POLICY OPTIONS ON MENTAL HEALTH

A WHO-GULBENKIAN MENTAL HEALTH PLATFORM COLLABORATION

FUNDAÇÃO CALOUSTE GULBENKIAN

World Health Organization

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Policy options on mental health: a WHO-Gulbenkian Mental Health Platform collaboration

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POLICY OPTIONS ON MENTAL HEALTH

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This report is the final one of a series of thematic papers, co-produced by the World Health Organization and the Calouste Gulbenkian Foundation's Global Mental Health Platform. The series covers the following topics:

- Social determinants of mental health
- Innovation in deinstitutionalization: A WHO expert survey
- Integrating the response to mental disorders and other chronic diseases in health care systems
- Promoting rights and community living for children with psychosocial disabilities
- Improving access to and appropriate use of medicines for mental disorders
- Policy options on mental health: A WHO-Gulbenkian Mental Health Platform collaboration.

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FOREWORD

This is the final report of the six-year collaboration between the WHO Department of Mental Health and Substance Abuse and the Gulbenkian Global Mental Health Platform, an initiative of the Calouste Gulbenkian Foundation aimed at reducing the global burden of mental health through the development and application of evidence and good practices to global mental health.

The Gulbenkian Mental Health Platform and the World Health Organization have collaborated to generate a series of thematic papers on pressing mental health issues of our time. Topics were identified by the Platform's advisory and steering committees, and prioritized according to the issues' potential significance in making a substantial improvement in the global mental health situation. It is perhaps not surprising, therefore, that the topics of the thematic papers are highly consistent with the six principles and four key objectives of WHO's Mental Health Action Plan (MHAP) 2013–2020.

Thematic papers in this series address important topics:

- Population-based strategies that can be implemented through health and non-health sectors to promote mental health and prevent mental disorders.
- Health-system based strategies to organize and deliver integrated care for mental disorders and other chronic health conditions.
- Innovative methodologies for shifting from institutional to community-based mental health care.
- Promoting rights and community living for children with psychosocial disabilities.
- Improving access to and appropriate use of medicines for mental disorders.

This final report constitutes a comprehensive and practical source of information and inspiration for national policy and decision-makers, legislators, justices, opinion shapers, and professional, formal and informal mental health workers willing to contribute to strengthening the response of all sectors to the still largely unmet needs of people with mental disorders, through the implementation of the WHO Mental Health Action Plan at national level. The report cross references the evidence assembled under the five key areas that were identified and prioritized by WHO and the Gulbenkian Mental Health Platform and the experience generated by country workshops conducted in Brazil, Cabo Verde, Georgia, India and Portugal. This report identifies 32 policy options to promote and strengthen the implementation of the WHO MHAP.

We trust that you will find this report innovative and useful, and we encourage you to read the accompanying thematic papers from this series, too.

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This report was written by Emiliano Albanese with assistance from Kali Tal (University of Bern). Dan Chisholm, Tarun Dua, Alexandra Fleischmann, Michelle Funk, Fahmy Hanna, Vladimir Poznyak, Geoffrey Reed, Chiara Servili, Mark van Ommeren (World Health Organization) and Corrado Barbui (WHO Collaborating Centre for Research and Training in Mental Health and Service Evaluation, Verona, Italy) provided inputs and extensively revised the first draft of the report. The following international experts were involved in a second round of review, discussion, revision and finalization: Jose-Miguel Caldas de Almeida, President of Lisbon Institute of Global Mental Health; Melvyn Freeman, Chief Director of Noncommunicable Diseases at the National Department of Health, Pretoria, South Africa; Marian Jacobs, Emeritus Professor of Paediatrics and Child Health at University of Cape Town; and Mirta Rosese Periago, Director Emeritus of the Pan American Sanitary Bureau. We are grateful to the work and assistance of Grazia Motturi for the publication of the report.

A number of experts contributed to the development of the series of thematic papers and the national workshops; their contribution is acknowledged in the relevant publications.

ACRONYMS AND ABBREVIATIONS

CAPS	psychosocial care centres (Brazil)
CBT	cognitive behavioural therapy
CC	collaborative care
CCM	chronic care model
CHMRI	Child Health and Nutrition Research Initiative
CRC	Convention on the Rights of the Child
CRPD	Convention for the Rights of Persons with Disabilities
EBM	evidence-based medicine
EML	essential medicines lists
GDP	good distribution practices
GGMHP	Gulbenkian Global Mental Health Platform
GSP	good storage practices
ICD	International Classification of Diseases
IEHK	Interagency Emergency Health Kit
IMAI	Integrated Management of Adult and Adolescent Illness
IPT	interpersonal psychotherapy
LMICs	low- and middle-income countries
MHAP	Mental Health Action Plan (WHO)
mhGAP	Mental Health Gap Action Programme
MNS	mental, neurological and substance use (disorders)
MSD	Department of Mental Health and Substance Abuse (WHO)
NCDs	noncommunicable diseases
NIMHANS	National Institute of Mental Health and Neurosciences (India)
RCT	randomized controlled trial
SAARC	South Asian Association for Regional Cooperation
SDGs	Sustainable Development Goals
SES	socioeconomic status
TRIPS	Trade-Related Aspects of Intellectual Rights
WTO	World Trade Organization

EXECUTIVE SUMMARY

This is the final report of the six-year collaboration between the WHO Department of Mental Health and Substance Abuse and the Gulbenkian Global Mental Health Platform, an initiative of the Calouste Gulbenkian Foundation aimed at reducing the global burden of mental health through the development and application of evidence and good practices to global mental health.

Context

The WHO Mental Health Action Plan is rooted in a vision of "a world in which mental health is valued, promoted and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination". Although in recent years remarkable advances and progress paved the way for the design of mental health policies and reforms of mental health systems, there is an urgent need to translate and scale up specific policy options, actions and programmes. The effective implementation of the WHO MHAP is our greatest hope that the response of governmental policies, health systems and services to the huge burden that mental disorders impose on those who are affected, their families and society at large, ceases to be inadequate, insufficient and inappropriate, as it is in most countries.

Purpose

The report is intended as a tool to sensitize policy-makers and society at large about the pending issues related to mental health, contrasting with the remarkable amount of experience, best practices and evidence available to inform the design and implementation of mental health plans, programmes and specific actions in countries. The report constitutes a comprehensive, yet practical source of information and inspiration for national policy- and decision-makers, legislators, justices, opinion shapers, and professional, formal and informal mental health workers striving to strengthen the response of all sectors to the still largely unmet needs of people with mental disorders, through the implementation of the WHO MAHP at national level.

Key messages

We have identified 32 policy options to promote and strengthen the implementation of the WHO MHAP, across five key areas that were identified and prioritized by WHO and the Gulbenkian Mental Health Platform (social determinants of mental health, deinstitutionalization, integration of mental health care into health-care systems, rights of children with psychosocial disabilities, and access to and use of psychotropic medicines). These policy options are actions that complement the implementation options presented in the WHO MHAP and are relevant for both the six principles and approaches (universal health coverage, human rights, evidence-based practice approach, life-course approach, multisectoral approach, empowerment of persons with mental disorders) and the four objectives of the MHAP (leadership and governance for mental health; integrated care in community settings; promotion and prevention in mental health; information systems, evidence and research).

INTRODUCTION

Background and context

WHO defines mental health as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to their community. Mental disorders encompass a wide range of mental and behavioural disorders described in the International Statistical Classification of Diseases (ICD) and Related Health Problems (10th and upcoming 11th edition, ICD-10 and ICD-11). These include depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, and intellectual disabilities and developmental and behavioural disorders that typically arise from childhood through adolescence, including autism.

The burden of mental disorders worldwide is huge. Collectively, mental disorders are highly prevalent, and associated with both disability and premature mortality (Whiteford et al, 2013). Persons diagnosed with severe mental disorders live, on average, 20 years less compared with the general population (Liu et al, 2017; Wahlbeck et al, 2011) and the impact of mental disorders extends from the afflicted to their families, communities and society at large. Worldwide, health and social systems and services are largely unprepared and insufficient to respond to the mental health needs of the population, or simply absent. Systematic human rights violations and discrimination against people with mental disorders and their families persist in all world regions.

