mhGAP FORUM 2016
“Moving forward with the Global Mental Health Agenda”
Eighth Meeting of the mhGAP Forum
Hosted by WHO in Geneva on 10 and 11 October 2016
Summary Report

Context
The World Health Organization (WHO) is leading the effort for achieving the objectives of the Mental Health Action Plan 2013-2020, adopted by the World Health Assembly in May 2013. mhGAP Forum is a partnership event organized by WHO every year in Geneva around World Mental Health Day (10 October) to exchange information on the implementation of the Plan and strengthening collaboration among partners.

mhGAP Forum
On 10 and 11 October 2016, WHO hosted its mhGAP Forum, attended by nearly 50 Member States, including several at Ambassador level, as well as by 150 other participants from United Nations agencies, international development partners, philanthropic foundations, NGOs, academic and research institutions, and WHO Collaborating Centres.

The focus of this year’s Forum was the Consultation on draft Global Action Plan on public health response to dementia. A further focus was on psychological first aid, reflecting the theme of this year’s World Mental Health Day. The Forum also launched the mhGAP Intervention Guide version 2.0 and the WHO group interpersonal psychotherapy (IPT) guide for depression. Progress made in implementation of Comprehensive Mental Health Action Plan 2013 -2020 was reviewed.

The programme and list of participants are attached as Annex A.
Session 1: Mental Health Gap Action Programme:

Launch of mhGAP Intervention Guide version 2.0

mhGAP-IG was first launched in 2008. It provides evidence-based guidance to help countries increase access to mental health care by strengthening the non-specialized health care providers’ capacities and has already been used in diverse settings in more than 90 countries. The new version 2.0 is based on field users’ feedback as well as literature updates: modules were revised, algorithms were reoriented vertically and links between disorders were emphasized. The next steps are for the mhGAP-IG 2.0 to be available on e-platforms and development of training and operations manuals. This will require close collaboration with partners.

Panel discussion on the use of mhGAP-IG

✓ *Does the world need mhGAP?* - Benedetto Saraceno

The answer is unambiguously positive “the world needs mhGAP but it also needs the commitment of those who promote it.” mhGAP was conceived to reduce the treatment gap worldwide, while promoting the protection of human rights, addressing social determinants and understanding of local context. Four questions can be used as a quality checklist for mhGAP implementation: Is mhGAP concerned enough with cultural factors? Is mhGAP concerned enough with local socio economic context? Is mhGAP too unbalanced towards the bio-medico model? Is mhGAP concerned with re-orienting the overall mental health system?

✓ *From evidence to implementation* - Graham Thornicroft

Literature is emerging on countries experience in implementing mhGAP. Lessons learned are: adapt mhGAP to the context, value staff time, understand that practical issues limit implementation, healthcare staff might face stigma, take into account the high staff turnover by training and re-training new and old staff, support and supervision are crucial, build upon staff knowledge, address system issues such as referral pathways, and support middle and senior managers who may experience burnout.

✓ *Use of mhGAP-IG in the field* - Julian Eaton

The following recommendations were made: fieldwork should also focus on middle-income countries, mhGAP should be implemented as part of changing the health system, the use of mobile networks is important and psychological interventions should be developed further.

✓ *Use of mhGAP-IG by Ministry of Health* - Rabib El Chammay

The Lebanon Ministry of Health’s experience implementing mhGAP lies in three areas: advocacy towards decision makers, training at university, and implementation in non-specialized settings. mhGAP is used in a systematic manner since 2013 and has been already implemented in 75 centres. Lessons learned: providers find it difficult to transform symptoms into questions and to screen for mental disorders (the master chart is not sufficient). Addressing their own mental health problems increase their commitment towards the project.

✓ *Use of mhGAP-IG in distance training* - Dévora Kestel

PAHO has developed an online platform on public health issues, including mhGAP. Their aim is to transform mhGAP into a flexible web platform that enables creativity: using different modules and tools, offer the possibility to interact between participants and tutors, etc. Three rounds of invitations to countries to participate in the training have already been organized (2013, 2015, 2016).

✓ *Use of mhGAP-IG in research* - Pamela Collins

After 6 years of funding in global mental health in LMIC, increasing evidence shows that mhGAP helps reducing disparities. The 5 guiding principles of the organization are: initiating task shifting,
increasing mental health equity/access to care, integrate mental health with other chronic diseases, integrate public health trends (epidemiology) and build research capacities in the US and outside. mhGAP can assist with several of those and set standards of evidence-based interventions, but research can also do something for mhGAP. It also contributes to the evidence base that informs mhGAP.

