion of primary care staff receiving mental health training. Less than half of countries provided data on training of the other mental health professionals. Of those that provided data, there is a large range among the countries in the provision of training, with generally low percentages of primary care
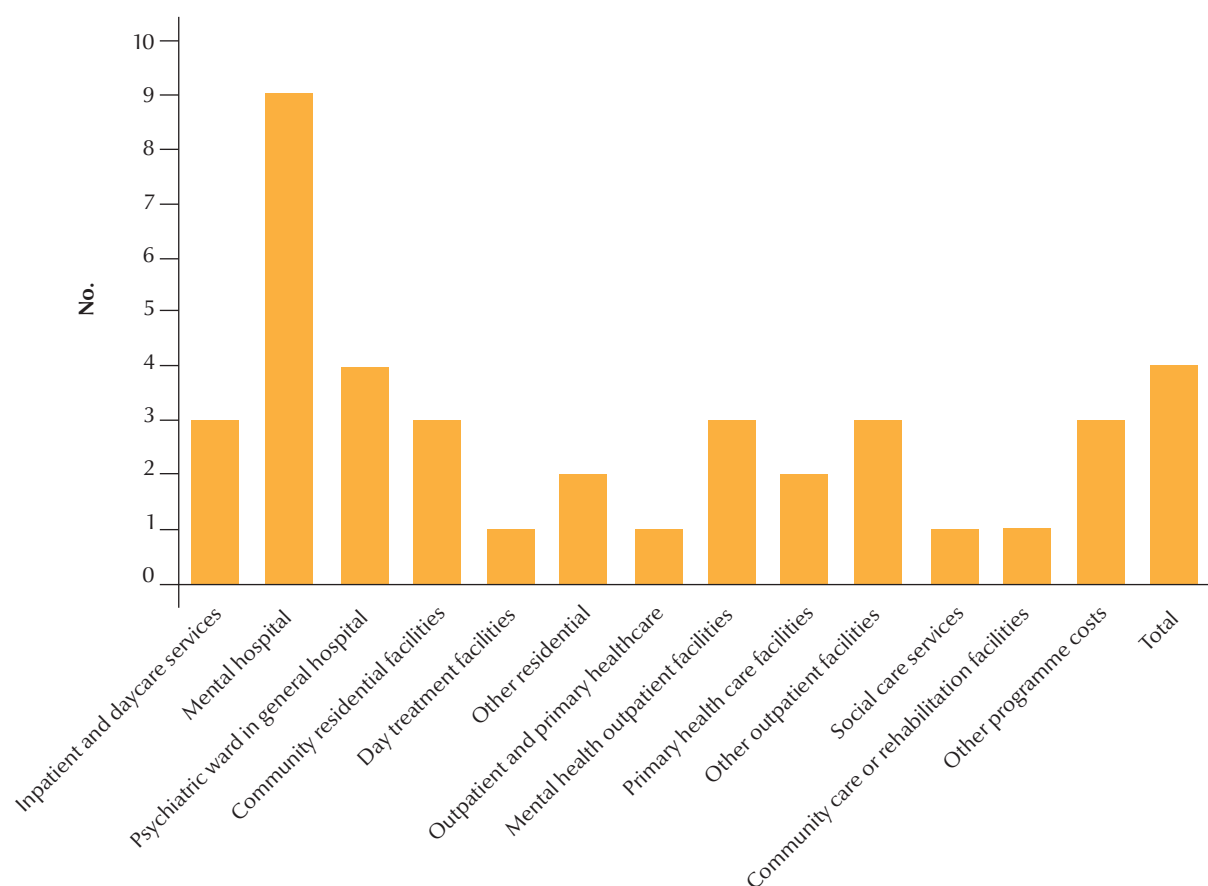
Figure 4 Number of Eastern Mediterranean Region countries reporting on annual government spending on different types of mental health care (Source: Mental Health Atlas 2014)

Table 2 Median number of health professionals per 100 000 population in Eastern Mediterranean Region countries in 2011 and 2014 (psychiatrists and nurses were further categorized by the country's health system group)

Type of health professional	Year 2011		Year 2014	
	Median	Range	Median	Range
Psychiatrists	0.86	0.01–8.18	0.77	0–5.44
Group 1 countries	2.18		2.76	
Group 2 countries	0.91		0.66	
Group 3 countries	0.06		0.08	
Nurses (both psychiatric nurses and general nurses working in mental health facilities)	3.3	0.10–29.12	4.21	0–24.70
Group 1 countries	10.71		12.89	
Group 2 countries	2.37		2.99	
Group 3 countries	0.32		0.12	
Other medical doctors, not specializing in psychiatry	0.28	0.01–13.95	0.15	0–50.09
Psychologists	0.41	0–2.29	0.81	0–5.16
Social workers	0.47	0–3	0.27	0–3.02
Occupational therapists	0.04	0–1.73	0.17	0–1.13
Other health or mental health workers working in mental health facilities	4.35	0.04–55.53	2.47	0–118.47

Sources: Mental Health Atlas 2011 (1) and Mental Health Atlas 2014.

staff receiving training in the past 2 years. In all countries, there is provision of some mental health training for medical doctors. However, the percentage of medical doctors receiving such training varies greatly. Other health-care workers receive training in some countries, although the proportion of these staff trained across the Region is considerably lower than that of medical doctors (Table 3).

Table 3 Number of Eastern Mediterranean Region countries reporting on mental health training across primary care health-care professionals and the percentage median number who received training in 2014

Type of health professional	No. of countries reporting on training	% of primary care staff who received training in the past 2 years	
		Median	Range
Medical doctors	11	29	15–99.5
Nurses	11	5	0–54
Midwives	7	2	0–58
Community health workers	5	5	0–76
Other health care workers	7	16	0–100

Source: Mental Health Atlas 2014.

Service availability and utilization

Indicators for mental health service provision include the availability of facilities ranging from the number of psychiatric beds across different settings to the number of day-care and outpatient facilities. The Atlas questionnaire included questions about the utilization of outpatient facilities.

A total of 20 countries in the Region reported that they have at least 1 mental health hospital; 14 countries have psychiatric beds in general hospitals and 5 countries have psychiatric beds in community residential facilities. In 2014, the reported distribution of psychiatric beds in mental health hospitals, general hospitals and community settings was 65%, 18% and 17% respectively. This distribution is largely unchanged from the 2011 distribution of 66%, 18% and 16% respectively.

There is a wide range in the average number of beds in each level of mental health service. The median number of psychiatric beds in mental health hospitals is 220 (range 14 to 779), in general hospitals is 17 (range 3 to 60) and in community residential facilities is 33 (range 6 to 124).

There are 8 countries with mental health day-care or day-treatment facilities. Four countries have only 1 such facility. Of the remaining 4 countries, the median number of day-care facilities is 31 (range 2 to 117). The median number of places in a day-care facility is 10 (range 1 to 46) across the Region.

Outpatient facilities are reported by 18 of the countries. The number of such facilities varies widely from 1 in Kuwait to 4356 in Pakistan. The median number of patients seen in a week in mental health outpatient facilities across the Region is 100.

There is huge variation of the availability of mental health services across the Region. The total number of psychiatric beds per 100 000 population has decreased in 2014 as compared with 2011. However, this decrease is only reflected in group 2 countries, whereas group 1 and 3 countries had an increase in their total number of psychiatric beds per 100 000 population over the same period. The median number of day-care facilities has increased marginally to 0.008 per 100 000 population but still remains 10 times lower the global median in 2011. The median number of outpatient facilities is almost halved in 2014 as compared with 2011 but the number of outpatient visits per week has increased by almost 5-fold over the same period (Table 4).

Service coverage

Service coverage is a measure of the number of persons with a mental disorder who received treatment in the past year. The Atlas questionnaire enquired about the total number of persons with mental disorders who received care at the different levels of service and also the mental disorders of those who received care.

The median treated prevalence of mental disorders in hospitals in the Region is about 46 per 100 000 population (29 per 100 000 population in psychiatric wards of general hospitals and 1116 per 100 000 population in outpatient facilities) (Table 5). Therefore, about 1 in every 15 patients seen in outpatients is admitted to a psychiatric bed.

Inpatient care

The Atlas questionnaire collected data on the length of stay and legal status of persons with mental disorders who were inpatients within the past 1 year.

Ten countries provided data. In the majority of countries, the length of stay is most often less than 1 year. Substantial percentages of persons with a mental disorder staying for 1 to 5 years are reported in Iraq, Syrian Arab Republic, United Arab Emirates and Lebanon, with a range from 28% to 51%. Stays of more than 5 years occur most frequently in Jordan, United Arab Emirates, Iraq and Lebanon, with a range from 34% to 56%. Eight of the countries that provided data had a corresponding data-set from 2011. The Islamic Republic of Iran and Pakistan have a similar distribution of lengths of stay in 2011 and 2014. Kuwait, Lebanon and Occupied Palestinian Territories have shorter inpatient stays in 2014 than in 2011. In Jordan, Qatar and Syrian Arab Republic the duration of inpatient stay has increased in between 2011 and 2014 (Figure 5).

Table 4 Number of mental health facilities/utilization per 100 000 population at different levels of services in Eastern Mediterranean Region countries in 2011 and 2014

Variable	Year 2011		Year 2014	
	Median	Range	Median	Range
Psychiatric beds in mental health hospitals	5.4	0.38–40.06	4.5	0–23.9
Psychiatrics beds in general hospitals	0.51	0–3.4	0.64	0.09–7.3
Psychiatric beds in community residential facilities	n/a	n/a	1.2	0.5–6.8
All psychiatric beds	7.0	0.73–41.16	6.1	0.7–24.2
Group 1 countries	8.3	n/a	10.5	1.4–24.2
Group 2 countries	7.8	n/a	6.4	1.1–16.7
Group 3 countries	3.0	n/a	4.2	0.7–7.3
Day-care facilities	0.005	0–0.17	0.008	0.003–0.44
Outpatient facilities	0.28	0.035–2.1	0.17	0.02–2.4
Outpatient visits per week	279	n/a	1 310	378–10 614

Sources: Mental Health Atlas 2011 (1) and Mental Health Atlas 2014.
n/a = data not available from published Mental Health Atlas 2011.

The 11 countries which provided data on involuntary admissions to inpatient mental health hospitals reported a median of 26% of admissions being involuntary (range 0% to 95%). Four countries provided data on psychiatric wards in general hospitals that showed a median at 32% of admissions being involuntary (range 2% to 71%). Only 1 country reported on involuntary admissions to mental health community residential facilities, showing that the proportion was 34% of admissions.

Continuity of care after discharge

Follow-up in the community after discharge from psychiatric inpatient settings is a useful indicator of the integration of mental health services into health services across inpatient and community settings.

Only 4 countries provided data on follow-up of patients within 1 month after discharge from psychiatric inpatient settings and, because of the wide range across the different countries, no meaningful data can be compiled at the regional level.

Social support

Information on the integration of mental health services with social services is provided by data on social support in the community in the form of either monetary or non-monetary support.

There are limited data on the social support received by persons with mental disorders in the EMR. Only 5 countries provided data on the number of persons with mental disorders who received monetary social support in the past year, and only 2 reported on non-monetary support.

Mental health promotion and prevention

A total of 21 countries provided information on the presence and implementation of national mental health promotion and prevention

Table 5 Median number of patients treated per 100 000 population in settings with responses from 5 or more Eastern Mediterranean Region countries in 2014

Care setting/type of mental disorder	No. of countries reporting on coverage	Median	Range
Mental hospitals			
All mental disorders	13	46	4–1151
Non-affective psychoses	6	12	3–47
Bipolar disorders	6	1	0.2–38
Moderate to severe depression	6	10	0.1–77
Psychiatric ward in general hospitals			
All mental disorders	9	29	0–1017
Mental health outpatient facilities			
All mental disorders	8	1116	37–3810

Source: Mental Health Atlas 2014.
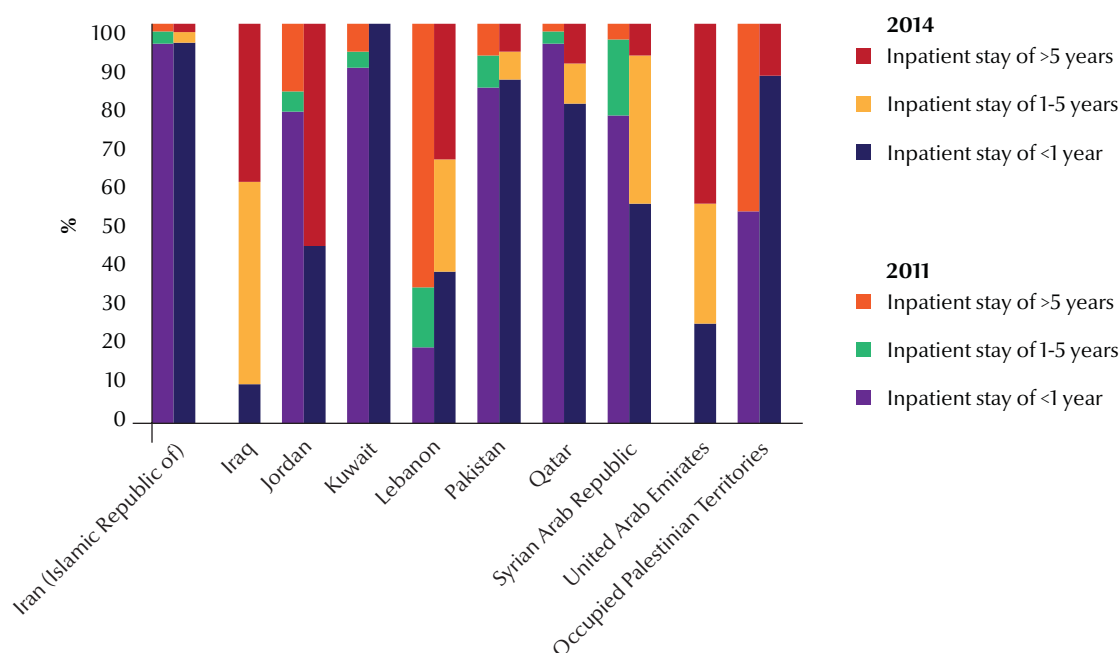
Figure 5 Percentage of inpatients with duration of stay < 1 year, 1–5 years and > 5 years in the Eastern Mediterranean Region countries [Sources: Mental Health Atlas 2011 (*1*) and Mental Health Atlas 2014]

programmes. Promotion and prevention programmes are present in 15 countries in the Region (Figure 6). Countries with 10 or more programmes include members of each of the 3 EMR health system groups.

Suicide rate

The Atlas questionnaire asked about the existence of suicide prevention strategies at national, regional and local level in each country as well as the crude suicide rate.

Of the 21 countries who reported on this indicator, only 4 countries have national suicide prevention strategies. Only 5 countries were able to provide data on suicide rates.

Core mental health indicator set

The collection of mental health data is important to inform and focus planning and implementation towards the goals of the WHO comprehensive Mental Health Action Plan. The Atlas 2014 questionnaire to countries in the Region asked about the collection of mental health data and the reporting of these in a mental health report.

Dedicated mental health reports have been produced in half of the countries in the Region in the past 2 years. Most other countries have reported mental health data only in general health statistics. Two countries did not compile a mental health report in the past 2 years and 1 country did not report on this indicator.

Summary of key findings

1. *Mental health policy:* Most EMR countries have updated mental health policies but these are only partially implemented. In many countries there remains a need to review and revise mental health policy in line with internationally agreed human rights instruments.

2. *Mental health legislation:* Most EMR countries have stand-alone mental health legislation and about half of them have revised legislation in the past 10 years. Most of the countries with updated stand-alone mental health legislation have not imple-

mented it. Although aspects of existing legislation were compliant with human rights instruments in most countries, there remains a need for further review and revision.

3. *Stakeholder involvement:* Stakeholder involvement is underdeveloped in almost all EMR countries. This represents an important opportunity to develop partnerships to catalyse and influence change and improvement in the planning and delivery of mental health services.

4. *Mental health spending:* The majority of countries in the EMR have not reported specific data on mental health spending, which suggests a lack of a specific budget for mental health. Mental health spending is lowest in countries where the government is not the main source of funding.

5. *Mental health workforce:* There has been a greater increase in 2014 in the supply of psychiatrists and nurses in group 1 countries as compared with group 2 and group 3 countries and this could represent an increased investment in the mental health workforce in these countries.
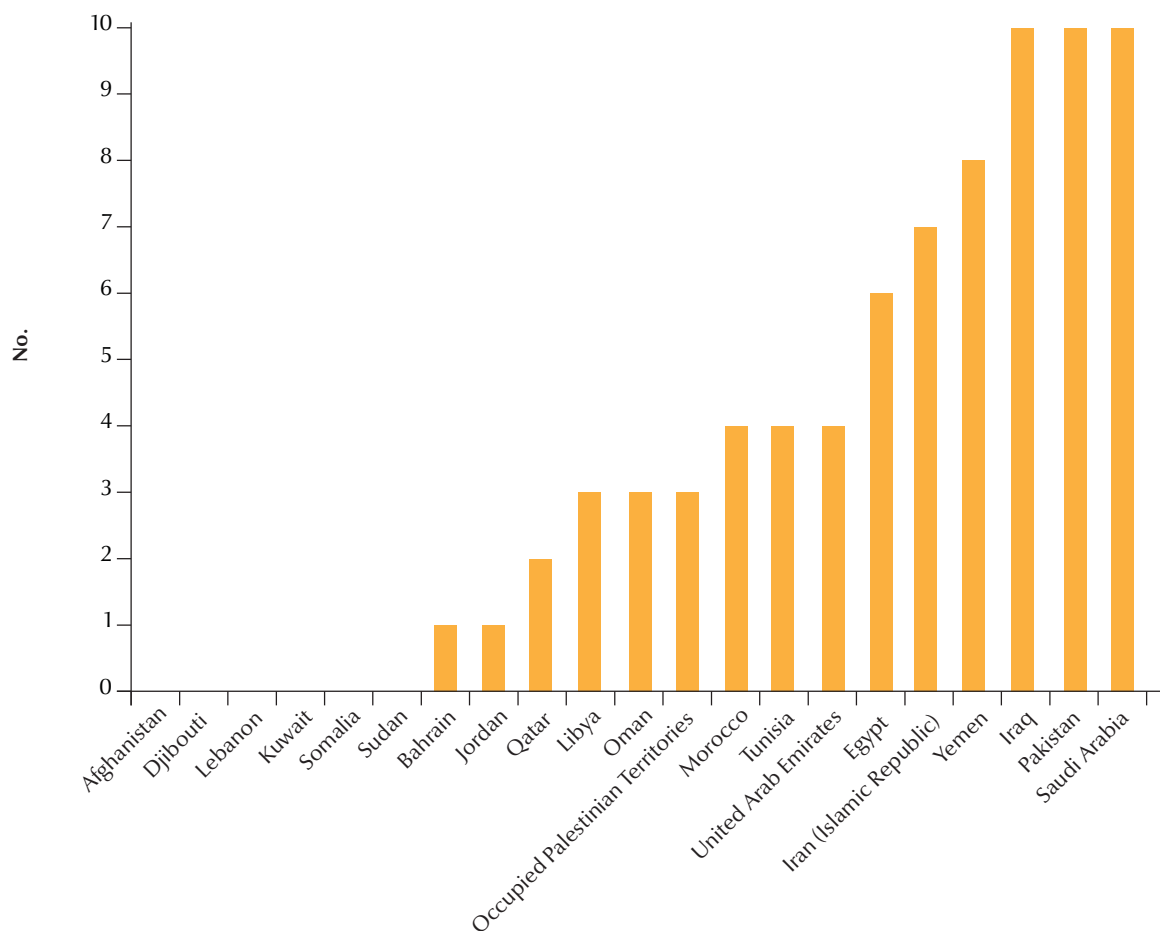
Figure 6 **Number of mental health promotion and prevention programmes reported by Eastern Mediterranean Region countries (Source: Mental Health Atlas 2014)**

There is a suggestion from the data that key components of the mental health workforce have fallen in group 3 countries.

6. *Mental health training in primary care:* Less than half of EMR countries report comprehensively on training for primary care staff on mental health. There is considerable variation on training received by health-care professionals, but overall the median rate of in-service training across the Region is low.

7. *Service availability and utilization:* There is very great variation in the provision of mental health-care facilities in different countries across the Region. The distribution of psychiatric beds remains largely unchanged from 2011 but the total number of beds per 100 000 population has reduced. The availability of mental health day-care or day-treatment facilities remains 10 times lower than the global average reported in 2011. The number of outpatient facilities has decreased from 2011 but there has been an increase in the number of outpatient visits.

8. *Service coverage:* Information on service coverage is limited in the Region. Few countries were able to provide comprehensive data about people with mental disorders who have received care.

9. *Inpatient care:* There are limited data on inpatient care from countries in the Region, with less than half of all countries providing comprehensive data. Among the countries that provided data, there was a reduction in the length of hospital stay in some of them, which may be a positive indicator of the development of community mental health services in these countries.

10. *Continuity of care after discharge:* There are limited data on the follow-up of patients after discharge from inpatient care and this could indicate a lack of governance structures for the transition of care to community settings.

11. *Social support:* Limited data on the provision of social support in the community across the Region may indicate that there is potential for the increased integration of social support systems with mental health services across the EMR.

12. *Mental health promotion and prevention:* There is a wide range in the num-

bers of promotion and prevention programmes; this appears to be irrespective of a country's level of development or wealth as represented by the health system grouping. More than one-quarter of countries in the Region have not yet started to address mental health promotion and prevention programmes.

13. *Suicide rate:* Suicide rates are poorly reported across the Region and a majority of countries do not have any suicide prevention strategy in place. This presents an opportunity for the development of prevention strategies (*3*).

14. *Core mental health indicator set:* Although almost all EMR countries re-

ported having captured and reported on mental health data over the past 2 years, this regional analysis suggests that there are gaps in the data collection and that current information systems may not be in line with target indicators of the comprehensive Mental Health Action Plan and Mental Health Atlas.

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Reorganization of mental health services: from institutional to community-based models of care

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إعادة تنظيم خدمات الصحة النفسية: من نماذج رعاية مؤسسية إلى نماذج رعاية مجتمعية

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الخلاصة: إن خدمات الصحة النفسية في إقليم شرق المتوسط غالباً ما تكون مركزية ومؤسسية، وتعتمد على القليل من القوى العاملة المتخصصة. ويخلق هذا فجوة كبيرة في معالجة المرضى المصابين باضطرابات نفسية شائعة ومسبِّبة للعجز، ويحمِّل الفرد وأسرته ومجتمعه عبئاً لا داعي له. ويمكن إيجاز إعادة تنظيم خدمات الصحة النفسية في الإقليم في ست خطوات: (1) إدماج تقديم التدخلات الخاصة بالاضطرابات النفسية ذات الأولوية في برامج الرعاية الصحية الأولية والبرامج ذات الأولوية القائمة، (2) تعزيز منهجي لقدرات العاملين في مجال الصحة غير المتخصصين على تقديم الرعاية الصحية النفسية، (3) توسيع نطاق الخدمات المجتمعية (فرق توعية مجتمعية معنية بالتعريف بمناطق الخدمات الصحية)، ودعم المرافق السكنية، ودعم التوظيف، ودعم الأسرة)، (4) إنشاء خدمات للصحة النفسية في المستشفيات العامة، وذلك بالعيادات الخارجية وكذلك بالأقسام الداخلية للرعاية الحرجة، (5) الحد تدريجياً من عدد أَسِرَّة الإقامة الطويلة في المستشفيات النفسية من خلال الحدّ من حالات دخول جديدة، (6) توفير تمويل انتقالي لفترة من الزمن على مدى فترة من الزمن، لتوسيع نطاق الخدمات المجتمعية وتقليص عدد المؤسسات النفسية بالتوازي مع ذلك.

ABSTRACT Mental health services in the Eastern Mediterranean Region are predominantly centralized and institutionalized, relying on scarce specialist manpower. This creates a major treatment gap for patients with common and disabling mental disorders and places an unnecessary burden on the individual, their family and society. Six steps for reorganization of mental health services in the Region can be outlined: (1) integrate delivery of interventions for priority mental disorders into primary health care and existing priority programmes; (2) systematically strengthen the capacity of non-specialized health personnel for providing mental health care; (3) scale up community-based services (community outreach teams for defined catchment, supported residential facilities, supported employment and family support); (4) establish mental health services in general hospitals for outpatient and acute inpatient care; (5) progressively reduce the number of long-stay beds in mental hospitals through restricting new admissions; and (6) provide transitional/bridge funding over a period of time to scale up community-based services and downsize mental institutions in parallel.

Réorganisation des services de santé mentale : des modèles de soins institutionnels aux modèles communautaires

RÉSUMÉ Les services de santé mentale dans la Région de la Méditerranée orientale sont essentiellement centralisés et institutionnalisés. Ils reposent sur un personnel spécialisé qui est rare. Cette situation crée un large fossé thérapeutique pour les patients atteints de troubles mentaux courants et handicapants, et fait porter une charge inutile pour l'individu, sa famille et la société. Six étapes pour la réorganisation des services de santé mentale dans la Région peuvent être présentées de la manière suivante : 1) intégrer l'offre des interventions pour les troubles de santé mentale prioritaires dans les programmes de soins de santé primaires et les programmes prioritaires existants ; 2) renforcer systématiquement les capacités du personnel de santé non spécialisé à fournir des soins de santé mentale ; 3) intensifier les services communautaires (équipes communautaires de proximité pour une zone de desserte définie, établissements résidentiels bénéficiant d'assistance aide à l'emploi et soutien apporté à la famille) ; 4) établir des services de soins de santé mentale dans des hôpitaux généraux pour les soins externes et les soins aigus chez le patient hospitalisé ; 5) réduire progressivement le nombre de lits de long séjour dans les hôpitaux de soins de santé mentale en diminuant le nombre des nouvelles admissions ; 6) fournir un financement de transition/provisoire pendant une certaine durée pour intensifier les services communautaires et parallèlement réduire la taille des institutions de santé mentale .

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The case for reorganizing mental health services: the optimal mix of services

Mental disorders are common and disabling. About 1 person in every 10 worldwide is suffering from a mental disorder, and 1 in 4 families has a family member with a mental disorder (1). Rates of mental disorder are even higher in countries affected by complex emergencies. The vast majority of people with a mental disorder do not receive treatment. The treatment gap, i.e. the proportion of people who require care but do not receive treatment, has been estimated to be more than 90% in the Eastern Mediterranean Region (EMR). The limited resources that are available for mental health care in these countries are often deployed inefficiently in maintaining large psychiatric hospitals that are inaccessible to the majority of the population, may result in poor clinical and social outcomes and have even been associated with human rights violations.

Yet effective pharmacological and psychosocial treatments are available for depression, schizophrenia, epilepsy, alcohol and substance abuse and these treatments can be successfully applied in integrated, community-based mental health services in low-income countries (1,2). Hence there is a compelling case for reorganizing services into a decentralized, integrated community-based model of delivery for mental health care.

The major demographic changes which are taking place in almost all the countries of the EMR should be carefully considered when planning the scaling-up and reorganization of mental health services. The child and adolescent population is growing fast and this phenomenon should drive public health policy-makers when they plan mental health care and services, to avoid the risk of focusing exclusively on services for the adult population. In addition, the massive migration from rural to urban areas which is ongoing should also significantly influence not only the location of services but also the ability of services to address the new and specific needs of populations who are recently urbanized and often live in critically underserved environments.

Achieving reorganization: catalysts for change

Despite previous attempts to improve mental health services, decentralization and integration in the EMR is patchy, services are inadequately funded and resources remain centralized in mental hospitals (Figure 1). Successful initiatives in the Region have identified and taken advantage of opportunities to catalyse change:

- Crisis can be a catalyst for change. Emergency situations provide the opportunity for review and adoption of new approaches, as exemplified by developments in Afghanistan, Iraq, Jordan and Somalia.

- The community itself can provide crucial impetus and direction for the reorganization of services. This invaluable resource needs to be facilitated by fostering the development of family/carer and user groups. Box 1 is a case study from Morocco illustrating the how family associations can play a role in mental health care in the community.

