MENTAL HEALTH GAP ACTION PROGRAMME (mhGAP)

4th meeting of the mhGAP Forum

Special Focus on the draft Global Mental Health Action Plan

Hosted by WHO in Geneva on 10 October 2012

Summary Report of the Meeting

Context

The mhGAP Forum, which is convened every October in Geneva, is an informal group to promote global collaboration and coordinated action aimed at supporting national efforts to address mental disorders. The central challenge over the past years has been to scale up mental health services to address disorders in low-resource settings.

Persistent inequalities in social, cultural, economic, political and environmental factors are among key determinants of mental health and mental disorders, which in turn places certain individuals and groups at a significant higher risk of experiencing mental health problems. People with mental health disorders experience higher rates of disability and mortality, which hold back the ultimate objectives of any development agenda: to improve human development and eradicate poverty.

Business as usual thus cannot be an option and transformational change is needed. As the challenges of addressing mental disorders are highly interdependent, a new, more holistic approach is needed to promote, for all resource settings, a response that includes public policies in sectors other than health, with a focus on a limited set of objectives and targets to promote well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders. Accordingly, the World Health Assembly adopted Resolution WHA65.4 in May 2012 entitled “Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level”. The Resolution calls for the WHO Director-General to develop a comprehensive mental health action plan in consultation with Member States, NGOs, international development partners, technical agencies and relevant stakeholders.

mhGAP Forum

The mhGAP Forum is an informal and evolving group of Member States, intergovernmental and non-governmental organizations, including UN Agencies, international development agencies, philanthropic foundations, research institutes, universities and WHO Collaborating Centres.

The vision of the mhGAP Forum is to provide effective and humane care for all people with mental, neurological and substance use disorders, with a particular focus on the poor and the vulnerable ones in low- and middle-income countries, by improving service delivery, reducing the treatment gap, and increasing financial and human resources for mental health care.

The Forum gives strategic guidance to the WHO Secretariat on raising the priority accorded to mental health in development work at global and national levels, provides support by raising the priority given to mental health on the agendas of relevant high-level forums and meetings of national and international leaders, and rallies stakeholders and people to address
the main mental health conditions included in mhGAP, in accordance with the recommendations included in the Programme.

The fourth meeting of the mhGAP Forum took place at the World Health Organization, Geneva, on 10 October 2012. The Forum was attended by 29 Member States and 50 partner organizations, including United Nations agencies, philanthropic foundations, NGOs, academic and research institutions, and Collaborating Centres. The focus of this year’s Forum was the “zero draft” Global Mental Health Action Plan 2013-2020. The Action Plan aims to provide guidance to Member States, WHO, and international partners to promote focused, aligned and country-owned responses to address mental health and to guide investments to deliver maximum returns for people most in need. The programme and list of participants are attached as Annex A.

Opening Session
The WHO Deputy Director-General, Dr Anarfi Asamoa-Baah, welcomed the delegations and partners by focusing on the significance of the World Health Assembly Resolution adopted in May 2012 and the importance of developing a comprehensive Global Action Plan on Mental Health with inputs from all stakeholders that rests on the core values of human rights and is based on concrete objectives and targets.

Currently, around 75% of people with mental, neurological and substance use disorders in developing countries do not have access to proper care and treatment presenting enormous challenges in delivering care and protecting the human rights of people with disorders. The resources available for mental health are insufficient, inequitably distributed and inefficiently used. The vast majority of countries allocate less than 2% of their health budgets to mental health. To realize the future we want for all in which mental health is valued and promoted, mental disorders are prevented, and in which persons affected by these disorders are able to access care, a high degree of policy coherence at the global, regional, national and sub-national levels will be required. WHO’s Deputy Director-General underlined that the mental health agenda should therefore be considered as a truly global agenda with shared responsibilities for all countries. Accordingly, fostering international cooperation and coordination in this area will enable the transformative change needed to strengthen and integrate mental health policies and programmes into health-planning processes and the national development agenda of each Member State. Dr Shekhar Saxena, Director of the WHO Department of Mental Health and Substance Abuse, then took the floor to brief participants on the preparatory process leading towards the World Health Assembly in May 2013 which will consider the final draft Mental Health Action Plan 2013-2020. He summarized the work under way and provided an overview of the ‘zero draft’ Action Plan, including the proposed actions to be taken by Member States, international and national partners and WHO. Its simplicity, transparency and multi-dimensionality will help to rally broad support for the objectives and the targets of the Mental Health Action Plan, and the broader emphasis on mental health will shift policy attention well beyond the health sector that dominated previous agendas focused on mental disorders. The Representatives of Member States were then invited to make statements.