Session 2: Consultation on draft Global Action Plan on public health response to dementia

The WHO Secretariat convened an informal consultation on the prepared “zero draft” of the action plan with Member States, United Nations agencies and other relevant non-State actors during the morning session of Day 1 of the mhGAP Forum. The session was co-chaired by HE Ambassador of Switzerland Valentin Zellweger and HE Ambassador of Brazil Guilherme Patriota. Forty-six Member States were represented by their Geneva-based missions.

Shekhar Saxena presented the proposed structure and content including the action plan’s vision, goal, cross-cutting principles as well as seven strategic action areas. Each action area contains suggested actions for Member States, WHO Secretariat and international, regional and national partners as well as a proposed global target and indicator. The floor was then given to Member States, UN agencies and selected nongovernmental organizations for brief statements. A total of 19 Member States, 1 UN agency and 2 civil society representatives made statements:

✓ The overall feedback on the action plan was positive, highlighting its comprehensiveness, timeliness and strategic importance.
✓ Member States appreciated the focus on human rights and universal health coverage, the inclusion of people with dementia and their carers, as well as the plan’s emphasis on dementia risk reduction. The importance of promoting dementia research and international research collaboration was also highlighted. Member States with existing national dementia plans further welcomed the close alignment of the global action plan with their national policy documents.
✓ Several suggestions were made to further strengthen the action plan for example by framing the action plan’s goal in a more positive light; increasing the global target for dementia awareness raising to 100%; linking the action plan operationally more closely to other WHO action plans on NCD, mental health and ageing; and including palliative care as part of the dementia care continuum.
✓ Some clarifications were requested by Member States and non-State actors with respect to the rationale and baseline of proposed targets and indicators.

Session 3: Celebrating World Mental Health Day

Psychological First Aid: Supporting People following Crisis Events (Presentation by Leslie Snider)

Psychological First Aid (PFA) was covered in this year’s theme for World Mental Health Day 2016. Leslie Snider of Peace in Practice gave a lunch time seminar on PFA to mhGAP participants and WHO Geneva staff. Gabriel Ivbijaro, President for the World Federation of Mental Health (WFMH), introduced the seminar explaining the importance of first aid in mental health. Despite the large audience, the session was interactive and participatory. PFA is first-line support for people affected by crisis events, that usually needs to be followed by other types of mental health and psychosocial support, and that can be offered by both professionals and lay people, including neighbours and first
responders. It is non-intrusive care and support that involves listening without forcing people to talk, assessing and helping people to address their practical needs, comforting and calming, and connecting people to information, loved ones and social support. There are a wide range of humanitarian organizations and helpers around the world who have learned and applied PFA in various crisis contexts, as part of disaster preparedness, general capacity building and emergency response. Various ways in which PFA has been used and adapted around the world were covered, including the 20 language translations. Those in the audience who have used PFA within their organizations shared their experience and how it has been helpful to them. The importance of cultural and contextual adaptation, as well as self and team care, was emphasized. As people rush in to help, learning PFA reminds all to respond to fellow human beings in the often profound and transformative context of crisis events in more humane and compassionate ways – ways that do no harm. Read more on World Mental Health Day 2016.

Session 4: Small group discussions

Group session 4.1 – Community engagement toolkit for suicide prevention

Communities play a critical role in suicide prevention. They can provide social support to vulnerable individuals, engage in follow-up care, fight stigma and support those bereaved by suicide. This toolkit is a practical step-by-step guide aimed at supporting organizations, institutions or motivated individuals to engage the community and identify, prioritize and implement suicide prevention activities as appropriate to their local context.

In collaboration with the Mental Health Commission of Canada and drawing from their experience from the #308conversations initiative, wherein each of Canada’s 308 Members of Parliament was invited to engage communities through holding a conversation about suicide prevention, this community engagement toolkit has been developed. Following the international review of the first draft, a number of discussion points were put forward for the small group discussion, with the objective to receive feedback on the following points:

- When collecting information about the infrastructure and what is already done in the community, is social mapping appropriate? What other tools could be used?
- When selecting activities for implementation in the community, how to best integrate community needs with the evidence base?
- When prioritizing activities, what would be the most appropriate tools?

Also, the pilot testing of the toolkit was discussed, with regard to both methodology and potential sites.

