MENTAL HEALTH AND SUBSTANCE USE
SUMMARY

Unlike the MDGs, the SDGs include mental health and substance use disorders that, together with neurological and developmental disorders, are responsible for over 10% of the global disease burden.

SDG Target 3.4 calls for the promotion of mental health and well-being. Depression and suicide take a major toll on the health of the population. Nearly one in 10 people in the world suffer from a mental disorder. An estimated 804,000 deaths due to suicide occurred worldwide in 2012. Treatment coverage for mental disorders is very poor in many countries and significant scale-up will be required. Evidence-based guidelines for the management of depression and suicide are available, and the WHO Mental Health Action Plan 2013–2020 calls for a 20% increase in service coverage for severe mental disorders.

Dementia has become a major global health issue because it affects many people and their families (it is estimated that over 46 million people are living with dementia in 2015, a number expected to reach almost 75 million by 2030) and imposes major financial costs on societies (globally US$ 604 billion in 2010). Momentum is gathering with regard to the need to understand the causes of dementia and to develop appropriate prevention strategies and treatments. A broad public health approach is needed to improve the care and quality of life of people with dementia and family caregivers, articulated in a stand-alone dementia policy or plan, or integrated into existing health, mental health or old-age policies and plans.

SDG Target 3.5 calls for strengthening the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. Almost 2% of the global burden of disease is estimated to be associated with alcohol and other substance use disorders. Alcohol use is one of the major risks for NCDs and a target of reducing harmful use by 10% over the next 15 years has been set. The WHO global strategy on reducing the harmful use of alcohol calls for national policies to strengthen the public health response to harmful use and build capacity for prevention and treatment of substance use disorders and associated health conditions.

In 2013, some 27 million people worldwide suffered from drug use disorders; almost 50% injected drugs, and an estimated 1.65 million were living with HIV. Since 2006, the number of people using illicit drugs has increased by 38 million, reaching 246 million in 2013. The number of problem users has remained fairly constant at 27 million since 2008. Treatment coverage for drug use disorders continues to be low. A special session of the UN General Assembly will be held in 2016 to address the world drug problem.
In terms of years of life lived with disability (YLD), mental disorders impose an even greater burden, over one fifth of YLD being due to this cause. A large proportion of disorders is caused by depression and anxiety and people between age 15 and 59 are most affected.

The level of premature mortality among people living with mental disorders is more than twice that of those without mental disorders. The main causes are suicide and unaddressed physical health conditions such as cardiovascular disease, aggravated by poor access to and quality of health-care services, lifestyle factors and other social determinants of health such as poverty. In 2012, there were over 800 000 estimated suicide deaths worldwide with suicide rates varying considerably by region and by sex (Figure 7.2).

Approximately 1.8% of the worldwide disease burden is attributable to substance use disorders (1.2% to alcohol use disorders and 0.6% to drug use disorders). The burden due to substance use disorders varies considerably by region (Figure 7.3). For example, the DALY rate for the low-, middle- and non-OECD high-income countries in the European Region is five times higher than that of the Eastern Mediterranean Region, where the consumption of alcohol is banned in many countries. The disease burden peaks between ages 30 and 49, while the burden of drug use disorders occurs maximally between ages 15 and 29. In both cases, the burden declines rapidly after age 50, although alcohol use disorders continue to impose a significant disease burden up to age 70 and older. Harmful use of alcohol is among the top five risk factors contributing to the global burden of disease. Alcohol-attributable disease burden, which includes but is not limited to, alcohol use disorders, amounts to 5.1% of the global burden of disease and injury. Illicit drug use continues to constitute a serious threat to public health and to people’s safety and well-being – particularly that of children, young people and their families.

Needless to say, the burden imposed by mental and substance use disorders, goes beyond the immediate health impact of the diseases themselves, notably in terms of the responsibilities shouldered by family members in caregiving roles. Mental and substance use disorders also have an important economic impact. According to one recent study, the total economic output lost to these disorders in 2010 alone was US$ 8.5 billion worldwide, an annual sum expected to nearly double by 2030, barring a concerted response. Concerning economic costs attributable to alcohol use and alcohol use disorders alone, a separate study estimated a loss equivalent to 1.3-3.3% of GDP in a range of high- and middle-income countries, with over
two thirds of the loss accounted for by lost productivity.6 The global cost of dementia was estimated to be US$ 604 billion in 2010.7 Despite their significance as public health issues in all regions, mental and substance use disorders did not figure in the MDGs. The SDGs, on the other hand, address the issues as part of the broader NCD target (3.4), which calls for efforts to promote mental health and well-being, and in Target 3.5, which explicitly targets substance abuse and focuses on narcotic drugs and harmful use of alcohol (Figure 7.4). In addition, the UHC target (3.8) has clear implications for the provision of effective health promotion, illness prevention, curative, rehabilitative and palliative interventions to all people living with mental and substance use disorders.