Brazil (represented by HE Ms Maria Farani Azevêdo) strongly supported the development of the Mental Health Action Plan and stated that the country recorded a reduction of 20,000 psychiatric hospital beds from 2001 to 2010. Joblessness and hopelessness can lead to depression, alcohol, drugs abuse and ultimately suicide. She highlighted the need to build mental healthy and productive societies by tackling social and economic determinants of health, which are the root causes of many contemporary mental disorders. She recognized that human rights advocacy and empowerment of people and communities and community care approaches can benefit and reinforce progress.
Finland (represented by HE Ms Päivi Kairamo-Hella) welcomed the process under way to develop a global Mental Health Action Plan. Given the huge gap between the needs and the availability of mental health services, she expressed support to the continuous efforts for access to mental health services for those in need and for developing the quality of these services. The Ambassador highlighted the need to continue to explicitly include the promotion of mental health and prevention of mental disorders in the Action Plan; and to emphasize the role that health care services play in early detection of mental health needs and early intervention, as well as in the provision of follow-up and rehabilitation, where needed.

India (represented by HE Mr Dilip Sinha) cosponsor of the original WHO Executive Board resolution, also welcomed the work underway and the progress made so far in developing in the Action Plan. The Ambassador emphasized that the promotion of mental health and prevention of mental disorders must have a central role in the Action Plan. He highlighted that 10 million people are severely mentally ill in India while 5% of the population suffer from depression. He encouraged WHO to maintain addressing mental health as one of its key priorities.

Norway (represented by HE Mr Steffen Kongstad) welcomed the elaboration of the Global Mental Health Action Plan. He referred to the Norwegian’s Parliament plan aimed at increasing the ability of people with mental disorders to cope with their own lives and strengthen their independence. He called on all stakeholders to continue to place human rights and human dignity at the core of the Mental Health Action Plan.

Qatar (represented by HE Ms Alya Ahmed Saif Al-Thani) talked about the problems of stigma and discrimination faced by people with mental disorders and their vulnerability to human rights violations. She highlighted some of the key success factors of promoting mental health in Qatar and gave examples of Qatari centers working with children with disabilities and various segments of society. The Ambassador referred to the efforts to change laws to ensure the protection of the rights of persons with disabilities. She stressed the importance of supporting children’s mental health.

Switzerland (represented by HE Mr Alexandre Fasel), a cosponsor of the original WHO Executive Board resolution, underlined the disproportionately low levels of attention that mental health receives worldwide. He referred to the lack of resources to treat and prevent mental disorders and the need to reduce the gap between the need and the provision of services. He encouraged mental health to be considered through a life course approach. He also stressed the importance of strong information systems and research on mental health.

The United Kingdom (represented by HE Ms Karen Elizabeth Pierce) recognized the large treatment gap for mental health disorders and the subsequent human and economic cost. She spoke of the need to transform not only the treatment of mental illness but also the attitude to it. She recognized the Global Mental Health Action Plan as a vital building block to establish an international consensus about what needs to be done to intensify efforts to address mental health. She flagged the role of legislation in reinforcing legally the goals of policies and plans in line with international human rights and standards. The United Kingdom also referred to the financial support provided by the UK Department for International Development to foster research on global mental health, especially in low- and middle-income countries.

The United States of America (represented by HE Ms Betty King) a cosponsor of the original WHO Executive Board resolution, strongly supported the work under way to
develop the Action Plan and highlighted that global, regional and national strategies to address the needs of people with mental disorders will need to be based on evidence and shaped with the full involvement of those excluded. The USA also referred to the activities of the US Federal Agencies in the area of mental health.

Finally, the Minister Counsellor of Ethiopia described the grim situation of mental health coverage in the African Region where mental health ranks last in the list of priorities. The progress made in Ethiopia to integrate mental health services in non-specialized health institutions was highlighted. She also emphasized the importance of promoting a comprehensive and multisectoral approach in addressing global mental health from different perspectives.

The full text of the statements of the Member States can be found in Annex B.