The following general feedback points resulted from three sub-group discussions:

- Address the safety of participants with lived experience, who have lost a loved one to suicide or who are at risk of suicide;
- Address the impact of power relations on the community decision making process;
- Address the importance of community cohesion;
- Give further consideration to the length of the toolkit;
- Consider multiple media (e.g. hard copy, electronic, app) for the final product;
- Consider sites in the Arctic or among veterans for the pilot.
Specific feedback received was as follows:

<table>
<thead>
<tr>
<th>Social mapping</th>
<th>Needs versus evidence</th>
<th>Prioritizing action</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Agreement on general process;</td>
<td>• Personal preferences, lack of data, and stigma influence the process;</td>
<td>• A four-level prioritization matrix was proposed, consisting of the following</td>
</tr>
<tr>
<td>• Rename it;</td>
<td>• Agreement that evidence needs to be kept in mind and a multi-faceted approach should be taken.</td>
<td></td>
</tr>
<tr>
<td>• Focus on describing the features of locations, and on identifying strengths and weaknesses in the community.</td>
<td></td>
<td>dimensions: community needs, evidence, feasibility, and timing.</td>
</tr>
</tbody>
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Group session 4.2 – Consultation on draft Global Action Plan on public health response to dementia

The small group session on the global action plan on the public health response to dementia in the afternoon of Day 1 followed up on the discussions during the morning’s plenary. It presented Member States and non-State actors with more opportunities to provide input and feedback. The session was attended by 56 delegates (34 Member States, 1 UN agency, 18 NSAs and 3 observers). A total of 10 statements were made including detailed commentaries from four Member States as well as the following stakeholders: Alzheimer’s disease International; Dementia Alliance International; Geneva NGO Committee on Ageing; United Nations Research Institute for Social Development (UNRISD); the WHO Collaborating Centre in Geneva; and Global Action Alliance on Dementia and Alzheimer’s disease (GAADA).

Member States highlighted the need to integrate dementia into other national strategies as appropriate for national contexts and welcomed the action plan’s focus on human rights with its reference to the United Nations Convention on the Rights of Persons with Disabilities (CRPD); the linkage to the new global Sustainable Development Goals’ (SDG) commitment of “leaving no one behind”; and the dedicated action areas on dementia awareness raising, risk reduction, dementia care/workforce training, carer support and research.

Similarly, non-State actors also welcomed the SDG linkage and human rights focus, albeit requesting more countries to ratify the UN CRPD and to monitor and address human rights violations for people with dementia. Emerging themes for suggestions to strengthen the action plan further included: reframing the action plan’s goal using more positive language; emphasising equitable and affordable access to dementia prevention, care and research; increasing global target 1 (national dementia policies and plans), global target 2 (dementia awareness raising) and global target 5 (carer support programmes/respite services); linking global target 3 (dementia risk reduction) more strongly to the NCD action plan by including dementia in future revisions of the NCD action plan; including rehabilitation and palliative care in the dementia care continuum and emphasizing the need for dementia-friendly initiatives more.
Group session 4.3 – Progress on WHO’s Parents Skills Training programme for developmental disorders

In this session Chiara Servili and Erica Salomone presented the WHO Parent Skills Training (PST) Programme for caregiver of children aged 2 to 9 years with developmental disorders/delays. The programme, developed with support from Autism Speaks, aims at improving the caregiver/child relationship, promoting child’s functioning and developmental outcomes and sustaining caregiver’s role and functioning. An additional aim of the program is to target stigma and promote inclusion. PST can be implemented by a range of non-specialist providers as part of a network of community-based services. A “field trial” version of PST intervention package, which includes planning, adaptation and evaluation guides, facilitator guide and participant booklets, is currently available upon request.

Lucia Murillo from Autism Speaks reported on country support being provided for implementation of PST. The intervention is being evaluated in 15 countries both with projects aiming at testing acceptability and feasibility in local settings, and with three RCTs (Pakistan, underway, and Italy and China, planned). Supervision, including extensive use of videos, and live practice in training have been found to be critical to ensure that both specialists and non-specialists are comfortable and competent in coaching caregivers. Cultural adaptation will be key to ensure full uptake of the programme, with linguistic differences to be carefully addressed.

Usman Hamdani from the Human Development Research Foundation (Pakistan) reported on the cRCT currently ongoing to evaluate the effectiveness and cost effectiveness of PST along with a transition to scale implementation project. The study, involving 2700 families in a rural area, specifically aims at addressing implementation bottlenecks with the use of technology-assisted task shifting.