- External donor pressure can be the driver to ensure that models of service delivery are effective and efficient and
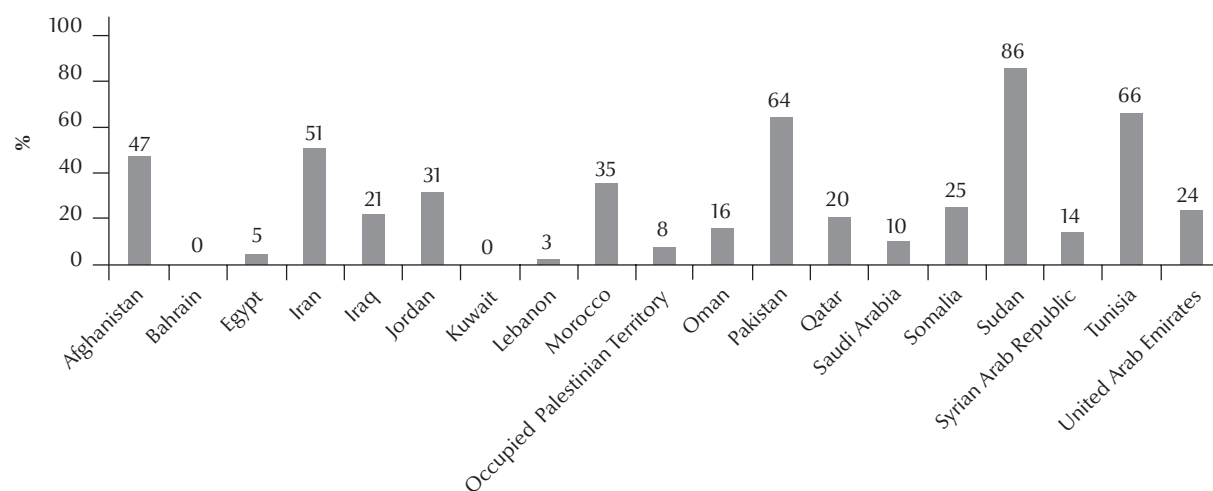
Figure 1 Percentage of all psychiatric beds that are in general hospital and community residences in countries of the Eastern Mediterranean Region

that they meet standards of quality and human rights.

- Adoption of mental health policy and legislation incorporating internationally accepted human rights conventions can drive service reorganization since it requires a service model that can successfully meet the requirements of the legal framework. The right to community-based services is expressly recognized in Article 19 of the United Nations Convention on the Rights of Persons with Disabilities.

- Momentum generated by the development of delivery platforms for priority programmes, e.g. HIV/AIDS, maternal and child health and noncommunicable diseases, can sometimes provide opportunities for reorganizing the service delivery model for mental health.

What needs to be done?

The World Health Organization (WHO) has developed the Service Organization Pyramid Model for an Optimal Mix of Services for Mental Health (Figure 2). This model incorporates the recovery paradigm, which proposes that people with mental disorders are central to their own recovery and can manage their mental health problems themselves, supported by family, friends and community institutions. At successively higher levels of the pyramid the mental health needs of the individual require more intensive professional assistance with commensurate higher costs of care.

Integrate mental health care into primary health care

Although all countries in the Region have made some progress towards integrating mental health services into the primary health care system, there is considerable variation in the extent of integration (Figure 3). The case study in Box 2 looks at how the Islamic Republic of Iran has successfully integrated mental health services into all levels of care nationwide. Integration of mental health into primary care improves identification and treatment rates for priority mental disorders and promotes access
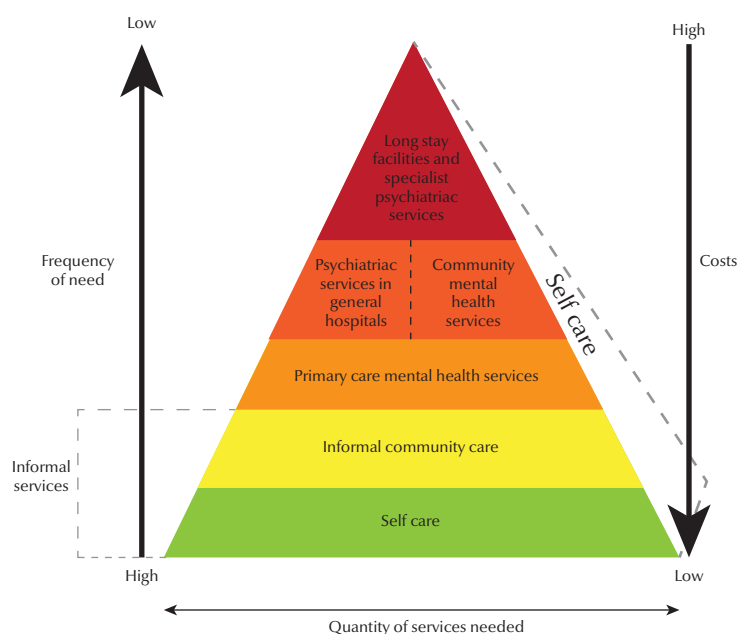
Figure 2 WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (3)

and holistic care for comorbid physical and mental health problems (3). Even in countries where primary health care services are weak, this can be achieved if primary care workers are provided with training followed by sufficient support and supervision by secondary-level services. The WHO Mental Health Gap Action Programme (mhGAP) provides resources to support the provision of front-line services for a range of priority conditions to be delivered through primary health care and other non-specialist settings.

Community-based services for mental health care delivery

Community-based services, such as mental health outpatient facilities and day-treatment facilities are underdeveloped in the EMR compared with the rest of the world, and the provision of community residential facilities is much lower than in European countries. There is a widespread clinical consensus that people receiving community-based mental health care have better health and mental health outcomes and better quality of life than those treated in institutional psychiatric settings (5). Community services can be scaled-up in resource-poor settings by using non-mental-health professionals (6–8). Box 3 shows a case study from Palestine. Adopting a whole community approach

can compensate for health service manpower shortages and provide avenues to incorporate income generation and group management interventions (9).

Psychiatric units in general hospitals

Across the EMR the availability of psychiatric beds in general hospitals is about one-third of that found in the rest of the world. Two-thirds of psychiatric beds in the EMR are still located in mental hospitals, the remainder being almost equally divided between general hospitals (18%) and community residences (16%). There is a very wide variation between EMR countries in the extent to which psychiatric beds are located in community settings (Figure 1).

General hospital settings provide an accessible and acceptable location for 24-hour medical care and supervision of people with acute acerbations of mental disorders, in the same way that these facilities manage acute exacerbations of physical health disorders. Although there is a consensus that acute inpatient services are necessary both to diagnose and to treat patients, the number of beds needed is contingent on which other services exist locally and on local social, economic and cultural characteristics.

Scale-back and refocus psychiatric hospitals

Successful deinstitutionalization programmes involve investment in community-based services, development of human resources with an appropriate skill mix and parallel funding to manage the transition. The range and capacity of residential long-term care that will be needed in any particular area is dependent upon which other services are available or developed locally, and upon social and cultural factors, such as the amount of family care provided (10). When deinstitutionalization is carried out carefully for those who previously received long-term inpatient care, the outcomes are more favourable for most patients who are discharged into community care (11–13). Improvement of quality of care in psychiatric hospitals and processes of deinstitutionalization should be encouraged, developed and monitored (14). Existing psychiatric hospitals in the EMR can respond to this need by developing as tertiary centres of excellence. However, it should be noted that in some countries the total number of psychiatric beds in psychiatric and general hospitals is very low and in those cases the effort should be directed towards increasing mental health beds in general hospitals in spite of the well-known resistance to
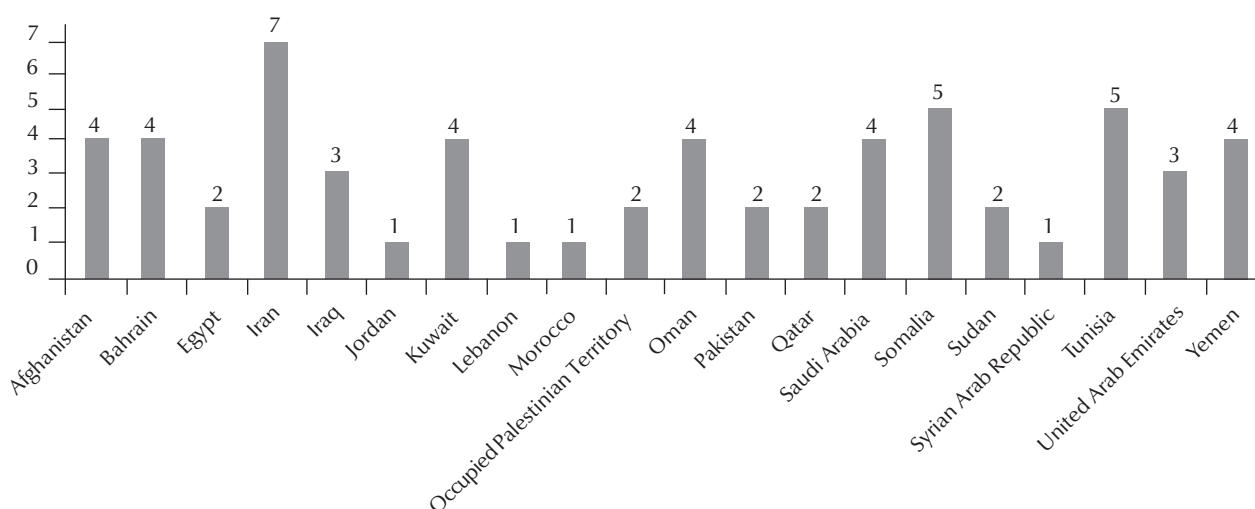
Figure 3 Progress towards integration of mental health into primary care in countries of the Eastern Mediterranean Region: crude sum of 7 primary health care indicators collected in the *Mental health atlas 2011* (4)

Box 2 Case study: integration of mental health into primary health care in Islamic Republic of Iran

A national mental health programme in the Islamic Republic of Iran was adopted by the Ministry of Health and Medical Education in 1988. Based on the evaluation of pilot projects, the Ministry decided to scale up the model of integrated primary and mental health care services to the whole country.

The scope of practice and clinical priorities are defined for the different levels of health care. At village level, the responsibilities of the behvarz (community health workers manning health houses in the community) was expanded to include mental health. In addition to training on mental health as part of their general curriculum, they attend refresher courses held by general practitioners, psychologists or psychiatrists at the provincial level. They are continually supervised by more senior health workers at the primary care centres.

The primary care centres are responsible for identifying and treating severe mental disorders, common mental disorders, epilepsy and mental retardation. General practitioners, who manage urban and rural primary health centres, receive a 1–2-week training session in mental health, as well as refresher training every 1–3 years. This training is provided by a provincial-level psychiatrist. The general practitioners in turn train the disease control technicians in their catchment area, focusing on diagnosis, management and referral of mental disorders.

The district health centres are responsible for the planning, management, implementation and supervision of activities within their health network of rural and urban health centres and village health houses. They in turn are supervised and supported by the provincial mental health units staffed by a psychiatrist and a psychologist, who are responsible for the technical, organizational and administrative management of the services at the periphery.

The deans of the medical universities in every province are responsible both for medical education and for health services in their catchment area, with full collaboration from the senior provincial health administration, especially the directors of the primary care network. This promotes continuity of care across different tiers of the system.

The Islamic Republic of Iran's strong ties between its medical education and health sectors facilitates the training of health workers throughout the country. As such, the medical universities provide strong scientific support for the programme. Nationwide training of general practitioners and behvarz using specially designed manuals and learning support tools has been completed on a province-by-province basis over the last 2 decades, and continues for new health workers and for those who need retraining and upgrading of their skills. A referral system for patients from health houses to specialized university facilities is in place.

Research on treatment pathways indicates that the expansion of mental health care into primary care has reduced assistance sought from traditional practitioners; first contact with a traditional health practitioner for a mental health problem has decreased from 40% in 1990 to 14% in 1998 and 16% in 2000. Integration of mental health in primary health care has also provided the foundation for expanding the scope of service to other areas. For example, a national suicide prevention programme is being implemented through training general practitioners in the treatment of depression (especially in regions where suicide rates are high), referral of suicidal patients, follow-up of people who have attempted suicide and control of potential social contagion. Nevertheless, challenges remain, such as the high mobility of general practitioners, particularly in more remote areas, and the fact that the behvarz who are essential to the programme's success in rural areas do not exist in urban settings where the private health sector is dominant and not well-regulated. Public–private partnerships are weak or nonexistent. Therefore, currently efforts are underway to develop community mental health centres with outreach services in the urban areas where 70% of the population is living.

this by professionals working in general hospitals. The WHO QualityRights Tool Kit is a useful resource to guide the process of examining the human rights situation in institutions and guiding collaborative reform (15). While reducing the numbers of patients residing in long-stay facilities will release resources to pay for the development of community-based mental health services, it needs to be stressed that parallel dual funding will still be required during the period of reorganization.

Integrate mental health into priority health service delivery platforms

An integrated approach to addressing mental health in the context of care for HIV, maternal and child health and noncommunicable diseases has been shown to be cost-effective and efficient (16–18). Maternal and child health programmes are population- and community-based and can provide a platform for equitable care, especially in rural and difficult-to-access communities (19,20) and offer the chance to treat the "whole patient", which has beneficial effects not only for the individual but also for his/her family. Box 4

Box 3 Case study: developing community mental health services in Palestine

In Palestine, the mental health resources of the Ministry of Health have historically been concentrated ian tertiary psychiatric facilities with minimal investment in community-based care. Other problems included outdated models of care (i.e. the biomedical treatment model), shortage of mental health professionals, lack of training for mental health and primary care workers and the large treatment gap for people who need mental health care but are not able to attain it due to lack of awareness, misconceptions, stigma and discrimination.

Since 2002 WHO, in collaboration with the Palestine Ministry of Health and other partners, has supported an ongoing process of mental health care reform throughout the West Bank and Gaza. Overall, the reform initiative seeks to: improve the accessibility to quality mental health services in all levels of care; develop a community-based care system for mental health; and improve health-care-seeking behaviour among patients in need of care.

Stigma towards mental health care among health workers remains a problem. Despite much effort, directors of general hospitals have so far refused to introduce psychiatric acute care beds. Without ongoing support from donors, the sustainability of the local Friends and Family Associations is a concern. While the merits of establishing such associations cannot be disputed, it is important to note that a high degree of organizational capacity-building and support may be needed for a sustained period of time. Mental health workers may not be best qualified to provide such support. It may be better to try to link these associations with well-established organizations.

The reform process has involved interventions at multiple levels and across all areas of West Bank and Gaza, with a potential impact on the entire population. The process of integration of mental health into primary health care was initially piloted in one district (including 7 clinics) in Gaza. After a successful 6-month pilot period, the programme was expanded to a second district. The current implementation plan involves moving to a new district at 6-month intervals, until all 5 Gaza districts are reached. The successful integration of mental health into primary health care has shown that it is possible to develop mental health services in low-resource and conflicted-affected settings.

summarizes how mental health services have been integrated into maternal and child health services in Pakistan.

User and carer involvement

Increasing participation of service users and carers is one of the major advances made in mental health care in the last decades. The recovery movement has validated the active engagement of

Box 4 Case study: integration of mental health in maternal and child health services in Pakistan

Mental health has been integrated into maternal and child health services in Pakistan using the Five-Pillars (5-PA) Approach to Maternal Psychosocial Well-Being. The approach is derived from the Thinking Healthy Programme: a cognitive–behaviour therapy-based psychosocial intervention for mothers with depression and their infants. The Thinking Healthy Programme is a targeted intervention for women suffering from perinatal depression and their infants. It was evaluated in a community-based setting in rural Rawalpindi by female community health workers, known in Pakistan as "lady health workers". There is good evidence for its effectiveness and it is aligned with the WHO Mental Health Gap Action Programme (mhGAP) intervention guidelines.

5-PA is an adaptation of the Thinking Healthy Programme in order to integrate it into a child nutrition and development programme. Thus, it is an example of delivery of mental health care to mothers and infants through a maternal and child health platform. The adaptation targets not only depressed women but also all mothers during pregnancy and in the 2 years after giving birth. The key feature of the approach is that it is integrated into and facilitates the delivery of a community-health-worker-delivered intervention for early child nutrition and development. Thus, whenever the community health worker delivers a session for child nutrition or development, she uses 5-PA to strengthen the key message and to provide the psychosocial intervention.

A pilot study has been successfully completed in one rural area and 120 community health workers have been trained. Evaluation of its impact is being tested through a cluster randomized controlled trial. Pilot results show that community health workers were able to apply the 5-PA effectively to their work, and the approach was found to be useful by them, their supervisors, the mothers and the families.

people in accepting and overcoming the challenges of disability associated with mental health problems (20). Facilities should support service user involvement in decision-making at all levels, including the running of the facility as well as their personal treatment and care plans. Users might be also included in contributing to designing research studies as it is the case in a few countries such as the United Kingdom. Community mental health services should support families coping with the problems associated with chronic mental disorder in a family member, for example by developing programmes designed to decrease family burden and improve psychological support.

Key recommendations for ministries of health

The key recommendations summarized in Table 1 address 6 strategic interventions for service reorganization for ministries of health. Service reorganization cannot be carried out in isolation and it must be underpinned by policy and legislative reforms, complemented by promotion and preventive interventions, and informed by information, evidence and research. Furthermore the active involvement of users and carers should be promoted in the planning and review of delivery of care and reorganization of services.

Table 1 Key recommendations for strategic interventions for mental health service reorganization for ministries of health in countries of the Eastern Mediterranean Region

Key recommendations for strategic intervention	Essential actions for all countries	Actions for consideration by countries with more resources
1. Integrate delivery of interventions for priority mental disorders, as identified in the WHO Mental Health Gap Action Programme (mhGAP), in primary health care and priority programmes.	• Integrate care of priority disorders into the basic package of services offered within primary health care. • Integrate care for common mental disorders into the routine care for people affected by noncommunicable diseases, maternal and child health problems and HIV/AIDS. • Ensure availability of essential psychotropic medications in primary health care settings.	
2. Systematically strengthen the capacity of non-specialized health personnel for providing evidence-based and quality services for priority mental disorders (identified in mhGAP).	• Enhance the capacity of primary health care workers at all levels to provide integrated mental health care for priority mental disorders, using the mhGAP intervention guide and training materials. • Provide refresher training and supervision to primary health care workers.	• Include recognition and management of common mental disorders into training curricula of all health personnel including integration into family physician programmes.
3. Scale up community-based services, e.g. via community outreach teams for defined catchment areas, supported residential facilities, supported employment and family support.	• Develop, via training/retraining and supervision, multidisciplinary community mental health teams to deliver integrated community-oriented mental health care. • Develop new cadres within the workforce who are appropriate to the needs of the reorganized mental health system (e.g. project managers, case managers and counsellors). • Establish multidisciplinary outreach teams to liaise with and support primary health care services.	• Provide psychological, pharmacological and social interventions for children and adolescents with mental health problems. • Develop other community services, e.g. daycare centres and community residential facilities with different levels of support provided by specialized and nonspecialized teams. • Promote integration of mental health interventions with income-generation programmes and social services, e.g. education and housing.
4. Establish mental health services in general hospitals for outpatient and acute inpatient care.	• Develop outpatient care in general hospitals staffed by core multidisciplinary mental health teams catering to a defined catchment area. • Set up inpatient services for provision of care within the defined catchment area of people with acute exacerbations of mental disorders. • Ensure availability of essential psychotropic medications in mental health units in general hospitals.	• Liaise and coordinate with existing community mental health teams. • Provide liaison psychiatric interventions to other departments of the hospital.

Table 1 **Key recommendations for strategic interventions for mental health service reorganization in countries of the Eastern Mediterranean Region (*concluded*)**

Key recommendations for strategic intervention	Essential actions for all countries	Actions for consideration by countries with more resources
5. Progressively reduce the number of long-stay beds in mental hospitals through restricting new admissions.	• Assess the needs of long-stay inmates. • Use the WHO QualityRights Tool Kit to monitor and improve the quality of care and dignity of persons admitted to mental hospitals. • Reduce the number of admissions from areas served by community mental health services and/or general hospital psychiatric units. • Plan to progressively reduce the number of beds.	
6. Provide transitional/bridge funding over a period of time to scale up community-based services and downsize mental institutions in parallel.	• Determine the costs and resources available, and budget accordingly to ensure that reorganization of services is realistic and achievable. • Calculate the costs of each component of reorganization and the total costs for each year. • Define how components of reorganization are going to be financed (e.g. state funding, donors). • Adjust timeframes of reorganization in accordance with resources available in different years.	

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Informing mental health policies and services in the EMR: cost-effective deployment of human resources to deliver integrated community-based care

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إعـلام سياسـات وخدمـات الصحـة النفسيـة في إقليـم شرق المتوسـط: التوزيـع الفعـال مـن حيـث تكلفـة المـوارد البشريـة لتقديـم الرعايـة المتكاملـة المسـتندة إلى المجتمـع المحلـي

جبريل إيفبيجارو، فكرام اتل، دانيـل شيسـهولم، ديفيد جولدبرج، توفيق خوجة، تود إدوارد، يعقوب إينوم، لوتشيا كولكيفيتش

الخلاصة: مـن أجـل بلـوغ التوقعـات المتوخّـاة مـن خطـة العمـل العالميـة للصحـة النفسيـة للأعـوام 2013–2020 في بلـدان إقليـم شرق المتوسـط، ومواصلـة السـعي نحـو تحقيـق التغطيـة الصحيـة الشـاملة، ينبغـي عـلى جميـع مقدمـي الرعايـة الاجتماعيـة الصحيـة الابتـكار وتطويـر خدماتهـم لتقديـم الرعايـة الصحيـة المبنيـة عـلى الأدلـة، والتكلفـة الفعّالـة، والتـي تحقـق أفضـل نتائـج للمريـض. وبالنسـبة للقـوى العاملـة في الرعايـة الأوليـة والمجتمعيـة، فـإن هـذا يشـمل الأطبـاء المارسـين، والممرضـات المارسـات، والممرضـات المجتمعيـات، والأخصائيـين الاجتماعيـين العاملـين في المجتمـع، والمسـؤولين عـن الإسـكان، والعاملـين في الصحـة مـن غـير المهنيـين، والمنظمـات غـير الحكوميـة، والمجتمـع المـدني بـما في ذلـك القـادة الروحيـين والمعالجـين في المجتمـع. وهـذه المقالـة تقـدم أفضـل الأدلـة الحاليـة لدعـم هـذا التحـوّل، كـما تناقـش النُّهُـجَ الرئيسـية لتحقيـق ذلـك، بـما في ذلـك المـزج بـين المهـارات بالإضافـة إلى/أو تحـول المهـام، والرعايـة المتكاملـة. وقـد تـم تحديـد العوامـل الهامـة التـي ينبغـي مراعاتهـا لدعـم المـزج بـين المهـارات وتحـول المهـام، والرعايـة المتكاملـة الجيـدة فيـما يتعلـق ببلـدان إقليـم شرق المتوسـط.

ABSTRACT For EMR countries to deliver the expectations of the Global Mental Health Action Plan 2013–2020 & the ongoing move towards universal health coverage, all health & social care providers need to innovate and transform their services to provide evidence-based health care that is accessible, cost-effective & with the best patient outcomes. For the primary and community workforce, this includes general medical practitioners, practice & community nurses, community social workers, housing officers, lay health workers, nongovernmental organizations & civil society, including community spiritual leaders/healers. This paper brings together the current best evidence to support transformation & discusses key approaches to achieve this, including skill mix and/or task shifting and integrated care. The important factors that need to be in place to support skill mix/task shifting and good integrated care are outlined with reference to EMR countries.

Orienter les politiques et les services santé mentale dans la Région de la Méditerranée orientale : déploiement de ressources humaines d'un bon rapport coût-efficacité pour une prestation de soins communautaires intégrés

RÉSUMÉ Pour que les pays de la Région de la Méditerranée orientale puissent répondre aux attentes créées par le Plan d'action mondial sur la santé mentale 2013-2020 et pour faciliter le mouvement continu vers la couverture sanitaire universelle, tous les acteurs de la prestation de soins socio-sanitaires doivent faire preuve d'innovation et transformer leurs services afin de fournir des soins de santé fondés sur des bases factuelles qui soient accessibles, d'un bon rapport coût-efficacité et procurent les meilleurs résultats pour les patients. Pour ce qui est des personnels aux niveaux primaires et communautaires, ceci concerne les médecins généralistes, les infirmières praticiennes, les infirmières communautaires, les travailleurs sociaux communautaires, les responsables des logements sociaux, les travailleurs de la santé non professionnels, les membres des organisations non gouvernementales et de la société civile, y compris les leaders et les guérisseurs spirituels communautaires. Le présent article rassemble les meilleures bases factuelles actuellement disponibles à l'appui de cette transformation et examine les approches principales à cet égard, y compris l'éventail des compétences et/ou la délégation des tâches et les soins intégrés. Les facteurs importants qui doivent être en place à l'appui de l'éventail des compétences/la délégation des tâches et de bons soins intégrés sont présentés dans le contexte des pays de la Région de la Méditerranée orientale.

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Case for transforming mental health services in the EMR

The countries of the Eastern Mediterranean Region (EMR) continue to undergo rapid social and cultural changes, which bring both advantages and challenges. For countries in the Region to meet the expectations of the World Health Organization's (WHO) Global Mental Health Action Plan 2013–2020 (*1*) and to progress towards universal health coverage (*2*), all those involved in the provision and delivery of health and social care need to innovate and transform their services so that these deliver evidence-based health care that is accessible and cost-effective and has the best patient outcomes.

The Mental Health Atlas 2011 describes resources for mental health in the EMR and shows large variations in health-care expenditure, manpower and health systems delivery among the Member States of the EMR (*3*). This is reflected in differing life expectancies and literacy rates and variations in the contribution of neuropsychiatric disorders to the national burdens of disease. There is also variability in governance across the countries of the Region in terms of mental health policy, mental health plans, mental health legislation and mental health financing. There is a need to learn from current best practice within the EMR and similar health economies to ensure that individual countries, independent of the resources available to them, can work towards achieving best practice.

Challenges shared by all nations of the Region, regardless of income, are a shortage of medical manpower (including a shortage of psychiatrists, general medical practitioners, social workers, psychologists, occupational therapists and mental health nurses); a lack of integrated primary care services; and variable access of patients to psychotropic medication, due to differences among countries in prescribing rights of secondary and primary care personnel.

With improving medical technology many people are likely to live longer and with increasing age there will be increasing morbidity and multi-morbidity. It needs to be recognized that mental and physical health co-morbidity will continue to be the norm rather than the exception.

A recent review of projections for global mortality and burden of disease shows that noncommunicable diseases and mental health will continue to be the leading causes of mortality and morbidity in low-, medium- and high-income countries. (*4*) There is increasing evidence that noncommunicable diseases and mental health co-morbidity have an additive effect (*5–8*) and this suggests that mental health-care skills need to be embedded throughout the primary care workforce. In a review of 23 low- and medium-income countries it has been estimated that if nothing is done to address chronic diseases in developing countries, US$ 84 billion of economic production could be lost, in addition to the high costs of care to the health systems (*9*). We need a new primary care workforce that will work in the community, utilizing all evidence of best practice obtained from low, medium- and high-income countries (*9–11*).

Global changes in patterns of morbidity also provide opportunities for innovation and new ways of working. In order to achieve the benefits of universal health coverage there is a need to develop a comprehensive approach to care, with clearer pathways and with a defined role for the state, for health commissioners, hospital health providers, primary care providers, nongovernmental organizations, civil society and other community health and social care providers. There is a need to recognize the role of the individual patient and his/her carers in self-care and health promotion.

Despite the shortage of specialists in low- and medium-income countries of the EMR, there are effective treatments for common mental health problems that can be applied in a primary care setting. This also makes it possible to address co-morbidity, to improve access

to mental and physical health care and use a patient-centred approach, which ultimately reduces the stigma of mental illness (*7,10,12*). One of the key innovations required is to develop and deliver an appropriately skilled workforce within the primary care system, through skill mix (*13–16*) and/or task-shifting (*17–19*) supported by an evidence-based system of collaborative or integrated care (*20–22*).