To capture the perspective and contributions of civil society, the opening session was concluded with the comments on the “zero draft” Global Mental Health Action Plan by an NGO, World Vision International; and a WHO Collaborating Centre, Griffith University, Brisbane, Australia.

World Vision International spoke of the increasing number of NGOs engaged in mental health and psychosocial care as part of their field work. They recognized the Action Plan as one of the landmark opportunities, not only to truly advance mental health care globally, but also to work with donors and link the NGO mental health work to Member States’ priorities and advocate for an increase in financial resources for mental health care.

The WHO Collaborating Centre, Griffith University, emphasized the substantial role of Collaborating Centres’ research tradition and expertise in the implementation of the Action Plan. WHO Collaborating Centres can help to generate further evidence for effectiveness of interventions. They can also assist in increasing capacity to scale up the interventions; and monitor their impacts. The WHO Collaborating Centre gave an example of work done in the area of suicide prevention, where collaboration between the WHO Collaborating Centre and WHO offices at Headquarters and WPRO has been extremely rewarding.

**Session One:**

Session one focused on the Action Plan’s vision, cross-cutting principles, goal, objectives, and targets. Interventions were made by 30 participants and focused on the need to strengthen the Action Plan. The following areas were specifically mentioned among others:

- comorbidity with physical problems and coexistence of mental disorders;
- the linkage of mental health with HIV/AIDS and NCDs;
- reference to discrimination and disabled people; the linkage with social determinants of health, e.g. nutritional and environmental aspects;
- inclusion of spirituality as a dimension; the concept of recovery;
- the quality aspect of health and social services; the concept of culture, acceptability and inclusion;
- description of suicide, not to emphasize only the young but in terms of “vulnerable populations”;
- interventions for suicide prevention for young people; research component, to add more information on models being implemented on scaling and integrating mental health care into primary health care;
- the roles and support to caregivers and families;
- the issue of important and parallel role of NGOs;
mental health issues in women and girls;
mental health issues in children; and
role of e-mental health tools in implementation.

On human rights, participants spoke of the need to address the issue of chaining patients with mental disorders and the need to outlaw this practice through mental health laws. As regards human resources, the need to take into consideration the mental health of human resources managing people with mental disorders; and further emphasize the capacity building of non-specialist human resources (pre-services training and in-service training). It was pointed out that the availability of psychotropic medications in many settings can be linked to lack of human resource capacity.

The following issues were raised for clarification: the scope and types of mental disorders; the inclusion of dementia; the inclusion of epilepsy; linkage with mhGAP; and the definition and use of consistent terminology across the Action Plan. Questions were also raised on the concept of implementation of Action Plan – who, how and what are the implementation tools; what are the financing mechanisms for implementation.

Clarifications were also sought on the integration of mental health into primary care and the concept of community-based services; and the relationship/collaboration/stepped care approach between community based care and institutionalized care. In primary health care situations with very limited human resource capacity, the challenge is to marry the community integration into existing health system.

Further suggestions on information systems were that suicide should be taken outside of injuries data to help recognize its importance as major public health problem and possibly better data collection; and to strengthen the issue of inclusion of mental health indicators in countries’ health information system.

The following points were made on targets:

- Reduction of long stay mental beds: In countries where mental health is not a priority, having this indicator will mean that services will never be improved. It should be clarified that it is focused on long stay beds and not short stay beds. Beds need to decrease in psychiatric/mental hospitals and to increase in general hospitals and community based care.
- Target on 5% of health budget for mental health: WHO budget should reflect what is being asked of Member States even though it might be not feasible to achieve. How to disentangle specific mental health vs. the budget for mental health that is allocated in general health budget, as mental health is to be integrated into primary care.
- Target 3.1: Vulnerable groups need to be defined.
- Target 3.2: Need to put a specific percentage for rates of suicide, if possible; however it is a political issue – one needs to know the baseline as well as effective measures of reduction.

The moderator clarified that community meant bringing not just patients in the community but bringing services (team, resources) to the community. The reduction of beds means beds in general hospitals vs. beds in psychiatry institutions – a shift from psychiatric institutions to general hospitals.

Clarifications provided by WHO:
Dr Shekhar Saxena provided clarification on some of the issues raised. The concept of mental disorders was clarified: the Action Plan will follow the ICD, and include all disorders in mental and behavioural chapter of ICD-10. This will include dementia, substance use disorders (substance abuse and dependence), and other mental disorders (e.g. depression, anxiety, psychosis, bipolar, and others).