The session was then opened up to all participants for feedback. The discussion was moderated by Usman Hamdani. There was an opportunity for the team to explain the theoretical background of PST, which led to debate what could constitute a ‘desirable outcome’ and what strategies can promote the full engagement of families with heterogeneous needs. The group also discussed the importance of involving children in the evaluation of the programme and strategies to facilitate this process. The group provided suggestions on how to best assess the potential for scalability, taking into account both opportunities and risks stemming from the high demand for PST. A variety of delivery strategies, possible adaptations and mechanism of engagement were discussed. The possibility of a RCT in other high-income country, such as the UK was explored. The group was invited to contribute to subsequent reviews of PST.

Julian Eaton provided a commentary, stressing the value of having an open attitude towards sharing materials and adapting them to various contexts. Critical issues that were highlighted included the importance of carefully considering the need to overcome existing models of care when they are perceived to negatively influence access to care, and the need to ensure the implementation of PST occurs with careful consideration (and address) of multiple additional needs (safeguarding, physical, educational needs..) that children may have.

Group session 4.4 – Mental health and psychosocial assistance during and after emergencies

Mental health is increasingly seen as a key concern in humanitarian and public health emergencies. The well-attended mhGAP forum’s group discussion on emergencies highlighted WHO’s work in providing mental health and psychosocial support (MHPS) in recent major humanitarian emergencies (with a focus on Iraq, Syria, and Yemen), during the Ebola outbreak (with a focus on Guinea and Sierra Leone), and more recently in response to Zika (with a focus on developed normative guidance). The work during many recent emergencies has involved training health workers in the use of the mhGAP
guidance after training on psychological first aid. Challenges in providing MHPSS in emergencies often include limited mental health services before the emergency and restricted access in conflict settings. Recent successes included implementing systematic supervision systems in challenging contexts such as Guinea and Syria.

Information and explanation was provided on a number of key resources developed by WHO and partners, namely: “IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings” (IASC, 2007), “Assessing mental health and psychosocial needs and resources – toolkit for humanitarian settings” (WHO & UNHCR, 2012) and “mhGAP Humanitarian Intervention Guide” (WHO & UNHCR, 2015). A recent external review of the IASC guidelines and its implementation has suggested no need for revising guidelines, though the review did suggest a need to escalate the work to implement the guidelines.

The group discussion provided examples of instances where these products have been successfully used to strengthen care systems during or after an emergency. These included creation of a service framework in Sierra Leone and a recent capacity building project led by UNHCR to train 500 non-specialists in the mhGAP Humanitarian Intervention Guide in refugee settings.

During lively discussions, participants highlighted the ongoing challenge in providing supervision to health workers delivering MHPSS interventions, the need for an mhGAP guide for community health workers and the need for resources to support the mental health of aid workers.

**Session 5: Reception and networking**

Station A - iSupport, WHO’s e-programme for caregivers of people with dementia

This station was run by Anne Margriet Pot and Tarun Dua of the Department of Mental Health and Substance Abuse. Millions of people provide care for people with dementia globally. Caregiving impacts are overwhelming: the deterioration of the carer’s physical and mental health, lost productivity as carers are forced to quit work, and staggering economic consequences, with informal care costs estimated at $252 billion worldwide in 2010. Therefore, mhGAP includes several recommendations to support carers of people with dementia, for example by providing information on dementia and skills training, such as how to deal with challenging behaviours. However, such support is not widely available or accessible.

iSupport is meant to make information and skills training convenient, affordable, and engaging while minimizing utilization obstacles such as access and transportation issues and stigma related to seeking support. iSupport is not yet public, however, the generic version is available for countries to translate and adapt the programme. For example, in the last months iSupport is adapted to the Indian setting where it will be field-tested soon.

This station offered a unique opportunity to view iSupport by the attendees of the mhGAP Forum. The station was well-attended and involved active discussion with professionals, carers and even a person with dementia. Several attendees at the mhGAP Forum meeting experienced the burden of providing care for a family member with dementia themselves. It was encouraging to receive so much positive feedback. For any news on iSupport visit: [http://www.who.int/mental_health/neurology/dementia/isupport/en/](http://www.who.int/mental_health/neurology/dementia/isupport/en/).
Station B - Global Clinical Practice Network (GCPN)

At the 2016 mhGAP Forum, WHO introduced a new, interactive format for acquainting Forum participants with some of the innovative mental health initiatives being led by WHO. Specifically, during the networking hour, interactive stations were set-up for participants to visit and learn more about some exciting new WHO products and networks by directly interacting with representatives with expertise in each of the spotlighted initiatives.