Workforce transformation

The impact and financial cost of long-term health problems in 23 low- and medium-income countries similar to those in the EMR has been estimated at US$ 84 billion if nothing is done to address problems such as heart disease, stroke and diabetes (*6–9*). When mental health co-morbidity is added into the equation, this loss may be as much as 70% greater. Research shows that integration of mental health care into primary care is effective, cost-effective and safe, and this is true in high-, medium- and low-income countries (*20*). EMR Member States require a template that can be applied to support integration in their specific health-care setting, while recognizing that each country will have a different starting point depending on the resources and manpower that are already available. Techniques that can be applied to develop the workforce to meet this challenge are skill mix and task shifting.

Defining skill mix and task shifting

The terms task shifting and skill mix tend to be used interchangeably in the literature, and it is therefore necessary to clarify the terms.

Skill mix can be defined as a group of professionals working together within the same team, each contributing to the

care of the same individual patient by following a single pathway in an integrated fashion or in a collaborative way using a stepped-care approach (*14–16,20*). This technique is well-known and well-tested in primary care globally and this article will propose how this concept can be applied to mental health-care delivery in the EMR.

Task shifting is a methodology through which activities previously provided by clinicians are transferred to others within or outside the team. There are over 50 years of evidence demonstrating its safety and effectiveness in low-, medium- and high-income countries (*20*). For example, a randomized controlled trail in India showed that interventions for depressive and anxiety disorder led by lay health workers decreased the prevalence of common mental disorders and resulted in a reduction in suicide attempts (*21*).

The effectiveness of task shifting and skill mix depends on the quality of the people who are taking on the new roles (*19*) and there is therefore a need to train the new workforce appropriately.

Skill mix and task shifting–key enablers

Key steps need to be in place to achieve successful skill mix or task shifting. These include:

- *A clear philosophy and initiative which defines the scope of the collaboration or integration.* This would include the type of patients or clients who will be managed, the funding arrangements, the infrastructure required and which patients or clients will be excluded from the type of service provided.

- *Leadership and clinical champions who will provide the governance, the vision and mission and advocate for a transformed service.* They will be responsible for the monitoring and implementation of clinical governance and quality improvements. One way to ensure the engagement of leadership is to set up

a board of stakeholders who must include psychiatrists, general practitioners and other members of the primary health-care workforce, patient organizations, community links and other organizations that have an interest in supporting the success of the initiative.

- *Appropriate infrastructure and information technology in place to support a change in working.* This would include patient records and data-sharing agreements supported by a legal framework across the patient pathway.

- *A well-defined clinical pathway which aligns the different components of the workforce necessary to deliver the pathway.* The workforce required can be calculated using disease incidence and prevalence data, the numbers of patients who are already being managed and an estimate of the numbers that will need to be managed to better meet the burden of disease. In order to identify what will be needed from the extended workforce the pathway needs have definitions of the expected parameters of self-care and the nature of the evidence-based interventions required to address the disease burden.

- *A supportive legislative or policy environment that supports integration and workforce development.* There may need to be changes in legal requirements to ensure that skill mix and task shifting are properly applied and this would include a clear definition of the role enhancements within the workforce. There needs to training in the competencies required by the workforce to perform their new roles, using the principles of patient-centred care and taking into account public health needs and expectations (*15*).

- *A clear policy for the accreditation of a new workforce and clarity of task.* This must include a framework for continuous professional development, mentoring schemes, supervision and career progression.

- *Expanding the curriculum of medical and nurse training to include collaborative care, mental health and working within systems.* Current core and professional

training needs to be transformed to focus on integrated practice and joint working in order to overcome barriers across sectors.

Understanding the new terminology

New roles and responsibilities brought about through a transformation process often require the introduction of new, culturally appropriate terminology. The terminology adopted to address the issue of changing and evolving clinical roles should make little difference as long as the change is supported by collaborative stepped or integrated care. There is sufficient evidence of the cost–effectiveness of this approach in primary and community settings (*12,17,22,23*).

What is important for successful transformation is that any process that includes skill mix or task shifting and integration is bidirectional. This means that there should be parity between mental and physical health-care delivery to avoid the risk of marginalizing mental health. An example is the need to train midwives and health visitors in mental health-care skills as well as maternity and paediatric skills so that they can play an active role in screening for mental illness and develop appropriate management plans in collaboration with local primary health-care networks to achieve the best outcome for their patients and families. General hospital staff require mental health training and input from local mental health services or from primary care mental health services. Similarly, specialist mental health services require input from physical health services in primary and secondary care.

What patients, their families and carers require is an integrated, simplified pathway supported by appropriate human resources and policies to support this change in practice.

Well-defined skill mix and task shifting also enhances the role of the family doctor, as some of them will become

general practitioners with a special interest (GPwSI) in primary care mental health (*24*). Countries of the EMR will require support to transform their primary health-care workforce and to simplify access to such care. This can be achieved by general medical practices adopting a model of primary care networks supported by community and hospital resources.

There are currently variations in prescribing rights of health-care providers and hence in patients' access to medication across the EMR and therefore there will be a need to ensure better access in primary care to psychological therapies and to the range of psychopharmacological interventions. The is also a need to focus on mental health promotion, for example by developing the skills of the general population in mental health first aid, by improved management of long-term physical health conditions (many of which are co-morbid with common mental health conditions) and by improved access to substance misuse treatment interventions (including smoking cessation). This is what is meant by "primary care transformation".

Strategies for delivering integrated care

Delivering mental health care in the community and via the primary health-care system is not achieved just by an increase in number of workers. Primary care transformation requires the existing workforce to work differently and for new workforce roles to be developed (*20,21*).

An example of this from a high-income country is the use of navigators. A navigator is a single, named individual who can help people with multiple morbidities and those who are vulnerable, especially those with long-term health conditions, to navigate their way through complex systems (e.g. across health, social care, housing,

employment and education) and who can help to pull together integrated care packages across sectors and services (*25–27*).

An analysis of integration in health research, policy and practice noted that system-wide collaboration must go beyond the health sector. It suggested that that the well-being of the most vulnerable health-system users, whose mental and physical symptoms lead to disorders with persistent impairments, may be a sensitive indicator of a society's need for integrated care, and that full social participation for vulnerable groups requires sustained access to jobs, schools and other services. This requires cooperation among the education, social services, labour and justice sectors (*27–30*).

Key factors supporting good integrated care

Information-sharing systems

To support the effective day-to-day provision of integrated care to people with mental health problems it is essential that information systems are compatible within and across different organizations. The system would establish individual electronic records of patients' integrated health and social care needs and interventions; would have the facility to record information about education, housing, welfare benefits and employment status, identifying specific occupational health needs; and would require the ability to anonymize and aggregate health and social care records to inform a needs assessment of the local population and hence local joint and multi-agency commissioning plans.

Shared protocols

Shared protocols between two or more organizations, or parts of an organization, are needed to set out the responsibilities of each in delivering an agreed service and/or outcome. Where shared protocols have been established,

the evidence suggests they work well, although it is important to ensure that staff "buy-in" to the protocol. Shared protocols should be developed within and across the range of statutory, independent and voluntary organizations that support people with mental health problems.

Improved access to primary care psychological and pharmacological therapy

The effectiveness of improving access to primary care psychological and pharmacological therapy has been demonstrated in the United Kingdom, Ireland, New Zealand and Saudi Arabia. It is hoped that it will reduce some of the intercountry variation across the EMR that was highlighted in the Mental Health Atlas 2011 (*3*).

Joint funding and commissioning

Separate funding streams hinder integrated care, while pooled funding and services commissioned across boundaries increase the likelihood of patients receive better care. Combining health, social care and other budgets (e.g. for education) at a local commissioning level provides the opportunity to mirror the service delivery requirements of people who need a single, coordinated approach to manage their mental health condition. Commissioners need to be aware that the support of people with mental health needs extends beyond traditional health and social care interventions, to help with issues related to lifestyle choices such as exercise and smoking.

Co-located services

The co-location of primary care and specialist mental health staff is strongly supported in the literature and could bring significant benefits to patients in terms of a better integrated response to their needs, so long as the staff understand their respective roles and responsibilities and work collaboratively, and willingly, together. There is no evidence

that the merging of organizations involved in providing different aspects of care to people with mental health needs would in itself improve that care.

Liaison services

There are significant benefits to establishing both psychiatric liaison services in physical health-care settings and physical care liaison services in mental health-care settings. Commissioners need to be more aware of the evidence for the effectiveness of such services, the improvements to integrated patient care and the cost savings that can be made.

Navigators or case managers

There is benefit in having a single, named individual who can help people navigate their way through complex systems across health, social care, housing, employment and education (among other services) and help to pull together integrated care packages. This would go a long way to ensuring that people received effective, integrated care.

Reduction of stigma

A public and a health-care workforce who are better informed about health and mental health issues would help to create

an environment in which a truly integrated response to poor mental health could be established. In addition to continuing work in raising the public's mental health awareness, both primary and secondary schools need to ensure that emotional and mental health issues are fully integrated into what children are taught about health and healthy living in the widest sense. This would mean that young adults intending to move into careers in health and social care already have a basic understanding of the indivisibility of physical and mental health, so that the formal professional training on holistic and integrated care
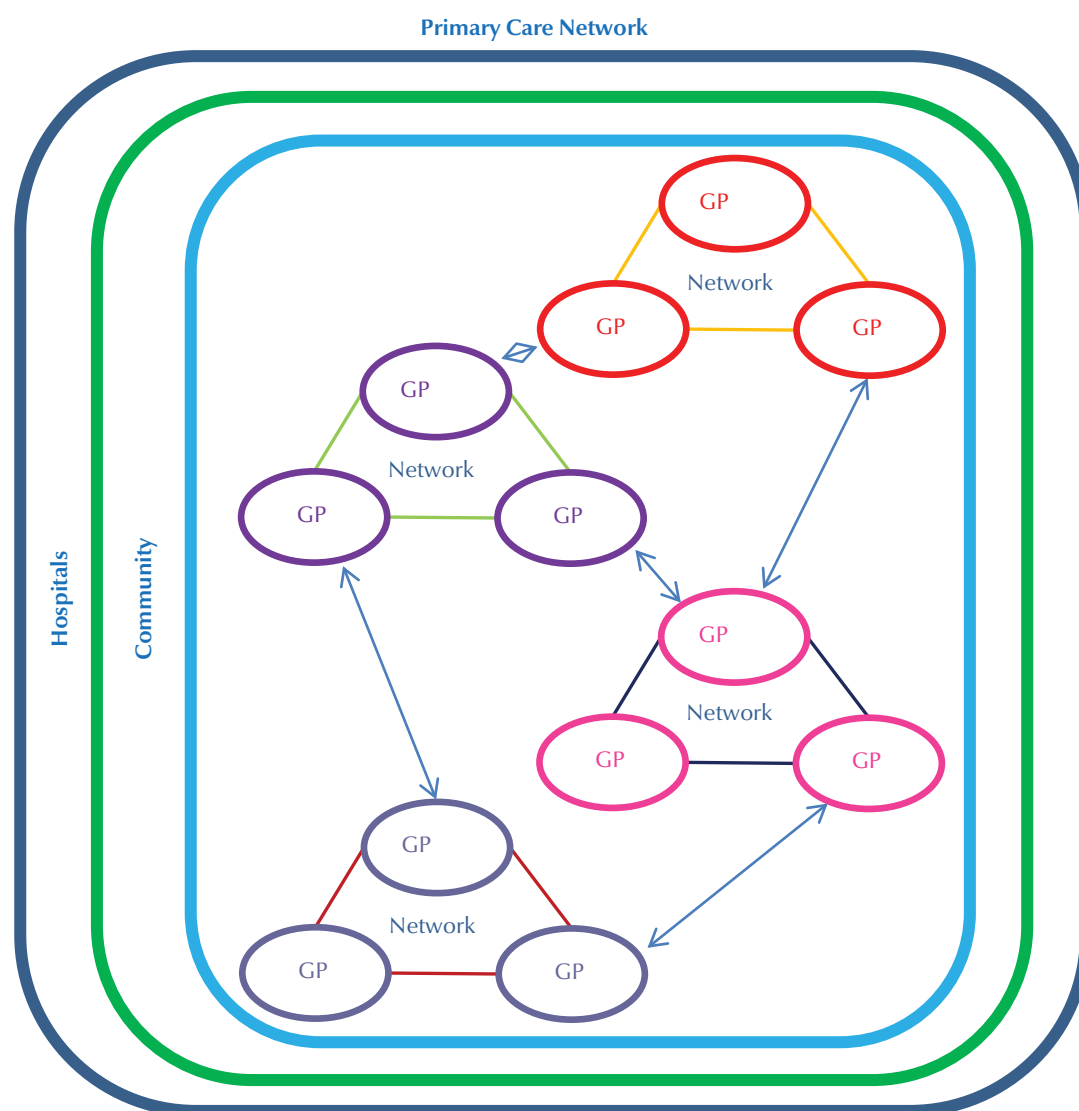
Figure 1 A primary care network represents a geographical area served by general medical practices, community resources and hospital. Each circle represents a general practice working collaboratively with other general practices as a primary care network

that they receive from day one will come to them quite naturally. By itself, though, this is not enough; there is a small, but good, evidence base suggesting that interpersonal contact involving people with mental health problems can reduce the risk of their suffering stigmatizing attitudes and behaviour from other.

Aligning hospital care to primary care

An essential component supporting primary care mental health transformation are well-organized mental health hospital and secondary level health services which align with and support the local primary health-care networks (Figure 1).

Conclusion

To successfully transform mental health services in the EMR it is essential that successful models for integrated services in local areas are scaled up both nationally and regionally in order to provide health and social care benefits to as many individuals in the population as possible. This will contribute to the delivery of the Global Mental Health Action Plan 2013–2020 and universal health coverage.

Leadership across all sectors is an essential component in the delivery of integrated or collaborative mental health care. This requires high-level commitment and collaborative relationships across all grades of health service managers and clinicians.

Some practical steps need to be taken by the EMR Member States, supported by the WHO and other important stakeholders such as the World Organization of Family Doctors (WONCA), World Federation for Mental Health (WFMH) and other academic and health policy institutions to transform primary-care mental health. These are summarized in Table 1.

Table 1 Scaling up primary-care based mental health services in the Eastern Mediterranean Region (EMR)

Step 1: Region-specific measures

• Establish a multisectoral regional committee across EMR to:
  – articulate the vision across the region and summarize the case for change;
  – provide technical expertise;
  – share best practice across the Region;
  – share resources to avoid duplication;
  – coordinate lessons learnt;
  – agree operational, governance, financial and performance frameworks.
• Agree an EMR matrix for monitoring performance.
• Agree for co-morbid physical and mental health conditions to be tackled, including diabetes, respiratory conditions and musculoskeletal conditions that are common in primary care.
• Agree a structural framework for data collection that will be used across all sectors for benchmarking.
• Agree the minimum data set to be collated by countries across the whole Region.
• Agree that the population be covered by each primary-care network.
• Identify gaps in the workforce and propose the development of a new workforce.

Step 2: country-specific measures

• Establish a national accountability and joint decision-making group in each Member State to ensure that country-specific issues are covered, including proposed national information technology solutions, the identification of national clinical priorities and definition of population groups per unit.
• Establish a national clinical reference group.
• Agree a national formulary for prescribing.
• Agree pathways for access to psychological therapies.
• Agree geographical limits of each primary-care network.
• Confirm information sharing agreements and proposed incentives.
• Agree an accreditation process for new skills and a method of monitoring safety and clinical pathway fidelity.
• Agree a national matrix for monitoring performance.
• Design and implement incentive schemes to support change.
• Agree the scope of national scaling-up.
• Map all the local resources that can be deployed as part of skill mix.

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Integration of mental health into priority health service delivery platforms: maternal and child health services

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إدماج الصحة النفسية في برامج تقديم الخدمات الصحية ذات الأولوية: خدمات صحة الأمومة والطفولة

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الخلاصة: إن برامـج صحـة الأمومـة والطفولـة هـي البرامـج الأكثـر منطقيـة وملاءمـة لإدمـاج رعايـة الصحـة النفسـية بطريقـة منصفـة وميسـرة وشـاملة. وإن مثـل هـذا الإدمـاج ينطـوي عـلى إمكانيـة تحسـين كل مـن الصحـة النفسـية والبدنيـة بشـكل تـآزري. والخطـوات الرئيسـية لإدمـاج ناجـح تشـمل: أ) الاعـتراف – في أعـلى المحافـل السياسـية الدوليـة والوطنيـة – بـأن الصحـة النفسـية والرفاهيـة مكـوِّن أسـاسي مـن مكونـات صحـة الأمومـة والطفولـة التي لا تنافـس برامـج صحـة الأمومـة والطفولـة بـل تكملهـا، ب) تكييـف تدريـب القائمـين والمشرفـين عـلى تقديـم رعايـة صحـة الأمومـة والطفولـة والرعايـة الأوليـة بحيـث يتمكنـوا مـن التعـرف عـلى مشـاكل الصحـة النفسـية لـدى الأمهـات والأطفـال، مـع ملاحظـة أن هـذا بـدوره سـوف يمكِّنهـم مـن أن يكونـوا مقدِّمـي رعايـة صحيـة أكثـر فعاليـة، ج) ملاءمـة التدخلـات الفعالـة مـع السـياقات المحليـة، د) الاسـتثمار في بحـوث تطبيقيـة حتـى يتسـنّى تنقيـح هـذه النُّهُـج وتوسـيع نطاقهـا، ممـا يـؤدي إلى نتائـج أفضـل لجميـع برامـج صحـة الأمومـة والطفولـة.

ABSTRACT Maternal and child health (MCH) programmes are the most logical and appropriate platforms for integration of mental health care in an equitable, accessible and holistic manner. Such integration has the potential to improve both mental and physical health synergistically. Key steps to successful integration include a) recognition, at the highest international and national policy forums, that mental health and well-being is a generic component of MCH that does not compete with MCH programmes but instead complements them; b) tailoring the training and supervision of MCH and primary care personnel so they can recognize and assist in the management of common maternal and child mental health problems, recognizing that this, in turn, will enable them to be more effective health-care workers; c) adapting effective interventions to local contexts; and d) investing in implementation research so that these approaches are refined and scaled-up, leading to improved outcomes for all MCH programmes.

Intégration de la santé mentale dans des plateformes de prestation de services de santé prioritaires : services de santé de la mère et de l'enfant

RÉSUMÉ Les programmes de santé de la mère et de l'enfant sont les plateformes les plus logiques et adéquates pour l'intégration de soins de santé mentale d'une manière équitable, accessible et holistique. Une telle intégration a le potentiel d'améliorer la santé mentale et physique de manière synergique. Les étapes clés pour une intégration réussie sont les suivantes : a) reconnaître, dans les forums politiques nationaux et internationaux de très haut niveau que la santé mentale et le bien-être sont des composantes génériques de la santé de la mère et de l'enfant, qui ne font pas concurrence aux programmes de santé de la mère et de l'enfant mais viennent plutôt les complèter ; b) adapter la formation et la supervision du personnel de soins de santé primaires et de santé de la mère et de l'enfant pour qu'il identifie les problèmes courants dans ce domaine et contribue à leur prise en charge, reconnaissant que cette démarche leur permettra de devenir des agents de santé plus efficaces ; c) adapter des interventions efficaces aux contextes locaux ; et d) investir dans la recherche sur la mise en œuvre pour que ces méthodes soient affinées et intensifiées, afin d'améliorer les résultats de tous les programmes de santé de la mère et de l'enfant.

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Why integration?

Mental health problems affect 10–20% of children and adolescents and 15–20% of mothers worldwide, and account for a large portion of the global burden of disease. The most logical and appropriate platforms for integration of interventions to prevent or manage many such problems are community-based maternal and child health (MCH) services (1). There are a number of advantages to such integration (1,2), as outlined below.

1. Effective treatments exist for most common maternal and child mental health problems (3,4), but few patients have access to such treatments. In many low- and middle-income countries, the ratio of specialists to population is 1:0.5 million and in some, as low as 1:4 million. Even in developed countries only 2 in 10 adults, and an even lower number of children, with common mental health problems receive care from a mental health specialist in any given year. As MCH programmes are population and community-based, these are more likely to provide equitable care, especially to rural and difficult-to-access communities.

2. Integrated treatment programmes in which health and social care providers are supported to manage common mental health problems offer a chance to treat the whole patient, an approach that is more patient-centred and is often more effective than one in which mental, physical and reproductive health problems are each addressed in different so-called "silos", without effective communication between providers (1,2). Community health workers (CHWs), especially MCH workers, are best placed to adopt an ecological approach to care. This is particularly important for children, whose psychosocial well-being is closely linked to the mental health of the parents and the quality of the family and school environment.

These workers have a knowledge of community resources and health and social and education services, and can better respond to the specific needs of local communities.

3. Integrated care programmes that can address maternal and child mental health needs in the context of MCH care settings are often more attractive to patients and family members who are concerned about the stigma associated with mental and developmental disorders and about mental health treatment settings.

4. Integration with MCH platforms is suitable for taking into account mental health needs across the life-course. Frontline MCH workers can establish trusting and long-term relationships with children and families and prevent mental health problems by promoting healthy lifestyles and by providing early identification and timely preventive and curative interventions for common behavioural, emotional and social problems in children and for risk factors in the perinatal period.

5. There are benefits too for MCH programmes themselves when there is integration with mental health care services. For example, treating maternal depression can improve the capacity of mothers to be more receptive to MCH programmes, improve their ability to care for their children, and improve mother–infant interaction.

Key steps for integrating maternal and child mental health into MCH platforms

The following steps could facilitate integration of maternal and child mental health into MCH platforms (1,2).

Engaging stakeholders

Stakeholders need to agree that mental health interventions within maternal and child health platforms advances maternal and child health, and frontline clinicians must see the value of adding these interventions to their current services. Joint assessment by the managers of the priority health programmes and by mental health professionals and service planners also enhances ownership and commitment to achieve the planned outcomes within agreed timelines.

Analysing goals, functions and resources

The next step is a detailed analysis of the goals, functions and resources (human and financial) of the CHW or MCH programme in which mental health care will be integrated. This step should include attention to the existing knowledge and skills of health-care providers about identification and care of common mental health problems; recognition of when to refer; inclination/motivation to enhance their skills; and the perceived benefits of these skills to advance their professional and programmatic goals.

Identifying shared and achievable objectives

Identifying shared and achievable objectives requires joint assessment of the needs and feasibility of integration; the identification of key tasks; and the training, support, and supervision needed for clinicians to provide these interventions. Attention must be paid to congruence of the integration efforts with the overall objectives of the priority programmes and to the resources needed to ensure initial success and sustainability. It is advisable to begin with limited but clear and specific objectives. For example, the initial target for integration of maternal mental health care within MCH programmes may be the identification and management of maternal depression to achieve better infant nutritional and development outcomes (5) (see Box 1).

Changing the role of mental health specialists

A change in the role of specialist mental health professionals from providers of individual care to consultants is needed for adaptation and implementation of mental health interventions and for training and supervision of CHW and MCH workers.

Developing effective intervention programmes

Effective intervention programmes need to be developed with skills-sets that logically group together in terms of content, training and operational use. Box 1 illustrates a case study from Pakistan that attempts this with an intervention for maternal psychosocial well-being integrated into a child nutrition and early development programme. Most of the required functions can be performed by a range of workers, many of who are already part of MCH services, thus allowing some flexibility in planning and adaptation and marginal additional investments. Particular skills, such as behaviour-change communication, motivational coaching, patient education and self-management support can be critical for providing effective MCH care. These care management tasks or work packages can be effectively assigned to non-specialist health workers who are well-positioned to bring them into the community, thus extending the reach of primary care. Such intervention programmes should be tailored to a life-course approach, integrating with the stages of preconception, perinatal and early childhood through to adolescence and early adulthood.

Assigning responsibilities and establishing a monitoring mechanism

Clear and explicit responsibilities need to be assigned to the health-care providers and managers of the priority programmes and to the mental health team at each level. Flowcharts and referral algorithms, such as the World Health Organization's Mental Health Gap Action Programme (mhGAP)

Box 1 Case study: Five-Pillars (5-PA) Approach to Maternal Psychosocial Well-Being

5-PA is derived from the Thinking Healthy Programme (THP), a cognitive-behaviour therapy-based psychosocial intervention for mothers with depression and their infants. THP was a targeted intervention for women suffering from perinatal depression and their infants and was delivered by community health workers (CHW) in rural Rawalpindi, Pakistan. In a randomized controlled trial to evaluate the approach there were impressive improvements in maternal depression and functioning compared with controls (6), and THP was adopted by the World Health Organization as a first-line low-intensity treatment for perinatal depression (see http://www.who.int/mental_health/maternal-child/thinking_healthy/en/)

5-PA is an adaptation of the THP to integrate it into a child nutrition and development programme (5). Thus, it is an example of the delivery of mental health care to mothers and infants through an MCH platform. The adaptation targets not only depressed women but all mothers during pregnancy and in the 2 years after giving birth.

The key feature of the approach is that it is integrated into, and facilitates the delivery of, a CHW-delivered intervention for early child nutrition and development. Thus, whenever the CHW delivers a session for child nutrition or development, she uses the 5P approach to both strengthen the key message as well as provide the psychosocial intervention. In practice, the approach works as follows:

Pillar 1. Family support. An initial home visit emphasizes family participation, and the training manual gives specific instructions on how this can be facilitated. Family members are encouraged to be active partners for the whole duration of the programme. Strategies to engage key decision-makers, such as mothers-in-law and husbands, are emphasized.

Pillar 2. Empathic listening. Each session begins in an open-ended fashion, with the CHW allowing the woman to talk freely. She uses active listening skills to convey empathy and makes a list of problems the woman faced in performing the desired behaviours that the CHW might have suggested in her previous visit.

Pillar 3. Guided discovery using pictures. Each new health message related to play, stimulation or nutrition is conveyed using this approach. Using carefully researched pictures, the CHW discusses both undesired and desired behaviours. She is trained not to impose her views but to allow the mother and family to consider each viewpoint and come to their own conclusions. The idea is that the basis of any behaviour change begins at the cognitive level.

Pillar 4. Behavioural activation. Once the message is received and accepted, the activities related to it have to be made manageable so that a sense of mastery is achieved. The training manual has suggestions for how each nutrition or play-related task can be broken down and monitored with the help of family members.

Pillar 5. Problem-solving. The CHW spends time discussing the problems the woman faced in carrying out the tasks suggested in the previous session (see Pillar 2). She discusses possible solutions, which she can generate through discussion with the family or through her supervision.

intervention guide (7), can be very helpful in this step of planning. They can also then be linked to the monitoring mechanism using a limited number of clear, relevant and agreed-upon goals.

Stepping-up intervention

Intervention needs to be systematically adjusted—"stepped up"—if patients are not improving as expected with input from a specialist consultant. Patients who continue to show no response to treatment or have an acute crisis should be referred to mental health specialty care.

Developing human resources

Sustainable models need to be developed to train and increase the number of culturally and ethnically diverse lay and specialist providers to deliver evidence-based services. Capacity in low- and middle-income countries can be increased by creating regional centres for mental health research, education, training and practice that incorporate the views and needs of local people as well as a life-course approach.

Addressing stigma related to mental illness

Stigma related to mental illness that could impede the integration of mental health into MCH programmes can be addressed through community awareness programmes.

Creating parity between mental and physical illness

Parity can be created between mental and physical illness in terms of investment into research, training, treatment and prevention. This would be facilitated by incorporating a mental health component into international MCH aid and development programmes.

Barriers and challenges

Health-care systems vary in their ability to respond to national health care needs. Many health-care systems, and

particularly those in fragile post-conflict settings, lack the core health system elements needed to provide the most basic set of services. Problems include poor financing and a fiscal infrastructure largely dependent on external aid; fragmentation of structures and services; weak systems for procurement (including inadequate supply of medications and poor or no access to diagnostic services); inadequate or weak governance and leadership; and a workforce that is often overwhelmed and experiencing high turnover. Integration may be the only feasible option to address mental health problems in the context of a weak health system, and doing so can contribute to systems strengthening more generally.