The number of people living with dementia worldwide has been increasing during the past decades, linked with the rapidly ageing world population. It is estimated that there were over 46 million people living with dementia in 2015, a number that is expected to almost double every 20 years.10 There are marked differences in the levels of the incidence of dementia between regions, with high-income countries having much higher incidence rates than low-income countries.

Data availability for alcohol use has only recently improved, and past global and regional trends are difficult to assess. In 2012, about 6% of all deaths worldwide was attributable to the consequences of alcohol consumption, with a significant proportion of those deaths being due to cardiovascular diseases and injuries. It has been estimated that 38% of the world population age 15 or older had drunk alcohol in the past 12 months, and 16% engaged in heavy episodic drinking.11

TRENDS

There was a 9% decrease in the estimated global number of suicides between 2000 and 2012.1 The global age-standardized suicide rate fell by 26% over the same period, and has declined in all regions except the African Region, among men in the Eastern Mediterranean Region, excluding high-income OECD countries, and women in the high-income OECD countries.

With regard to depression, while it is known to be common, data are not adequate to provide reliable estimates of global and regional trends. Treatment coverage is low. According to an analysis of the World Mental Health Surveys, even in high-resource settings, only 50% of people living with depression get any treatment, and about 40% get treatment that would be considered to be only minimally adequate.8,9

The estimated number of people using illicit drugs has increased by 38 million to 246 million over the period of 2006–2013, while the number of problem users, who use drugs in a high-risk manner, has remained fairly constant at 27 million since 2008. Almost half of problem users (12.2 million) injects drugs, and an estimated 1.65 million have been infected with HIV, also as a result of unsafe injection practices such as needle sharing in 2013.12

POSITIVE DEVELOPMENTS

A major reason for the progress in some areas has been the increasing recognition of the importance of mental health and well-being, as well as healthy lifestyles, for successful human, social and economic development. Not only has the motto of “no health without mental health” struck a chord with national health ministries and international partners, but the consequences of inaction for economic growth are now better appreciated by public policy-makers.

From the landmark 2001 World Health Report on mental health,13 the publication of two Lancet series drawing attention to the fact that up to nine out of 10 people living with mental disorders do not get even basic care in many countries around the world,14,15 to the launch of the WHO Mental Health Gap Action Programme (mhGAP)16 and the Grand Challenges in Global Mental Health supporting new research, there has been an important sharpening of focus on mental disorders. A major milestone was reached with the development and endorsement of the WHO Mental Health Action Plan 2013–2020 by Member States.17 Other milestones include the development and endorsement of the WHO global strategy to reduce the harmful effects of alcohol in 2010,18 and the development and implementation of the joint WHO and United Nations Office on Drugs
and Crime (UNODC) Programme on Drug Dependence Treatment and Care (currently operational in more than 15 less-resourced countries), as well as the generation of new WHO guidelines and tools on identification and management of substance use disorders.19,20,21,22,23 Mental disorders were not included in the WHO Global Action Plan for the Prevention and Control of NCDs 2013–2020 or the political declaration arising from the United Nations High-level Meeting on NCDs.24 Their absence in these strategically important documents was a factor in the decision of a number of WHO Member States to push for the development of a dedicated WHO action plan on mental health.17 The political declaration, however, recognized the important contribution of harmful use of alcohol as one of the four major risk factors for NCDs and the WHO Action Plan for the Prevention and Control of NCDs 2013–2020 reinforced the WHO global strategy by calling for at least a 10% reduction by 2025 in the harmful use of alcohol compared to 2010. The UN General Assembly has also passed a resolution to hold a special session on the world drug problem in 2016.