Station B, highlighted the WHO's Global Clinical Practice Network (https://gcp.network/en). The focal points for the GCPN station were Jose Luis Ayuso-Mateo and Tahilia Rebello, who presented on behalf of Geoffrey Reed, who leads this initiative in collaboration with an expansive group of international collaborators (https://gcp.network/en/leadership).

What is the Global Clinical Practice Network (GCPN)?
- The GCPN represents the largest most geographically, disciplinarily, and lingually diverse practice-based research networks in mental health;
- The network includes approximately 13,000 mental health and primary care professionals from 151 WHO member nations;
- The GCPN is a global network of professionals who, through the integration of science and practice, are leading change and improving mental health care worldwide.

How did the GCPN start?
- The GCPN was established in 2012 by the WHO Department of Mental Health and Substance Abuse for the purposes of developing, testing and enhancing the guidelines for Mental and Behavioural disorders for the next version of the WHO’s global nosology system: the International Classification of Diseases, 11th revision (ICD-11).

What does the GCPN do?
- GCPN members are participating in the implementation of global field studies of the ICD-11;
- The GCPN will continue to contribute to the development of the ICD-11 through its approval by the World Health Assembly, planned for 2018. At the same time, GCPN is expanding to realize its broader potential.

Where is the GCPN going?
- Beyond the ICD-11, the GCPN represents a valuable asset for enhancing mental health research and training worldwide;
- By building international research capacity, GCPN will have the ability to take priority issues into the field. GCPN will serve as a catalyst for scientific and clinical research collaborations, sharing best practices in both research methodology and clinical care and management.

To learn more about the network, to register, and to consider opportunities to use the network for your own research, capacity building and advocacy initiatives, please visit: https://gcp.network/en.

Station C - Mental Health Innovation Network (MHIN)

The MHIN team utilised the opportunity of mhGAP Forum to:
- Showcase MHIN at a reputable, high-profile conference to relevant potential members
✓ Showcase innovations on MHIN using the mhGAP-IG 1.0 on a large map which encouraged other innovators to submit their projects to MHIN. They also produced an infographic showing these innovations which we tweeted to participants at the Forum.
✓ Connect with a constant flow of people who wanted to learn more about all aspects of MHIN, e.g. Innovations, Resources, Community area
✓ Gain around 25 new members, with many signing up on site
✓ Double their website sessions (one session = time period a person engages with the site) on 10 October compared to the average number of sessions for October 2016

MHIN team would like to invite all members of the global mental health community to join MHIN and use their community and networking features to discuss their work and promote World Health Day 2017 on depression.

Session 6: WHO’s work on scalable psychological treatments

The plenary opened on Day 2 with discussion of WHO’s work on scalable psychological interventions. Mark van Ommeren opened the session explaining that while mhGAP recommends psychological interventions, practical guidance on them has not been readily available to countries. WHO would like to make evidence based materials freely and easily accessible, including tools to guide implementation, training and supervision.

A summary was provided on current WHO activities including: Drink Less a program designed to reduce problematic alcohol use, Parent Skills Training for caregivers of children with developmental delay/ or other disabilities, iSupport an online program for caregivers of people with dementia, Self Help Plus a transdiagnostic stress management intervention for adults, Helping Young Adolescents Cope a transdiagnostic group treatment for young adolescents experiencing distress, and Computerized Behavioural Activation an online transdiagnostic treatment for adults experiencing distress.

In addition, three evidence-based WHO psychological manuals are now available: Problem Management Plus (PM+) a transdiagnostic intervention for adults impaired by distress in communities exposed to adversity, Thinking Healthy, an intervention for mothers with perinatal depression and Group Interpersonal Therapy (Group IPT) a group intervention for adults impaired by depression. The session proceeded with the launch of the WHO Group IPT manual by Myrna Weissman, who developed IPT along with her late husband, Gerald L Klerman. Weissman provided a summary of the historical origins of this intervention alongside an overview of the evidence for the use of IPT in different settings. This included RCTs of a culturally adapted Group IPT program conducted in Uganda that found significant results. Atif Rahman, who developed the Thinking Healthy program, also gave an account of the development and testing of this intervention. He shared the significant positive findings in reducing depressive symptoms in mothers and also improvements in various indicators of child development, such as reduced diarrhoea and improved immunisation levels. Lena Verdeli shared lessons learnt from implementation of real life settings using IPT. She highlighted the importance of ongoing supervision of IPT trainers, supervisors and counsellors. To conclude the plenary session, Pierre Ritchie from the International Union of Psychological Science (IUPsyS) shared reflections on barriers and facilitating factors for scaling-up evidence-based psychological interventions successfully. Comments from the floor were invited and discussed.
Session 7: Small group discussions