Policy-makers fear that mental health interventions will divert the energies of health-care staff and dilute the impact of other priority interventions. This view fails to take into account the holistic nature of health, and erroneously propagates the defunct theory of mind–body dualism. Most current evidence demonstrates the interconnectedness of physical and mental health and suggests that integrated interventions can achieve synergistic results.

A substantial obstacle to the integration of mental health care is lack of consensus over how to standardize and assign mental health-care tasks so that these can be delivered seamlessly by the same worker in a single programme. Consensus treatment packages, such as those in the mhGAP intervention guide, describe what counts as good and evidence-based care (7). But these packages need to be adapted for integration. For any health workforce to be effective, and for care packages to be delivered as intended, treatment guidelines need to be operationalized into coordinated roles and tasks. The starting point for effective integrated care pathways is to specify the skill-sets necessary to deliver integrated care effectively and to plan for the development and deployment

of these skills in the context of available human resources.

A major barrier remains the social exclusion and negative attitudes attached to mental health problems. Overcoming this barrier is as much a challenge for the public health professionals as for the communities they serve.

If the goal of improving women's well-being from childhood through to old age is to be achieved, healthy policies aimed at improving the social status of women are needed along with health policies targeting the entire spectrum of women's health needs. Integration of maternal mental health into the MCH agenda can provide a universally acceptable window of opportunity for creating healthy policies, from education to economic empowerment to legal and political mechanisms that enhance the status of women.

For the post-2015 agenda, mental health and noncommunicable diseases are seen as a central focus by public health experts globally, with a paradigm shift towards a comprehensive discourse. An integrated approach adopting so-called "systems thinking" that is guided by evidence-based resource allocation would ensure a responsive health system that is able to meet the needs of women and children. However, there are still those who lobby for attention to areas such as survival, nutrition, communicable diseases and who continue to be fixated on a singular condition or risk (e.g. poverty) without considering the synergies of action that an integrated approach would bring.

There is inadequate recognition of the link between mental health and other health conditions. Insufficient connections are made between mental health problems and other health conditions and how these impact each other in mothers and children. Without making this connection there is a risk that the burden of mental health problems is underestimated and mental

health care becomes alienated from mainstream efforts to improve health and reduce poverty.

Conclusions

This paper highlights the case for integrating maternal and child mental health interventions into mainstream MCH services. Such integration has the potential to improve both mental and physical health synergistically, with likely benefits throughout the life-course.

It discusses the key steps required and potential barriers to such integration. The responsibility to meet these challenges should be shared equally by mental health teams as well as the MCH community, and the following concrete measures should be taken as a matter of priority (*1*):

- Recognize, at the highest international and national policy forums, that mental health and well-being is a generic component of MCH that does not compete with MCH programmes but instead complements them.

- Tailor the training and supervision of MCH and primary care personnel so they can recognize and assist in the management of common maternal and child mental health problems. This, in turn, will enable them to be more effective health workers.

- Adapt effective interventions to local contexts and strengthen systems of supervision.

- Invest in research so that these approaches are refined and scaled-up, leading to improved outcomes to all MCH programmes.

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Mental health and psychosocial support in humanitarian emergencies

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الصحة النفسية والدعم النفسي الاجتماعي في حالات الطوارئ الإنسانية

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الخلاصة: إن النزاعـات المسـلحة والكـوارث الطبيعيـة تؤثّـر سـلباً عـلى الصحـة النفسـية والعافيـة لـدى السـكان المتضرريـن في الأجلـين القصـير والطويـل وتؤثـر عـلى رعايـة الأشـخاص الذيـن يعانـون مـن حـالات نفسـية مـن قبـل. وهـذا البحـث يعـرض بإيجـاز إجـراءات محـددة في مجـال الصحـة النفسـية والدعـم النفسـي الاجتماعـي يقدمهـا القطـاع الصحـي في مراحـل التأهـب لحـالات الطـوارئ والاسـتجابة لهـا والتعـافي منهـا. وتتمثـل التوصيـات العامـة لـوزارات الصحـة في: (1) تضمـين الصحـة النفسـية والدعـم النفسـي الاجتماعـي في الخطـط الصحيـة الوطنيـة والخطـط الوطنيـة للتأهـب للطـوارئ، (2) وضـع دلائـل إرشـادية ومعايـير وأدوات داعمـة وطنيـة خاصـة بتوفـير الصحـة النفسـية والدعـم النفسـي الاجتماعـي في حـالات الطـوارئ، (3) تعزيـز قـدرات العاملـين في مجـال الصحـة في التعـرف عـلى الاضطرابـات النفسـية ذات الأولويـة وتقديـم العـلاج لهـا أثنـاء حـالات الطـوارئ، (4) اسـتغلال الفـرص الناتجـة عـن الاسـتجابة لحـالات الطـوارئ في الإسـهام في تطويـر خدمـات الرعايـة الصحيـة النفسـية المسـتدامة.

ABSTRACT Armed conflicts and natural disasters impact negatively on the mental health and well-being of affected populations in the short- and long-term and affect the care of people with pre-existing mental health conditions. This paper outlines specific actions for mental health and psychosocial support by the health sector in the preparedness, response and recovery phases of emergencies. Broad recommendations for ministries of health are to: (1) embed mental health and psychosocial support in national health and emergency preparedness plans; (2) put in place national guidelines, standards and supporting tools for the provision of mental health and psychosocial support during emergencies; (3) strengthen the capacity of health professionals to identify and manage priority mental disorders during emergencies; and (4) utilize opportunities generated by the emergency response to contribute to development of sustainable mental health-care services.

Santé mentale et soutien psychosocial en situation d'urgence humanitaire

RÉSUMÉ Les conflits armés et les catastrophes naturelles ont des répercussions négatives sur la santé mentale et le bien-être des populations touchées à court et long termes et affectent la prise en charge des personnes atteintes de troubles de santé mentale préexistants. Le présent article détaille les actions spécifiques en matière de santé mentale et de soutien psychosocial menées par le secteur de la santé dans les phases de préparation aux situations d'urgence, d'organisation des secours et de relèvement. Les recommandations générales destinées aux ministères de la Santé sont les suivantes : 1) intégrer la santé mentale et le soutien psychosocial dans les plans nationaux de santé et de préparation aux situations d'urgence ; 2) mettre en place des directives et des normes nationales, et des outils d'appui pour la santé mentale et le soutien psychosocial en situations d'urgence ; 3) renforcer les capacités des professionnels de santé à identifier et prendre en charge les troubles de santé mentale prioritaires en situations d'urgence ; et 4) exploiter les opportunités générées par la riposte aux situations d'urgence pour contribuer à la mise en place de services de soins de santé mentale pérennes.

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The case for mental health & psychosocial support in emergency settings

Armed conflicts and natural disasters cause not only physical injuries but also major psychological and social suffering that undermines the long-term mental health and well-being of the affected populations. This in turn may ultimately be a threat to peace, human rights and economic development. People with pre-existing or emergency-induced mental health conditions can be especially vulnerable in humanitarian emergencies, while facilities for mental health care are often directly affected by emergencies, causing disruption of regular services and interruption of ongoing treatments. Yet there are effective individual, group and population level mental health and psychosocial interventions that can be applied in emergencies. Among the many priorities in emergencies, therefore, is the protectio+n and improvement of people's mental health and psychosocial well-being. This requires coordinated, cross-sectoral action (1–3).

WHO estimates that after an acute onset major emergency on average about 1 in 6 people (10–15%) will suffer a mild to moderate mental disorder. In addition, about 1 in 30 people (3–4%) will have a mental disorder that is so severe that it undermines their ability to function and survive in a chaotic emergency environment (4). Mental health and psychosocial problems are frequently raised as an issue by the media, governments and humanitarian agencies during high-profile emergencies, but they need similar attention during all kinds of humanitarian emergencies including protracted emergencies that fall "out of the spotlight" of the media.

This paper summarizes the key actions for mental health and psychosocial support (MHPSS) by the health sector in the preparedness, response and recovery phases of emergencies.

Preparedness phase: planning

In the preparedness phase for MHPSS in emergency settings, which is part of national emergency planning, it is recommended to:

- embed MHPSS in national health policies and strategies and emergency preparedness plans;

- map existing formal and non-formal resources and practices in MHPSS (5);

- orient staff in the health, protection and other sectors as well as workers in the community in "psychological first aid" (6);

- train and supervise health-care staff in the management of priority mental health conditions that are relevant to emergencies, using the World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR), Mental Health Gap Action Programme (mhGAP) *Humanitarian intervention guide* (mhGAP-HIG) (7);

- prepare emergency stocks of essential psychotropic medications. At a minimum there should be availability of amitriptyline (or fluoxetine), phenobarbital (or carbamazepine), biperiden, haloperidol and diazepam (8);

- develop emergency preparedness plans for people with severe or chronic mental illness residing in institutions and in the community, as per Action Sheet 6.3 of the Inter-Agency Standing Committee (IASC) *Guidelines for mental health and psychosocial support in emergency settings, 2007*) (1).

Response phase: action

Assessment of MHPSS needs

Assessment of MHPSS needs during the response phase should involve mapping of existing resources and capacities, including what is being done by organizations and how affected people are coping. Tools exist to conduct MHPSS assessments of needs and resources (5). Assessments and situational analyses have been conducted in various countries of the Eastern Mediterranean Region by United Nations' agencies (9) and nongovernmental organizations such as the International Medical Corps (e.g. in Libya and Jordan, available at http://www.mhpss.net).

The provision of essential MHPSS services should not be delayed by assessments, but should go hand-in-hand with them.

During a humanitarian crisis epidemiological surveys to estimate the prevalence of mental disorders are not needed to justify investing in MHPSS or to start planning services. In specific cases, and if well conducted, prevalence surveys can be justified, for example to inform advocacy efforts and to add to the current scientific evidence.

Coordination of MHPSS interventions

In order to coordinate interventions in the response phase MHPSS activities need to be discussed and integrated within the work plans of the relevant sectors, especially those in health, protection and education. MHPSS does not constitute a separate cluster or sector and therefore accountability for MHPSS activities remains within the relevant clusters or sectors. In order to avoid fragmentation of MHPSS over various clusters or sectors in emergencies with numerous MHPSS managers it is recommended to establish a cross-sectoral MHPSS working group with strong functional links to (sub) clusters or sectors for health, protection, child protection, sexual and gender-based violence and education, and co-chaired by a health agency and a protection agency. The group can provide a forum for information exchange by mapping the situation, for example using the 4Ws tool (Who is doing What Where and

until When) (*10*), by cross-sectoral multi-agency assessments and by organizing joint workshops and trainings.

Provision of MHPSS interventions

Mental health interventions in non-specialized health settings

Non-specialist health staff, with a brief training and good clinical supervision, are able to provide basic evidence-based interventions for people with mental, neurological and substance use disorders in emergencies. Every health facility in an emergency setting (including mobile clinics, general hospitals, field hospitals, primary health care facilities) should have at least one staff member who is trained and supervised to identify and manage mental health problems in adults and children. It is recommended to base this on the guidance of the WHO/UNHCR's mhGAP-HIG (*7*). The Interagency Emergency Health Kit specifies certain essential medicines for mental health care in emergencies (*8*).

Evidence-based psychological interventions

Some evidence-based psychological interventions (e.g. cognitive–behaviour therapy, interpersonal therapy and stress management) could potentially be implemented by lay workers, provided they are well trained and supervised (*11*). However, many popular generic counselling programmes lack a robust evidence base. Some psychological interventions can even be harmful when implemented by undertrained, unsupervised helpers. One-off sessions of so-called "psychological debriefing" have been found to be ineffective and potentially harmful and their use should be discouraged (*12*).

Supervision and referral pathways

Mental health interventions at the lower levels of the health-care system must be supported by mental health services at higher levels of the health system,

through ongoing clinical supervision and referral options.

Psychological first aid

Community workers, including volunteers, as well as staff involved in providing various services and activities (e.g. health facilities, child friendly spaces, schools, protection services), can offer psychological first aid to people in acute distress (*5*). Orientation seminars in psychological first aid can be brief, as little as a half day or one day (*13*).

Protection of people with severe mental disorders

It is essential to address the safety, basic needs and rights of people with severe mental health problems in institutions and in the community in times of humanitarian emergency. Mental hospitals and residential homes for people with severe mental problems need to be visited regularly, especially in conflict settings, because severe neglect and abuse of people in institutions is common in emergencies. Safety, basic physical needs (water, food, shelter, sanitation and medical care), human rights surveillance and basic psychiatric and psychosocial care must be provided throughout the crisis. People with severe mental disorders in the community and their care-givers also need access to appropriate support, information and mental health services.

Collaboration

Dissemination of information

Lack of information is a key concern and a major source of anxiety in populations affected by humanitarian emergencies. It is therefore important to disseminate information to the community on the current emergency situation, relief efforts and available services and supports. This may be done through various media, including bulletin boards and pamphlets at health-care facilities.

Links between different levels of services

People with mental health and psychosocial problems may have major

challenges in accessing mental health care as well as other basic support and services. Within each emergency, systems should be developed to link vulnerable individuals to the assistance they need. One way to do this is by adding case managers or MHPSS outreach workers to health services. Links should also be established between different levels of mental health support and services (e.g. links from the community level to facility-based clinical mental health services).

Community support

It is useful to engage community workers and volunteers in order to strengthen self-help and social support among community members, including marginalized groups. This can include:

- early childhood development activities (especially important in food crises) (*14,15*);

- support for emergency relief (e.g. building shelters) that is initiated by the community;

- support for social support activities that are initiated by the community; and

- facilitation of community support to marginalized people including people with mental disorders.

Early recovery

It is necessary to initiate plans and create the momentum to develop a sustainable community mental health system as part of an early recovery phase.

Recovery phase: opportunities

A number of countries in the world, especially in the Eastern Mediterranean Region, have seized opportunities during and after emergencies to build better mental health-care services (*21,22*). Emergencies often mobilize considerable attention towards, and resources for, the psychological

Box 1 Case study on mental health and psychosocial support in humanitarian emergencies: experiences from Libya

Decades of neglect and the 2011 conflict left Libya's mental health system with only 12 psychiatrists. Libya's services had been highly centralized in psychiatric hospitals in the main urban centres of Tripoli and Benghazi, and the country did not have a postgraduate training programme in mental health. During 2011, hundreds of Libyans with war-related symptoms or pre-existing mental disorders aggravated by the emergency flocked to the few existing mental health facilities seeking treatment from a system that was unable to cope.

A new mental health programme led by the Libyan Ministry of Health and the Libyan National Centre for Disease Control, and supported by WHO, aimed to transform Libya's institution-based and centralized approach to mental health care into to a decentralized and community-based approach. The goal was to make mental health services available to the most remote and underserved areas of the country through capacity-building of professionals of many disciplines. This included a diploma course for general practitioners in primary mental health care and a diploma course for psychologists in psychotherapeutic interventions. Candidates for the two intensive training programmes were selected from underserved areas.

The programme led to the creation of multidisciplinary teams that provided services in geographical locations where no mental health services existed. Specialists were assigned to Ministry of Health mobile teams to support and supervise these new services. Hundreds of service users have been using outpatient multidisciplinary services every month. In 2013 the programme trained psychiatrists, nurses, social workers, volunteers and programme managers. It also ran advocacy campaigns to raise awareness about mental health among the public and professionals, in order to combat stigma and facilitate the introduction of the new community-based services to different geographical areas. Long-term training programmes have been designed and will be implemented to establish the first locally graduated Libyan psychiatrists (*18*).

In 2014, the political and security situation in Libya markedly deteriorated, which disrupted many training activities and compromised the presence of international organizations in the country. However, despite the political upheaval, some of the recently trained local professionals in Libya started to provide services in new locations in 2014. The first community mental health centre in Kufra opened in the south of the country and new mental health clinics were established in the cities of Ajdabya and Zawia. Service provision in these new mental health facilities is provided by multidisciplinary teams of Libyan professionals, who have continued, against the odds, to provide services for the people of their country.

Box 2 Case study of reorganization of mental health services in humanitarian settings from Jordan

The influx of displaced, war-affected Iraqis into Jordan has drawn substantial mental health support from aid agencies and short-term humanitarian funds from donors. Within this context, the Ministry of Health of Jordan and WHO initiated a mental health programme in 2008 to provide community-based mental health care to Iraqis and Jordanians, through the adoption of a comprehensive, multidisciplinary, biopsychosocial approach (*16*).

Collaboration with a range of stakeholders, led by the Ministry of Public Health, has been key towards the setting up of integrated mental health services. Jordan was one of the first countries to pilot the Mental Health Gap Action Programme (mhGAP). So far, approximately 90 general health workers at 21 primary health-care centres in three governorates (four cities) have been trained on the mhGAP base course, and continue to receive monthly supervision and follow-up. Four community mental health centres (outpatient centres) in Amman, Irbid and Ma'an—staffed by multidisciplinary teams including psychiatrists, psychologists, social workers and nurses—provide comprehensive care in the community. A model acute inpatient unit was set up at the National Centre for Mental Health which has led to three further mental health inpatient units at King Abdullah Hospital (Irbid), Jordan University Hospital (Amman) and Ma'an Governmental Hospital (Ma'an). The first organization representing mental health service users and their families (Our Step Association) is dedicated to supporting people with mental health problems through advocacy, awareness, fighting stigma and promoting mental health and human rights in the community. The Association works closely with WHO and the Jordanian Ministry of Health outpatient centres to provide vocational, rehabilitation, educational and recreational activities to its members. In 2013, the Association started using the WHO Quality Rights Toolkit to provide support to improving the rights of service users at facilities (*17*).

The plans are to scale up the integration of mental health in primary health care through the implementation of mhGAP in three governorates (Ma'an, Tafilah, Zarqa) and to establish inpatient and outpatient mental health units in Zarqa.

For further information see the following: the chapter on Jordan in the WHO's 2013 publication Building back better: sustainable mental health care after emergencies (*16*); YouTube videos on Mental health reform in Jordan (*18,19*); and the WHO MiNDbank database of resources for Jordan (*20*).

welfare of affected people, while decision-makers become more willing to consider options beyond the status quo. The media frequently highlights the psychological suffering of survivors and this may increase the willingness and financial ability of national and international agencies to support mental health and psychosocial assistance to affected people. Therefore, humanitarian emergencies may create unique opportunities for better and more sustainable mental health services. Momentum needs to be generated at an early stage so that investments continue after an acute crisis. See Boxes 1 and 2 for cases studies from Libya and Jordan.

Key recommendations for ministries of health

- Embed MHPSS in national health and emergency preparedness plans.

- Put in place national guidelines, standards and supporting tools for the provision of MHPSS during emergencies.

- Strengthen the capacity of health professionals to identify and manage priority mental disorders during emergencies.

- Utilize opportunities generated by the emergency response to contribute to the development of sustainable mental health-care services.

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Promotion of mental health and prevention of mental disorders: priorities for implementation

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تعزيز الصحة النفسية والوقاية من الاضطرابات النفسية: أولويات التنفيذ

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الخلاصة: هناك أدلة دامغة من دراسات عالية الجودة على أن تعزيز الصحة النفسية وتدخلات الوقاية الأولية يمكن أن تقلل من مخاطر الاضطرابات النفسية، وتعزز العوامل المحصِّنة اللازمة لصحة نفسية وبدنية جيدة، وتؤدي إلى آثار إيجابية طويلة الأمد على مجموعة كبيرة من النتائج الاجتماعية والاقتصادية. إن هذا البحث يستعرض الأدلة المتاحة بُغْيَة توجيه تنفيذ التدخلات التي تعزز الصحة النفسية وتقي من اضطراباتها في إقليم شرق المتوسط. ويحدد البحث عدداً من المجالات ذات الأولوية التي يمكن أن تولد مكاسب صحية واجتماعية واضحة لدى السكان وأن تنفَّذ وتستمر بتكلفة معقولة. وإن هذه التدخلات تغطي فئات من السكان على امتداد الحياة من الطفولة إلى البالغية، وتشمل إجراءات تقدَّم عبر مواقع وبرامج تقديم مختلفة. وقد تم تحديد "أفضل المارسات" كتدخلات توجد أدلة ليس فقط على فعاليتها بل كذلك على جدواها في ظل محدودية الموارد. وتتم دراسة الآثار المترتبة على النتائج من أجل تنمية القدرات.

ABSTRACT There is compelling evidence from high-quality studies that mental health promotion and primary prevention interventions can reduce the risk of mental disorders, enhance protective factors for good mental and physical health, and lead to lasting positive effects on a range of social and economic outcomes. This paper reviews the available evidence in order to guide the implementation of mental health promotion and prevention interventions in the Eastern Mediterranean Region. The paper identifies a number of priority areas that can generate clear health and social gains in the population and be implemented and sustained at a reasonable cost. The interventions cover population groups across the lifespan from infancy to adulthood and include actions delivered across different settings and delivery platforms. "Best practices" were identified as interventions for which there is evidence not only of their effectiveness but also of their feasibility within resource constraints. The implications of the findings for capacity development are considered.

Promotion de la santé mentale et prévention des troubles mentaux : priorités pour la mise en œuvre

RÉSUMÉ Selon des preuves irréfutables issues d'études de haute qualité, la promotion de la santé mentale et les interventions de prévention primaire permettent de réduire le risque de troubles de santé mentale, de renforcer les facteurs protecteurs pour une bonne santé mentale et physique et de produire des effets positifs durables sur un éventail de problèmes socioéconomiques. Le présent article examine les preuves disponibles afin d'orienter la mise en œuvre d'interventions pour la promotion et la prévention de la santé mentale dans la Région de la Méditerranée orientale. Il identifie un certain nombre de domaines prioritaires qui peuvent générer de nettes améliorations sanitaires et sociales dans la population et être mis en œuvre puis pérennisés pour un coût raisonnable. Les interventions couvrent des groupes de population de tout âge, de la petite enfance à l'âge adulte et comprennent des actions menées dans des milieux variés et à partir de plateformes de prestation différentes. « Les meilleures pratiques » ont été identifiées comme étant des interventions pour lesquelles non seulement l'efficacité, mais aussi la faisabilité ont été prouvées dans un contexte de compression des ressources. Les implications des résultats en matière de renforcement des capacités sont en cours d'étude.

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Introduction

The World Health Organization's (WHO) comprehensive mental health action plan (2013–20) clearly identifies that good mental health is an integral component of population health and well-being and contributes to the functioning of individuals, families, communities and the social and economic prosperity of society (1,2). There is a solid case for investing in mental health promotion and primary prevention, whether on the grounds of improving population health and well-being, reducing social and health inequities, protecting human rights or improving economic efficiency and development (1–3). Despite the growing recognition of the importance of good mental health, it remains a neglected aspect of public health in many countries. The WHO regional strategy on mental health and substance abuse in the Eastern Mediterranean Region (EMR) incorporates a clear focus on the implementation of evidence-based mental health promotion and prevention as one of its six strategic components (3). This includes developing strategies for mental health promotion and prevention in mental health, public health and other public policies requiring high-level collaboration across government departments and sectors.

Strategies focused on curing mental ill health alone will not necessarily deliver improved mental health at a population level (1). Mental health promotion and prevention strategies have been introduced in many countries globally as the most sustainable method of reducing the increasing burden of mental disorders and improving overall health and well-being. There is compelling evidence from high-quality studies that mental health promotion and prevention interventions, when implemented effectively, can reduce risk factors for mental disorders, enhance protective factors for good mental and physical health and lead to lasting positive effects on a range of social and economic outcomes (4–10). Mental health promotion and prevention needs to be integrated into population health improvement and development strategies, together with primary and secondary health care delivery.

This paper provides a briefing for policy- and decision-makers in the EMR on the evidence for mental health promotion and primary prevention interventions, identifying priority areas for action based on their effectiveness and feasibility of implementation. The international evidence from across high-, middle- and low-income countries shows that there are effective and feasible interventions for promoting mental health and preventing mental ill health that represent a cost-effective use of resources and a strong case for policy investment. This paper provides a guide, based on best available evidence, to support decision-making in identifying priority areas and best practice for implementation.

Frameworks for action

Mental health promotion is concerned with promoting positive mental health and employs intersectoral strategies for strengthening protective factors and enabling access to resources and supportive environments that will keep individuals and populations mentally healthy (4,7). Prevention aims to reduce the incidence, prevalence or seriousness of specific mental health problems, such as anxiety and depression (11). Primary prevention can be universal or it can target populations at risk (selective and indicated) and is distinguished from secondary prevention that focuses on early detection and treatment, and tertiary prevention that aims to reduce disability and enhance rehabilitation of people with mental disorders. Current frameworks for mental health promotion and prevention seek to intervene at different levels, by strengthening individuals, strengthening communities, reorienting health services and promoting intersectoral actions to remove structural barriers to mental health at a societal level (4,5,7).

Assessing best evidence

The evidence for effectiveness of interventions was taken from existing databases, systematic reviews and meta-analyses in high-income countries and in low- and middle-income countries (LMICs). This paper draws particularly on a review of the evidence of mental health promotion interventions in LMICs completed for the WHO Task Force on Mainstreaming Health Promotion (10), a systematic review on interventions for young people in LMICs (8), meta-analyses of interventions to reduce stigma (12,13), a review paper on mental health literacy (14) and a review of population and community level mental health promotion and prevention interventions (15).

In selecting priority interventions based on available evidence, so-called "best practices" are understood to be interventions for which there is not only evidence of their effectiveness but also of their feasibility in relation to their cultural acceptability as well as the capacity of existing service delivery systems to deliver the intervention to the intended target population within existing resource constraints (16). "Good practices" are interventions that do not meet all these criteria but are recommended based on the best available evidence. Given the paucity of cost–effectiveness studies on mental health promotion and prevention research in the Region, we recommend a set of best practices based on cost-effective evidence from high-income countries and evidence of feasibility in LMICs. Feasibility was determined on the basis of whether a task-sharing approach[1] was

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[1]   Task-sharing refers to "the redistribution of tasks to less specialized cadres or cadres with tailored training to perform a specific task under the supervision and support of specialists" (64).

successfully adopted by a number of randomized control trials, given the limited evidence of interventions that have been scaled up more broadly in LMICs. A technical paper which gives full details of the research evidence supporting this briefing document is also available for consultation (*17*).

Implementing mental health promotion and prevention strategies: priorities for action

Priority areas for implementation are identified based on the available evidence on mental health promotion and primary prevention interventions from high-, middle- and low-income countries in terms of their ability to improve mental health and lead to social and economic benefits, and the feasibility of their implementation. The interventions cover population groups across the lifespan from infancy to adulthood, and include actions that can be delivered across different settings and delivery platforms.

Promote infant (aged 0–3 years) and maternal mental health (best practice)

Integrating mental health promotion and prevention interventions, such as parenting interventions to promote mother–child interaction, into routine pre- and postnatal care services, including home-visit parenting programmes, leads to improved parenting and child development, improved maternal health and social functioning and reduced behavioural problems in children (*18,19*). Antenatal screening and targeted prevention interventions improve detection and management of postnatal depression for women at risk of depression and intimate partner violence (*20,21*). The effects of early years interventions are especially evident for the most vulnerable families, including those living in poverty and war-torn areas, and for mothers

with depression (*22–25*). Studies also show the sustained added value of combining psychosocial stimulation with nutritional supplements for extremely disadvantaged children who have stunted growth (*24*). Economic analyses of several early childhood interventions show that they can repay their investment with savings to government and benefits to society, with those at risk making the most gains (*6,21*). Home-visiting interventions which integrate the promotion of mental health have demonstrated long-term positive outcomes for mothers and babies, have the potential to be scaled up in LMICs and are recommended as a best practice.

Promote early child mental health development (aged 3–6 years) through preschool education/enrichment programmes (good practice)

High quality early childhood enrichment programmes result in enduring gains in children's social and emotional well-being, cognitive skills, problem behaviours and readiness for school (*19,26,27*). Long-term effects on school attainment, social gains and occupational status have been found, with greater benefits for higher risk and more disadvantaged children (*28,29*). Pre-school programmes indicate a benefit-to-cost ratio as high as 17.6 to 1 (*28*), with favourable benefit–cost ratios being reported for even the most intensive programmes. Examples of successful implementation in LMIC contexts include the development of a preschool programme for families of low education in Bangladesh (*30*) and the long-term impact of the Turkish Early Enrichment Project implemented by mothers with the help of local paraprofessionals (*31*). Due to the limited evidence on scaling up in LMICs, enrichment/preschool education integrating emotional and social skills development for children is recommended as a good practice.