Progress is also being driven by the emerging global consensus regarding which evidence-based interventions should be singled out for prioritized scale-up, based on an analysis of their cost-effectiveness, affordability and feasibility. For example, evidence that the cost of delivering a treatment package for conditions such as depression, bipolar disorder and schizophrenia would require only a modest investment is driving the scale-up of key interventions.25,26 Similarly, evidence regarding the effectiveness of task sharing by non-specialist health workers working with specialist mental health professionals is suggesting new approaches to health workforce capacity development.27,28,29

WHO has supported these trends by providing guidance regarding interventions for mental, neurological and substance use disorders in non-specialized health settings,30 which presents a series of protocols and tools which are currently being implemented to a greater or lesser extent in over 80 countries.31 There has also been a substantial increase in the funding of global mental health research, about US$ 50 million in the last five years alone, which has enabled the generation and dissemination of new evidence on the impact and viability of a range of intervention strategies for addressing mental disorders in low- and middle-income countries.32,33 That national governments are also taking note is borne out by the most recent WHO Mental Health Atlas survey,34 which shows that over two thirds of countries now have a specific policy or plan for mental health, and that over half have a stand-alone mental health law.

There has also been progress on the monitoring front, notably with regard to the epidemiology of mental disorders using common instruments for assessment and consistent analytical methods; several major multicountry initiatives are in progress.35 These studies have provided more comparable estimates of the extent, distribution and nature of mental disorders in all regions of the world, thereby helping to define the burden better, and have also contributed to better classification of mental health conditions.36,37,38,39

**CHALLENGES**

Despite the achievements mentioned above and the factors that have contributed to the successes, several significant challenges remain.

* Lack of funding: While the political will to invest in mental health continues to grow, it is still far from adequate. Public spending on mental health continues to be very low at 2% or less of total health-care spending in most low- and middle-income countries, or less than US$ 2 per capita.35 This funding is mainly spent on inpatient care. Similarly, while development assistance for mental health increased between 2007 and 2013, both in relative and absolute terms, reaching US$ 134 million annually on average, as a proportion of overall development assistance for health it was less than 1%.40

* Global dementia epidemic: Prevalence and incidence projections indicate that the number of people with dementia will continue to grow, particularly among the
oldest old, and countries in demographic transition will experience the greatest growth. The huge cost to health systems will be just one aspect of the challenge faced. For 2010, the costs were estimated at US$ 604 billion per year and costs are set to expand even faster than dementia prevalence.

Lack of quality data: Country health information systems do not routinely collect data on a core set of mental health indicators in over two thirds of countries, and are unable to provide reliable information on the extent of service coverage for even severe mental disorders.

Stigmatization: Negative attitudes to people living with mental and substance use disorders abound, both among the general public and health-care providers. Such attitudes have been compounded by the lack of “objective” markers or diagnostic tests for mental illnesses, which is often interpreted as evidence for these not being “real” diseases. There is a lack of awareness and understanding of dementia in most countries, resulting in stigmatization and barriers to diagnosis and care, which negatively impact both the affected person and their families.

Lack of advocacy: The lack of strong advocacy groups, such as the civil society organization movements that have been remarkably successful for HIV, prevents mental health issues being brought to the fore.

Ease of access: In the particular case of alcohol use, an additional challenge relates to “profit driven disease” as policies and regulations that govern commercial interests interfere with public health objectives. The constantly changing market of illicit drugs and transit routes, along with new psychoactive substances regularly being reported, pose additional challenges in tackling this problem.

**STRATEGIC PRIORITIES**

The way forward for mental health and substance use primarily lies in the appropriate and effective implementation of the already approved WHO Mental Health Action Plan 2013–2020 and the global strategy to reduce the harmful use of alcohol. Concerning other drug use, the 2016 United Nations special session devoted to the world drug problem is expected to provide the strategic direction and actions for the years to come.

While investment in mental health research has grown over the last five years, in making the case for mental health with regard to sustainable development, it is necessary to undertake more nuanced research and analyses of the relationship between mental health, poverty and inequality leading to the development of what has been referred to as the “political economy of mental health”. The effects of poverty on mental health in settings of particular inequality need to be studied, and the impact of poverty alleviation strategies on mental health better understood.

The WHO Mental Health Action Plan 2013–2020 has the following objectives and targets:

- **To strengthen effective leadership and governance for mental health:**
  - Target: 80% of countries will have developed or updated their policies/plans for mental health in line with international and regional human rights instruments (by 2020).
  - Target: 50% of countries will have developed or updated their laws for mental health in line with international and regional human rights instruments (by 2020).
To provide comprehensive, integrated and responsive mental health and social care services in community-based settings:
- Target: service coverage for severe mental disorders will have increased by 20% (by 2020).