Group session 7.1 – Excess mortality among persons with severe mental disorders
The session was opened by Shekhar Saxena, setting out the reasons for WHO's interest and engagement in this area. He also acknowledged technical and financial assistance from Fountain House in this area of work, as well as technical expertise from many international experts, some of them present in this session. He then presented, in brief, the report of a meeting WHO had organised in November 2016 on this topic and pre-publication copy of a Forum paper that has been accepted for publication by World Psychiatry, along with several invited commentaries. A multilevel model of risks for excess mortality in persons with severe mental disorders and a framework for interventions was presented as a summary of the work done so far. This was followed by comments by Ken Dudek and Ralph Aquila from Fountain House- describing the rationale for their interest in this area and also the reasons for their collaboration with WHO. Graham Thornicroft then described the extent of the problem and commented on strategies and solutions to decrease excess mortality among persons with severe mental disorders. Comments were also made by Paolo del Vecchio on the situation in US and the efforts made by SAMHSA to address this. There was general discussion with some valuable suggestions being received on follow up activities, including the need for a policy brief to be disseminated widely and some guidance on future research challenges.

Group session 7.2 – Progress on WHO's QualityRights initiative
The session was opened by Michelle Funk and Natalie Drew who provided a brief overview of the WHO QualityRights project, including achievements to date and future plans and activities. Following this Dainius Puras, Julian Eaton and Roberto Mezzina each provided brief reactions, highlighting their respective perspectives on the QualityRights initiatives as well as potential challenges for its implementation in countries. The session was then opened up to all participants for discussion. Participants highlighted that the QualityRights initiative is a significant leap forward in promoting and protecting the rights of people with psychosocial disabilities, providing a pragmatic means of changing the current unacceptable violations so many people face. The area of human rights in mental health is stronger on national and international agendas, in large part due to the coming into force of the CRPD. The QR project is a means to operationalise these rights in countries. Barriers to implementation include paternalistic attitudes and power imbalances in the mental health field which take time to shift. The issue of risk is also important to address though this should not detract from efforts to empower people with psychosocial disabilities. Participants also emphasised the importance of engaging with all sectors, including the police, social services, employment and other sectors, and highlighted the collaborative nature of QualityRights as a major strength, since it brings all key national stakeholders in order to promote a unified effort to reform in countries.

Group session 7.3 – Next steps in mhGAP implementation

✓ Country experiences
Scaling up epilepsy care in Ghana: Presented by Cynthia Sottie, Ghana Ministry of Health.
The country has implemented a successful gradual scaling up of integrating epilepsy treatment within primary health care using mhGAP-IG. The four-year demonstration project showed a 20% treatment gap reduction for epilepsy care using mhGAP in 10 districts of the country. Further scale up will take place.
Pacific Islands: Presented by Yuta Setoya, WHO WPRO.
mhGAP-IG trainings have been conducted in all of the 14 island countries (800 persons trained in total). Yuta Setoya highlighted the success of the programme despite geographical challenges and a very low level of awareness in the population. The next steps for the sub-region are to combine training
on Noncommunicable Diseases and mental health, increase advocacy and awareness and refresher training using mhGAP-IG version 2.0 for those already trained.

✓ **E- and m-versions of mhGAP-IG**
Ken Carswell presented the application (web + smartphone) emphasising that the objective of the project is to develop a clinical decision-making support tool and a training tool that could be available on a variety of devices. Its development is an iterative process i.e. conducting feedback cycles between users and developers. All participants recognized the need for such a tool and someone even said “it excellently captures the mhGAP structure”. Participants also gave other constructive feedback, such as: the app should support different translations from the start and further features should be included. Further features that were suggested included - help section/user guidance section, trauma related content, advice on referral pathways, assessment of severity, the use of the app by service users and caregivers should be considered (e.g. for self-identification and referral), ensure that the app can be used in low bandwidth areas, the app should integrate training pre/post tests.