The World Health Organization leads the global response to adequately address mental health issues. In 2013, the 65th World Health Assembly (resolution WHA 65.4, May 2012) adopted the comprehensive Mental Health Action Plan (MHAP), developed in consultation with Member States, civil society and international partners. The WHO MHAP takes a comprehensive and multisectoral approach to achieving this ambitious goal: to "promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders" (WHO, 2013).

Purpose of this report, intended audience and proposed uses

In 2011, the Calouste Gulbenkian Foundation established the Gulbenkian Global Mental Health Platform (GGMHP). The initiatives it has undertaken, in close collaboration with the WHO, have made it a key stakeholder in the global mental health community. The Gulbenkian Platform is intended to make a significant contribution to mental health in collaboration with WHO to improve mental health care in low- and middle-income countries (LMICs); and to promote human rights of people with mental disabilities. This report is based on the many actionable policy options the Gulbenkian Platform and WHO identified across five priority themes (social determinants of mental health, deinstitutionalization, integration of mental health care into health-care systems, rights of children with psychosocial disabilities, and access to and use of psychotropic medicines), integrating and expanding on the implementation options included in the MHAP. The report is intended to meet the needs of national policy-makers and mental health professionals. Its goal is to inform and assist all those, in every region, who implement the WHO comprehensive MHAP.

CHAPTER 1: THE GULBENKIAN MENTAL HEALTH PLATFORM THEMATIC PAPERS

The Platform was designed to promote translation from evidence to global and national policy and practice. The GGMHP Steering Committee[1] and Advisory Committee[2] provided scientific credibility and offered guidance. WHO and the GGMHP consulted the Advisory Committee and identified five themes with the potential to narrow the existing knowledge gap and inform policy and programmes implementing the WHO MHAP, nationally and internationally. By combining country experiences and updating available evidence, WHO staff and international experts produced five thematic papers. These five papers were produced jointly with WHO and a network of more than 50 mental health experts from high-, low- and middle-income countries. These five papers used an updated evidence base to identify policy options. They can be found on the WHO and GGMHP websites (http://www.gulbenkianmhplatform.com/technical), or obtained as printed copies.

Three international fora were convened at the Calouste Gulbenkian Foundation in Lisbon, Portugal (in 2013, 2014 and 2016). There, the Platform presented and discussed the papers the GGMHP and the WHO had jointly produced. Several hundred people attended the three fora, which were also streamed online to allow hundreds more to follow. The fora were recognized as unique spaces of intellectual freedom, where professionals, services users and family representatives and the general public had the opportunity to ask questions, challenge and report personal experiences in an open and non-threatening environment. Moreover, in November 2014, the forum hosted the Mind Rights Film Festival, fostered and supported by the Platform and the Calouste Gulbenkian Foundation, showcasing 90 cinematographic works from 23 different countries. The film festival aimed to promote the rights of people with mental disorders, spread knowledge, raise public awareness, and encourage social inclusion of people with mental disabilities and fight against their stigmatization.

In this chapter we provide a brief overview of the five papers. In Chapter 3 we illustrate the relevance of these five papers, highlighting relevant actionable policy options across the cross-cutting principles and objectives of the WHO MHAP.

1 Benedetto Saraceno (Scientific Coordinator of the GGMHP, Nova University of Lisbon); José Miguel Caldas de Almeida (Faculty of Medical Sciences of the Nova University of Lisbon); Jorge Soares and Sérgio Gulbenkian (Calouste Gulbenkian Foundation).

2 Paulo Ernani Gadelha Vieira (President, Fiocruz, Brazil); Mariam Jacobs (Dean, Faculty of Health Sciences, University of Cape Town, South Africa); Arthur Kleinman (Esther and Sidney Rabb Professor of Anthropology, Harvard University, United States of America); Sir Michael Marmot (Professor of Epidemiology and Public Health, University College, London, United Kingdom); Mirta Roses Periago (Director Emeritus, Pan American Health Organization, Washington, DC, United States of America); Parthasarthy Satishchandra (Director and Professor of Neurology, National Institute of Mental Health and Neurosciences, Bangalore, India); Shekhar Saxena (Observer to the Advisory Committee and Director of the Department of Mental Health and Substance Abuse, WHO, Geneva Switzerland).

Social determinants of mental health

The conditions in which people are born, grow, live, work and age are all social determinants of health. Policy choices influence and moderate social determinants of health because they have an effect on income, wealth, education, and access to and use of services at local, national and global level. Socioeconomic status (SES) is the relative position of a family or individual in a hierarchical structure, reflecting their access to or control over wealth, prestige and power. Socioeconomic status is a key modulator of both physical and mental health. The social determinants of health operate at individual, household and community levels, and often result in health inequalities. These are unfair and avoidable differences in health status between groups of people within countries and between countries. Social and health inequalities are "societal" rather than individual risk factors for poor mental and physical health. Poor mental health can also be a cause of social and physical health inequalities. For example, those with mental disorders may suffer stigma, discrimination, social exclusion and impoverishment. The paper provides a comprehensive, evidence-based overview of the social determinants of mental health, and explores how these can be effectively modulated to promote mental well-being and prevent mental disorders across the life course. (http://www.who.int/mental_health/publications/gulbenkian_paper_social_determinants_of_mental_health/en/)

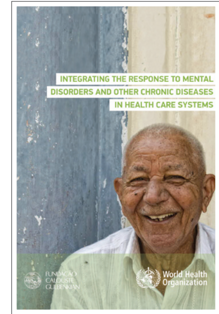
Innovation in deinstitutionalization: A WHO expert survey

Despite decades of promoting deinstitutionalization, mental health service delivery is still largely dominated by hospital care, which absorbs the largest proportion of the mental health budget, particularly in LMICs. There is an urgent need for a radical shift in the way mental disorders are managed, away from long-term institutionalization and towards community-based mental health care.

The WHO and the GGMHP conducted a survey in 2014 that identified five overarching principles for deinstitutionalization, and gave several practical examples: First, community-based services must be in place; second, the health workforce must be committed to change; third, political support (highest level) is crucial; fourth, timing is key; and fifth, additional financial resources are needed.

In addition, the survey identified salient methods to downsize psychiatric hospitals and improve community-based services. These methods included, mobile clinical and outreach services; psychiatric beds outside mental health hospitals; discharge planning or hospital-to-community residence transfer programmes; residential care in the community; revision of hospital and services admission procedures; tailored regional, local and even hospital level plans, in addition to but consistent with national policies and strategies; support of the workforce and improved work conditions; stimulate and support self-help and user groups in the community. (http://www.who.int/mental_health/publications/gulbenkian_innovation_in_deinstitutionalization/en/)

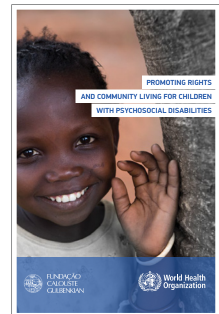
Integrating the response to mental disorders and other chronic diseases into health care systems



Strong links exist between mental disorders and other chronic diseases such as heart disease, diabetes and HIV/AIDS, not just in terms of their common co-occurrence but also in terms of their underlying determinants and their public health consequences. The prevention and management of these chronic conditions can be enhanced by taking a more holistic, integrated and person-centred approach.

Integrating mental health services into general, non-specialized health care is a key strategy to expand coverage, and for overall integration of services at the level of the health-care system. This thematic paper clearly illustrates that while various programmes for integrating mental disorders have been tried out, they typically involve training and support primary health workers to identify and treat common mental disorders, link with secondary care mental health specialists for supervision and referral when required, and integrate mental health services with management of other chronic diseases, especially in people with comorbid or multimorbid conditions. (http://www.who.int/mental_health/publications/gulbenkian_paper_integrating_mental_disorders/en/)

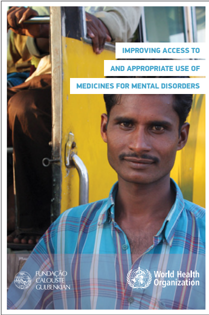
Promoting rights and community living for children with psychosocial disabilities



The family is the natural environment for the growth and well-being of children – for their full and harmonious development. Most countries urgently need to make a radical policy shift. They should cease placing children with psychosocial disabilities in institutions, and instead support them in the community. Institutionalization is damaging to children, and especially to children with psychosocial disabilities. Because deinstitutionalization requires action at various levels, and across sectors, governments must be strongly engaged in the project and lead it.