Implement parenting and family strengthening programmes for school-going children (aged 3–16 years) (good practice)

Universal and targeted parenting and family strengthening interventions promote child emotional and behavioural adjustment, particularly in younger children (aged 3–10 years) and can prevent conduct disorder in at-risk families (*32–34*). The benefits of targeted parenting programmes for the prevention of persistent conduct disorders outweigh the costs around 8 to 1 in high-income countries (*6*), with benefits accruing mainly in the criminal justice system. In view of limited evidence from LMICs, parenting/family strengthening interventions for school-going children are suggested as a good practice, with the recommendation that studies in the EMR be conducted to demonstrate their effectiveness and feasibility.

Promote young people's (aged 6–18 years) life skills and resilience through whole school-based interventions in primary and post-primary schools (best practice)

Universal (for all children) social and emotional learning interventions in primary and post-primary schools lead to long-term benefits in children's social and emotional functioning and academic performance (*35,36*). Interventions employing a whole-school approach (involving staff, students, parents, the school environment and the local community) are more effective than curriculum-only programmes, including addressing problems such as bullying (*37*). School-based interventions which enhance coping skills, resilience and cognitive skills for children at higher risk are effective in preventing anxiety and depression and have been adapted successfully in LMIC settings (*8,38*).

These interventions can be feasibly delivered by teachers in low-resource settings, and economic analyses show

that social and emotional learning interventions are cost-saving in terms of the positive impact on crime and health outcomes (6). Universal and targeted school interventions are recommended as a best practice.

Implement selective class-room-based interventions for vulnerable children (orphaned by HIV or living in areas of conflict/war) (good practice)

The prevalence of mental disorders in children living in countries at war and with complex emergencies is extremely high. In the EMR, estimates of mental disorders in schoolchildren range from 22.2% in Afghanistan to 54.4% of boys in Palestine (3). Classroom-based interventions which aim to reduce distress and enhance resilience and coping skills have been found to improve psychological functioning and coping in some studies but not in others (39,40). Positive effects seem to be moderated and mediated by personal attributes, including age and sex as well as the severity of risk and difficulties, and may be more suited to contexts where the risks and difficulties are less severe (41).

Promote the mental health and social well-being of adolescents and young people (aged 12–18+ years) through out-of-school multicomponent interventions (good practice)

Out-of-school youth empowerment programmes improve the mental health of young people in LMICs through promoting life skills, greater gender equity, reduced intimate personal violence and poverty reduction, thus addressing some of the social determinants of mental health. Multicomponent, community-based interventions that address emotional and sexual health, HIV prevention, substance misuse, violence prevention and literacy and social functioning among vulnerable youth show the potential for scaling up initiatives (8). The implementation of youth empowerment programmes is recommended as a good practice based on evidence from the Ishraq intervention

in Egypt, which provides an example of a promising intervention from the EMR delivered using a task-sharing approach (42).

Facilitate community empowerment interventions to promote mental health and reduce the risk of mental disorders for families in poverty and debt (good practice)

Poverty and debt impact negatively on mental health; people experiencing unmanageable debt have been shown to be at higher risk of mental disorders and suicide. Combined community microfinance and health training interventions have positive mental health and social benefits, including improved well-being and psychological health, improved nutrition, higher educational attainment, reduced risk of violence and improved social participation, empowerment and economic well-being (43). Microcredit schemes, which combine microfinance and training interventions that promote essential life skills, asset building and resourcefulness, are more effective in terms of mental health benefits (44). There is encouraging evidence from initiatives such as the IMAGE intervention in South Africa, which combines training on gender issues and HIV with microfinance initiatives for women (45,46), and an economic empowerment initiative for AIDS orphaned children, which has also shown positive impacts on participants' self-esteem and reduced levels of depression (47). Microfinance interventions for young adults and women, which are cost-effective from both a societal and public health perspective, are recommended as a good practice.

Train primary health care providers in opportunistic mental health promotion and prevention interventions for adults and older people (good practice)

Many adults and older people with mental health problems in the EMR first seek care from primary health-care practitioners (3). The training of primary health-care providers in screening

and brief interventions for alcohol misuse can reduce harmful alcohol use, and training in the identification and management of mental disorders can prevent suicide (48). Brief interventions by primary health-care practitioners on alcohol consumption is considered more cost-effective than policy-level interventions (see the section on policy/regulations) in countries where the rate of harmful drinking is low and risky drinking is not widespread (49). Brief, passive psychoeducational interventions for individuals with depression and psychological distress should also be considered, given evidence from high-income countries that these interventions can reduce symptoms (50).

Advocate for workplace policies & programmes that will improve the mental health of working adults (good practice)

Integrating mental health into workplace health and safety regulations, including workers' rights, job security, increased job control and autonomy and anti-bullying measures, will improve and maintain good mental health at work, with the gain from comprehensive approaches being reflected in reduced absenteeism, improved well-being and improved productivity (6,51–53).

The new SOLVE training package, developed by the International Labour Organization, is designed to reduce the incidence of work-related stress, workplace violence (physical and psychological), tobacco, alcohol and drug misuse and HIV/AIDS. This intervention, which has been implemented in several LMICs (53), is recommended for implementation supported by more rigorous research on its impact in the EMR.

Implement suicide prevention programmes (good practice)

While suicide rates in the EMR countries are generally lower compared with other WHO regions (54), relatively high suicide rates have been observed among young women and men aged

15–29 years in LMICs in the EMR (8.6 and 7.6 per 100 000 respectively) and women and men aged 60 years and older (7.0 and 10.8 per 100 000 respectively) (54). The "criminalization" of suicidal behaviour in such countries may explain to some extent why reported suicide mortality rates are lower in the EMR than in other regions (55,56).

There is growing evidence to support the implementation of a broad range of interventions to reduce and prevent suicide and self-harm in different settings and cultural contexts. Some of the interventions that have been found to be effective include: responsible media reporting, restricting access to the means of suicide, training of health personnel for early recognition and management of priority mental, neurological and substance use disorders (57,58), and school-based skills training and social support for at-risk students (58). However, further evaluation together with modifications to the context of EMR countries is needed. Setting up systems to capture information about the rates of suicides and suicide attempts, the methods of suicide employed and the demographic characteristics of victims, as well as action towards decriminalization of suicide, could be the first step for countries of the Region towards suicide prevention. Regulations restricting access to commonly used lethal means of suicide (region-specific) is also a cost-effective means to reduce suicide rates (52).

Promote mental health literacy and reduction of stigma through multicomponent public awareness campaigns and community-based educational training interventions (good practice)

Mental health literacy is defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (14). Stigma towards people with mental disorders is multifaceted, comprising ignorance (lack of knowledge), prejudice (stigmatizing attitudes) and discrimination (being treated unfairly) (59).

Drawing on recent systematic reviews, meta-analyses of stigma interventions (12,13) and a review paper on mental health literacy (14), the following interventions for promoting mental health literacy and reducing stigma can be identified: mass promotion through the media, setting up of dedicated websites, school education programmes, and mental health first aid training. The evidence for their effectiveness comes primarily from high-income countries. Therefore, at this point the decision to scale up these interventions in LMICs has to be taken based on the context of individual countries. Furthermore, there have been no studies on the cost–effectiveness of such interventions.

- Mass mental health literacy promotion programmes can improve the general public's knowledge of mental disorders and to some extent improve the public's acceptance and reduce their prejudice towards people with mental health problems. However, these can be costly to implement and their broader impacts are not known (60).

- Internet interventions are at least as effective as face-to-face interventions at reducing the stigma of mental health (13). They have the capacity to reach large numbers of people, even in low-income countries. Adapting existing websites designed for high-income countries could be relatively inexpensive to implement for low-income countries.

- Mental health education programmes in schools can improve mental health knowledge of children (61). While most studies of school programmes have been carried out in high-income countries, one of the best evaluated in a low-income country was carried out in rural Pakistan. This demonstrated improved knowledge not only in students, but also in adults in the broader community (62).

- There are a number of programmes that train members of the public to assist people who are at risk of developing a mental health problem or who are suicidal or in crisis. Mental health first aid training is the best-researched intervention and has been found to change people's knowledge, attitudes and behaviour towards mental ill health (63). This type of training is being implemented in a number of low- and middle-income countries, including two Eastern Mediterranean countries (Saudi Arabia and Pakistan).

Discussion

This review has identified a number of priority areas and best practices for implementation in promoting mental health and preventing mental ill health across the lifespan and different settings and delivery platforms. Based on available research from high-, middle- and low-income countries, there is convincing evidence of the effectiveness of interventions that could feasibly be implemented in the EMR. The limitations of this review must be acknowledged in terms of the bias towards English language publications and the possibility that studies published in other languages may not have been accessed. In addition, studies not employing experimental designs were not included and, therefore, some potentially promising interventions may have been excluded in the search process. The paucity of cost–effectiveness studies from countries within the Region is a clear limitation. However, the interventions identified are based on well-designed research studies and clearly demonstrate what can be achieved when the necessary resources, expertise and capacity are made available. The review findings support the recommendation of a number of priority interventions, as outlined in Box 1.

Developing the capacity for implementing the priority areas and best practices identified in this review is a critical next step in promoting population mental health in the Region. This includes

promoting a better understanding among policy-makers, health professionals and the public more generally of the need for mental health promotion and prevention interventions and how these contribute to achieving the goals of population health, social and economic well-being and the broader development agenda at a country level. Treatment approaches alone will not be sufficient to meet the challenge of the growing burden of mental disorders and it is critical that countries invest in early intervention, prevention and promotion of good mental health at a population level.

Implications for policy and practice

At a policy level, there is a need for strategic investment in developing and supporting national leadership, technical expertise and workforce development for mental health promotion and prevention in the EMR. Collectively,

the evidence in this review points to the potential of scaling-up intervention approaches that can be sustained at a reasonable cost through the use of trained paraprofessionals and preexisting structures and resources working collaboratively on a cross-sectoral basis. Workforce capacity for mental health promotion and prevention needs to be developed across the health, education, community and related sectors, with a focus on harnessing available skills and resources for the implementation of evidence-informed best practices. Planning and implementation groups will need to be established in order to design and facilitate action at a regional, country and district level. Local expertise will be required in contextualizing policies and translating international evidence into effective actions tailored to the cultural and socioeconomic contexts of countries in the Region. The provision of training and skill development in the implementation of promotion and

prevention approaches will be needed in order to support the delivery of best practices by local professionals and community workers. The development of workforce competencies in promotion and prevention work will need to be given greater priority in public health and mental health services at both regional and country level to ensure that the necessary commitment and expertise will be mobilized effectively.

Implications for research

The best practice interventions identified in this review have achieved success across a diverse range of countries and contexts. However, few have been scaled up at a country level. Therefore, evidence of the feasibility of implementing these in an effective and sustainable manner in the EMR needs to be strengthened. Further research is needed to demonstrate the cost–effectiveness of the best practices as applied in the regional context. As there are a

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Box 1 Recommended priority actions for promotion of mental health and prevention of mental disorders in the Eastern Mediterranean Region

- Promote infant (aged 0–3 years) and maternal mental health through integrating mental health promotion and prevention into routine pre- and postnatal care services and home visiting programmes.

- Promote early child mental health development (aged 3–6 years) through preschool education/enrichment programmes.

- Implement parenting and family strengthening programmes for school-going children (aged 3–16 years).

- Promote young people's (6–18 years) life skills and resilience through whole school-based interventions in primary and post-primary schools.

- Implement selective classroom-based interventions for vulnerable children (orphaned by HIV or living in areas of conflict/war).

- Promote the mental health and social well-being of adolescents and young people (aged 12–18+ years) through out-of-school multicomponent interventions.

- Facilitate community empowerment interventions to promote mental health and reduce the risk of mental disorders for families in poverty and debt.

- Train primary health-care providers in opportunistic mental health promotion and prevention interventions for adults and older people.

- Advocate for workplace policies and programmes that will improve the mental health of working adults.

- Implement suicide prevention programmes, including regulations on restricting access to commonly used lethal means of suicide, decriminalize suicide and establish improved reporting systems.

- Promote mental health literacy and reduction of stigma through multi-component public awareness campaigns and community-based educational training interventions.

limited number of studies providing robust evidence in certain action areas, it will also be important to determine how well-validated interventions developed in high-income countries could be adapted and implemented in the Region. Implementation research is needed to examine the level and quality of planning, delivery and resourcing required to ensure successful adaptation and transferability of interventions across diverse cultural and socioeconomic settings. The development of culturally valid measures of mental health that will support the evaluation of culturally appropriate interventions in the Region is identified as an area for methodological development that will be critical to the advancement of work in this area. Strengthening local research capacity will be an important aspect of supporting and advancing the development and evaluation of mental health promotion and prevention interventions in the regional context.

Conclusions

There is an urgent need to invest in building the policy, practice and research capacity for mental health promotion and prevention in the EMR to ensure that resources are in place for implementing and evaluating the interventions identified as best practices and good practices in the local context. Developing the regional evidence base on the implementation, outcomes and actual costs of the interventions described in this paper is an important next step, together with further work on the cultural adaptation and tailoring of implementation approaches to local needs and resources. Workforce capacity needs to be built for the integration of interventions into existing public health, mental health and development programmes and social policies in partnership with the health, social services, education, employment and community sectors. This will ensure a positive impact on population mental health, especially for the most vulnerable communities, together with wide-ranging health, social and economic benefits for society.

Acknowledgements

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Mental health surveillance and information systems

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الخلاصة: إن نظم المعلومات الروتينية المتعلقة بالصحة النفسية في العديد من بلدان إقليم شرق المتوسط بدائية أو غير موجودة، مما يجعل من الصعب فهم احتياجات السكان المحليين والتخطيط وفقاً لذلك. إن المكونات الرئيسية لترصد الصحة النفسية ونظم المعلومات المتعلقة بها هي: التزام وقيادة وطنية للتأكد من جمع المعلومات ذات الصلة وتبليغها بصورة عالية الجودة، ووجود حد أدنى من البيانات المتعلقة بالمؤشرات الرئيسية للصحة النفسية، وتعاون بين القطاعات مع تبادل كافٍ للبيانات، وجمع روتيني للبيانات يُستكمل بمسوحات دورية، ومراقبة الجودة والحفاظ على سرية المعلومات، والتقنية والمهارات اللازمة لدعم جمع البيانات وتبادلها ونشرها. إن التدخلات الاستراتيجية ذات الأولوية تشمل: (1) التقييم الدوري لموارد وقدرات الصحة النفسية المتوفرة والإبلاغ عنها باستخدام منهجيات موحدة، (2) الجمع الروتيني للمعلومات والإبلاغ عن توافر الخدمات والتغطية والاستمرارية، بالنسبة للاضطرابات النفسية ذات الأولوية، مصنفة حسب السن والنوع والتشخيص، (3) التسجيل الإلزامي والإبلاغ عن حالات الانتحار على المستوى الوطني (باستخدام رموز التصنيف الدولي للأمراض ذات الصلة).

ABSTRACT Routine information systems for mental health in many Eastern Mediterranean Region countries are rudimentary or absent, making it difficult to understand the needs of local populations and to plan accordingly. Key components for mental health surveillance and information systems are: national commitment and leadership to ensure that relevant high quality information is collected and reported; a minimum data set of key mental health indicators; intersectoral collaboration with appropriate data sharing; routine data collection supplemented with periodic surveys; quality control and confidentiality; and technology and skills to support data collection, sharing and dissemination. Priority strategic interventions include: (1) periodically assessing and reporting the mental health resources and capacities available using standardized methodologies; (2) routine collection of information and reporting on service availability, coverage and continuity, for priority mental disorders disaggregated by age, sex and diagnosis; and (3) mandatory recording and reporting of suicides at the national level (using relevant *ICD* codes).

Systèmes d'information et de surveillances de la santé mentale

RÉSUMÉ Les systèmes d'information de routine pour la santé mentale dans de nombreux pays de la Région de la Méditerranée orientale sont rudimentaires ou font défaut, ce qui rend difficile la compréhension des besoins des populations locales et la planification correspondante. Les composantes clés des systèmes d'information et de surveillance de la santé mentale sont les suivantes : un engagement et un rôle de premier plan à l'échelle nationale pour garantir que des données pertinentes et de haute qualité sont recueillies et transmises ; un ensemble de données minimales servant d'indicateurs clés pour la santé mentale ; une collaboration intersectorielle permettant le partage approprié des informations ; le recueil de données systématique complété par des enquêtes périodiques ; un contrôle qualité et la confidentialité ; et de la technologie et des compétences pour appuyer le recueil, le partage et la diffusion des données. Parmi les interventions stratégiques prioritaires, on peut citer : 1) l'évaluation périodique des ressources et des capacités en santé mentale disponibles et la notification de ces informations à l'aide de méthodologies normalisées ; 2) le recueil et la notification de données systématiques sur la disponibilité des services, leur couverture et leur pérennité pour les troubles de santé mentale prioritaires, ventilées par âge, sexe et diagnostic ; et 3) l'enregistrement et la notification obligatoires des suicides à l'échelle nationale (à l'aide des codes CIM pertinents).

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The case for mental health surveillance & information systems

Surveillance involves the collection, analysis and interpretation of health data and the timely communication of these data to policy-makers and others. The availability of relevant information enables actions to be monitored and improvements in service provision to be detected. Mental health information systems are vital for collecting, processing and analysing information about mental health determinants, needs, system responses and the impact of interventions. But it is also crucial that findings are communicated in a form that is accessible and useful to those who will utilize them. Only then can the mental health information system perform its functions of facilitating effective planning, budgeting, delivery and evaluation of mental health care. This information loop from data collection, through analysis and reporting to informed implementation of plans (Figure 1), needs to be driven by an infrastructure

of training andt supervision of all staff involved, of quality assurance and of confidentiality. These activities require clear leadership to oversee and manage the process in its entirety.

Preliminary findings from the World Health Organization (WHO) *Mental health atlas* survey 2014 [in press] shows that more than one-third of Eastern Mediterranean Region (EMR) countries have not published a specific mental health information report in the past 2 years. Approximately half were unable to provide any financial information and less than one-sixth knew their total expenditure for mental health. About two-thirds of countries in the Region did not know the total number of staff in the mental health workforce. Although more than half could report the number of persons treated at mental hospitals, the great majority of countries were unable to report the number of persons with mental disorders who received care in mental health outpatients departments or in primary care facilities. About half of EMR countries had data on length of stay and involuntary admissions, but few reported on the proportion of

persons discharged from hospital who had a follow-up visit within one month. Only one-quarter of EMR countries were able to report data on numbers of suicides. Suicide rates in EMR countries may be under-reported or even unreported for social, religious and cultural reasons. The difficulty in providing information for the *Mental health atlas*, particularly on expenditure on mental health care, number of professionals working in different settings, mental health service coverage and suicide data, suggests that many countries are managing with very rudimentary information systems, making it difficult for them to understand the needs of local populations and to plan accordingly.

What information is needed for mental health policy, planning and evaluation?

Collecting a small number of carefully selected indicators thoroughly and consistently over time (both within and across countries) is more effective than collecting a large number of indicators that are never implemented. The collected indicators should be meaningful to health planners, acceptable to stakeholders, valid, reliable, comparable over time and sensitive to change. They need to be disaggregated by sex and age and by other variables, in order to capture the diverse needs of subpopulations, including individuals from geographically diverse communities (for instance, urban versus rural) and vulnerable populations.

Three WHO sources—the Comprehensive Mental Health Action Plan 2013–20 (*1*); the EMR Regional Framework (*2*); and the WHO Mental Health Gap Action Programme (mhGAP) monitoring and evaluation tool kit (*3*)—can be used to identify a minimum data set for mental health. A set of indicators assembled from the Comprehensive Mental Health Action Plan and the EMR Regional Framework are included in Table 1.
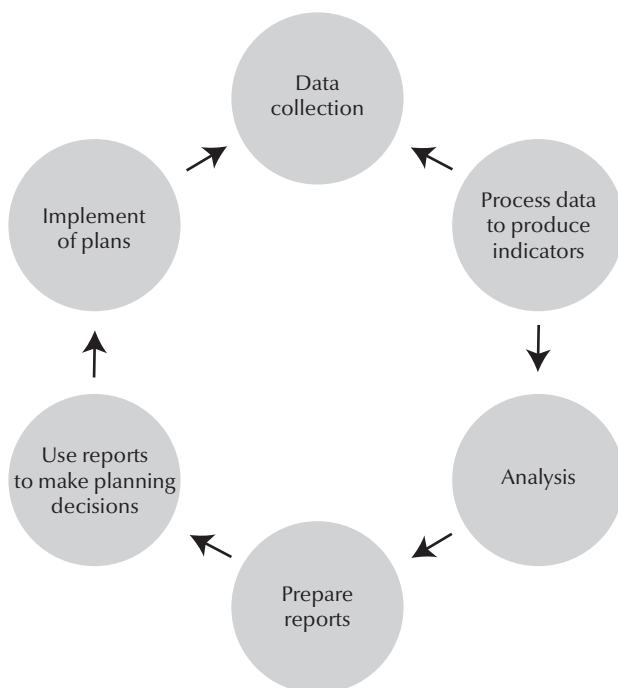

Figure 1 **Information loop of data collection**

How can information for mental health be generated?

Data relating to internationally agreed as well as locally determined mental health indicators can be collected routinely or periodically. Ideally, most of the data requirements should be generated on a routine basis via local information systems; for example, deaths attributable to suicide and self-harm should be recorded in vital registration systems, while cases of mental disorder receiving care and treatment should be identifiable through facility-based recording systems (see Box 1 for an example from Saudi Arabia).

In situations where routine health information systems may not yet be in place or functioning well, or where more periodic assessment may be sufficient (e.g. the compliance of local mental health legislation with international or regional human rights instruments), periodic but regular surveys can be used to monitor developments. For example, in

Table 1 Proposed mental health indicators for the Eastern Mediterranean Region

Periodic survey	Routine national HMIS	Routine national information system other than HMIS
• Country has an operational multisectoral national mental health policy/plan in line with international/regional human rights instruments. • Country has an updated national mental health legislation in line with international/regional human rights instruments. • Inclusion of specific priority to mental health conditions in basic packages of health care, of public and private insurance/reimbursement schemes. • Mental health and psychosocial support provision is integrated into the national emergency preparedness plans. • A proportion of mental health facilities are monitored annually to ensure protection of human rights of persons with mental conditions using quality and rights standards. • Functioning programmes of multisectoral mental health promotion and prevention in existence.	• Routine data and reports at national level available on a core set of mental health indicators. • Proportion of persons with mental health conditions utilizing health services (disaggregated by age, sex, diagnosis and setting). • Proportion of general hospitals which have mental health units including inpatient and outpatient units. • Proportion of PHC facilities having regular availability of essential psychotropic medicines. • Proportion of PHC facilities with at least one staff member trained to deliver non-pharmacological interventions. • Proportion of health-care workers trained in recognition and management of priority mental conditions during emergencies. • Proportion of community workers trained in early recognition and management of maternal depression and to provide early childhood care and development and parenting skills to mothers and families.	• Proportion of schools implementing the whole-school approach to promote life skills. • Annual reporting of national data on numbers of deaths by suicide.
• Financial resources: government health expenditure on mental health • Stakeholder involvement: participation of associations of persons with mental disorders and family members in service planning and development.	• Human resources: number of mental health workers. • Capacity building: number and proportion of primary care staff trained in mental health. • Service availability: number of mental health care facilities at different levels of service delivery. • Inpatient care: number and proportion of admissions for severe mental disorders to inpatient mental health facilities that a) exceed one year and b) are involuntary • Service continuity: number of persons with a severe mental disorder discharged from a mental or general hospital in the last year who were followed up within one month by community-based health services.	• Social support: number of persons with a severe mental disorder who receive disability payments or income support.

Based on the World Health Organization Comprehensive Mental Health Action Plan (1) and the Eastern Mediterranean Region Regional Framework (2); and additional mental health service development indicators identified by the WHO Secretariat.
PHC = primary health care; HMIS = health management information system.

order to measure current and increased service coverage for severe mental disorders—a core mental health indicator of the global Action Plan—many countries may consider carrying out a baseline and repeat survey of provider facilities in one or more defined geographical areas of the country.

Table 2 provides examples of expected data collection strategies and sources for a number of key mental health indicators.

How can information be used?

The information loop is completed when the information is presented in a meaningful way and it is used to inform service planning. In 2010 the regional report based on the WHO Assessment Instrument for Mental Health Systems (AIMS) found that 71% of countries had a formally defined list of mental health data items to collect, and 65% of countries had published the data; however, only 30% published the data with comments (5). In other words, although information was being collected, it was seldom analysed so that it could be used as a tool for action.

Traditionally, reporting has been in the form of printed statistical tables with a commentary, but Internet-based technology now offers the opportunity for information integrated from different sources to be disseminated rapidly to end-users in a relevant and interactive format at a local, national, regional or global level. The WHO Regional Office for the Eastern Mediterranean (EMRO) is currently engaged in developing a regional National Health Information Systems (NHIS) strategy and a set of core health indicators which countries should report to EMRO on a regular basis. The strategy anticipates that NHIS will be required to move to systems that are deployed on the Internet, and by design are integrated based on principles of data warehousing. This will enable the access of data from different sources, and facilitate circulation of accessible data.

Whatever reporting system is in place, it is important that policy-makers and service planners have the skills to interpret and apply the evidence from information systems; and that reporting is part of an ongoing dialogue with policy-makers and service planners, to ensure that information is relevant and presented in a useful format.

Key recommendations

1. Periodically assess and report the mental health resources and capacities available using standardized methodologies.

- Establish a national focus of expertise and leadership to implement the development, reporting and use of mental health surveillance and information involving collaboration between relevant service providers working in the field of mental health: ministries of health, university hospitals, psychiatric associations, private hospitals, nongovernmental organizations and key opinion leaders.

- Develop procedures, regulations and training to ensure that the processes of collecting, analysing, reporting and using data meet standards of quality and confidentiality.

2. Routinely collect information and report on service availability, coverage and continuity, for priority mental disorders disaggregated by age, sex and diagnosis.

- Develop or strengthen national mental health information systems incorporating the indicators in Table 1.

- Collaborate with the EMR regional strategy for NHIS strengthening to develop information systems that utilize web-based technologies and data warehousing to facilitate the integration of information. These will enable the access of data from different sectors and settings, and facilitate circulation of accessible data.

3. Record and report on deaths as a result of suicide at the national level (using the relevant *International classification of diseases* (ICD) X-codes).

Table 2 Examples of expected data collection strategies and sources for a number of key mental health indicators

Level	Indicators (examples)	Data source(s)/ collection methods
National	• Existence of mental health policy and laws • Mental health expenditure • Suicide rate • Civil society and stakeholder involvement	• Physical availability of policy or law • National health accounts • Vital registration system • Periodic survey
District	• Human resources for mental health • Mental health training for primary health-care workers • Availability of mental health services	• Health information system • Health information system • Health information system; periodic survey
Facility	• Hospital admissions (total, involuntary) • Follow-up rate (continuity of care)	• Health information system; facility records • Health information system; facility records
Individual	• Service uptake and use • Social and economic determinants	• Demographic and health survey; integrate items in information systems of other sectors, e.g. housing, education, employment, prisons

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Mental health research: developing priorities and promoting its utilization to inform policies and services

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بحوث الصحة النفسية: تحديد الأولويات والتشجيع على التركيز عليها في إعلام السياسات والخدمات

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الخلاصة: إن الاستثمار في مجال البحوث المتعلقة بالوقاية من اضطرابات الصحة النفسية ومعالجتها في إقليم منظمة الصحة العالمية لشرق المتوسط منخفض بشكل لا يتناسب مع مستوى المراضة. وإن رفع مستوى بحوث الصحة النفسية في إقليم شرق المتوسط يمكن أن يولد فوائد هائلة من حيث الحد من العجز وتحسين النتائج والوقاية من الوفاة المبكرة، وذلك من خلال التشخيص المبكر والعلاج الأفضل والتأهيل المجتمعي. ولضمان حدوث ذلك يجب على بلدان الإقليم أن تعمل معاً لتحديد الأولويات البحثية وحشد الموارد وتطوير القدرات البشرية وقدرات البنية التحتية وإضفاء الطابع المؤسسي على الاستفادة من نتائج البحوث في توجيه وضع السياسات ونماذج تقديم الخدمات. إن موجز الأدلة هذا يوصي الدول الأعضاء في إقليم شرق المتوسط بالعديد من التدخلات الاستراتيجية الرئيسية، وهي: اعتماد جدول أعمال وطني لبحوث الصحة النفسية ذات الأولوية، ووضع خريطة منهجية لتمويل البحوث الوطنية والدولية من أجل تحديد وتأمين الموارد اللازمة لدعم تنفيذ البحوث ذات الأولوية، وتعزيز القدرات الوطنية على إجراء البحوث ذات الأولوية، والتتبع الدوري لمخرجات البحوث المتعلقة بالصحة النفسية، وتعزيز الحوار بين الباحثين وواضعي السياسات/ مديري البرامج.

