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## » WHO highlights global underinvestment in mental health care

The 10th of October this year was World Mental Health Day and appropriately the 2011 Atlas on Mental Health was launched that day by the World Health Organization.

Equally appropriate was the choice of the person who launched the report, Mr Kjell Magne Bondevik, former Prime Minister of Norway. In the summer of 1998 he took leave of his post in order to be treated for depression. "I was one of four people who will require treatment for a mental health problem in their lifetime."

Fortunately, Mr. Bondevik lives in Norway, a country with almost 1,500 psychiatrists, one for every 3,000 Norwegian citizens. It is also a country with a mental health policy, plan and legislation. "Had I lived in Afghanistan," he says, "I would have had much more difficulty

in seeing a psychiatrist because there are only two in the entire country, one for 16 million people."

The statistics reflect those in the Atlas, especially the inadequate expenditure on mental health care. Average global spending on mental health is still less than US\$ 3 per capita per year, and in low-income countries expenditure can be as little as 25 US cents per person per year. Even these small expenditures are poorly allotted.

"That's because governments tend to spend most of their scarce mental health resources on long-term care at psychiatric hospitals," says Dr. Ala Alwan, Assistant Director-General of Noncommunicable Diseases and Mental Health at WHO.

"Today nearly 70% of spending on mental health goes to mental institutions. If countries spent more at the primary care level, they would be able to reach more people and start to address problems early enough to reduce the need for expensive hospital care."

The data in the Atlas report includes 184 WHO Member States and covers 98% of the world's population. The theme of this year's World Mental Health Day was "investing in mental health." As Mr. Bondevik puts it,

*"greater advocacy to increase resources for mental health is sorely needed. Sadly the vast majority of people who will need mental health care at some period in their life will never receive it."*



Mr Kjell Magne Bondevik launches the Mental Health Atlas 2011.



The third mhGAP Forum at WHO Headquarters in Geneva

## » Partners report progress

The third mhGAP Forum took place on 10 October 2011 at WHO Headquarters in Geneva. It was attended by 21 Member States as well as partner organizations including WHO Collaborating Centres, non-governmental organizations, professional federations, and other international agencies. This provided an opportunity for WHO and its partners to celebrate the launching of the Mental Health Atlas 2011. The theme of this year's Forum was the progress in implementing mhGAP in countries.

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Four countries: Ethiopia, Jordan, Nigeria and Panama – figured in the first wave of implementation. Another four countries: Belize, Brazil, India and Uganda – are being covered in the second wave of implementation.

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Dr Sheila Ndyabangi of **Uganda** in her detailed description of the opportunities and constraints in the implementation of mhGAP said that the main challenge was the limited availability of funds. Uganda's mental health budget is about 1% of the national health budget and there is no national committee for implementing mhGAP. On the positive

side there is a well organized and structured mental health system and a high level of enthusiasm among mental health managers and staff.

Dr Vikram Patel attributed barriers to implementing mhGAP in **India** to poor accountability, fragmentation of the health sector, shortages in specialists and the lack of commitment of primary care workers. There is one psychiatrist for 314,551 people. Mental health expenditure amounts to only 0.06% of 1% of GDP spent on health, and, worse, there are vast inequities in the distribution of even these limited resources.

Dr Roberto Tykanori who represented **Brazil** made the point that "some mental disorders have economic and social origins. It was absolutely necessary to combat stigma and discrimination because most poverty reduction programmes do not focus on people living with mental or psychosocial disorders. The basic premise of mental health care in Brazil is social inclusion."

Dr Claudina Cayetano stated that **Belize** undertook two major projects in 2011 towards implementation of mhGAP. One was integrating mental health into primary care and the other involved competency training of community health nurses in mental health. The leading mental health disorders were identified as depression, alcohol use, and self harm/suicide.

In an update on implementing mhGAP, Dr Getahun Tsehaysina reported that **Ethiopia** has begun training its primary health personnel to identify and treat priority mental disorders and has made a commitment to sustain this programme for its lasting impact.

Dr Yadira Boyd reported that **Panama** started its first training of 20 medical doctors and 11 nurses in two areas of the country in August of this year. There is an on-going review of all training material on depression and epilepsy in Spanish.

Speaking for **Jordan**, Dr Bassam Hijawi said that one unusual constraint on implementing mhGAP was the instability and conflicts in surrounding countries which led to continuous waves of displaced people in Jordan. There was insufficient involvement of mental health specialists and no recognition of the role of nurses. He emphasized the "strong support of the Royal Family, international NGOs, and WHO's technical assistance."