The Convention for the Rights of Persons with Disabilities (CRPD) and the Convention on the Rights of the Child (CRC) together provide a strong legal framework to promote the mental health of children, and the deinstitutionalization of children with psychosocial disabilities. These conventions have the legal force to influence the shaping of a national policy, and should be used by relevant stakeholders to hold all actors accountable to principles that have concrete impact on practices, and on the organization of services. (http://www.who.int/mental_health/publications/promoting_rights_and_community_living/en/)

Improving access to and appropriate use of medicines for mental disorders



"Access" is the timely use of services based on needs (Peters et al, 2008). Access to medicines is a key component of access to health services. Certain key national policy measures are crucial to ensure the high quality of psychotropic medicines. Governments and relevant regulatory authorities are responsible for: licencing, assessment and authorization, inspection and surveillance, building (implementing) good distribution practices (GDP) and good storage practices (GSP), controlling quality and advertising, setting up and maintaining a surveillance system for adverse reactions, and providing independent information to prescribers and to services users. This paper describes these activities in detail, across a purposely designed framework, and it demonstrates their importance in improving access to and the appropriate use of medicines for mental health. (http://www.who.int/mental_health/management/improving_access_medicines_mental_disorders/en/)

CHAPTER 2: THE GULBENKIAN MENTAL HEALTH PLATFORM TRIALOG NATIONAL WORKSHOPS

Though science often generates new knowledge and evidence, much of it is not translated into public health policy or practice, and it even more rarely informs local implementations of health-care services. WHO and the GGMHP jointly organized and held national workshops thematically related to the five papers to promote the translation and impact of their findings at the national level. The workshops also revealed issues expected to be pertinent to implementation of MHAP in other countries in the region.

The workshops were held in Rio de Janeiro, Brazil (23–25 March 2015); Bangalore, India (13–15 November 2015); Tbilisi, Georgia (16–18 March 2016); Lisbon, Portugal (alongside the third International Platform Forum held in Lisbon, 24–25 November, 2016); and Praia, Cabo Verde (23–24 March 2017). All five workshops encouraged interaction between often diverse groups of participants. Partners in each country prepared technical documents to focus the discussion on the region in which the conference was held, with data on the local situation, needs, constraints and implementation experiences and actions. Plenary sessions and presentations that illustrated the salient contents of the relevant thematic paper preceded and fostered general and focused discussions among experts.

The intense and extended debate and structured iterative discussions followed a “trialog” model, which was conceived to encourage equal, active participation of:

- national health authorities (ministry of health and other ministries);
- national professionals (including academicians, researchers, and health, development and social services workforce); and
- international experts and stakeholders (from WHO, and international research and academic institutes).

The trialog model was successful, and contributed to achieving the main objective of each workshop: to promote the translation and impact of the findings of the relevant thematic paper at national level. The salience of the themes discussed also contributed to the success of the workshops. In some workshops, representatives from other countries in the region participated.

In this chapter, we summarize the main outcomes of each national workshop; and propose a detailed list of actions relevant to the topic of the respective thematic paper. Although these actions are specific to the region or country, they may be relevant for other regions, countries, settings and contexts because they integrate and expand the content of the thematic papers accounting for the relevance of advances, barriers and effective strategies at a national level. All recommendations made by participants to the workshops were done so in their personal capacities, and not on behalf of their government or respective institutions.

Workshop on innovation in deinstitutionalization – Rio de Janeiro, Brazil

Brazil is one of the largest and most populous countries in the world. The Brazilian reform of mental health services began in the 1980s and has been going on for more than three decades. The phased expansion of community-based mental health services in all regions of the country is widely regarded as a highly inspiring example of a well-designed and effectively implemented strategy to decentralize and significantly downsize institution-based care.

The Gulbenkian trialog, held in Rio de Janeiro from 23–25 March 2015, focused on innovation in deinstitutionalization. The workshop was attended by several hundred academicians, health and social care professionals, government representatives and international experts who based their discussion on a comprehensive, data-based report of the Brazilian experience in deinstitutionalization over the past 30 years, and the WHO/Gulbenkian paper *Innovation in deinstitutionalization: A WHO expert survey* (WHO, 2014a). The trialog format of the workshop allowed discussions to take full advantage of the rich Brazilian experience, through a critical interpretation of its success and the major challenges encountered during the enduring reform of the national health sector.

The following recommendations were made:

1. Expand the community mental health centres – psychosocial care centres (CAPS) and psychiatric wards in general hospitals, and develop and scale up effective prevention programmes for mental disorders, including substance abuse.
2. Include all general hospitals in the network of mental health care to contribute to a further reduction in the number of beds in psychiatric hospitals, through an improved gateway system to regulate hospitalizations, respond effectively to emergencies in mental health and prevent long-term institutionalization, particularly among those with substance use disorders, children, adolescents and the elderly.
3. Support the expansion of the “Going Back Home Program” (Brazil Ministry of Health, 2017), and of back-referral to community-level services of deinstitutionalized patients, while improving the provision of mental health care and collaborative care models at the primary care level, assuring training and supervision of health and social services staff (which) incorporates the principles of recovery.
4. Empower, support and actively involve health service users and their family members to develop and implement policies and actions that promote deinstitutionalization, expand housing and social support programmes in cooperation with social services.
5. Assure stable government funding to stimulate and support epidemiological research into mental disorders and their impact; and on needs, access to, use of, and the response of mental health services; and also to document this situation through routinely collected data.
6. Halt violations of human rights at all levels, embracing an ethical and human rights framework for mental health which is fully compliant with the CRPD.
7. Broaden and deepen intersectoral actions aimed at comprehensive care, and promote effective coordination with the social welfare system.

Workshop on integration of mental disorders and other chronic diseases into health care systems – Bangalore, India

The Gulbenkian Platform and the Indian National Institute of Mental Health and Neurosciences (NIMHANS) organized an international workshop, with support from WHO, to discuss the integration of mental health care and chronic diseases in the Indian health and social care systems, and neighbouring countries. The workshop was held from 13–15 November 2015, in Bangalore (India) and was attended by over 150 mental health professionals, health ministry officials, researchers and health service users from some South Asian Association for Regional Cooperation (SAARC) countries (Bangladesh, India, Maldives, Nepal and Sri Lanka), who based their discussion on the WHO/Gulbenkian thematic paper *Integrating the response to mental disorders and other chronic diseases in health care systems* (WHO, 2014b) and a technical document about the Indian context prepared by NIMHANS.

Noncommunicable diseases (NCDs), including mental disorders, are highly prevalent in the region and have a high individual and societal impact. The urgency to address NCDs, including mental disorders, requires a transformation of health systems grounded on evidence-based approaches for integrated care. During the three-day workshop, participants discussed specific policy options and actions, and made the following recommendations for India and the SAARC countries.

1. Launch and sustain awareness campaigns on common mental disorders, suicidal behaviour and alcohol and drug use disorders, with clear messages that these disorders are common and can be treated, and that their identification and management should be part of the management of chronic NCDs, and, at the same time, their risk factors and care should be managed as part of mental health care.
2. Individuals with chronic diseases and their families should be empowered and supported to promote an informed access to, and use of, existing infrastructure (including health and social services) and human resources at the community level. This support should include financial protection towards the attainment of universal health coverage.
3. Once integrated care is in place, its quality and continuity can further benefit from the use of technology platforms to enable integrated patient information systems.
4. Collaborate with other sectors relevant to mental health, including the private sector, civil society and governmental departments such as the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy, Women and Child Welfare, Social Justice and Empowerment, Labour, Education, Justice, Finance and others.
5. Ensure monitoring, evaluations and operational research for programmes and plans relevant for the recommendations mentioned above.