✓ **Training package and implementation material**
Neerja Chowdhary presented a brief summary of the plan for development of the training package for mhGAP-IG version 2.0. The proposed training will follow the cascade model with material for the Master trainer, a Facilitator guide and Participant job aids supported with resource material consisting of PowerPoint slides, case vignettes, role plays and training videos. Supplementary material will include a refresher-training course. Peter Hughes described his experience of using mhGAP-IG to train field workers and provided recommendations for Version 2.0 training material. Participants feedback highlighted: the usefulness of the videos for training and the need to adapt them further for language, cultural relevance; the CMH module may require longer duration of training; importance of selecting the right trainers for the training of trainers; the need for a special package to help migration from mhGAP version 1.0 to version 2.0.

✓ **Tools for mhGAP IG implementation**
Fahmy Hanna presented all the tools currently available on EZcollab and other platforms to support implementation of mhGAP. A framework for mhGAP Version 2.0 Implementation was presented based on the implementation module currently included in the new guide. He also presented WHO plans to develop an operational manual for mhGAP implementation. Operational manual will cover planning for mhGAP implementation and training, adaptation methods, tools for monitoring and evaluation, guidance on supervision and training, intersectoral collaboration, advocacy and mhGAP implementation in special situations e.g. humanitarian settings and very low resource settings. Participants recommended to train managers and policy makers on mhGAP implementation, to use more often mhGAP for education and pre-service training and to integrate mhGAP with psychological intervention manuals (depression + PM+).

**Group session 7.4 – Adolescent mental health**

The session was opened by Chiara Servili, David Ross and Khalid Saeed who provided a brief overview of WHO current work and initiatives in this field, including the new mhGAP Child and Adolescent Module, the Global Accelerated Action for the Health of Adolescents (AA-HA) Framework and the School Mental Health Package being pilot tested in the Eastern Mediterranean Region. Knowledge gaps and priorities for actions were discussed along with opportunities for strengthened collaborative efforts to meet the mental health needs of adolescents in countries.
Following this Atif Rahman and Usman Hamdani shared additional information on their research project for testing the WHO EMRO School Mental Health package in Pakistan and Alexandra Fleischmann presented WHO suicide prevention strategies and tools. Inka Weissbecker then provided brief comments, highlighting the importance of interagency collaboration and integrated adolescent health programming.

The session was then opened up to all participants for feedback. Myron Belfer moderated the discussion. Participants shared their experiences with implementation of school-based interventions and development of adolescent mental health policies, involving intersectoral collaboration and engagement of youth. Risks and opportunities in adoption of task shifting approaches and use of digital media were also discussed.

In closing the session, Chiara Servili read a short remark provided by Marilena Viviani, Director of UNICEF Geneva Liaison Office, in which she articulated how mental health is a part of UNICEF learning agenda of the adolescent health programme and an integral part of child protection and maternal, newborn and child health strategies and actions.

**Session 8: Moving forward**

The last plenary session began with presentation of summaries from the small group discussions, emphasising the conclusions from each of them and also the steps to be taken by each of the stakeholder groups. Some specific commitments were made to advance the agenda towards implementing the Mental Health Action Plan 2013-2020. This was followed by a presentation by Dainius Puras on his mandate as the UN Special Rapporteur on the Right to Health, describing his recent activities and also his plans for the future in the area of human rights and mental health. WHO then presented the summary results from a meeting jointly organised by World Bank and WHO- Out of Shadows: making mental health a global development priority, as a part of the Spring Annual Meeting of WB Group and participated by the President of World Bank and Director General of WHO. Details of this event can be found at: [http://www.who.int/mediacentre/events/2016/mental-health-meeting/en/](http://www.who.int/mediacentre/events/2016/mental-health-meeting/en/)

A briefing was also provided on the plans World Health Day 2017 on the theme of depression. This is planned as a one year campaign and initial material was launched and suggestions invited from all partners. Details can be found at: [http://www.who.int/campaigns/world-health-day/2017/en/](http://www.who.int/campaigns/world-health-day/2017/en/)

The Forum came to a close with thanks to all participants and a commitment on the part of WHO to provide all possible collaboration in efforts to implement the Mental Health Action Plan 2013-2020.
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Acknowledgments

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ANNEX A

mhGAP Forum

Moving forward with the Global Health Agenda

Provisional agenda

Monday, 10 October

08:00 – 09:00 Registration

09:00 – 10:30 Session 1: Mental Health Gap Action Programme:
  - Launch of mhGAP Intervention Guide version 2.0
  - Panel discussion on the use of mhGAP-IG
    - Does the world need mhGAP? - Benedetto Saraceno
    - From evidence to implementation - Graham Thornicroft
    - Use in the field - Julian Eaton
    - Use by MoH - Rabih El Chammay
    - Use in distance training - Dévora Kestel
    - Use in research - Pamela Collins