On behalf of **Nigeria**, Ms. Cecilia O. Yahaya also struck an optimistic note, declaring that "the passage of the Health Bill in the National Assembly hopefully before the end of the year should also throw up needed resources for adequate funding of mental health disorders".

## Breaking the silence on mental health

From 1997 to 2000 and again from 2001 to 2005, Mr. Bondevik was Prime Minister of Norway. It was in 1998, 10 months after taking office, that he suffered from depression. Far from concealing his illness, he announced publicly that he had had a depressive reaction to overwork and would go on sick leave for depression. Three- and-half weeks later he was back on the job. While most Norwegians seemed tolerant of his condition, he faced stigma and, indeed, some Parliamentarians questioned his fitness for the post. His experience turned Mr. Bondevik into a global advocate for mental health.

Since 2005, Mr. Bondevik has been deeply involved in promoting international human rights. He founded the Oslo Centre for Peace and Human Rights and is currently its president. He has expanded his activism in the field of human rights to include mental health.

Mr. Bondevik often speaks about his depression and how it changed him for the better, both as a human being and as a politician. He actively supports WHO's conviction that people with mental health conditions often can and do recover.

During a lunch-time seminar Mr Bondevik spoke about his personal experiences with mental health to an audience of Forum participants and WHO staff. In his talk, which he called *"Breaking the silence on mental health,"* the former Norwegian Prime Minister said, *"many years ago I believed that mental disease would never happen to me. It happened only to others. But life has taught me a lesson because it did happen to me."*

*"And then I learned another important lesson. It was the necessity to dare to make known my weaknesses and to accept all the painful feelings involved. As a leader I asked myself, is it possible to have and to admit weaknesses when one is a leader? Yes, I do believe one can."*



International mhGAP meeting, Rimini, Italy

## » Training gurus from all over the world meet in Italy

The publication of WHO's mhGAP Intervention Guide in 2010 led to numerous requests for a training package to accompany the guide. WHO is currently doing just that. We realize that practical training material is essential if governments and NGOs are to scale up the care of people with mental, neurological and substance use (MNS) disorders in non-specialized health care.

Altogether, the Intervention Guide covers 11 MNS conditions such as epilepsy and depression. The first drafts of training materials that can be used by trainers for four of these conditions -- psychosis, depression, self-harm/suicide and epilepsy -- were written in Ethiopia, Jordan and Zambia close to field conditions. In addition, training materials covering the entire Intervention Guide were reviewed by more than 100 experts in early 2011, and the material was pilot-tested in Ethiopia, Jordan, Panama, and Nigeria.

In close collaboration with WHO, the Italian NGO, Cittadinanza, organized a mhGAP meeting in Rimini, Italy, on capacity building

in non-specialized mental health care in October 2011. Approximately 70 participants from all over the world representing governments, NGOs, academia and foundations attended. They discussed different aspects of capacity building, including training preparations, supervision, refresher training, training of trainers, and evaluating training. WHO has used some important comments made in Rimini to strengthen the training package and hopes to make it available for further field testing early next year. This will be a key step towards improving care and services for people with MNS disorders.

## » Research programme to provide new answers

Do we know all that we need to know about scaling up care for mental, neurological and substance use (MNS) disorders? The answer to this question is an obvious no. That is why WHO is partnering with a research programme that will help us provide some answers to expanding mental health care and services. The Programme for Improving Mental Health Care, PRIME, is a six-year research project aimed at developing evidence on the implementation and scaling up of treatment programmes for priority MNS disorders.

PRIME is funded by the UK government's Department for International Development (DFID) and led by the Centre for Public Mental Health at the University of Cape Town, South Africa. Also involved as a partnership consortium of five low- and middle-income countries are Ethiopia, India, Nepal, South Africa and Uganda.

PRIME will first develop an integrated mental health care plan consisting of intervention packages for MNS disorders for delivery in primary and maternal health care. This will be followed by an assessment of the feasibility, acceptability and impact of the packages of care within existing health care systems. Finally, there will be an evaluation of the scaling up of these packages of care at the level of administrative health units.

WHO will work closely with local partners in each participating country to develop the most suitable mental health service plan and package

for selected disorders. WHO will also provide technical support and expertise in evaluating delivery of these packages, especially their feasibility, affordability and their impact on health, social and economic outcomes.

WHO expects this research to lead to better policy and practice on scaling up care for MNS disorders in the participating countries and elsewhere. For further information, please see the programme website: <http://www.prime.uct.ac.za/>



1st meeting of the PRIME group, June 2011



*Dr Claudina Cayetano, Belize, receiving an award for "Outstanding Achievement in the Field of Mental Health Care" from Professor Fritz Baumann, President, Swiss Foundation for World Health – Geneva, 10 October 2011.*