Workshop on promoting the human rights of children with psychosocial disorders, and adults with mental disorders – Tbilisi, Georgia

The workshop held from 16–18 March 2016, was co-convened by the Gulbenkian Platform, the Global Initiative on Psychiatry-Tbilisi, and the Ministry of Labour, Health and Social Affairs of Georgia, and in collaboration with WHO. The workshop had the primary objective to contribute to the implementation of the Georgian 2015–2020 National Mental Health Strategy. Similar to the situation in other countries, the mental health needs of the population are largely unmet in Georgia, and there is an urgent need to radically reform the mental health system, promote human rights, and substantially expand and improve the quality of mental health care. The 50 participants from governmental and professional bodies, academia and international organizations based their discussion on the WHO/Gulbenkian thematic paper *Promoting rights and community living for children with psychosocial disabilities* (WHO, 2015), and on a background document that reported a situation analysis conducted by the local Global Initiative on Psychiatry. Participants achieved a consensus on practical and explicit strategies, and made the following recommendations:

1. Make appropriate legislation changes, set up a monitoring system to identify human rights violations, and carry out regular assessment missions in mental health hospitals and other mental health services, at the beginning and throughout the duration of the processes of mental health reform, and the existing child welfare and protection reform.
2. Promote deinstitutionalization of children with psychosocial disabilities, and facilitate their reintegration into society and access to psychosocial services, and maintain adequate financing of social workers and teachers to guarantee appropriate, accurate and complete management of each case.
3. Shorten hospital stays to the minimum necessary duration, and reduce re-admissions also through improved management practices of acute episodes, thus favouring the continuation of recovery at the community level.
4. Strengthen community-based mental health services through the development of residential opportunities for discharged patients, and of mobile teams and outreach services to provide care and treatment, including rehabilitation. Promote a case management approach and multidisciplinary team work, making investments in capacity building and task-shifting (or task-sharing) of primary health-care workers, and in their training and supervision.

Workshop on social determinants of mental health – Lisbon, Portugal

Between 2010 and 2014 Portugal experienced a dramatic economic crisis. The consequent high unemployment, declining incomes, financial deprivation and declining SES had a significant impact on the population's mental health. The Gulbenkian trialog national workshop, held in Lisbon in 2016 brought together international experts, national government representatives, academicians and mental health professionals, who based their participative discussion on the *Social determinants of mental health* WHO/Gulbenkian paper (WHO, 2014c), and who brought new insights and a variety of perspectives to the discourse. The following actionable recommendations were made for a government-led, coordinated response, aimed at alleviating and mitigating the mental health impact of the economic crisis:

1. To meet the mental health challenges of the economic crisis, mental health should be considered one of the priorities in the public health agenda. The economic crisis could present an opportunity to reform the mental health system through innovative and responsive policy.
2. The governance and financing of mental health services should radically change to promote reform of the system.
3. A holistic and comprehensive strategy should be adopted with the involvement of several sectors, including measures to improve social protection, decrease income inequalities, mitigate the impacts of unemployment, and improve the efficiency and quality of the mental health system.
4. To address the impact of unemployment, active labour market and family support programmes should be strengthened.
5. National mental health plans that promote measures to improve access to integrated and community-based mental health care should be effectively implemented.
6. Measures proposed in the national mental health plan should aim to improve access to integrated and community-based mental care, collaborative care models and long-term, rehabilitation programmes; the Programa de Cuidados Continuados, continuing care model (Government of Portugal, 2016) should be refinanced and re-launched.

Workshop on improving access to and appropriate use of medicines for mental disorders – Praia, Cabo Verde

The final trialog workshop took place in Praia, Cabo Verde (23–24 March 2017), organized in collaboration with WHO and the Medical Association of Cabo Verde, with the support of the Lisbon Institute of Global Mental Health. The workshop was attended by around 60 participants, including health professionals, mental health professionals, and ministry officials from Portuguese-speaking African countries (Angola, Cabo Verde, Guinea-Bissau and Mozambique), as well as international experts.

There was general agreement that the framework proposed in the WHO/Gulbenkian thematic paper *Improving access to and appropriate use of medicines for mental health* (WHO, 2017) applies to each of the four Portuguese-speaking African countries, and that barriers may impact both demand and supply of psychotropic medicines in equal measure. Thus, actions should improve rational selection, availability, affordability and appropriate use of (essential) medicines, and be mapped according to the level of health care: international, national (or subnational), district level, and community, household and individual level.

After two days of discussion in plenary sessions and in working groups, the representatives of the Portuguese-speaking African countries agreed on several actions to improve access to, and appropriate use of, medicines for the management of mental disorders. These actions concurred with those recommended in the thematic paper, and will require further efforts to be implemented.

1. Develop a drug selection process.
2. Promote information and training activities for professionals and health service users on the selection process.
3. Regulate the availability of psychotropic drugs.
4. Implement a reliable health and supply system.
5. Ensure the quality of psychotropic drugs.
6. Develop a community mental health-care system.
7. Develop policies for financial accessibility of medicines.
8. Develop pricing policies and promote a sustainable financing system.
9. Adopt evidence-based guidelines.
10. Monitor the use of psychotropic drugs.
11. Promote training activities for professionals and health service users on the critical evaluation of scientific evidence and the adequate use of psychotropic drugs.

Some specific priorities were recognized for implementation within the countries.

CHAPTER 3: RELEVANCE OF THE FIVE THEMATIC PAPERS AND RELATED WORKSHOPS FOR THE WHO COMPREHENSIVE MENTAL HEALTH ACTION PLAN PRINCIPLES, APPROACHES AND OBJECTIVES

WHO'S comprehensive MHAP (WHO, 2013) relies on six cross-cutting principles and approaches, and four objectives (Appendix 1). WHO proposes actions and related options for its implementation, but acknowledges that marked diversities of culture, mental health, health and social systems, and variable resources create different constraints and open different opportunities across countries, with some countries facing greater challenges in effectively and efficiently implementing the action plan. WHO has indicated that the implementation options presented in the MHAP are neither comprehensive nor prescriptive, but intended as "illustrative or indicative mechanisms through which actions can be undertaken in countries".

In this chapter, we use the five GGMHP thematic papers and the related workshops to elucidate the usefulness of the WHO MHAP principles, approaches and objectives to national mental health policy and actions intended to improve mental well-being, prevent mental disorders, offer care, help recovery, promote human rights, and ultimately reduce the mortality, morbidity and disability of persons with mental disorders.

We describe actionable policy options "vertically" around the six cross-cutting principles and approaches, and the four objectives of the mental health action plan. The report can also be consulted and read "horizontally" by focusing on a specific theme (for example, social determinants). We use different background colours for each of the five themes to facilitate ease of horizontal reading. The synoptic table provides the page numbers and locations of this information, and may be used to navigate the report.

The MHAP seven principles and approaches, and four objectives are summarized at the beginning of this chapter.

Overview of the Mental Health Action Plan 2013 - 2020

Vision

A world in which mental health is valued, promoted, and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

Cross-cutting Principles

Universal health coverage

Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.

Human rights

Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

Evidence-based practice

Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

Objectives and Targets

To strengthen effective leadership and governance for mental health

Global target 1.1: 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020)

Global target 1.2: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).

To provide comprehensive, integrated and responsive mental health and social care services in community based settings

Global target 2: Service coverage for severe mental disorders will have increased by 20% (by the year 2020).

Goal

To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

Life course approach

Policies, plans, and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

Multisectoral approach

A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

Empowerment of persons with mental disorders and psychosocial disabilities

Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

To implement strategies for promotion and prevention in mental health

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).

Global target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020).

To strengthen information systems, evidence and research for mental health

Global target 4: 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 the year 2020).