To implement strategies for promotion and prevention in mental health:
- Target: 80% of countries will have at least two functioning national, multisectoral promotion and prevention programmes in mental health (by 2020).
- Target: the rate of suicide in countries will be reduced by 10% (by 2020).

To strengthen information systems, evidence and research for mental health:
- Target: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by 2020).

A broad public health approach is needed to improve the care and quality of life of people with dementia and family caregivers. The key strategic priorities set out in “Dementia: a public health priority”,7 which was developed jointly developed by WHO and Alzheimer’s Disease International are:
- promoting a dementia-friendly society;
- making dementia a national public health and social care priority worldwide;
- improving public and professional attitudes to, and understanding of, dementia;
- investing in health and social systems to improve care and services for people with dementia and their caregivers;
- increasing the priority given to dementia in the public health research agenda.

The clear recognition of the substance use issue under SDG Target 3.5 is a major step forward. The main approach to strengthen the reduction of the harmful use of alcohol and its health and social consequences will be based on implementation of the WHO global strategy to reduce the harmful effects of alcohol and its suggested policy options for national action.18 Public health advocacy and partnerships, increased technical support and capacity-building, strengthened international activities on production and dissemination of knowledge, and mobilization and pooling of available resources to support global and national action to reduce harmful use of alcohol will form the key elements going forward to reduce the individual and societal impacts of harmful use of alcohol.
With regard to substance use (other than alcohol) and drug use disorders, action will need to be based on strengthening public health responses to the world drug problem and increasing engagement of the health sector in the prevention of non-medicinal drug use and prevention and treatment of drug use disorders. It is expected that by 2030, countries will have developed or revised their relevant national policies and programs to increase treatment coverage for substance use disorders. Key activities should include raising awareness of the disease burden due to harmful substance use and promotion of an integrated health service response to substance use disorders through primary health care and community-based specialized health and social services. All this will need to be backed by a strong political commitment that will possibly be demonstrated at the planned United Nations Special Session on the world drug problem in 2016.
DEPRESSION AND SUICIDE

Mental disorders occur in all regions and cultures of the world, the most prevalent being depression and anxiety, which are estimated to affect nearly one in 10 people on the planet (676 million cases). The prevalence of depression among women is substantially higher than among men. At its worst, depression can lead to suicide. An estimated 804,000 suicide deaths occurred worldwide in 2012, an annual global suicide death rate of 11.4 per 100,000 population, and for every suicide there are many more suicide attempts.

TRENDS

There has been a 9% decrease in the number of global suicide deaths from 2000 to 2012, at the same time as the global population has increased. The global age-standardized suicide mortality rate has fallen 26% between 2000 and 2012 and rates have fallen in all regions except in the African Region, among men in the Eastern Mediterranean Region and women in the high-income OECD countries. (Figure 7.5).

Just over 75% of all suicide deaths occur in low- and middle-income countries. Globally, among young adults between ages 15 and 29, suicide accounts for 8.5% of all deaths and is ranked as the second leading cause of death (after road traffic injuries). In high-income countries, three times as many men die of suicide than women; in low- and middle-income countries the male to female ratio is 1.5.

Despite the serious health impact of mental disorders very few of the people who need treatment receive it. According to the World Mental Health Surveys, even in high-resource settings only one half of those with depression get any treatment and about 40% get treatment that would be considered to be minimally adequate, while in low-income countries coverage is much lower. In Nigeria, for example, only one fifth of those with a depressive episode get any treatment and only 1 in 50 gets treatment that is minimally adequate (Figure 7.6).

The incidence and prevalence of depression and other common mental disorders peak in the middle years of adulthood, and lead to a significant loss of productive years. Estimates suggest that households with people with a mental disorder have earnings that are between 16% and 33% lower than the median level of income in countries, and people living with such disorders lose roughly a month every year off work. Common mental disorders such as depression also frequently occur together, and at least two thirds of those with a mental disorder have at least one chronic disease.
POSITIVE DEVELOPMENTS

Country actions: In the past half-century, the decriminalization of suicide in many countries has made it possible for those with suicidal behaviours to seek help, if available. Comprehensive national strategies or action plans, especially in high-income countries, and, in some countries, restriction of access to means of suicide such as pesticides or legislation restricting firearm ownership have also contributed to the improvements.