ABSTRACT Investment in research on the prevention and treatment of mental health disorders is disproportionately low in the WHO Eastern Mediterranean Region (EMR) relative to the disease burden. Scaling-up mental health research in the EMR could generate enormous returns in terms of reducing disability, improving outcomes and preventing premature death, through early diagnosis, better management and community-based rehabilitation. EMR countries must therefore work to identify research priorities, mobilize resources, develop human and infrastructure capacities and institutionalize use of research findings to guide development of policies and service delivery models. Several key strategic interventions for EMR Member States are recommended: adopt a prioritized national mental health research agenda; systematically map national and international research funding to identify and secure resources to support the implementation of the agenda; strengthen national capacity to undertake prioritized research; periodically map research output in mental health; and foster dialogue between researchers and policy-makers/programme managers.

Recherche en santé mentale : établissement de priorités et promotion de son utilisation pour orienter les politiques et les services

RÉSUMÉ L'investissement dans la recherche sur la prévention et le traitement des troubles de santé mentale est disproportionnellement faible dans la Région OMS de la Méditerranée orientale par rapport à la charge de morbidité. L'intensification de la recherche en santé mentale dans la Région de la Méditerranée orientale pourrait générer d'énormes retours en termes de réduction des incapacités, d'amélioration des résultats et de prévention des décès prématurés, au moyen du diagnostic précoce, d'une meilleure prise en charge et de la réadaptation communautaire. Les pays de la Région doivent œuvrer ensemble afin d'identifier les priorités de recherche, de mobiliser des ressources, de renforcer les capacités humaines et matérielles et d'institutionnaliser l'utilisation des résultats de recherche pour orienter l'élaboration de politiques et de modèles de prestation de services. Plusieurs interventions stratégiques clés pour les États Membres de la Région de la Méditerranée orientale sont recommandées : l'adoption d'un programme de recherche national en santé mentale ; la cartographie systématique du financement de la recherche national et international pour identifier et sécuriser les ressources à l'appui de la mise en œuvre du programme d'action ; le renforcement des capacités nationales permettant d'entreprendre une recherche par priorités ; la cartographie périodique des résultats de la recherche en santé mentale ; et la promotion du dialogue entre chercheurs et responsables des politiques/des programmes.

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The need for EMR-specific mental health research

According to Professor Mahmoud Fathalla, former Chairman of the Advisory Committee on Health Research at the World Health Organization (WHO), "Research should not be considered as a luxury. On the contrary, health research is needed more when resources are scarce." There are several reasons that Region-specific research needs to be prioritized and undertaken. Mental health research is critical for guiding rational policy development, strategic programme planning and the reorganization of mental health services. Furthermore, evidence-based action can reduce the social impact and economic costs of mental disorders. A recent analysis by the World Economic Forum estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 trillion over the next 20 years (1). However, the cost of researching mental health and subsequent treatment is often completely offset by the economic gains of implementing the findings of research. As an example, a United Kingdom report on the cost-efficiency of 15 evidence-based mental health interventions found that there was a significant return in investment for the government and other sectors, especially when tackling early identification and intervention (2). Regional research prioritizing early interventions could harness similar savings for governments, as well as tackling health inequities, decreasing disability and mortality, and ultimately fostering country development.

Although global priorities for mental health research have been established, Region-specific priorities need to be considered. The WHO Eastern Mediterranean Region (EMR) is a diverse group of countries, with vastly differing economic levels and health systems (3). A large proportion of its Member States are experiencing unrest and conflict, which makes it the ideal location for developing a comprehensive evidence base in the much neglected area of research on the effects of crises and conflicts on mental health.

What is the current situation in the EMR?

Funding

Globally, investment in research on the prevention and treatment of mental health disorders is disproportionately low in the EMR relative to the disease burden. Although there are no figures available on EMR countries' spending on mental health research, the regional average spend on research is 0.3% of gross domestic product (GDP), with 97% of the funding coming from government sources (4).

Although mental health has started to be recognized in the EMR as a public health priority in recent years, this has not yet translated into greater investment in research. Estimates show that 16.5% of the research-related activities in WHO Regional Office for the Eastern Mediterranean (EMRO) were focused on noncommunicable diseases and conflict health, even though these represent 59% of disability-adjusted life-years in the Region (5). There is some evidence that research output tracks GDP, but economic resources have been shown to not be the only factor responsible for health research outputs in the EMR (6).

In recent years, Grand Challenges Canada, an initiative funded by the Canadian Government, has begun investing heavily in mental health, by enabling learning, enhancing linkages, disseminating knowledge and leveraging resources, by supporting the development of the Mental Health Innovation Network.[1] Unfortunately the EMR is currently under-represented in the allocation of project investment, as Table 1 shows, with only 4 projects located in the Region (3 in Pakistan and 1 in Afghanistan) (7). Other funding bodies that are also underrepresented in the Region include the Wellcome Trust, which is currently funding mental health research projects and programmes across Africa and Asia, but none in EMR countries.

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[1]   Grand Challenges Canada has supported the development of the Mental Health Innovation Network, a global community for mental health innovators, which can be accessed at: http://mhinnovation.net

Table 1 Breakdown of Grand Challenges Canada projects by round and amounts invested globally and in the Eastern Mediterranean Region (EMR)

Funding round	No. of projects globally	No. of projects in EMR	Amount invested globally (CAD × millions)	Amount invested in EMR (CAD × millions)
Round 1	14	2	19.4	2.00[a]
Round 2	21	1	10	0.25
Round 3	22	1	7.7	0.27
Total	57	4	28.1	2.52

Source: Grand Challenges Canada (7).
[a]Estimate.
CAD = Canadian dollars.

Capacity and human resources

Promotion of a research environment at the university level and investment in research has been proposed by several studies previously, and this stands equally for research within mental health (8). EMRO is already supporting mentorships and fellowships within health, with 1417 fellowships for individuals from Member States supported during January 2006 and December 2010 in different fields of health (5). It is not clear, however, how many of these were related to mental health. An important step has been the establishment by the United States National Institute of Mental Health of Collaborative Hubs for International Research in Mental Health within 2 EMR countries, Afghanistan and Pakistan, forming part of the South Asian Hub for Advocacy, Research and Education on Mental Health (SHARE).[2]

The great majority of literature on mental health published in the leading international journals is derived from European and North American countries. Although publications from the EMR have steadily been rising in the past few decades, the Arab world produces only approximately 17% of the global average output of mental health publications per million population, which is comparable with countries of Latin American and the Caribbean. Between 1999 and 2006 publications originating from Arab nations that focused on mental health were only about 1% of the global figure of over 100 000 publications for the same period (9).

Prioritization

The topics covered by country-specific mental health publications from the EMR shows that mood disorders, anxiety disorders and substance abuse have been most frequently researched (Table 2) (9). The majority of publications from Arab

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[2] More information on the SHARE hub is available at: http://www.centreforglobalmentalhealth.org/sites/www.centreforglobalmentalhealth.org/files/uploads/documents/BROCHURE-SHARE.pdf

Table 2 Specific mental health disorders addressed in country specific publications from the Eastern Mediterranean Region (EMR) between 1996 and 2005 (estimated *n* = 950[a])

Topic	% of articles from EMR
Mood disorders	14.1
Anxiety disorders	12.4
Substance abuse disorders	11.1
Psychotic disorders	4.4
Mental retardation	2.6
Mental health services	2.3
Eating disorders	2.2
Suicide	2.2
Training of physicians in psychiatry	2.0
Personality disorders	1.5
Genetic studies of mental diversity	1.5
Sleep disorders	1.1
Diversity of determinants, services, cultural issues and psychometric properties of instruments	Remaining

Source: Jaalouk et al. (9).
The study did not include information from Afghanistan, Islamic Republic of Iran or Pakistan.
[a]An average of 95 country-specific publications produced during the decade suggests it was based on approximately 950 publications.

countries cited in the PubMed database between 1987 and 2002 were epidemiological (Table 3), and almost all were hospital-based (52%) or community-based (37%); only 4% were based in primary care (10).

Two research priority setting activities have been undertaken in recent years for mental health, one by members of the Lancet Mental Health Group (11) and another by the Mental Health and Psychosocial Support in Humanitarian Settings–Research Priority Setting project (12). These have highlighted the need for better alignment between researchers and practitioners, and concluded that it would be best to fill critical knowledge gaps by investing in research into 3 areas: health policy and systems; epidemiology; and improved delivery of cost-effective interventions.

Establishing mental health research as a priority: strategies

There are several key strategic interventions that need to be followed at a national and regional level to establish mental health research as a priority in EMR. These interventions—which are credible, feasible and cost-effective—are summarized below:

Adopt a prioritized national mental health research agenda

Mental health must be highlighted as a research priority at the regional, national and institutional levels. Consideration should be given to supporting implementation research that informs the development of policies/programmes and service delivery models.

The criteria developed by the Lancet Mental Health Group (11) and the Mental Health and Psychosocial Support in Humanitarian Settings–Research Priority Setting project (12) can be used by the EMR to develop specific priorities. The steps used by the Lancet group were:

- gathering technical experts and defining the context;

- creating a systematic list of research options;

Table 3 Mental health publications from Arab countries distributed by type of study, 1987–2002 (*n* = 338)

Type of study	No.	%
Epidemiological	207	61.2
Psychometric	36	10.7
Clinical	35	10.4
Literature review	17	5.0
Basic science	16	4.7
Health systems research	16	4.6
Knowledge, attitudes and practice	11	3.3
Total	**338**	**100.0**

Source: Afifi (10).

- scoring listed research options against explicit criteria, for example: likely to generate new knowledge in an ethical way; likely to be efficacious and effective; likely to reduce the burden of disease; likely to be affordable, deliverable and sustainable; predicted effect of intervention on equity;

- addressing stakeholders' values; and

- undertaking programme budgeting, marginal analysis and advocacy.

Alternatively, the 6 goals developed for establishing the Grand Challenges Canada can be used by countries to guide the prioritization agenda (7):

- Goal A: Identify root causes, risks and protective factors;

- Goal B: Advance prevention and implementation of early interventions;

- Goal C: Improve treatments and expand access to care;

- Goal D: Raise awareness of the global burden;

- Goal E: Build human resource capacity;

- Goal F: Transform health-system and policy responses.

Systematically map national & international research funding to identify and secure support

- Clear mapping of what is being spent nationally and regionally on mental health research needs to be undertaken, and EMR countries should have evidence of return on investment to secure additional financial support by development partners and sectors other than health. The World Bank, regional development banks, national development agencies, nongovernmental agencies and other foundations could be potentially targeted.

- It is important to enhance the quality of research in the Region by investing in cost-effective operational and implementation research, based on the nationally and regionally defined priorities. Greater representation within international journals will draw attention and funding to the defined national priority agenda.

Resources other than finance should be pursued. Ethically sourced human, educational and infrastructural resources are all necessary components to stimulate mental health research.

Enhance national capacity to undertake prioritized research

The single most important factor is the shortage of trained researchers in the EMR. Opportunities for training and supervision in research are limited. To combat this shortage and the risk of "brain-drain" of trained researches, research must be given a higher priority and become a well-established and resourced area within the EMR. ESSENCE on Health Research, a collaborative initiative of the WHO Special Programme for Research and Training in Tropical Diseases, has developed a guiding document that incorporates current knowledge and best practice on health research capacity to form clear principles that can be used by EMR countries to make effective decisions (*13*).

- Individual countries need to establish research-orientated training programmes linked with ongoing project collaborations within the Region, and liaise with established institutions in other regions that are strong in the area of mental health research, to support capacity building initiatives with short-term staff loans and sabbaticals. See the case study on the SHARE initiative for an example of research collaboration within South Asia (Box 1).

Periodically map the research output in mental health

- A bank of validated mental health research needs to be established in EMR, for researchers to contribute to and decision-makers to consult systematically (for example through a regional hub of the Mental Health Innovation Network).

Foster dialogue between researchers and decision-makers

- Communication between mental health researchers and decision-makers in EMR needs to improve, with stronger more formalized communication taking place between researchers, health managers, planners, civil society, donors and policy-makers. This should be fostered by knowledge management and translation activities to facilitate the sharing of evidence of mental-health-reach with relevant policy-makers. Decision-makers must be made aware of the importance that evidence can play in sound policy-making. For this to happen, it is vital that decision-makers are orientated on how research is undertaken, how to evaluate its quality and how to utilize it in decision-making efficiently. This will facilitate the exchange of information on successful initiatives and innovative activities, both within and outside the Region.

Box 1 Case study of research collaboration in mental health research by the South Asian Hub for Advocacy, Research and Education on Mental Health (SHARE)

SHARE is a multi-country network of institutions in South Asia, created to support mental health research throughout its region (*14*). Since 2011, SHARE has brought together researchers and practitioners from 16 organizations across 6 countries in South Asia.

The objective of this hub are to generate evidence for affordable and effective interventions for treatment of mental disorders, to increase mental health capacity to address relevant policy questions and to foster the uptake of mental health research into policy and practice.

SHARE is implemented through a partnership between academic leaders in global mental health, innovators in mental health services research, civil society stakeholders and policy-makers. SHARE is one of the Collaborative Hubs for International Research on Mental Health funded by the National Institute of Mental Health in the United States of America.

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Commentary

Mental health policy and strategic plan

M.K. Funk[1] and N.J. Drew[1]

Why have a mental health policy?

A mental health policy provides a coherent framework for action, based on broad consultation among stakeholders. It serves to identify and promote guiding principles, values and standards for action, thus working to meet population needs for mental health promotion, prevention, treatment, rehabilitation and prevention of premature mortality

The key components that need to be addressed in a mental health policy include human rights; service organization and delivery; human resources; sustainable financing; civil society and advocacy; quality improvement; information systems; and evaluation.

Key strategic interventions for countries include the development and implementation of a multisectoral policy/strategic action plan for mental health in line with the Comprehensive Mental Health Action Plan 2013–20 and the establishment of a common governance structure, appropriate to the national context, to facilitate and monitor implementation of the multisectoral national policy/strategic action plan.

Case for mental health policy and strategic plan (*1,2*)

A mental health policy is an official statement by a government or health authority that provides the overall strategic direction for mental health by defining the vision, values, principles, and objectives. Such a policy establishes a broad model for action to achieve that vision.

Policies and plans can help to ensure improved access to community-based services and continuity of care for people with mental health conditions; facilitate the development of effective interventions for preventing mental health problems and promoting mental health; ensure cost-effective allocation of resources; prioritize the allocation of resources for mental health; and foster linkages between health and social services and other key sectors, for example the education sector and the criminal justice system.

Mental health policy and strategic plans are important tools for putting into effect the provisions of mental health legislation in the same way as legislation can facilitate the goals of mental health policies and plans [see paper on mental health legislation in this Supplement (*3*)].

A comprehensive, evidence-based, human rights-oriented policy and strategic plan framework, along with the political will for their implementation, is critical to ensuring that mental health services meet the needs and requirements of people with mental health conditions.

In some countries, mental health issues and actions will be incorporated within the general health, disability or other relevant policies and plans, while in others, depending on the context, a dedicated mental health policy and plan will be developed in addition to the incorporation of mental health issues into other relevant policies and plans (*4*).

Key components of a mental health policy and plan (*1,2*)

The key components of a mental health policy include a vision statement, clear objectives and areas for action which then get translated into a mental health action plan that defines the strategies, concrete actions, time frames, targets and indicators used to measure progress and outcomes. The priority areas for action form the substance of the policy and plan and will clarify how the country will promote the elements itemized below.

- *Human rights:* Promoting the rights of people with mental health conditions should be a key feature of mental health policy and provides a clear purpose and justification for change. Specific issues for marginalized or disadvantaged groups need to be considered and addressed, for example mental health issues relating to children and adolescents, older persons, persons with HIV/AIDS, women, children in orphanages, prisoners, ethnic minority groups, refugees, migrants and internally displaced people.

- *Service organization and delivery:* The 3 major strategies for facilitating the development of an effective network of mental health services are: shifting care away from large psychiatric hospitals, developing community-based services, and integrating mental health into general health services [see paper in this Supplement on service reorganization (*5*)]. The policy should assure access to appropriate pharmacological and non-pharma-

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cological interventions for preventing mental disorders and promoting mental health treatment and recovery. Access to non-health-care interventions in other sectors should also be emphasized to promote inclusion, for example welfare rights, employment and livelihoods, and access to justice. It should address how the mental health workforce will be recruited, trained and retained and establish the direction for supervision and support structures and referral pathways for mental health [see paper in this Supplement on human resources (6)]. Information systems are key to improving the effectiveness and efficiency of the mental health services by enabling well-informed decisions to be taken that improve the quality of care. The areas for action should clarify how mental health indicators will be integrated into the general health information system and how this will be implemented [see paper in this Supplement on mental health surveillance and information (7)].

- *Strengthening civil society and advocacy:* Organizations comprising persons with mental health conditions can benefit the mental health system in many ways, including by strengthening advocacy efforts, improved understanding of human rights, their participation in decision-making processes, and the development of community support groups for people with mental health conditions as well as their families and carers. The policy and plan need to specify how persons with mental health conditions will be engaged.

- *Quality improvement:* High quality care means that the latest evidence-based interventions are provided, that available resources are used efficiently, and that services remain accountable to those who use them. Actions should highlight how quality improvement will be achieved and measured (developing national standards for mental health, assess-

ment and accreditation of facilities, review of mental health competencies of health care staff, etc.).

- *Sustainable financing:* Different components of the policy will need to be financed, including the service infrastructure, equipment and technology, and the delivery, training and remuneration of the workforce [see paper in this Supplement on investing in mental health (8)].

- *Evaluation:* Evaluation is central to determining whether the objectives set out in the policy and plan are being realized and for allowing decision-makers to make short- and long-term service and policy-related decision and changes. The policy and plan should specify how and when implementation efforts will be evaluated [see paper in this Supplement on mental health research (9)].

Key recommendations for ministries of health: how to proceed (*1,2*)

The steps outlined below should be used flexibly, and not in a rigid sequential manner. The process adopted should be based on existing and established processes for policy development within the country (10). See Boxes 1 and 2 for cases studies from Jordan and Qatar.

Establish a multisectoral policy

Establish or update a multisectoral policy/strategic action plan for mental health in line with international/regional human rights instruments with targets based on the Comprehensive Mental Health Action Plan 2013–20.

Set up an overarching entity to oversee and draft the policy and plan

Developing a policy and plan should be carried out by a multi-disciplinary group representing different interests in mental health: professionals, policymakers, civil society, persons with mental health conditions and mental health

service users, and representatives from other sectors. Ideally this entity will be mandated by, and situated under, the Ministry of Health so as to have buy-in and commitment to follow the process through.

Gather information, consult and negotiate

To build political will, it is important to strategically use existing information on the mental health situation to advocate for change, to engage civil society in making the case for reform and to consult and negotiate with all stakeholders even before policy development begins (*11*).

The relevant authority should collect information about the mental health needs of the population (including the most vulnerable and hard-to-reach groups) as well as the current mental health system and services. Key mental health issues can be prioritized by reviewing national and international literature and through interaction with key people in other countries.

It is also important to listen to and work with stakeholders, including persons with mental health conditions and their families and carers, as equal partners and develop policy options that blend the different views with evidence derived from national and international experiences.

Define the vision, values, principles, and objectives of the policy

The substance of the policy may be established through describing the vision, values, principles, and objectives for mental health. The vision usually sets high but realistic expectations for mental health, describing what is desirable for a country, whereas values and principles represent ethical standards and core rules guiding the policy. Objectives should be aimed at improving the health of the population, responding to people's expectations and requirements, and providing financial protection against the cost of ill-health.

Achieve political approval and endorsement of the policy

Submit the draft policy to the policy-making forum. Prior to its adoption, it may be necessary to conduct lobbying and advocacy. This may involve, for example the joining of forces of different advocates for the reform so as to create a single, unified and strong coalition force; the dissemination of information about the policy through pamphlets and flyers, newspaper articles, radio and television broadcasts; organizing meetings with and sending letters and documents to key parliamentarians and other influential decision-makers, and so on. It is useful to identify and engage persons of influence who may serve as "champions" for the reform. These may include senior officials within the Ministry of Health, parliamentarians, journalists or well-known national personalities. It is also useful at an early stage in the reform process to identify the potential obstacles as well as facilitating factors and strategies to overcome these and to aid the implementation of the new law.

Operationalizing the objectives of the policy

Draft the mental health action plan providing the details for operationalizing the objectives of the policy by outlining concrete strategies, activities, time frames, and budgets for their attainment.

- Transform the objectives of the mental health policy into areas for action.

- Formulate the core strategies of the mental health plan with respect to each of the areas for action.

- Define clear and explicit targets and indicators for each strategy.

- Define detailed activities that will enable the strategy to be realized.

- Outline the expected outputs of each activity as well as the potential obstacles and delays that could inhibit the realization of the activity.

- Decide on the specific roles and responsibilities for governmental agencies (health, education, employment, social welfare, housing, justice); academic institutions; professional associations; general health and mental health workers; organizations of persons with mental health conditions and family and carer groups; other relevant non-governmental organizations.

- Define a time frame for each strategy, indicating when each strategy will begin and for how long it will function.

- Calculate the costs of each strategy as well as the total costs of the plan for each year, and define how the strategies are going to be financed (e.g. state funding, social insurance, donors, private insurance, out-of-pocket payments).

Box 1 Case study on mental health policy from Jordan

Jordan's Mental Health Programme was initiated in 2008 in the wake of the influx of refugees from Iraq. In 2009, a national steering committee was established representing a wide range of stakeholders. In addition, over a 2-year period, a wide range of stakeholders from governmental and semi-governmental bodies, universities and affiliated teaching hospitals, the military sector, users associations, nongovernmental organizations, community-based organizations, and media were consulted and involved in drafting the National 10-year Policy which was launched in 2011. The wide consultative process served to get the endorsement of key decision-makers. A 2-year Action Plan on Mental Health was also developed in January 2011.

The policy includes 12 areas of action encompassing: governance; service organization; human resources; finance; information system; prevention and promotion; human rights and legislation; rehabilitation; psychotropic medications; advocacy, research; monitoring, evaluation and quality improvement. A mental health unit was established within the Primary Health Care Directorate at the Ministry of Health to support the governance component of the policy and to facilitate the implementation of the policy and plan. A multidisciplinary National Technical Committee was formed to advise and support the mental health unit.

The main developmental challenges included difficulty in achieving consensus around the priority areas of action, adopting the bio-psychosocial approach, and downsizing mental hospitals. Specific challenges during the implementation of the policy and plan revolved around shortages of human resources due to financial constraints, high turn-over of staff (relocation to other centres, retirement, etc.), work load in primary health care, and resistance from professional groups.

Particularly successful features of the activities implemented under the policy and plan include:

- integrating mental health into primary health care and channelling trained secondary care staff to provide supervision to primary health care staff;

- introducing mental health units to general hospitals;

- adoption of the multidisciplinary, bio-psychosocial approach at the secondary care level;

- the establishment of Our Step Association to support mental health service users and families.

Additional information on mental health reform in Jordan can be seen via the following links: Part 1: http://www.youtube.com/watch?v=m7Xq96eGZCw; Part 2: http://www.youtube.com/watch?v=DaZrDTfZ6KA.

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Box 2 Case study on policy development and implementation in Qatar

The launch of the Qatar National Vision 2030 in October 2008 and Qatar's National Development Strategy 2011–2016, provided the impetus and momentum for the formulation of Qatar's National Health Strategy 2011–2016. Mental Health Design is one of the 39 projects under the Qatar National Health Strategy. The National Mental Health Committee led the consultation process involving stakeholders from multiple sectors and disciplines. This resulted in the development and launch of the National Mental Health Strategy in December 2013. The process enjoyed support at the highest political level.

The National Mental Health Strategy includes 10 key pledges to deliver an improved comprehensive mental health system in Qatar. These are:

• raise public awareness about mental health and reduce the stigma associated with mental illness;

• make mental health information resources widely available;

• ensure most people can access their treatment in primary care and community settings;

• develop specialist services that meet the differing needs of individuals and groups;

• ensure care is individually tailored and based on treatments that work;

• develop a sustainable, high-quality mental health workforce for Qatar;

• provide a coordinated multisectoral approach to mental health policy development and planning;

• enact a mental health law in Qatar;

• report improvements in patient care using the mental health minimum data set;

• ensure mental health research evidence translates into improvements in clinical practice and patient outcomes.

Implementation milestones have been defined and agreed and aligned with the wider National Health Strategy for Qatar. In order to ensure sustainability, governance and resources identified to support implementation are firmly embedded within the National Health Strategy governance structures overseen by the Minister of Health and the Prime Minister, who is the Chair of the Supreme Council for Health.

Lessons learned

• Political mandate, leadership and commitment to ensure resources are available are vital.

• Strong leadership and support from key stakeholders is important to drive change forward.

• Consultation and communication with all stakeholders is important to actively involve them in making improvements.

• Advance planning is essential.

Additional information can be found on the National Health Strategy website (http://www.nhsq.info/).

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• Adjust the time frames of the strategies and activities in accordance with the resources available in different years.

Governance structure

• Establish a common governance structure, appropriate to the national context, to facilitate and monitor implementation of the multisectoral national policy/strategic action plan.

• Set up an entity/body responsible for defining rules and procedures for operation of public, private and non-governmental organizations/sectors, delineating the roles and responsibilities for stakeholders. This body should be properly resourced to facilitate and monitor the implementation of the provisions of the national policy/strategic action plan.

Policy and law reform initiatives

Anticipate and input into other government policy and law reform initiatives in related areas, for example disability, health systems, primary health care, and maternal health, in order to mainstream and integrate the key mental health issues and to ensure that there are no inconsistencies with the mental health policy.

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Commentary

Mental health legislation

M.K. Funk[1] and N.J. Drew[1]

Why legislate for mental health?

Mental health legislation provides a framework and standards for the protection/promotion of the rights of people with mental health conditions and to codify the principles, values, aims and objectives of mental health policies and plans.

It is crucial that mental health legislation promotes integrated, community-based care and support and acts to improve the quality of services and promote the rights of people with mental health conditions. It is also essential that it ensures informed consent, confidentiality and the involvement of users and their families in decision-making.

National mental health legislation should be developed/updated in line with international human rights covenants and instruments. Governments and legislating bodies need to adopt rules, regulations and codes of practice for implementing the legislation [see WHO checklist on mental health legislation (1) (Annex 1)]. It is also imperative to establish operational structures and mechanisms to support the implementation of such legislation.

The case for mental health legislation (1,2)

In many countries no legal framework exists to protect and promote the rights of people with mental health conditions, rendering them vulnerable to human rights violations both in the treatment that they receive and in their day-to-day lives within the community. Legislation provides a legal framework to ensure that critical issues affecting their lives, both in mental health facilities and in the broader community context, are addressed. It enables the codification and consolidation of the fundamental principles, values, aims and objectives of mental health policies and plans [see (3)].