Table 1. **Cross-references of the WHO MHAP and the five thematic papers**

	WHO comprehensive Mental Health Action Plan									
WHO/Gulbenkian Platform thematic papers	Principles and approaches						Objectives			
	Universal health coverage p.15	Human rights p.17	Evidence-based practice p.19	Life-course approach p.20	Multisectoral approach p.21	Empowerment of persons with mental disorders p.22	Leadership and governance for mental health p.24	Community-based services p.30	Promotion and prevention in mental health p.38	Information systems and research p.41
Social determinants of mental health	p.15	p.17	p.19	p.20	p.21	—	p.24	p.31	p.38	p.41
Innovation in deinstitutionalization	p.15	p.18	—	—	p.22	p.23	p.25	p.31	—	p.42
Integrating response to mental disorders and other chronic diseases	p.16	p.18	—	p.20	p.22	p.23	p.26	p.33	p.39	p.42
Promoting rights for children with psycho-social disabilities	p.16	p.18	—	p.21	p.22	p.23	p.27	p.35	—	—
Improving access to and appropriate use of medicines	p.17	—	p.20	—	—	—	p.28	p.35	p.39	p.42

Mental Health Action Plan – principles and approaches

Principle 1: Universal health coverage

Universal health coverage is the first of the six cross-cutting principles of the WHO MHAP. It is a key target of Goal 3 (good health and well-being) of the United Nations Sustainable Development Goals (SDGs) (www.undp.org). As it pertains to mental health, universal health coverage requires that "regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health". Universal coverage extends to strategies, programmes and interventions for promoting mental health, and preventing mental disorders.

According to the WHO Mental Health Atlas 2014 (WHO, 2014d), more than 45% of the world's population lives in countries where the ratio of psychiatrists to population is less than 1:100 000. Neurologists are even scarcer. Under such circumstances, it is impossible to expect specialists alone to meet the needs of people affected by mental, neurological and substance use (MNS) disorders. Some other way to achieve universal health coverage, and of serving the millions of people who need access to services, is required.

Social determinants of mental health

Universal health coverage is intended to break the vicious cycle in which low SES contributes to poor mental health, which in turn lowers SES. Universal health coverage should substantially improve access to and use of basic health and social services, especially among the most disadvantaged groups. However, only focusing on the most disadvantaged people is not enough. Reducing health inequalities will also reduce the steepness of the social gradient along which inequalities in physical and mental health exist. Most of the population experiences some degree of unnecessary and unfair health inequity.

POLICY OPTION 1

Actions, access to, and use of health and social services should be universal, but also calibrated to address the level of disadvantage faced by communities and patients.

Innovation in deinstitutionalization

Providing mental care in psychiatric hospitals or inpatient services does not move countries towards universal health coverage. In several LMICs, there are few psychiatric hospitals, mostly in urban settings and far from the city centres. Therefore, these large institutions are hard for both the rural and urban population to reach. It may be even harder for people with mental disorders to access them because stigma and discrimination are attached to the use of such services. Limited access to inpatient care contributes to hinder response to the unmet needs of most persons with mental disorders, who need to receive care in their community.

POLICY OPTION 2	**For those with mental disorders, a key part of care is to ensure that their lives are integrated in society. Integration requires that community-based health services collaborate with social services. In most of the world resources should be shifted from long-stay, large, centralized inpatient mental health services to community mental health services.**

Integrating response to mental disorders and other chronic diseases

Mental disorders have several features in common with those of other chronic communicable and noncommunicable diseases: they share several underlying causes, risk factors and consequences. Mental disorders and other chronic diseases are highly interdependent and they often co-occur, so they are best managed through integrated approaches.

POLICY OPTION 3	**It is not enough to scale up existing health services. Universal health coverage for people with mental disorders requires the transformation of health systems, which must implement evidence-based approaches to effective and efficient care for mental disorders which are integrated with the approaches to the management of other chronic diseases.**

Promoting rights for children with psychosocial disabilities

On 20 November 1989, the Convention on the Rights of the Child (UN General Assembly, 1989) was adopted and opened for signature, ratification and accession by United Nations General Assembly resolution 44/25. It entered into force on 2 September 1990. Several articles of the CRC promote principles for the provision of universal health coverage, and focus on the most vulnerable subgroups.

Article 23 (3) of the CRC specifies the right to health and social care of disabled children:

> "[...] Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health-care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development".

Article 24 of the CRC is also relevant to universal health coverage:

> "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services".

Improving access to and appropriate use of medicines

Patients and caregivers need easy access to essential medicines for treating mental disorders. To improve access, key barriers must be defined and identified, including supply and/or demand constraints. Without access to necessary medications, health-care services cannot effectively treat patients in need, and are severely limited in the services they can provide.

POLICY OPTION 4

Governments must design and implement policies that take the circumstances and the needs of their population into account, and outline a specific plan of action for ensuring that patients get the medications they need. This is a key element of universal health coverage, "access to medicines for all" is now enshrined in the SDGs, target 3.8 (universal health coverage). The 194 States which have signed UN Resolution 54 (A/RES/79/1 – September 2015) can take this opportunity to design and adopt national policies that make medications more affordable for mental health patients.

Principle 2: Human rights

According to the WHO MHAP, "mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities (CRPD) and other international and regional human rights instruments" (WHO, 2013). People with mental disorders, intellectual disabilities or substance abuse problems are often victims of health-care systems that deprive them of human rights, and of discrimination. It is essential to assess and improve respect for human rights, and encourage their observance at all levels of the mental health system, across all services. Specific actions may and should be taken to identify problems in existing health-care practices, as part of a wider and comprehensive policy, planning, and legislative reform, grounded in respect for and promotion of human rights.

Social determinants of mental health

Throughout adult life and in old age, employment, security, freedom from violence, freedom from discrimination, and right to participate in the community all have a remarkable impact on mental health, and they all contribute substantially to modulating the risk of mental disorders and to the success of treatment and care. For children, these social determinants of their mental health are equally pertinent. The right of children to have the best possible start in life is the foundation for generating the greatest societal and mental health benefits. All children have the right to attain optimal development that promotes their mental health, in childhood and throughout the life course. Access to optimal educational opportunities and to appropriate social and health care can significantly reduce differences in social circumstances and the effect of social inequalities on health.

Innovation in deinstitutionalization

In many countries, the quality of mental health care in both inpatient and outpatient facilities is poor, and may even harm patients or actively hinder their recovery. Treatments for mental illness are often intended to keep people and their conditions "under control", rather than to enhance their autonomy or improve their quality of life. Patients with mental illness may be perceived as being "objects of treatment", rather than human beings with the same rights and entitlements as everybody else. They may not be consulted about their care or recovery plans, and may even be forced into treatment. Inpatient facilities often provide the worst environments. Long-term care institutions have often been associated with human rights violations. People may be locked away for weeks, months and sometimes years in psychiatric hospitals or social care homes, where they may experience terrible living conditions and be subject to dehumanizing, degrading treatment, including violence and abuse.

POLICY OPTION 5

Deinstitutionalization, along with expanding and improving services at the community level, can reduce stigma and discrimination, and is associated with better quality and coverage of care, and better protection of the rights of people with mental disorders.

Integrating response to mental disorders and other chronic diseases

The slogan "no health without mental health" alludes to the huge contribution of mental disorders to the global burden of disease and to the complex and marked interaction between mental disorders and other health conditions (infectious, NCDs and injuries) that often co-occur (Prince et al, 2007). It also refers to the inadequate amount and poor quality of treatment and care received by people with mental disorders and comorbid physical conditions. The interplay between mental and physical ill health influences help-seeking behaviours, diagnosis, quality of care, treatment (including adherence) and prognosis. Article 24 of the CRPD states that States Parties shall "require health professionals to provide care of the same quality to persons with disabilities as to others [...]".

POLICY OPTION 6

Integrating response to mental disorders and other chronic diseases can improve the amount and quality of care provided to those with mental disorders, and promotes their right to "the enjoyment of the highest attainable standard of health without discrimination on the basis of disability".

Promoting rights for children with psychosocial disabilities

The CRC, in conjunction with the CRPD, provides a framework for operation at a policy level. The human rights argument is compelling: governments must respect human rights, paying attention to the most marginalized social groups, including children who need special safeguards because of their vulnerability during physical and mental development. All policies that directly and indirectly promote the human rights of children with psychosocial disabilities must conform to this principle. Such policies can be examined retrospectively, and improved to better meet those goals.