Global standards: The development and dissemination of depression treatment and suicide prevention guidance as part of the mhGAP Intervention Guide, which is based on systematic reviews of the relevant international literature and is now being used in over 80 countries worldwide. This includes a better understanding of strategies to prevent suicide.

Advocacy and awareness: In some countries, increased rates of awareness about and treatment of depression and alcohol use disorders are aided, for example, by special articles in high-impact global periodicals and multimedia products such as “I had a black dog; his name was depression” (which has had more hits than any other WHO webpage).

Research funding: Increased research funding into mental health services research, including randomized controlled trials of interventions to manage depression in resource-constrained settings.

Better treatments: New treatments have become available for depression, both for acute episodes and relapse prevention, in terms of medications and psychological interventions that are effective and produce fewer side effects.

CHALLENGES

Poor detection of mental illness: Low rates of recognition of depression, both by people suffering from it and by health-care providers.

Stigma: High rates of stigma around depression and suicide, which impedes help-seeking by individuals and the development of services by health authorities. Around 25 countries still have laws or sanctions that may be applied for attempted suicide, potentially deterring people from seeking help.

Lack of preventive action: Unwillingness or difficulties in restricting access to the means of suicide (especially access to firearms, but also pesticides).

Lack of access to treatment: Many facilities in low- and middle-income countries do not have the capacity to provide basic treatment for depression, as health workers are not trained in mental health issues and medicines are not available.

STRATEGIC PRIORITIES

SDG Target 3.5 aims to promote mental health and well-being. Moderate and severe depression are included within the Mental Health Action Plan 2013–2020 target to increase service coverage for people with severe mental disorders by 20% by 2020. Member States have committed to developing and providing comprehensive, integrated and responsive mental health and social services in community-based settings. Suicide prevention is also an integral component of the Action Plan, with the target of reducing the rate of suicide in countries by 10% by 2020.

For national responses to be effective, a comprehensive multisectoral suicide prevention strategy is needed, including:

- improving coverage of mental health services and access to treatment for mental and substance use disorders, early identification and effective management of suicidal risk, as well as follow-up and community support of those who attempted suicide;
- reducing harmful use of alcohol;
- restricting access to the most common means, including pesticides, firearms and certain medications;
- responsible media reporting and social media and crisis helplines;
- public awareness programmes to raise awareness and reduce stigma;
- targeted prevention strategies for vulnerable groups.
DEMENTIA

The world’s population is ageing. Improvements in health care in the past century have contributed to people living longer and healthier lives. However, it has also resulted in an increase in the number of people with NCDs. Even though dementia mainly affects older people, it is not a normal part of ageing. A syndrome rather than a single illness, dementia is caused by a variety of brain illnesses that affect memory, thinking, behaviour and the ability to perform everyday activities.

TRENDS

The number of people living with dementia worldwide was estimated at 46.8 million in 2015, a number that is estimated to reach 74.7 million in 2030 and to 131.5 million by 2050. The incidence of dementia increases exponentially with increasing age. A recent review concluded that the incidence of dementia doubled with every 5.9 years’ increase in age, from 3.1 for every 1000 person years at age 60–64 to 175 for every 1000 person years at age 95 and over (Figure 7.7). There are marked differences in the levels of the incidence of dementia between regions, with high-income countries having much higher incidence rates than low- and middle-income countries.

POSITIVE DEVELOPMENTS

Global advocacy and awareness: Increased recognition of the importance of the issue, as exemplified by the world’s first G8 dementia summit held in London in December 2013, which led to increased awareness and investments in dementia research, is encouraging as was the first WHO Ministerial Conference on Global Action Against Dementia held in March 2015.

Country action: The development of national dementia strategies leading to prioritization and action at the country level is also a marker of success. There is a growing movement to enhance the public understanding of dementia through advocacy campaigns such as “dementia friends.” These efforts are intended to provide people with more information about dementia and encourage more people to help those with dementia in the community improve their lives.

Better data: With improved efforts at harmonization and coordinated data collection efforts, there is increasing understanding of the epidemiology, burden and impact of dementia especially in low- and middle-income countries. The collaboration between research networks across the globe holds promise for generating more comparable data over time.