10:30 – 11:00 Coffee break

11:00 – 12:30 Session 2: Consultation on draft Global Action Plan on public health response to dementia
  - Welcome - WHO Secretariat
  - Election of the co-chairs
  - Summary of the draft action plan - WHO Secretariat
  - Comments by Member States
  - Comments by UN Agencies
  - Comments by other relevant stakeholders

12:30 – 13:00 Lunch break

Sandwiches and drinks will be served outside the EB room
13:00 – 14:00  
**Session 3: Celebrating World Mental Health Day**

- Introduction - Gabriel Ivbijaro and Mark van Ommeren
- Psychological First Aid - Leslie Snider

### 14:00 – 16:00  
**Session 4: Small group discussions (meeting rooms to be allocated)**

- **4.1: Community engagement toolkit for suicide prevention**
  - Introduction - Alexandra Fleischmann
  - Comments by Louise Bradley and Lakshmi Vijayakumar
  - Feedback and inputs for contents
  - Planning of field testing and final product
  - Discussion

- **4.2: Consultation on draft Global Action Plan on public health response to dementia** (continued from the plenary)

- **4.3: Progress on WHO’s Parents Skills Training programme for developmental disorders**
  - Introduction and overview of the capacity building and implementation tools - Chiara Servili and Erica Salomone
  - Sharing experiences with use of materials in countries - Lucia Murillo and Usman Hamdani
  - Comments by Julian Eaton
  - Discussion

- **4.4: Mental health and psychosocial assistance during and after emergencies**
  - Introduction - Mark van Ommeren
  - Comments on WHO response to Ebola and Zika emergencies
  - Overview of the key technical tools developed for use in humanitarian emergencies
  - Sharing experiences of partners who used or are currently using these tools
  - Discussion

### 16:00 – 18:00  
**Session 5: Reception and networking (WHO Restaurant)**

- Station A - iSupport, WHO’s e-programme for caregivers of people with dementia - Anne-Margriet Pot and Tarun Dua
- Station B - Global Clinical Practice Network (GCPN) - Jose Luis Ayuso-Mateo and Tahilia Rebello
- Station C - Mental Health Innovation Network (MHIN) - Doris Payer, Agnes Becker, Dan Chisholm, Fahmy Hanna and Ellen Morgan
Tuesday, 11 October

09:00 – 10:30  Session 6: WHO’s work on scalable psychological treatments

- Introduction - Shekhar Saxena and Mark van Ommeren
- Launch of Group Interpersonal Therapy (IPT) for Depression - Myrna Weissman
- Thinking Healthy - Atif Rahman
- Comments on scaling up psychological treatments
- Discussion

10:30 – 11:00  Coffee break

11:00 – 12:30  Session 7: Small group discussions (meeting rooms to be allocated)

- 7.1: Excess mortality among persons with severe mental disorders
  - Introduction and presentation on forthcoming World Psychiatry publications on this theme – Shekhar Saxena
  - Comments by Kenn Dudek, Ralph Aquila, Graham Thomeiroft and Paolo del Vecchio
  - Discussion

- 7.2: Progress on WHO QualityRights initiative
  - Introduction - Michelle Funk and Natalie Drew
    - Capacity building and e-training on human rights, recovery and supported decision making
    - CRPD compliant services
    - Assessing and improving service quality and human rights
  - Comments by Dainius Puras, Julian Eaton and Roberto Mezzina
  - Discussion

- 7.3: Next steps in mhGAP implementation
  - Introduction – Tarun Dua
  - Country experience
    - scaling up epilepsy care in Ghana - Cynthia Sottie
    - mhGAP in Pacific Islands – Yutaro Setoya
  - E- and m-versions of mhGAP-JG
  - Training and implementation material – Comments by Peter Hughes and Rabih El Chammany
  - Region specific issues - WHO Regional Advisors for mental health
7.4: Adolescent mental health
- Introduction and presentation on new mhGAP Child and Adolescent Module – Chiara Servili
- School Mental Health Package – Khalid Saeed
- Comments by Inka Weissbecker and Alexandra Fleischmann

12:30 – 14:00 Lunch break

14:00 – 16:00 Session 8: Moving forward
- Summaries from Small Group discussions
- Comments by Dainius Puras on his mandate as the UN Special Rapporteur on the Right to Health
- Plans for World Health Day 2017 on depression
- Discussion
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