POLICY OPTION 7

Member States are strongly encouraged to consult, use and conform to the CRC. Several articles of the CRC have implications for national health and social policies (e.g. Articles 23 and 24), for treatment and care (e.g. Article 25, "States Parties recognize the right of a child [...] to a periodic review of the treatment [...]."), and for health services organization and quality (including Article 3 (3), "States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities [...]") (UN General Assembly, 1989).

Principle 3: Evidence-based practice approach

The goal of the WHO comprehensive MHAP is to improve the mental health status of populations, while promoting the rights of persons with disabilities. It provides guidance for reducing the incidence, prevalence, and impact of mental disorders; and for improving the mental and social health services, particularly in community-based settings through a detailed translational agenda propelled by an evidence-based approach. The third approach of the WHO comprehensive MHAP reads as follows: "Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account".

Social determinants of mental health

Although the strength of the association varies between studies, most population-based studies conducted in LMICs agree that poverty and common mental disorders are strongly associated (Lund et al, 2010). Epidemiological studies conducted in Europe consistently found that low educational attainment, unemployment and social isolation were also associated with common mental disorders (Fryers et al, 2005). The poor and disadvantaged suffer disproportionately from common mental disorders and from the consequences of poor mental health because the relationship between mental disorders and SES is bidirectional (Blas and Kurup, 2010). Ample evidence suggests that socioeconomic circumstances have a causal role in determining mental health problems (social causation) and individuals with worse physical/emotional health "drift down" socioeconomically, or fail to rise (social selection). The two mechanisms coexist and perpetuate each other. The vicious cycle is further complicated by the detrimental effect of social disadvantage on chronicity and prognosis of mental disorders after their symptomatic onset. Moreover, there is good evidence that common mental disorders (including depression and anxiety disorders) are distributed according to a gradient of economic disadvantage (Campion et al, 2013), more marked in women than in men (McManus et al, 2009).

POLICY OPTION 8

Policy and specific actions should be informed by empirical evidence and conform to the "proportionate universalism" principle: health care should be universal, yet proportionate to need. A growing body of evidence, including from LMICs, informs and supports this policy and the actions needed to enact it. Universal, proportionate health care effectively promotes mental health, prevents mental disorders and favours rehabilitation. Many of these interventions can be successfully implemented in most countries, at all stages of economic development.

Improving access to and appropriate use of medicines

Treatment for mental disorders must be evidence-based. Indeed, the key components of access of populations to essential medicines (rational selection, availability, affordability and appropriate use) are evidence-based processes in which the values and preferences of patients are adequately accounted for.

POLICY OPTION 9

The adoption of evidence-based guidelines, used in conjunction with essential medicines lists (EML), are fundamental to the appropriate use of (essential) psychotropic medicines, across all levels of the health system.

Principle 4: Life-course approach

WHO recommends that, “policies, plans and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age”. At the centre of a life-course approach to mental health and mental disorders is the notion that timing and duration of exposure to risk and protective factors are key, and that treatment and care needs vary over the life course.

Social determinants of mental health

Taking a life-course approach to understanding and addressing mental and physical health inequalities is essential. The effects of social inequalities on mental health may be more detrimental at certain critical or sensitive times of life. Scientific consensus is that optimal development is indispensable to promote mental health and prevent mental disorders in adulthood. The effects of social inequalities on mental health may be cumulative.

POLICY OPTION 10

A life-course approach proposes actions and strategies for promoting, preventing, treating and caring for people with mental health conditions, while taking into account the varying effects of social inequalities on health, from before birth to old age.

Integrating response to mental disorders and other chronic diseases

The magnitude of the effect of certain risk factors may vary throughout the course of life. It changes at different developmental stages (including infancy, childhood and adolescence), in adulthood and old age. These changes have implications for promotion, prevention, treatment and care because subgroups of the whole population who need specific interventions can be identified and targeted.

POLICY OPTION 11

The health and social needs of people change with age or stage of life course, therefore integrating mental disorders and other chronic diseases in health-care systems is crucial to respond adaptively to these changing needs.

Promoting rights for children with psychosocial disabilities

Many mental health disorders are strongly influenced by early life experiences or by the absence of optimal stimuli. There is strong evidence (including mechanistic evidence) that institutionalization has negative consequences for health, development, psychology, and cognitive and behavioural function. We also know that the earlier children are placed in low-quality or inappropriate institutions, and the longer they stay there, the worse the consequences are for them.

POLICY OPTION 12

Clinical and social practice must avoid institutionalization of children with psychosocial disabilities. Existing policies about institutionalization should be carefully reviewed, and institutional practices averted to avoid present and future harms and to improve the outcome of children with psychosocial disabilities.

Principle 5: Multisectoral approach

The health sector alone cannot promote mental well-being, prevent mental disorders, and provide care to persons with these disorders. The approach must be multisectoral, and should consist of a "comprehensive and coordinated response for mental health (which) requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sector, as well as the private sector, as appropriate to the country situation".

Social determinants of mental health

The risk and protective factors associated with mental health operate at individual, family, community, structural and population levels. Addressing social determinants of health will require action across multiple public and private sectors and levels. Health inequalities can be reduced most effectively by prioritizing health equity in policy in all relevant sectors. The health sector may or may not lead this multisectoral approach. Effective leadership is indispensable to inspiring and making the case across sectors, and to encouraging the necessary negotiations and focus. Working in partnership with organizations and agencies beyond the health realm may improve social and economic conditions more than the health sector could achieve in isolation.

POLICY OPTION 13

All policy-makers, across all relevant sectors, must ensure that their strategies and actions will not harm, and have a good chance of reducing mental health inequities.

Innovation in deinstitutionalization

A successful process of deinstitutionalization has to be multisectoral, encompassing and actively involving sectors beyond the health sector. Former institutional residents need access to mental health services, including evidence-based clinical care, and also access to social services for help with housing, employment and community reintegration. The different type of services required are interdependent, and create a network that meets the social welfare or income needs, housing, employment and clinical follow-up needs of patients who have been deinstitutionalized.

Integrating response to mental disorders and other chronic diseases

Promoting and protecting public health requires concerted action from health departments, and from many government sectors and agencies, including ministries of planning and development, finance, law and justice, labour, education and social welfare.

POLICY OPTION 14

Governments should adopt a public health and whole of government approach to taking key, articulated actions and identifying practical steps towards integrated management of NCDs, including mental health. Multiple public and private sectors must actively participate in, and contribute to, devising and implementing a comprehensive and coordinated response.

Promoting rights for children with psychosocial disabilities

An integrated, multispectral approach is required to provide indispensable social services for children and their families, including education.

POLICY OPTION 15

Institutionalization should be ended for children. Care should be provided and integrated into communities when possible. Integration in the education system and the role of the education sector are therefore critically important for intellectual, emotional and psychological development.

Principle 6: Empowerment of persons with mental disorders and psychosocial disabilities

"Nothing about us without us" is a powerful slogan that affirms the requirement that no policy should be decided, or action be taken in mental health, without the highest achievable participation of persons with mental disorders and psychosocial disabilities. In many countries, these voices are silent or silenced. According to the WHO comprehensive MHAP (WHO, 2013), "Persons with mental disorders and psychosocial disabilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation", because it is right, and because they are the greatest hope that a collective effort will successfully mobilize resources to meet the challenges of a population's mental health needs, while striving for equity and justice. Mental health services should

be centred on persons and their needs. Only working in close consultation with users of these services (including persons with mental health disorders), can the design and improvement of services be truly responsive to the needs of those for whom the services are intended.

Innovation in deinstitutionalization

Empowering patients, their families and organizations of patients is crucial to successful deinstitutionalization. Empowering those with mental disorders will ensure that self-help and health service users groups are viable and effective. Consumer movements can effectively lead to expansion of community mental health services through advocacy campaigns. Empowering persons with mental disorders also requires transferring knowledge and sharing information about promoting human rights, including the right to be managed in the community and to effective, evidence-based care that is discussed with and approved by service users, their family members, or legal representatives.