Prevention: Recent advances in the understanding of dementia suggest that several modifiable risk factors contribute to dementia prevalence. An examination of the dietary and lifestyle risk factors suggests that minimizing saturated and trans fats, replacing meat and dairy products with vegetables and legumes, ensuring minimal intake of vitamin B12, aerobic exercise, reducing stress and engaging in leisure activities may all reduce the risk of dementia.

Setting standards: The development of clinical assessment and management guidelines for non-specialists as part of the WHO mhGAP Intervention Guide and its implementation across the world has also ensured that people with dementia get the appropriate care within primary care settings.
CHALLENGES

Global dementia epidemic: Prevalence and incidence projections indicate that the number of people with dementia will continue to grow, particularly among the oldest old, and countries in demographic transition will experience the greatest growth.7

Stigmatization: There is a lack of awareness and understanding of dementia in most countries, resulting in stigmatization and barriers to diagnosis and care. For those who are living with dementia (both the person and their family) stigma contributes to social isolation and to delays in seeking diagnosis and help. Improving the awareness and understanding of dementia across all levels of society is needed to decrease discrimination and to improve the quality of life for people with dementia and their caregivers.

Lack of effective treatment: While considerable progress has been made in the understanding of the underlying mechanisms for dementia in terms of what has been called the amyloid cascade, this has not led to the development of drug treatments of substantial impact.70 Currently available medications for dementia only provide some relief of symptoms and possibly slow down progression.71

Escalating cost: The huge cost of the disease will challenge health systems to deal with the predicted future increase of prevalence. The costs were estimated at US$ 604 billion per year in 201072 and are set to increase even more quickly than the prevalence. The costs are driven mainly by social care needs. Health-care costs account for a small proportion of the total, given the low diagnosis rate, limited therapeutic options and the underutilization of existing evidence-based interventions (Figure 7.8). In low- and middle-income countries, where nearly two thirds of people with dementia live, most of the caregiving burden is borne by informal caregivers such as family members. Going forward, it will be necessary to develop policies involving all stakeholders focused on improved health and social care services that include chronic disease management and long-term care.7

Lack of support for caregivers: Caring for dementia patients is overwhelming for caregivers. The stresses include physical, emotional and economic pressures. Caregivers require support from the health, social, financial and legal systems.

STRATEGIC PRIORITIES

A broad public health approach is needed to improve the care and quality of life of people with dementia and family caregivers. The aims and objectives of the approach should either be articulated in a stand-alone dementia policy or plan or be integrated into existing health, mental health or old-age policies and plans. Some high-income countries have launched policies, plans, strategies or frameworks to respond to the impact of dementia.7

The principal goals for dementia care are:
• diagnosing cases early;
• optimizing physical health, cognition, activity and well-being;
• detecting and treating behavioural and psychological symptoms;
• providing information and long-term support to caregivers.

The key strategic priorities set out in “Dementia: a public health priority”, which was developed jointly developed by WHO and Alzheimer’s Disease International are:7
• promoting a dementia friendly society;
• making dementia a national public health and social care priority worldwide;
• improving public and professional attitudes to, and understanding of, dementia;
• investing in health and social systems to improve care and services for people with dementia and their caregivers;
• increasing the priority given to dementia in the public health research agenda.

Figure 7.8
Distribution of costs of dementia by country income group, 20107

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<thead>
<tr>
<th>Country Income Group</th>
<th>Direct Medical</th>
<th>Direct Social</th>
<th>Informal Care</th>
</tr>
</thead>
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<td>20%</td>
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<td>Lower-middle-income countries</td>
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<tr>
<td>Lower-income countries</td>
<td>10%</td>
<td>50%</td>
<td>40%</td>
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SUBSTANCE USE AND SUBSTANCE USE DISORDERS

Psychoactive substance use (including alcohol and illicit drugs) is an important risk factor for poor health globally.\textsuperscript{11,73} The use of dependence producing substances may result in development of substance use disorders. The intoxicating effects of psychoactive substances, or their toxic effects on organs and tissues, or the mode of their administration, are also contributing factors to the development of diseases, injuries and other health conditions.\textsuperscript{12}

TRENDS

In 2012, 5.9% of all deaths worldwide was attributable to alcohol consumption with a significant proportion of alcohol-attributable deaths from cardiovascular diseases and injuries (Figure 7.9). Worldwide alcohol consumption in 2010 was 6.2 litres of pure alcohol per person age 15 or older: 38% of the world population age 15 or older had drunk alcohol in the past 12 months, and 16% engaged in heavy episodic drinking.\textsuperscript{11} There is considerable global variation (Figure 7.10), but no clear global trend between 2005 and 2010 could be observed in alcohol per capita consumption.