Modernising legislation is essential in order to establish and enforce the basic requirements for human rights protection, quality of care and service development, which in turn can lead to changes in ingrained attitudes and beliefs surrounding mental health. Conversely outdated legislation or laws can serve to reinforce stigma as well as discrimination and other human rights violations.

There are a number of approaches to enacting mental health-related legislation:

- **Integrated:** mental health legislation is included in other relevant legislation (for example general health, disability, discrimination, social welfare, education, employment, housing or judicial legislation), with no separate mental health laws.
- **Stand-alone:** a single, consolidated mental health law into which all issues of relevance to mental health are incorporated.
- **Combined:** integrated components as well as a specific mental health law. In some countries, for example, a separate mental health law exists to cover all those mental health issues that have not been addressed in general health legislation.

Achieving the optimum level of human rights protection and promotion for people with mental health conditions should be the chief consideration, regardless of which approach is used.

Key components of mental health legislation (1,2)

Laws must be reformed to reflect the shift away from involuntary treatment and towards the promotion of voluntary treatment and care. It must be assumed that people with mental health conditions have the capacity to make treatment decisions; and when their capacity is impaired, they must be provided with access to support. Free and informed consent should form the basis of mental health treatment and care. Various approaches have been adopted to promote autonomy in decision-making, including the personal ombudspersons systems (for example in Sweden), the open dialogue approach (for example in Finland) and the use of advance directives. There is emerging evidence for the effectiveness of these approaches although more research is needed in this area (4–7).

Mental health-related legislation plays an important role in promoting health equity and access to good quality care by encouraging the development of integrated, community-based mental health care; promoting autonomy and liberty; and preventing marginalization. This consistently shows better

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outcomes for adherence to treatment, clinical symptoms, quality of life, housing stability, and vocational rehabilitation (8–11) [see (12)].

Clear statements are needed on the rights of mental health service users and caregivers placing the service user at the centre of the mental health system while giving caregivers the support necessary to enhance both care and health for the service user. Legislation can also promote the effective participation of people with mental health conditions in national decision-making processes and service design and development.

Legislation can play an essential role in limiting the potential for violations and in providing opportunities for redress in cases of abuse on an equal basis with others. This includes provisions to safeguard against abuses related to involuntary admission and treatment, the use of seclusion and restraints, and clinical and experimental research. The law can establish independent mechanisms, such as visiting committees, to monitor conditions in mental health facilities and to ensure that these are acceptable, that care is appropriate, and that human rights are being respected (13).

Dealing with offences and penalties will vary from country to country. Nonetheless, in many countries, unless specific guidance is given in law regarding the level and extent of penalties to be imposed for particular offences, the courts may be unable to act effectively when the law is transgressed. Without specific provision in this area, the law's potential for promoting mental health and the rights of people with mental health conditions may not be fully realized (1).

Formulation and adoption of mental health legislation (1,2)

The national government/legislating body needs to establish a multidisciplinary drafting committee to review existing legislation affecting people with mental health conditions and to draft new laws. Such a committee should include sufficient collective expertise and understanding of mental health, human rights and legal issues, and might include, among others, persons with mental health conditions, family representatives, lawyers, health and mental health professionals, civil society organizations and people involved in defending human rights. Involving people with mental health conditions in the drafting process is paramount to ensuring that the law adequately reflects their interests and protects their rights.

An analysis of existing mental health-related laws needs to be carried out as legislation that impacts and affects mental health is often not contained in a single law. It is essential, therefore, that, prior to drafting any new laws, all relevant legislation is examined to see how well it promotes the rights of persons with mental health conditions, and to determine which laws need to be revised to ensure they are in line with the new law. Laws that may require examination include those covering general health, social welfare, disability, anti-discrimination, human rights, housing, employment, criminal justice, etc.

In formulating or amending legislation it is important to identify which United Nations (UN) and regional human rights treaties have been ratified by the country. It is essential to have a comprehensive understanding of what legal obligations these treaties place on the government and to ensure that these are reflected in the new law. Other UN and regional human rights standards not ratified by the country can also offer important guidance on what should go into a law, and a thorough review of all key international instruments is imperative (see Table 1). The UN "Convention on the rights of persons with disabilities" in particular should be studied and its principles and rights reflected in the law (14).

Governments and legislating bodies should undertake broad consultation, taking into consideration differing areas of expertise and viewpoints to ensure that the new or amended legislation is thorough and comprehensive and balances the priorities and opinions of the various stakeholders. This step is essential in building consensus and ensuring all stakeholders are behind the legislation. The consultation phase represents another key opportunity to engage with people with mental health conditions and/or their organizations, and to ensure that their views are being captured and reflected in the formulation of the law.

After the key principles of the legislation have been agreed through the consultation and negotiation process, the draft legislation needs to be prepared for submission to the law-making body. It is also important to ensure that appropriate costing for the implementation of the law has been prepared and submitted.

After submission and prior to adoption, it may be necessary to conduct lobbying and advocacy for the law. This may involve, for example, the joining of forces of different advocates for the reform to create a single, unified and strong coalition force; the dissemination of information about the law through pamphlets and flyers, newspaper articles, radio and television broadcasts; organizing meetings with and sending letters and documents to key parliamentarians and other influential decision-makers; and so on. It is useful to identify and engage persons of influence who may serve as "champions" for the reform. This may include senior officials within the Ministry of Health, parliamentarians, journalists or well-known national personalities.

At an early stage in the reform process, as well as identifying facilitating factors and strategies, it would be useful to identify any potential obstacles so as to overcome these and promote the implementation of the new law.

Implementation of mental health legislation (1,2)

It is important that governments and legislating bodies establish a body with a focused mandate to oversee implementation of the law and to provide overall governance to the process. Once the legislation has been accepted formally, this body will be responsible for drafting and adopting regulations and codes of practice through a consultative process. Regulations provide detailed guidelines for how the legislation should be implemented. Codes of practice can also be developed to benchmark the standards of good practice in the application of the law.

People who are directly affected need to be trained on the new legislation so that they are able to give effect to the spirit and the letter of the law. This includes persons with mental health conditions and their families, as well as health, mental health and social workers; lawyers; civil society organizations (including disabled persons organizations); magistrates; and other relevant stakeholders.

The law reform process is an important opportunity to foster understanding within the general population about the rights of persons with mental health conditions. Running awareness-raising campaigns can be a useful means towards changing attitudes and reducing stigma and discrimination in the community.

National governments need to identify or mobilize resources, both human and financial, to support the implementation of the new legislation. In some cases, before passing a law, the legislature will ensure that adequate resources are made available to implement it. Where this does not occur, resources will need to be identified. The implementation process needs to be monitored and any problems identified should be fully addressed.

Key recommendations for ministries of health: how to proceed

- Develop/update national mental health legislation in line with international human rights covenants and instruments.
- Draft and adopt rules/regulations/codes of practice for implementing the national mental health legislation.
- Establish operational structures/mechanisms to support the implementation of mental health legislation.

Table 1 List of United Nations and regional treaties relevant to mental health legislation

Name of treaty	Website (URL)
United Nations treaties	
Convention on the rights of persons with disabilities	http://www.ohchr.org/EN/HRBodies/CRPD/Pages/CRPDIndex.aspx
Optional protocol to the convention on the rights of persons with disabilities	http://www.ohchr.org/EN/HRBodies/CRPD/Pages/OptionalProtocolRightsPersonsWithDisabilities.aspx
International covenant on economic, social and cultural rights	http://www.ohchr.org/EN/ProfessionalInterest/Pages/CESCR.aspx
International covenant on civil and political rights	http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx
Convention against torture and other cruel, inhuman or degrading treatment or punishment	http://www.ohchr.org/EN/ProfessionalInterest/Pages/CAT.aspx
Optional protocol to the convention against torture	http://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx
Regional treaties	
African charter on human and peoples' rights	http://www.achpr.org/instruments/achpr/
American convention on human rights in the area of economic, social and cultural rights	http://www.oas.org/juridico/english/treaties/b-32.html
Additional protocol to the American convention on human rights in the area of economic, social, and cultural rights	http://www.oas.org/juridico/english/treaties/a-52.html
Inter-American convention on the elimination of all forms of discrimination against persons with disabilities	http://www.oas.org/juridico/english/sigs/a-65.html
Convention for the protection of human rights and fundamental freedoms	http://conventions.coe.int/treaty/en/Treaties/Html/005.htm
European convention for the prevention of torture and inhuman or degrading treatment or punishment	http://www.cpt.coe.int/en/documents/ecpt.htm

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Commentary

Investing in mental health

D. Chisholm[1]

Why invest in mental health?

Mental, neurological and substance-use disorders account for 9 out of the 20 leading causes of years lived with disability worldwide (more than a quarter of all measured disability) and 10% of the global burden of disease (which includes deaths as well as disability) (*1,2*). A recent analysis by the World Economic Forum estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 trillion over the next 20 years (*3*). Such an estimate marks mental health out as a highly significant concern, not only for public health but also for economic development and societal welfare.

Worldwide, current investments in mental health are extremely meagre. Many low- and middle-income countries allocate less than 2%—or even less than 1%—of their health budget to the treatment and prevention of mental disorders (*4*). Most of the funds that are made available by governments are specifically directed to the operational costs of specialized but increasingly outdated mental hospitals (which are commonly associated with isolation, human rights violations and poor outcomes). This inevitably curbs the development of more equitable and cost–effective community-based services.

It has been estimated that an integrated package of cost–effective mental health care and prevention can be delivered in community-based settings of low- and middle-income countries for US$ 3–4 per capita per year (*5*).

The World Health Organization (WHO) recently set out 4 criteria against which public health investments are commonly made (*6*): the protection of human rights, including the right to health; the current and future (health and economic) burden of disease; the avertable burden of disease (resulting from the provision of cost–effective services); and the reduction of social inequalities, including access to essential health services. Application of these criteria to mental health revealed that a robust investment case can be made on the grounds of enhancing individual and population health and well-being, reducing social inequalities, protecting human rights, or improving economic efficiency.

The consequences of *not* investing in mental health are manifold and include:

- low rates of public awareness or understanding about the causes and impacts of better or worse mental health;

- low rates of detection, diagnosis, treatment and care for persons suffering from mental disorders and psychosocial disabilities;

- high costs to businesses and national economies as a result of diminished productivity.

What to invest in for better mental health

There is now a body of evidence demonstrating not only the efficacy of interventions but also their cost–effectiveness, affordability and feasibility. This information is available at the global level (i.e. for countries at different income levels) for alcohol use (as a risk factor for disease), epilepsy, depression and psychosis (Table 1) (*5,6*). A range of effective measures also exists for prevention of suicide, prevention and treatment of mental disorders in children (including appropriate immunization and proper nutrition/stimulation), prevention and treatment of dementia, and treatment of substance-use disorders. However, there is a relative dearth of cost–effectiveness data for these interventions and conditions; more information is needed for low- and middle-income countries.

It is also important to note that the onset or presence of a mental disorder increases the risk of disability and premature mortality from other diseases—including cardiovascular disease, diabetes, HIV/AIDS and other chronic conditions—due to neglect of the person's physical health (by themselves, families or care providers), elevated rates of psychoactive substance use, diminished physical activity, an unhealthy diet and, in many cases, the side-effects of medication. Along with suicide, these chronic diseases produce a level of premature mortality far in excess of that of the general population; even in the relatively affluent context of Nordic countries the mortality gap has been estimated at 20 years for men and 15 years for women (*7*).

How to invest in mental health: financing the development of service

Mental health financing is a far-reaching topic that not only addresses the specific question of what services to purchase and how (purchasing function) but also

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Table 1 Strength of economic evidence on mental health and substance abuse interventions

Disorder	Intervention	Cost–effectiveness (cost per healthy year of life gained)	Affordability (cost per capita)	Feasibility (logistic or other constraints)
Epilepsy	Treat cases with (first-line) antiepileptic drugs	+++	+++	Feasible in primary care
Depression (moderate–severe)	Treat cases with (generic) antidepressant drugs plus brief psychotherapy as required	+++	++	Feasible in primary care
Harmful alcohol use	Restrict access to retail alcohol Enforce bans on alcohol advertising Raise taxes on alcohol	+++	+++	Highly feasible
	Enforce drink-driving laws (breath-testing) Offer counselling to drinkers	++	++	Feasible in primary care
Psychosis	Treat cases with (older) antipsychotic drugs plus psychosocial support	++	+	Feasible in primary care; some referral needed

Cost–effectiveness: +++ = very cost–effective (cost per healthy life year gained < gross domestic product (GDP) per capita); ++ = quite cost–effective (cost per healthy life year gained < 3 times GDP per capita); + = less cost–effective (cost per healthy life year gained > 3 times GDP per capita).
Affordability: +++ = very affordable (implementation cost < US$ 0.50 per person); ++ = quite affordable (implementation cost = US$ 0.50–1.00 per person); + = less affordable (implementation cost > US$ 1.00 per person).

more normative questions around how much should be raised for mental health service provision (collection function) as well as issues around equity of access and fairness of financial contributions (pooling function) (8). Financing is also intimately linked to other "building blocks" of the health system, notably the health workforce and service provision (see related commentaries in this supplement on service reorganization and human resources) (9,10).

Resource adequacy and needs

A basic initial requirement of any mental health service development effort is to assess what resources are available and needed to deliver services to the target population and meet programme goals. A first step is to ascertain what financial and other resources are *currently* available (numbers of mental health professionals, inpatient beds, day care places, etc., as well as overall expenditures), followed by an appraisal of expected service needs and costs at *target* levels of service coverage in the population. Concerning health spending, WHO has developed tools for

producing and analysing expenditures using the *System of Health Accounts 2011* (11), which distributes expenditures for those diseases for which the country has data available (as a result, it is no longer recommended that countries produce disease- or condition-level sub-accounts). This means that it is vital to institute appropriate expenditure codes for mental health (and associated comorbidities) where they do not exist, and identify the key disease categories to be highlighted and used for policy (such as schizophrenia and other severe mental disorders since they are prominent, highly disabling and high-cost diseases that account for a significant share of overall mental health spending). WHO has also developed tools for undertaking integrated planning and costing of prevention and control efforts, including a mental health module of the inter-United Nations agency strategic planning tool called *OneHealth* (12). Use of such tools shows the budgetary implications of scaling-up prioritized, cost–effective interventions and reveals the returns on such investments (in terms of improved health).

Conclusion: All countries can undertake a resource needs assessment for better planning. Also, countries can develop and use the system of health accounts (11) to track mental health expenditures.

Fair financing

A fundamental concern underlying the drive towards universal health coverage relates to the high and potentially catastrophic cost of health care and treatment (to individuals and households). Direct, out-of-pocket payments represent a regressive form of health financing – they penalize those least able to afford care – and represent an obvious channel through which impoverishment may occur. Since mental disorders are typically chronic, usually require ongoing support, yet are often excluded from essential packages of care, they pose a particular threat to the economic wellbeing of households. Alongside ongoing efforts to monitor progress towards universal health coverage, it is therefore important for countries to better ascertain the extent

to which mental health services are being directly financed by households in the form of out-of-pocket payments and what impact this is having on their income or economic welfare. Prepayment mechanisms such as national or social insurance represent a more equitable mechanism for safeguarding at-risk populations from the adverse financial consequences of mental disorders compared with out-of-pocket expenditures.

Conclusion: Resource-constrained countries can aim to ensure that priority interventions and services for persons with severe or highly-disabling mental disorders are included within national or social insurance schemes; wealthier nations can aim for comprehensive financial coverage.

Purchasing

How, where and to whom should available funds be most appropriately channelled for the purpose of delivering services to the population in need? A number of mechanisms are possible, each with their own underlying incentives, processes and implications. For example, mental health care providers can be paid on a "fee for service" basis, whereby a fixed price is agreed beforehand (for example, with social insurance or sickness funds) and reimbursed following the provision of a service, such as an outpatient consultation or an overnight inpatient stay. Here there is a clear incentive for providers to deliver as much care as they can, since the more they do the more they receive. This can lead to problems of over-provision or over-spend. By comparison, available funds can be directly allocated to government- or privately-run services at the sub-national level, most simply on a per capita basis (i.e. budgets are set in proportion to population size alone). Since the budget is fixed, there is strong pressure to keep overall expenditures under the set amount. However, such a mechanism overlooks the potentially large variations in mental health needs at the sub-national level: for example,

regions with large cities might be expected to have a larger or more complex case-mix than more rural regions. Such variations can be accounted for via the development of resource allocation formulae.

Conclusion: All countries can review (and if necessary, revise) the way in which mental health care providers are paid to ensure that this is in the best interests of service-users and tax-payers/contributors.

Funding the reorganisation of services

A specific financing issue for mental health concerns the relocation of services and resources away from long-stay mental hospitals (which are commonly associated with isolation, human rights violations and poor outcomes) towards non-specialized health settings. Efforts to change the balance of mental health care are often hindered by a lack of appropriate transitional funding. Transitional or dual funding is clearly required over a period of time in order to build up appropriate community-based services before residents of long-term institutions can be relocated. It is therefore crucial to present an evidence-based case for relocating the locus of care not only on the grounds of equity, human rights and user satisfaction but also on the grounds of financial feasibility over a defined transitional period. A related issue concerns the shifting of responsibilities and associated funding from health to social care and housing systems. It is therefore important that sufficient social and financial protection measures are put in place, for example via payment exemption schemes for people meeting a certain threshold level of physical or psychosocial disability.

Conclusion: All countries can plan and make provisions for the gradual relocation of care from long-stay mental hospitals towards non-specialized health settings. Transitional funding is an important enabling lever for such a relocation of care.

Who should invest in mental health?

A multiplicity of actors can and should be investing more in promoting, protecting and restoring mental health, including individuals and families, local communities, businesses and employers, national governments, and international agencies. As the ultimate guardians of population health, governments have the *lead responsibility* to ensure that needs are met and that the mental health of the whole population is promoted. In order to address current shortcomings in the efficient and fair allocation of societal resources to mental health, governments and other stakeholders need to not only improve the coverage, depth and quality of services but also ensure that appropriate institutional, legal and financing arrangements are put in place to protect human rights and to address the mental health needs of the population. It is important to emphasize that such financial arrangements need to extend beyond the health sector alone, for example in the form of welfare support or housing.

Key requirements and actions

Based on this overview, the following actions can be highlighted as priority requirements.

- Set up mechanisms for tracking expenditure for mental health.

- Carry out a resource needs assessment based on locally agreed service coverage targets and intervention priorities.

- Allocate a budget that is commensurate with the agreed service targets and priority interventions.

- Provide transitional/bridge funding over a defined period of time to scale-up community-based services and downsize mental institutions (in parallel).

- Include defined priority mental disorders in the national/social insurance reimbursement schemes.

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Review

Scaling up action for mental health in the Eastern Mediterranean Region: an overview

R. Gater[1,2] and K. Saeed[3]

The case for action

One of the most pressing challenges to health systems globally, and in the World Health Organization (WHO) Eastern Mediterranean Region in particular, is that of effectively reducing the prevalence of mental disorders and the related disability and mortality.

Mental disorders are common and disabling. At any given time, about 1 person in every 10 is suffering from a mental disorder, and about 1 in 4 families has a member with a mental disorder (*1*). Rates of mental disorder are even greater where there are complex emergencies, such as are being faced by many countries in the Eastern Mediterranean Region. Globally, mental, neurological and substance-use disorders account for 22.9% of non-fatal disease burden (measured as years lived with disability) and 7.4% of the global burden of disease (measured as disability adjusted life years, a metric which encompasses years lived with disability as well as early death) (*2*).

Rates of suicide have increased by 60% over the past 45 years (*3*). Globally, 800 000 people die by suicide each year, making it the tenth leading cause of death, and one of the 3 leading causes of death among people aged 15–44 years (*4*). Suicide is expected to account for more than 2% of the global burden of disease by 2020 (*5*).

The costs of mental disorders are already huge, and are expected to grow year-by-year. In 2010, the global costs of mental disorders were estimated at US$ 2.5 trillion (*6*). Over the next 20 years the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 trillion. It is estimated that the cost of mental disorders in high-income countries, in terms of expenditures incurred and loss of productivity, equates to about 4% of gross national product (*7*), and it is predicted that the costs of mental disorders will more than double by 2030, affecting low- and middle-income countries as well as high-income countries.

Effective pharmacological and psychosocial treatments are available for depression, schizophrenia, epilepsy and alcohol and substance abuse, and these treatments can be successfully applied in low-income countries (*1,8*). Nevertheless, the vast majority of people with a mental disorder do not receive treatment. The treatment gap between people who require care but do not receive treatment has been estimated to be more than 90% in the Eastern Mediterranean Region (*9*). The reason for this unacceptable gap is that mental disorders and services for those affected have been neglected in many countries worldwide (*2*). Until recently, mental health has not featured on the political agenda. Mental health policies and legislation have been either absent or outdated, and pay scant regard to the human rights of people with mental disorders.

Inadequate resources have been devoted to mental health: countries in the Eastern Mediterranean Region typically spend 2% of their health budget on mental health (*10*), which compares with the 5–10% required to match contemporary comprehensive health care systems. The median spend of US$ 0.15 per person on mental health is 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 (*11*). Furthermore, centralized and institutionalized care consumes a disproportionate amount of mental health expenditure. Evidence-based action can ensure that the limited resources available to mental health care are used cost-effectively.

The high prevalence, considerable disability and growing costs of mental disorders, taken together with the huge treatment gap despite the availability of cost-effective treatments, form a compelling case to reassess provision for mental health care. The WHO has taken up this challenge with the Comprehensive Mental Health Action Plan 2013–2020, which was adopted at the 66th World Health Assembly (*12*). This action plan sets out a new vision and goal for mental health: "A world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally-appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society

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and at work free from stigmatization and discrimination."

This is to be articulated through 4 objectives and 6 measurable global targets to be achieved by 2020. The 4 objectives are:

- to strengthen effective leadership and governance for mental health;

- to provide comprehensive, integrated and responsive mental health and social care services in community-based settings;

- to implement strategies for promotion and prevention in mental health;

- to strengthen information systems, evidence and research for mental health.

The Eastern Mediterranean regional framework for implementation of the Comprehensive Mental Health Action Plan 2013–2020 operationalizes these 4 objectives, and translates them into concrete measurable activities with a set of intermediate indicators that can be used to monitor progress towards the targets for 2020. This theme issue on mental health contains papers on the components of the framework that concisely review the best available evidence and practices and identify the "best buys" for the Eastern Mediterranean Region to address priority mental health needs. These are reinforced with a set of resources and WHO tools to support countries planning and implementing national mental health action plans. Within the countries of the Region, there are examples of outstanding models of mental health provision that have been developed in local areas, some of which are referenced in the papers published in this issue.

Situation analysis in countries of the Region (13)

All 22 countries in the Eastern Mediterranean Region have submitted data in response to the questionnaire for the forthcoming *Mental health atlas 2014*,

which collects a set of core mental health indicators to monitor progress in relation to the targets in the Comprehensive Mental Health Action Plan 2013–2020. Preliminary analysis of the *Atlas* suggests that some countries have started to address policy development and legislation, but there remain significant shortfalls in many areas, as detailed below.

- *Mental health policy and legislation:* Most countries report that they have a mental health policy (82%) and mental health legislation (77%), but only one-third are fully compliant with international human rights instruments. Mental health legislation in 23% of countries was enacted more than 10 years ago.

- *Service user empowerment and participation:* Around 23% of countries have a formal published policy on the participation of service users and carers. In most countries service-user involvement is absent during the formulation and implementation of mental health policies, plans, legislation and services.

- *Investment in mental health:* The government is the main provider of funds for care and treatment of severe mental disorders in 77% of countries. However, few countries were able to submit data to the *Mental health atlas* project on annual mental health expenditure by the government. This may indicate that budgets are not specifically allocated and ring-fenced for mental health.

- *Human resources:* The size of the mental health workforce varies greatly across the Region. Among the countries that submitted relevant data, about a quarter have more than 20 mental health staff per 100 000 population, two-thirds have 5–19 staff per 100 000 population, and 1 country has less than 1 staff member per 100 000 population.

- *Integration of mental health in primary health care:* The extent of mental health training for primary care doc-

tors and nurses varies greatly between countries. A median of 29% of primary care doctors and 5% of primary care nurses have received at least 2 days of mental health training in the past 2 years.

- *Mental hospitals:* In about one-third of countries, more than 85% of the mental health workforce is deployed to work in mental hospitals. Across the Region, a median of 74% of admissions were involuntary. Over one-third of reporting countries indicated that one-third or more of mental hospital patients had stays greater than 5 years.

- *Promotion and prevention:* Around 27% of countries have no mental health promotion and prevention programmes, and a further 27% have only 1–3 such programmes.

- *Suicide prevention:* Only 18% of countries have a national suicide prevention strategy, and only 23% were able to report data on numbers of suicides. The annual rate of suicide ranges between 4 and 44 per 1 000 000 population.

- *Information systems:* Almost half the countries have not published a specific mental health information report in the past 2 years although 14% have published reports on both the public and private sector. The difficulty in providing information for the *Mental Health Atlas 2014* questionnaire, particularly on expenditure, professionals working in different settings, service coverage and suicide, suggests that many countries are managing with very rudimentary information systems.

Effective leadership and governance for mental health

Planning and implementation for the transformation of mental health care will need robust and committed leadership and governance from

national governments (ministries of health) working with other public sector entities and other partners, in both the private sector and civil society, to implement the plan. Without effective leadership and governance, any attempt for national reform of mental health care will falter. This requires a dedicated mental health unit/department within the health ministry, and countries may consider appointing an individual director of the mental health unit/department responsible for overseeing the development and governance of policy, plans and legislation.

Government commitment to improving mental health can also establish national values for mental health care by adopting and promulgating the cross-cutting principles of the Comprehensive Mental Health Action Plan 2013–2020 in the governance framework. Having a wide representation in governance structures, including service users and families as well as a range of other stakeholders, is a means of ensuring that the principles of equitable universal health coverage; respect for human rights; culturally-sensitive evidence-based practice; addressing the whole life course; a coordinated and comprehensive multisectoral approach; and the empowerment and involvement of people with mental disorders and psychosocial disabilities are woven into the way that leadership and governance procedures are established and managed.

The key leadership and governance responsibilities are in the development and oversight of the implementation of mental health policies and plans, mental health legislation and finances. These form the supporting framework in which mental health services will be delivered. It is crucial that they complement and support each other; for example, mental health laws should codify the fundamental principles, values, aims and objectives of mental health policies and plans, and budgets need to be allocated to achieve the targets of the national mental health plan.

Mental health policy and strategic plan

A mental health policy expresses the national vision for mental health and articulates the key objectives and areas for action to achieve that vision. In the associated action plan these are translated into concrete actions, time frames, targets and indicators for measuring progress and outcomes. Some countries have a dedicated mental health policy and plan, while in others mental health is incorporated in general health, disability, or other related policies and plans. The important elements that need to be included in a mental health policy and plan are summarized in a separate paper in this theme issue (14).

Key strategic interventions for mental health policy and strategic plan

- Establish/update a multisectoral national policy/strategic action plan for mental health in line with international/regional human rights instruments.

- Establish a common governance structure, as appropriate to the national context, to facilitate and monitor implementation of the multisectoral national policy/strategic action plan.

Mental health legislation

Modern mental health legislation is important to establish and enforce the basic requirements for human rights protection, quality of care and service development. National legislation must also conform to legal obligations agreed in international human rights treaties such as the United Nations *Convention on the rights of persons with disabilities* (15). Mental health legislation may stand alone as a single, consolidated mental health law or it may be fully or partially integrated into other relevant legislation. In a separate paper in this theme issue, Funk and Drew delineate the aspects of mental health law that should be clearly articulated in the legislation (16).

Key strategic interventions for mental health legislation

- Review legislation related to mental health in line with international human rights covenants/instruments.

- Establish a mechanism to independently monitor the implementation of updated legislation.

Investing in mental health

Mental health financing is not only about costs but should also be informed by the cross-cutting principles of the Comprehensive Mental Health Action Plan 2013–2020. It is important to provide equitable access to services and a system of financial contributions that is fair and avoids the risk of potential catastrophic financial consequences of health care for individuals and their families. To meet the goal of this action plan, it is essential that governments take responsibility for ensuring that a national budget adequate to meet the mental health needs is secured, and that appropriate and fair financing arrangements are put in place to use the available resources in a cost–effective and equitable way.