Integrating response to mental disorders and other chronic diseases

Empowering persons with mental disorders depends on those preliminary actions which are aimed at reducing stigma, and which promote social participation. Services that integrate care for mental health disorders and other chronic conditions can significantly reduce stigma in health-care providers and the general population. Stigma and discrimination can be reduced by awareness campaigns about the common determinants, consequences, and co-occurrence of mental and physical chronic conditions. Improving public perception and empowering those with mental disorders will improve the treatment-seeking behaviours of patients and caregivers, and increase the likelihood they will access appropriate care.

POLICY OPTION 16

An integrated response requires stakeholder engagement, so governments should reach out to organizations of people with mental disorders and/or other chronic conditions, seek to engage them, and enlist their support.

Promoting rights for children with psychosocial disabilities

Empowering children with psychosocial disabilities, and their parents and caregivers, can have substantial positive long-term effects on mental health and social function. Empowerment gives children and their caregivers more autonomy, increases self-determination, and boosts their motivation, allowing them to share their experiences, provide reciprocal support through peer support groups, and communicate their perspectives and expectations. If children with psychosocial disabilities and their parents are empowered, they become aware of their rights and can represent their interests through self-advocacy, actively participating in national decision-making processes on issues that affect them (Mulheir, 2013).

Mental Health Action Plan – objectives

The WHO comprehensive MHAP has four objectives:

1. To strengthen effective leadership and governance for mental health.
2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
3. To implement strategies for promotion and prevention in mental health.
4. To strengthen information systems, evidence and research for mental health.

Specific action areas within each of these objectives are included in the action plan. The reader is also encouraged to consult Appendix 2 of the MHAP to familiarize themselves with the proposed options for implementation for each of the actions and to contextualize this report and integrate its content within the actions proposed by WHO to achieve the objectives of the MHAP.

Objective 1: To strengthen effective leadership and governance for mental health

Objective 1 of the mental health action plan is to strengthen effective leadership and governance for mental health. To facilitate and stimulate the implementation of the action plan at a local level, WHO identified four main action areas to achieve Objective 1: policy and law, resource planning, stakeholder collaboration, and strengthening and empowering people with mental disorders and psychosocial disabilities and their organizations.

Policy and law – A mental health policy is an official statement that defines the vision, values, principles and objectives necessary to establish a broad model of action to improve mental health and reduce the burden of mental disorders in a population. A mental health plan (or strategy) is a systematic and coordinated set of detailed actions designed to implement the policy and achieve its vision. A good mental health policy is evidence-based, and coordinates mental health with other health and social policies. All actors and stakeholders make a binding agreement to implement the policy. This is the indispensable preamble to developing, improving mental health services, and organizing them.

Social determinants of mental health

Two key principles of the CRPD are "full and effective participation and inclusion in society", and "equality of opportunity". Social inequalities hinder educational and employment opportunities and reduce active participation and inclusion of individuals and communities in society. This may, in turn, increase risk of poor mental health and affect treatment and rehabilitation.

Several articles of the CRPD can inspire and inform action to lessen the effect of the disproportionate distribution of resources (income, wealth and formal education) and of social inequalities. Country-level strategies, embedded into multisectoral policies, are likely to have the greatest impact on reducing mental health inequalities and the potential to reach large populations. A wide range of actions at country level,

including, alleviating poverty and increasing social protection across the life course, reducing inequalities and discrimination, preventing war and violent conflict, and promoting access to employment, health care, housing, and education, can have positive benefits for mental health.

Implementing accessible financial services is necessary to tackle poverty, empower people and communities, and ultimately reduce the effect of social inequalities on mental and physical health, particularly among the most disadvantaged (Brett, 2006). Microfinance programmes help the poorest earn a living, improve their businesses and provide a means for entire communities to work their way out of poverty. Preliminary results on the efficacy of microfinance in reducing exposure to financial stressors and the potential benefit on mental health are encouraging. Some interventions require limited financial and infrastructural investment and may be progressively scaled up and monitored to establish their impact and cost-effectiveness at a regional or national level.

POLICY OPTION 17

Policies that have the greatest potential to break the cycle of poverty and poor mental health, and that prevent social and economic inequities from being perpetuated across generations, should be emphasized.

Innovation in deinstitutionalization

Deinstitutionalization must be part of stated mental health policy, which should clearly specify the overarching principles that guide and inform the strategy and the specific actions and methods for deinstitutionalization, the timeline, order of events and the agencies responsible for each action. Although WHO recommends designing, implementing and monitoring national mental health policies, strategies and plans, it is useful to work on the local level, or even the hospital-level, to downsize institution-based services. However, the shortage of appropriately qualified staff is very often an important barrier to scaling up community-based services and progressively deinstitutionalizing.

POLICY OPTION 18

WHO and the GGMHP have highlighted four important financing concepts that policy-makers should consider when they decide how policies and legislation should be enforced, and when they determine the budgets that will support mental health strategies and plans.

- **First, successful deinstitutionalization may require *double funding*, since existing services may need to be maintained during the transition to community-based services, until community-based services are robust enough to handle the load. In resource-constrained systems where double funding is impossible, governments might provide bridge funding while money is transferred progressively from institutions to service users' home health districts.**
- **Second, *budgets for community-based mental health services need to be ring-fenced*. They should be closely monitored to ensure that funding and budgets are not usurped by physical health services, or mental health institutions that should be progressively sized down.**
- **Third, *financing can be used as a lever for change*. New laws can specify the proportion of the budget currently allocated to psychiatric hospitals that must be reallocated to develop community services. Public health insurance could stop paying (reimbursing) mental health hospitals for newly admitted patients to chronic wards.**
- **Fourth, *incentives can be used to foster innovation*. If financial incentives are created for good innovative projects, then new projects can be used to demonstrate the effectiveness, affordability and sustainability of community-based care after formal evaluation.**

Importantly, the specificity, resources, needs and constraints of each country, and region within a country, suggest that locally adapting national plans is crucial to success. Methods and strategies for deinstitutionalization do require careful adaptation.

Integrating response to mental disorders and other chronic diseases

Reforming policy, plans and programmes requires commitment from the government, formal policies, legislation and regulations. It also requires financing, negotiation and involving stakeholders. The MHAP attests to the consensus on key priorities. A guiding principle is *parity*, which raises mental health services to the level of other health services, so they are just as available, accessible and affordable at the point of delivery. Successfully implementing a national mental health policy requires defining specific actions. Reform cannot be successful unless these actions are integrated with existing health policies and into the health system, and across various levels (Valentijn et al, 2013).

- First, integration occurs at the micro-level of the service user or patient. In practice, this means that services are person-focused and coordinated to meet the needs of the patient, across diseases, settings and time.
- Second, integration also occurs at the meso-level of health-care organization and the community. This includes common information systems and professional partnerships based on shared competencies, roles, and responsibilities, which must coordinate to deliver a comprehensive continuum of health and social care to a defined population.
- Third, macro-level integration requires formulating policies, financing mechanisms and structures of shared governance.

An integrated response to mental disorders and other chronic diseases in health-care systems means that policy-makers and stakeholders oversee and coordinate the articulation of concerted actions. Health systems involve many actors, from individuals and their families and communities, to health-care providers, planners, and payers. Other actors are located outside the health sector, but their actions can influence (positively or negatively) the way health-care systems perform. For instance, private enterprises can take steps to safeguard the health and well-being of their employees. Even though more and more employers recognize the damaging effect of chronic diseases and mental health on business and economic outcomes and burden employers, there is still a broad implementation gap. Employers in both the public and private sector are key stakeholders, and should be actively involved in promoting mental health and implementing national mental health policy. Partnerships between workplaces and research institutions could provide evidence to strengthen the business case for workplace wellness programmes. In turn, the data gathered from implementation research could make these programmes more effective.

POLICY OPTION 19

The term "integration" covers prevention and management of mental disorders and other communicable and noncommunicable chronic diseases. Collectively, integration efforts span many levels of the health system.