It is estimated that in 2013, some 27 million people in the world suffered from drug use disorders, and almost half of them (12.2 million) injected drugs of which an estimated 1.65 million were living with HIV.\textsuperscript{12} About 5% of the population between ages 15 and 64 used illicit drugs in 2013. Since 2006, the number of people using illicit drugs has increased by 38 million, while the number of problem users remained fairly constant at 27 million since 2008.

Figure 7.9
Distribution of alcohol-attributable deaths, by broad cause category, 2012\textsuperscript{11}

Figure 7.10
Total alcohol per capita (15+ years) consumption in litres of pure alcohol, 2010\textsuperscript{11}
POSITIVE DEVELOPMENTS

**Political will:** Increasing political will, as reflected by global agreements on reducing the harmful use of alcohol and the UN General Assembly resolutions to address the drug problem globally, including the resolution to hold a special session of the UN General Assembly on the world drug problem in 2016.

**Linking with the NCD agenda:** Recognition of the harmful use of alcohol as a key risk factor for NCDs and endorsement of the global target of 10% relative reduction in the harmful use of alcohol by 2025 in the NCD Global Monitoring Framework.

**Better data:** Gradually, more data are becoming available on alcohol and illicit drug use in the world through WHO and UNODC databases and global reports, leading to increased awareness and supporting data on the impact of alcohol and drug use on population health and development.

**Interagency collaboration:** Within the UN system and beyond on addressing the harmful use of alcohol and the world drug problem, for instance, WHO and UNODC developed a programme on drug dependence treatment and care.75

STRATEGIC PRIORITIES

The clear recognition of the substance use issue under SDG Target 3.5 (strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol) is a major achievement. Going forward, strategies will be based on the implementation of global policy frameworks and action plans with a focus on public health policies and health systems, including the implementation of the WHO global strategy on harmful use of alcohol.

Key activities will include:
- public health advocacy and partnerships to strengthen commitment and capacity of governments and relevant parties at all levels to reduce the harmful use of alcohol worldwide;
- increased technical support and capacity-building to create, enforce and sustain the necessary policy and legal frameworks;
- strengthened international activities regarding the production and dissemination of knowledge on trends in alcohol consumption, alcohol-attributable harm and the societal responses;
- mobilization and pooling of available resources to support global and national action to reduce harmful use of alcohol in identified priority areas.

With regard to other psychoactive substance use and drug use disorders, action will be based on strengthening public health responses to the world drug problem and increasing engagement of the health sector in the prevention and treatment of substance use disorders. It is expected that by 2030 countries will have developed or revised their relevant national policies and programmes to increase treatment coverage for substance use disorders. Key activities will include:
- articulating ethical and effective policy options to reduce harmful use of substances and the associated health and social consequences, while ensuring access to controlled medicines for medical purposes;
- raising awareness of the disease burden due to harmful psychoactive substance use;
- strengthening partnerships and international collaboration and information exchange;
- disseminating evidence of effectiveness and cost-effectiveness of strategies and interventions in primary prevention, early intervention, treatment, rehabilitation and social reintegration;
- providing normative guidance, technical support and capacity-building in the area of prevention and treatment of substance use disorders and associated health conditions;
- promoting an integrated health service response to substance use disorders, including primary health care and community-based specialized health and social services;
- supporting the production and dissemination of knowledge on the epidemiology of substance use and its health consequences;
- maintaining and further developing the global information system on prevention and treatment resources for substance use disorders.76

CHALLENGES

**Stigma and neglect:** Stigmatization of substance use disorders and low priority given to these conditions in health systems in spite of the scope of preventable disease and social burden associated with psychoactive substance use.

**Lack of resources and response capacity:** Limited capacity of international institutions and limited investment in public health responses to substance use disorders at all levels. There is limited involvement of the public health sector in drug policy development and implementation in many countries and poor interaction between drug control and public health governmental sectors.

**Data gap:** Insufficient quality data on levels and patterns of substance use, especially for illicit drugs and especially in low- and middle-income countries.

**Commercial interests:** Interfering with public health interests with regard to policies and regulations for legally traded substances such as alcohol and prescription drugs.

**Prescription drug abuse:** Increased non-medical use of prescription medicines.