Alongside assessing resource needs and coverage targets, ministries need to prioritize adequate budgetary allocations to support the mental health policy/plans. These steps are linked to the 3 dimensions which are considered when moving towards universal health coverage (Figure 1). The adoption of community-based care and the integration of mental health into primary health care and other service delivery

platforms will expand the population that is equitably covered. Evidence regarding mental health interventions that can be delivered more cost–effectively in the community than in a hospital-based service is provided by Chisholm in a paper elsewhere in this theme issue (*18*).

Key strategic interventions for investing in mental health

- Include defined priority mental conditions in the basic health delivery package of the government and social/private insurance reimbursement schemes.
- Increase and prioritize budgetary allocations for addressing the agreed upon service targets and priorities, including providing transitional/bridge funding.

Reorganizing mental health services: from institutional to community-based models of care

The main thrust of the global action plan is transformation of the provision of mental health care so that it becomes accessible to all and makes efficient use of the resources available to provide effective mental health care in a way that is equitable while fully respecting the human rights of people with mental disorders and their carers. At the heart of mental health care is the health and social care service along with the promotion of mental health and well-being and the prevention of mental disorders. Together these form the interface of mental health care with individuals, families and communities. These complementary approaches are the means towards achieving the goal of the Comprehensive Mental Health Action Plan 2013–2020 "to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and

Figure 1 Universal health care cube (*17*)

disability for persons with mental disorders".

The WHO has proposed the service organization pyramid for an optimal mix of services for mental health (Figure 2). This model incorporates the recovery paradigm that people with mental disorders are central to their own recovery and they can manage their mental health problems themselves, supported by family, friends and community institutions. At successively higher levels of the pyramid the mental health needs of the individual require more-intensive professional assistance with correspondingly higher costs of care.

There is a strong consensus, supported by evidence reviewed by Saraceno et al., that a balanced approach to secondary mental health services incorporating both community and hospital services offers the best model for a modern mental health service (*20*). The components of this balanced approach are detailed here.

- *Integration of mental health into primary care and other priority healthcare programmes, such as Making Pregnancy Safer, the Expanded Programme on Immunization, and integrated child care programmes:* This wholly accords with the aims of the WHO Mental Health Gap Action Programme (mhGAP)
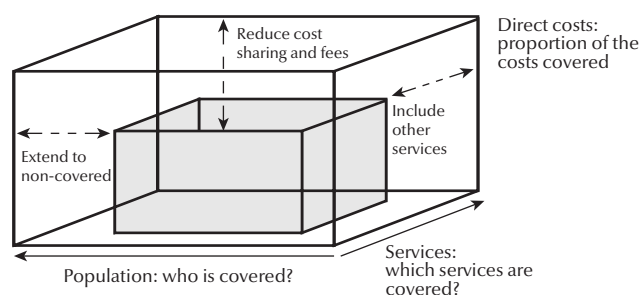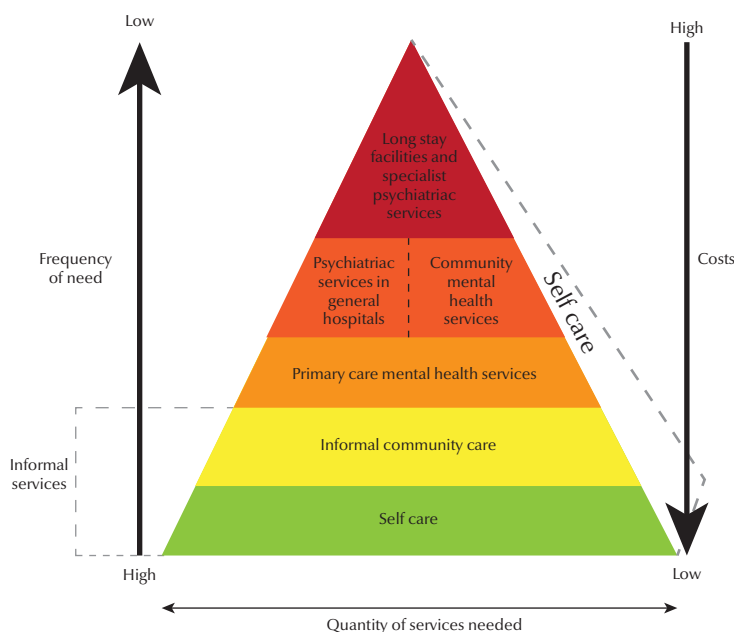

Figure 2 WHO service organization pyramid for an optimal mix of services for mental health (*19*)

to scale up care for mental, neurological and substance misuse disorders by delivering pharmacological and psychosocial interventions in non-specialized health care settings.

- *Scaling up community-based mental health services such as multidisciplinary community outreach teams for defined catchment populations, provision of supported residential facilities within community settings, supported employment, and family support:* Community-based care offers a cost–effective alternative that can support recovery and self-care, and patients report greater satisfaction. Many countries have developed successful pilot sites of community services, but few have scaled them up to cover the whole population to provide equitable access for all.

- *Establishing mental health services in general hospitals for outpatient and acute inpatient care:* Compared with the psychiatric hospital, this is more accessible to the majority of people, is less stigmatizing, and provides the ideal setting for coordinated treatment of comorbid physical and mental disorders.

- *Scaling down and refocusing psychiatric hospitals:* Centralized, institutionalized care in psychiatric hospitals is expensive, inefficient and inaccessible. Psychiatric hospital-based care consumes a disproportionate amount of mental health expenditure, and many inpatients become long-stay patients and have poor clinical and social outcomes. Rehabilitation programmes are often inadequate, and psychiatric hospitals are associated with human rights violations. Current long-stay patients will need careful assessment and planned rehabilitation to help them regain the skills to live outside the hospital supported by community mental health services. More-immediate action can, however, be taken to progressively reduce the number of long-stay beds in mental hospitals through restricting new admissions and providing community/general

hospital-based alternatives to admission to the psychiatric long-stay beds.

- *Human resources to deliver integrated community-based care:* Evidence on the development, deployment and retention of human resources for mental health services has been reviewed by Ivbijaro et al. (*21*). By engaging primary and general health care staff in mental health care, the coverage, availability, accessibility and acceptability of such care can be greatly expanded. Most of the recurrent mental health budget is spent on salaries. It is therefore crucial to recruit, develop and retain a multidisciplinary workforce with the mix of skills, involving task-sharing/shifting, training and supervision, to deliver community-based care. Where most mental health staff are based in psychiatric hospitals there will be a need for some to reorient and retrain to work in the community. There is a risk that those who remain in the hospital will become demoralized and one way to address this is through enhancing the expertise of the psychiatric hospital staff and transforming the hospitals into tertiary referral centres of excellence for specialized inpatient care or for patients with care needs that cannot be fully met by the mental health units based in general hospitals.

The optimal balance of mental health services for each country varies according to population needs and available resources: areas with low levels of resources may need to focus on improving mental health care in primary health care with specialist back-up, while countries with more available resources can supplement primary health care with more-direct care from specialist mental health services in the community and in hospital.

Key strategic interventions for reorganizing mental health services

- Establish mental health services in general hospitals for outpatient and short-stay inpatient care.

- Integrate delivery of evidence-based interventions for priority mental conditions in primary health care, supported by referral systems.

- Integrate delivery of interventions for mental health conditions into priority health programmes.

- Enable people with mental health conditions and their families through self-help and community-based interventions.

- Downsize the existing long-stay mental hospitals and ensure protection of the rights of people with mental health conditions.

Promotion and primary prevention: priorities for implementation

Mental health promotion and prevention interventions can improve the mental health of the population by reducing risk factors and addressing social determinants for mental disorders, enhancing protective factors for good mental and physical health, and contributing to lasting positive effects on a range of social and economic outcomes. Selected promotion and prevention programmes for reducing the increasing burden of mental disorders and improving the overall health and well-being of the population should be integrated into national health and development strategies.

Barry et al. review the extensive global evidence demonstrating that preventive interventions are cost–effective, feasible and affordable (*22*). This evidence has been used to identify the following "best buys" for the Eastern Mediterranean Region.

- *Infant and maternal health and combined nutritional and parenting skills:* Integrating mental health promotion and prevention into routine prenatal and postnatal care services improves child development and parenting

skills, reduces behavioural problems and improves maternal health and social functioning. This generates economic savings for government and benefits to society. Benefits are especially evident for the most vulnerable families, including those living in poverty or war-torn areas, babies who are undernourished and mothers with depression.

- *Life skills for schoolchildren:* Social and emotional learning interventions in schools produce sustained benefits in children's social and emotional functioning and their academic performance. Furthermore, they are cost-saving in terms of their positive impact on crime and health outcomes. Targeted interventions for children at higher risk (for example children living in a complex emergency) enhance coping skills, resilience and cognitive skills and are effective in preventing anxiety and depression.

- *Suicide prevention:* There is growing evidence that interventions such as responsible media reporting; restricting access to means; training of health personnel for early recognition and management of priority mental, neurological, and substance use disorders; and school-based skills training and social support for at-risk students are effective in high-income countries. However, further evaluation and modification is needed in the context of the countries of the Eastern Mediterranean Region. Preliminary measures towards suicide prevention that should be established in all countries of the Region include setting up systems to capture information about the rates of suicides/suicide attempts, methods employed and demographic characteristics along with the decriminalization of suicide.

- *Promotion of mental health literacy:* The evidence for the effectiveness of mental health literacy programmes such as mass media promotion, dedicated websites, school education programmes and mental health

first aid training is mainly from high-income countries. Therefore, the decision to implement these interventions has to be taken based on the individual context of each country. Internet interventions have been shown to be at least as effective as face-to-face interventions at reducing stigma, and it could be relatively inexpensive to adapt existing websites for Eastern Mediterranean Region countries.

Key strategic interventions for the promotion of mental health and primary prevention of mental disorders

- Integrate recognition and management of maternal depression and parenting skills training into maternal and child health programmes.

- Integrate life skills education, using a whole school approach.

- Reduce access to means of suicide.

- Employ evidence-based methods to improve mental health literacy and reduce stigma.

Mental health and psychosocial support in humanitarian emergencies

Complex emergency situations pose particular challenges, causing mental health problems that can go on to become persistent and disabling. The disruption of an emergency can also undermine the organization and provision of necessary care for people with an established mental disorder who are being treated in hospital or the community. A disproportionately high number of countries in the Region have had, or are continuing to deal with, complex emergencies. Van Ommeren et al. review the evidence for 4 strategic interventions aimed at helping countries prepare for and minimize the damaging effects of complex emergencies on mental health (*23*).

Key strategic interventions for humanitarian emergencies

- Embed mental health and psychosocial support in national emergency preparedness and ensure the strengthening of mental health systems as part of recovery.

- Train emergency responders to provide psychological first aid.

- Strengthen the capacity of health professionals in the recognition and management of priority mental conditions during emergencies.

- Implement evidence-informed interventions for psychosocial assistance to vulnerable groups.

Mental health surveillance and information systems

The core foundation of planning and development is evidence; this includes both evidence about the local needs and services and research evidence about innovations. Gater, Chisholm and Dowrick describe how information about local needs and service delivery is crucial to monitoring and planning improvements in service provision (*24*). The paucity of reliable information in many countries in the Region has impaired the ability of planners to develop services that are responsive and meet the needs of the population. The goal of the Comprehensive Mental Health Action Plan 2013–2020 requires relevant, high quality, mental health and service indicators to be collected and reported (Figure 3). Some of these indicators will be incorporated into routine national data collection and others may need to be supplemented by periodic surveys. The WHO is developing the use of recent advances in information technology to explore how the internet and data warehousing techniques can be best harnessed to support data collection, intersectoral collaboration and data sharing and dissemination.

Key strategic interventions for surveillance and information systems

- Integrate the core indicators within the national health information systems; a proposed list of core mental health indicators is included in the *Eastern Mediterranean regional framework for implementation of the comprehensive mental health action plan* (25).
- Routinely record and report suicides at national level.

Mental health research: priorities and use to inform policies & services

The second key source of evidence is mental health research, which has been reviewed by Regan et al. (26). Mental health research is critical to guiding rational policy development, strategic programme planning and the reorganization of mental health services. Prioritizing mental health research, particularly implementation research, can generate enormous returns in terms of reducing disability and preventing premature death. To an extent, the findings from mental health research can be generalized and applied in different countries but this does not necessarily take account of the culture, services, economics and other circumstances in countries of the Eastern Mediterranean Region. It is therefore important that countries identify their own research priorities, mobilize resources and enhance their human and infrastructural research capacity so that they have relevant research findings to guide the development of policies and service delivery models.

Key strategic interventions for mental health research

- Enhance the national capacity to undertake prioritized research.

- Engage stakeholders in research planning, implementation and dissemination.

Comprehensive systems approach of the Regional framework for implementing the Mental Health Action Plan 2013–2020

A comprehensive systems approach is the means by which sustainable change can be achieved. The mental health and social care services and the promotion of mental health and well-being and prevention of mental disorders are at the centre of mental health care delivery, but they can only perform their role successfully if properly supported by all the other components (Figure 4). They are directly influenced by resources and information (middle ring in Figure 4). They need to be manned by a workforce that is appropriately skilled and structured for the task. They need to be adequately financed, and during a period of change they require transitional funding so that the old and new services can be balanced and run in parallel while the new services are established. They need information and research to monitor how successfully they meet their objectives and to inform further planning, development and innovation. The mental health service needs essential medicines to be continuously available both in hospital and community settings. Mental health care delivery operates within the overarching framework set in the national policy and plan, and within the legal framework of mental health laws (outer ring in Figure 4). All these
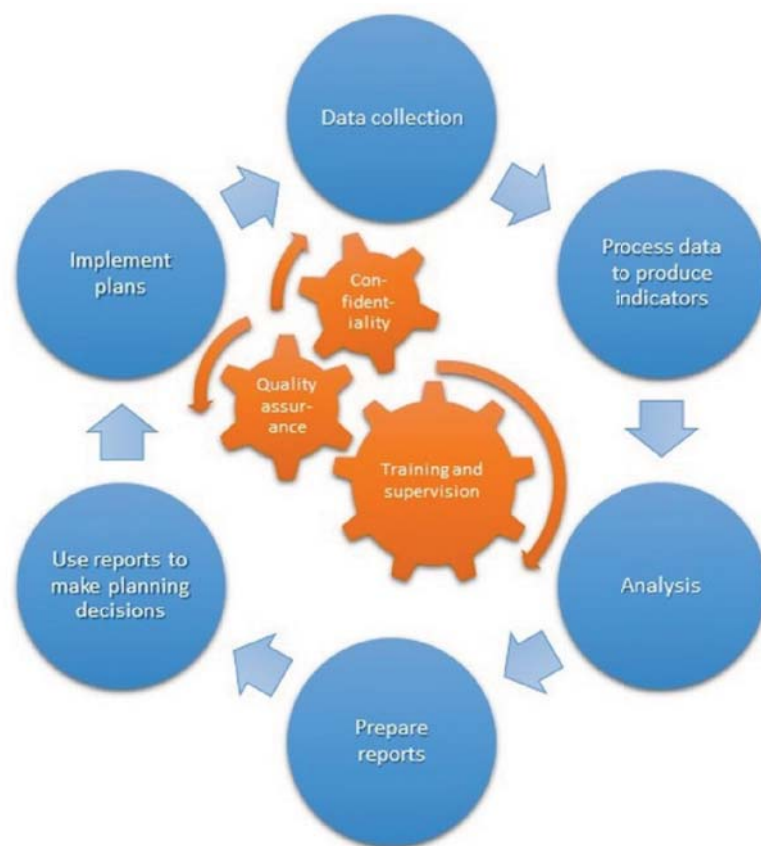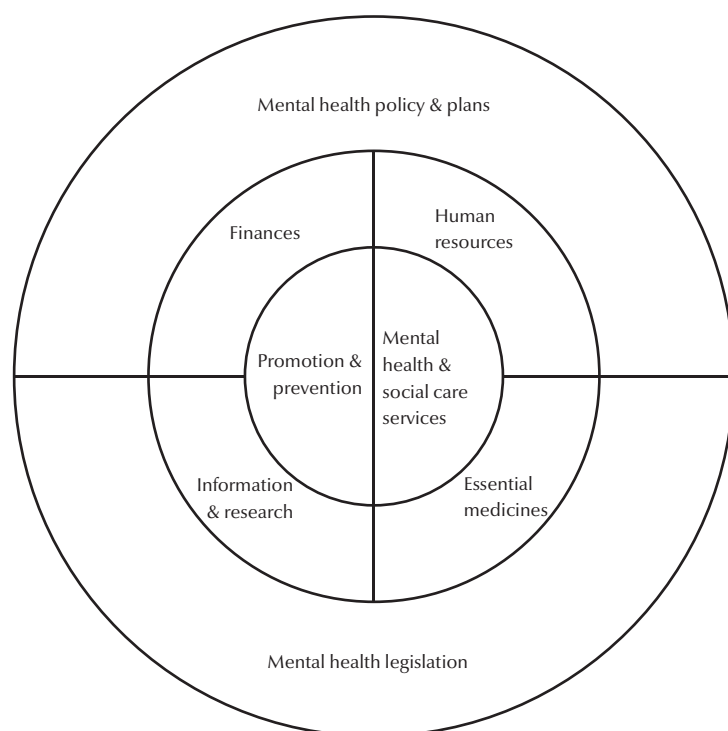

Figure 3 Information loop

Figure 4 Synergy of the components of the mental health service

component parts must be actively involved in meeting the mental health challenge and orchestrated so that they work harmoniously together. For example, resources must be made available at the right time in the process of service development, research must be relevant to inform future planning and development, and legislation must support the developing model of community care.

The key strategic interventions identified have been brought together in the Eastern Mediterranean regional framework for implementation of the Comprehensive Mental Health Action Plan 2013–2020 (25). In the framework, the implementation of the strategic interventions is supported by a set of WHO tools and proposed indicators that will be used biennially until 2020 to monitor progress towards the targets of the Action Plan.

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WHO events addressing public health priorities

Committing to action: mental health in the Eastern Mediterranean Region

No health without mental health

Mental health is an integral part of health and well-being, and in May 2012 the World Health Assembly acknowledged this fact by requesting the Director-General to develop a comprehensive mental health action plan, in consultation with Member States, covering services, polices, legislation, plans, strategies and programmes. The resulting global action plan, adopted by the Assembly in 2013, takes a multisectoral approach across the life course to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

Scaling up mental health action in the Region

The Comprehensive Mental Health Action Plan 2013–2020 has set out a clear road map for all stakeholders with agreed-upon targets and indicators. It provides the foundation for the development of a regional framework for action to scale up mental health in the Region.

To chart the way forward in consultation with Members States for a regional framework to scale up action on mental health in the Eastern Mediterranean Region, in line with the Action Plan 2013–2020, a meeting was held in Cairo, Egypt from 15 to 17 September, 2014. The participants included mental health focal points from Member States supported by experts who had, in preparation for the meeting, developed evidence briefs on priority areas to guide the drafting of the regional frame work and to facilitate discussions.

The meeting had the following specific objectives:

- Review currently available resources & capacities in the Region, and identify the main facilitators and barriers to implementing the provisions of the Action Plan and a regional strategy.
- Review the best available evidence and practices for addressing priority mental health needs.
- Agree on a regional framework for action based on the global action plan and priority next steps for scaling up national action on mental health.

Key areas of focus

The meeting programme was organized around the key domains, broadly mirroring the objectives of the Comprehensive Action Plan 2013–2020: governance; health care; promotion and prevention; and surveillance, monitoring and research.

The following major issues/challenges were identified.

1. Gvernance
- Financial protection of families and persons suffering from mental health conditions from sliding into poverty
- Availability of transitional/bridge funding for reorganization of mental health services from institutional to community-based
- Involvement & empowerment of user/family associations in developing and implementing policies, legislation and services

2. Health care
- Premature closure of mental hospitals, without parallel development of community services
- Organization of services based on the delineated catchments
- Enhancement of a mental health component in pre-service teaching /training needs of health professionals as opposed to the current reliance on in-service training
- Deinstitutionalization by changing attitudes and dismantling the culture of institutionalization of mentally ill persons rather than just reducing beds.

3. Mental health and psychosocial support in humanitarian emergencies
- Embedding of a mental health and psychosocial support component in emergency preparedness

4. Promotion and prevention
- Ensuring buy in from other sectors---what will be their gain
- Step-based approach to prevention and promotion, focusing on actions the health sector can directly influence, such as recognition and management of maternal postnatal depression, parenting skill training and nutritional interventions, expanding gradually to other sectors, e.g. education, poverty reduction
- Expansion of the scope of prevention to include early recognition and management of childhood disorders
- Availability of packages targeted at specific groups, e.g. adolescents, women, refugees

5. Surveillance, monitoring and research
- Cultural sensitivity about suicidal behaviours, while strengthening vital statistics registration systems to capture suicide-related deaths
- Paucity of research, in general, and implementation research, in particular, to guide policy and service developments
- Capacity for undertaking research
- Regional consortium for research into emergencies.

Box 1: Strategic interventions to scale up action on mental health in the Region

Governance

- Establish/update a multisectoral national policy/strategic action plan for mental health in line with international/regional human rights instruments
- Establish a common governance structure, as appropriate to the national context, to facilitate and monitor implementation of the multisectoral national policy/strategic action plan
- Review legislation related to mental health in line with international human rights covenants/ instruments.
- Establish a mechanism to independently monitor the implementation of updated legislation
- Include defined priority mental conditions in the basic health delivery package of the government and social/private insurance reimbursement schemes
- Increase and prioritize budgetary allocations for addressing the agreed-upon service targets and priorities, including providing transitional/bridge funding

Health care

- Establish mental health services in general hospitals for outpatient and short-stay inpatient care
- Integrate delivery of evidence-based interventions for priority mental conditions in primary health care, supported by referral systems
- Integrate delivery of interventions for mental health conditions into priority health programmes
- Enable people with mental health conditions and their families through self-help and community-based interventions
- Down-size the existing long-stay mental hospitals and ensure protection of the rights of people with mental health condition
- Embed mental health and psychosocial support in national emergency preparedness, also ensuring strengthening of mental health systems as part of recovery
- Train emergency responders to provide psychological first aid
- Strengthen the capacity of health professionals for recognition and management of priority mental conditions during emergencies
- Implement evidence-informed interventions for psychosocial assistance to vulnerable groups

Promotion and prevention

- Integrate recognition and management of maternal depression and parenting skills training in maternal and child health programmes
- Integrate life skills education (LSE), using a whole school approach
- Reduce access to means of suicide
- Employ evidence-based methods to improve mental health literacy and reduce stigma

Surveillance, monitoring and research

- Integrate the core indicators within the national health information systems
- Routinely record and report suicides at the national level
- Enhance the national capacity to undertake prioritized research
- Engage stakeholders in research planning, implementation and dissemination

The way forward for mental health in the Region

Following the three days of deliberations, the framework based on the principles underpinning the comprehensive action plan was modified to capture the needs and priorities of the Member States of the Region (see Box 1 for the strategic intervention proposed in the regional framework).

The next step is for each country to begin working on prioritizing the strategic interventions agreed upon in the regional framework and monitoring their progress using

the set of proposed indicators. A deliberate and concerted effort will be needed to actively involve all stakeholders, from decision-makers to the users of services in order to achieve vision of the action plan of a world in which mental health is promoted and protected and mental disorders are prevented, and persons affected by these disorders are able to exercise the full range of human rights, participate fully in society and at work free from stigmatization and discrimination and access high quality, culturally-appropriate health and social care in a timely way to promote recovery.

Proposed regional framework to scale up action on mental health in the Eastern Mediterranean Region

Domains	Strategic interventions	Proposed indicators
Governance	• Establish/update a multisectoral national policy/strategic action plan for mental health	• Country has an operational multisectoral national mental health policy/plan in line with international/regional human rights instruments[a]
	• Embed mental health and psychosocial support in national emergency preparedness and recovery plans	• Mental health and psychosocial support provision is integrated in the national emergency preparedness plans
	• Review legislation related to mental health in line with international human rights covenants/ instruments	• Country has updated mental health legislation in line with international/regional human rights instruments
	• Integrate priority mental conditions in the basic health delivery package of the government and social/private insurance reimbursement schemes	• Inclusion of specified priority mental health conditions in basic packages of health care of public and private insurance/ reimbursement schemes • Enhanced budgetary allocations are in place for addressing the agreed upon national mental health service delivery targets
Health care	• Establish mental health services in general hospitals for outpatient and short-stay inpatient care	• Proportion of general hospitals which have mental health units, including inpatient and outpatient units
	• Integrate delivery of cost-effective, feasible and affordable evidence-based interventions for mental conditions in primary health care and other priority health programmes[b]	• Proportion of persons with mental health conditions utilizing health services (disaggregated by age, sex, diagnosis and setting) • Proportion of primary health care facilities with regular availability of essential psychotropic medicines • Proportion of primary health care facilities with at least one staff trained to deliver non-pharmacological interventions
	• Provide people with mental health conditions and their families with access to self-help and community-based interventions.	
	• Downsize the existing long-stay mental hospitals	• Proportion of mental health facilities monitored annually to ensure protection of human rights of persons with mental conditions using quality and rights standards
	• Implement best practices for mental health and psychosocial support in emergencies[c]	• Proportion of health care workers trained in recognition and management of priority mental conditions during emergencies
Promotion and prevention	• Provide cost-effective, feasible and affordable preventive interventions through community and population-based platforms[d]	• Proportion of schools implementing the whole-school approach to promote life skills • Proportion of mother and child health care personnel trained in providing early childhood care and development and parenting skills to mothers and families • Proportion of mother and child health care personnel trained in early recognition and management of maternal depression • Availability of operational national suicide prevention action plan • Regular national campaigns to improve mental health literacy and reduce stigma using multiple delivery channels
	• Train emergency responders to provide psychological first aid	• Psychological first aid (PFA) training is incorporated in all emergency responder trainings at national level
Surveillance, monitoring and research	• Integrate the core indicators within the national health information systems	• Routine data and reports at national level available on the core set of mental health indicators
	• Enhance the national capacity to undertake prioritized research	• Annual reporting of national data on numbers of deaths by suicide

[a]**Operational:** refers to a policy, strategy or action plan which is being used and implemented in the country, with resources and funding available to implement it with a unit /department which has a specifically delineated budget, human resource allocation and authority to monitor the implementation of the policy/strategy in the country.

[b]**Cost-effective, feasible and affordable evidence-based interventions ("best buys") for management of mental disorders include**: treatment of epilepsy (with older first-line antiepileptic drugs), depression (with generic antidepressant drugs and psychosocial treatment), bipolar disorder (with the mood-stabilizer drug lithium), and schizophrenia (with older antipsychotic drugs and psychosocial treatment). However, there are a number of interventions for management of mental disorders starting in childhood and adolescence, anxiety and stress-related disorders and suicidal behaviours which can be classified as "**good buys**" and which are also part of the mhGAP intervention guide (mhGAP-IG) http://www.who.int/mental_health/mhgap/en/.

[c]**Best and good practices for mental health and psychosocial support in emergencies include:** strengthen community self-help and social support; support early childhood development (ECD) activities; train and supervise staff in the management of mental health problems that are relevant to emergencies; provide evidence-based psychological interventions through lay workers; ensure regular supply of essential psychotropic medications; address the safety, basic needs and rights of people with severe or chronic mental illness in the community and institutions; encourage dissemination of information to the community at large.

[d]**Best practices (cost-effective, feasible and affordable evidence-based interventions) for prevention of mental disorders and promotion of mental health include**: early child development and parenting skills interventions and laws and regulations to restrict access to means of self-harm/suicide. Mass information and awareness campaigns for promoting mental health literacy and reducing stigma; early recognition and management of maternal depression; identification, case detection and management in schools of children with mental, neurological and substance use (MNS) disorders; integrating mental health promotion strategies, such as stress reduction, into occupational health and safety policies; regulations to improve obstetric and perinatal care, strengthening immunization; salt iodization programmes; folic acid food fortification; and selective protein supplementation programmes to promote healthy cognitive development are recommended as "**good practices**"

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