This Action Plan is a broad unified framework that should help create an enabling environment to meet shared objectives and targets, support global solutions to global problems and guide national efforts, while supporting the empowerment of people to determine their own futures. The Action Plan is structured in a way that facilitates countries to develop and implement national efforts, transparent monitoring of progress and mutual accountability for results. Tailored to country-specific contexts and their initial conditions, national efforts will prioritize a core set of mental health conditions that address the needs of present and future generations. Simplicity and succinctness in further developing the Action Plan will be vital to ensure its focus and ultimate impact. This will demand tough choices.

The Action Plan is intended to have an annex to define the critical terms (e.g. community mental health care, severe mental disorders), as well as, improved definitions of institutional care, inpatient beds, community care.

General principles and key human rights-based practices, as laid out in the “zero draft” Action Plan would provide overall guidance for priority setting and choosing among policy options. This would contribute towards coherence among policies primarily at the national level, but where relevant, also at the regional and global levels. Examples include the key practice of shifting from institutional care towards community care. The target of 20% reduction in mental hospital beds relates to long-term stay and is not about beds in general hospitals and also not about short-term stay. Though today 63% of all inpatient psychiatric beds are in mental hospitals, this does not mean that in some African countries, where mental hospitals may be the sole means for mental health care, these beds should be taken away. The Action Plan also indicates that reduction of beds should be ‘with corresponding increase to community care’.

**Lunchtime Seminar: Round-table discussion on Depression**

The theme of the 2012 World Mental Health Day was “Depression: A Global Crisis”. The invited speakers were British parliamentarians, Mr Kevan Jones and Dr Sarah Wollaston who spoke of their personal struggles with depression and how their experiences changed them for the better both as a human being and as a politician. Other panel members included Ms Gunilla Von Hall of the UN Press Corps, Geneva, and Dr Shekhar Saxena, Director, Department of Mental Health and Substance Abuse. The session was moderated by Dr Hans Troedsson, newly appointed Executive Director. The lunchtime seminar opened with the presentation of the video, “I had a black dog, his name was depression” produced for WHO by the author Mr Matthew Johnstone. ([http://www.youtube.com/watch?v=XiCrniLOGYc](http://www.youtube.com/watch?v=XiCrniLOGYc)).

**Session Two:**

The focus of this session was on the recommended actions for Members States, international and national partners, and WHO. 21 participants made interventions. General comments on the Action Plan were that it was well structured and a useful tool to promote and monitor global action to address mental health. The importance of addressing mental health in a coordinated manner and framework was acknowledged. It was also recognized that the global Mental Health Action Plan, which should shape and help inform pathways to pursue broad mental health objectives and any specific targets within the global health and...
development agenda, was not the same as a workplan, which would need to be elaborated and refined through broad consultations with different sets of stakeholders who can contribute to detailed activities.

The following issues were raised during the discussion:

- exclusion of epilepsy;
- too much focus on mental disorders rather than mental health;
- weak links to WHO stated priorities;
- international partners to be associated with all activities;
- stigma not strongly enough reflected;
- more positive re-branding of mental health needed;
- should reflect mandate for greater integration;
- should include the importance of spirituality for well-being;
- could explore an alternative more bottom-up, country-driven approach,
- to clarify as to whether all the implementation options were optional or were some priority actions,
- raising the priority accorded to mental health on the health and development agenda
- to make the action plan discourse more global than a western public health model;
- more emphasis on transcultural issues, e.g. recognition of depression;
- potential value of other cultural models.

**Session Three - The way forward**

The WHO Assistant Director-General for Noncommunicable Diseases and Mental Health, noted that the development of the ‘zero draft’ Action Plan demonstrated a successful collaboration between Member States, UN Agencies, civil society partners and WHO. The Director of WHO’s Department of Mental Health and Substance Abuse, thanked Member States for their strong support. Comments were received from WHO staff in the regional offices. The focus of the discussion was on NGOs and their work in the area of mental health and how they would be able to support implementation of the Action Plan.

Following an Informal Consultation with Member States and UN Agencies on 2 November 2012, WHO will submit the final draft global Mental Health Action Plan, through the Executive Board at its 132nd session, for consideration by the Sixty-sixth World Health Assembly.

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