Integration is at the core of most existing health-care organization models, including the chronic care model (CCM) (Wagner et al, 1999), which links informed, actively engaged patients with proactive and prepared health-care teams. The CCM has shifted thinking about chronic disease management and its reform towards a more integrated, person-centred, and shared-care approach.

Promoting rights for children with psychosocial disabilities

It is the responsibility of governments to respect human rights, in all their acts, legislations and policies. Mental health policy should be designed to take account of the CRC (UN General Assembly, 1989) and the CRPD (UN, 2006). Children have the right to identity (birth registration), to be cared for by a parent, to be free from torture, degrading treatment and punishment. They have the right to live in the community, to education, to assistance, and to access to health services. Other relevant examples of rights of children include: the right to identity (Articles 7 and 18 CRC; Article 18 CRPD), which is obviously under the direct responsibility of States; and the right "to not be separated" (Article 9 CRC). Because all separations are regulated by law, the State is responsible for overseeing their application, ensuring they conform to Article 9 of the CRC.

POLICY OPTION 20	**Education policies must clearly support an "inclusive educational environment" and anticipate the infrastructure and staff required to provide additional support needed by children with disabilities. Governments should develop clear policies that define interactions between health, social and educational systems, so that children with mental illnesses are not denied education, and are optimally integrated. Moreover, policies must present the vision and actions to end institutionalization.**

Parents need reliable financial assistance and pensions, since these are essential to maintaining the health of a child with psychosocial disabilities. Such "subsidies" are long-term investments, reducing the future costs of illness (psychosocial disability throughout the life course), enhancing the child's development, education and social inclusion, and ensuring timely interventions. Parents, family members, teachers and representatives of the education sector are key stakeholders and must be informed and proactively involved by Member States, so that together they can design and implement policies to promote rights and community living for children with psychosocial disabilities. As said, these policies must comply with international conventions and standards. Ratifying conventions (including the CRC and CRPD) is not enough. To implement the shift from a statement of rights to a change of practice, relevant stakeholders, including national and local governments, nongovernmental disability organizations, and parents and children, must be involved both in enforcing and rigorously monitoring and developing new community-based options for children and families. The CRPD provides a legal framework to inform policy. Article 16 of the CRPD mandates that "States Parties shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities". In addition, Article 33 states that "persons with disabilities and their representative organizations, shall be involved and participate fully in the monitoring process" (UN, 2006). The voices of children should also be heard (see CRC Article 12).

POLICY OPTION 21	**Mental health services should be inspected and monitored by independent authorities, and actively involve health service users. They should be monitored routinely to detect when norms are violated, and to improve service. Practical tools and procedures will need to be developed to ensure that services are adequately monitored, and staff will need to be hired to do the monitoring.**

Improving access to and appropriate use of medicines

Since the concept of essential medicines was introduced, medications have become more accessible, but there are still several important barriers that hinder or prevent access to essential medicines for NCDs. One of these is the absence of a national mental health policy. Without a clear statement from the government or health authority on the overall direction for mental health care, there is no way to establish a model of action that makes all relevant actors and stakeholders accountable.

The WHO EML have been in existence since 1977, and are updated every two years. The EML are "the minimum medicine needs for basic health systems", to satisfy the priority needs. The EML promote health equity, and essential medicines policies (based on the WHO EML), and effectively improve medicine use (Holloway and Henry, 2014). An evidence-based, rather than experience-based, approach is needed to compile national EML. The ministry of health (or other authorities) must rely on evidence-based methods and processes and use the WHO EML to form national EML. The WHO EML can be locally adapted to change prescribing practices, and can be used to train and monitor health workers, and help them develop "rational prescribing habits".

POLICY OPTION 22

The WHO EML must be adapted locally, and should influence medicine policies (including negotiating prices for provision) and improve use of medicines. Policy (with legal "force") must state clearly: who can prescribe; at what level of the health system psychotropic medicines can be prescribed; to whom (thus may require formal diagnosis); and which are "controlled medicines" that require restricted access regulations. Some practice implications should be considered:

- **Can non-specialist (nurses) prescribe, and under which circumstances (training/supervision)?**
- **What can (and cannot) be prescribed at the primary health-care level?**
- **Prescription after formal diagnosis should be feasible.**
- **Double-locked cupboards and registries to record "movement" of medications.**

Resource planning – An integral component of evidence-based mental health policy, plans and actions is that resources be allocated according to plans, based on need. A budget must be allocated across relevant sectors, commensurate with the available resources necessary for implementing mental health plans and actions.

When supplies of medications are constrained, patients cannot make full use of health services. Allocating sufficient funds for procurement and distribution of medication is a prerequisite for making health care accessible. Without adequate funds, the cost of medication becomes prohibitive for both health systems and end health service users. This is especially true in countries that do not control the price of medicines through regulation.

All psychotropic medications in the WHO EML are off-patent. Off-patent (generic) drugs are far less expensive than non-generic alternatives, and generic drugs offer a complete set of treatment options for mental disorders/diseases. Moreover, the Doha Declaration on the Trade-Related Aspects of Intellectual Rights (TRIPS) Agreement and Public Health is an additional fundamental resource for governments that want to design and implement national drug policies. The Doha Declaration states that the World Trade Organization (WTO) and its Member States agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. The TRIPS Agreement can and should

be interpreted and implemented in a manner that supports WTO Members' rights to protect public health and to promote access to medicines for all. Governments can and should use national policies to control drug prices, while complying with WTO "requirements". Bulk procurement, while ensuring quality, should become the norm, at all levels of the health system. Bulk procurement based on a list of priorities allows savings and avoids duplication within therapeutic categories because medicine orders are pooled together. Competitive bulk procurement by generic name is now a major policy in most essential medicines programmes and in large hospitals in both developed and developing countries.

POLICY OPTION 23

Once a national policy is in place, countries should promote the "local" use of generic drugs by training providers/prescribers and educating the public. Affordability at the local level must be "tested", and public financial incentives may be required to promote the prescription of generic medications, and to enforce their reimbursement. Finally, generics must be incentivized at all levels of the health system.

Key lessons from the Gulbenkian Mental Health Platform workshops

Brazil – The Gulbenkian workshop held in Rio de Janeiro in 2015 focused on innovation in deinstitutionalization. There was unanimous agreement that governance is central to promote and realize change in health system structure and functioning, and that the main actor of the reform of the mental health system is the government.

India – The focus of the 2015 workshop was integration of mental health care and chronic diseases in the Indian health and social care systems. The importance of effective leadership was highlighted, in particular to strengthen stakeholder collaboration and empowerment of people with mental disorders and their organizations, who can advocate for and contribute to the design and implementation of national mental health policies.

Portugal – Better socioeconomic circumstances can be promoted only through the implementation of a holistic and comprehensive strategy that involves several sectors. All those who participated in the workshop in Lisbon in 2016 concurred that governance and policy at the highest national level are indispensable, not only to improve the efficiency and quality of the mental health system, but also to improve social protection, reduction of income inequalities and unemployment.

Georgia – all actions aimed at halting all forms of human rights violations against people with mental disorders must comply with the requirements of the CRPD legal framework. National policies, laws and services are under the direct responsibility of governments and must be consistent with international human rights instruments. However, an informed civil society can substantially influence and also actively participate in governance. These and other relevant remarks emerged during the workshop held in Tbilisi in 2016.

Cabo Verde – At the workshop held in Praia it was agreed that two key components of access to medicines for mental disorders (rational selection and affordability) depend, almost entirely, on planning, organizing and financing activities that are under the direct responsibility of the central and the regional governments.

Objective 2: To provide comprehensive, integrated and responsive mental and social care services in community-based settings

Objective 2 of the WHO comprehensive MHAP strongly emphasizes the need to radically reform mental health services. WHO proposed actions that span reorganization of mental health services to proactively identify and provide appropriate support to groups at high risk of mental illness, who lack access to services.

The broad consensus is that mental health care should systematically shift from long-term hospitals and structures towards community-based mental health care. This shift is necessary to expand coverage, improve the quality and appropriateness of care, and reduce human rights violations. It takes more than reducing hospital beds (de-hospitalization) to effectively deinstitutionalize mental health care. Significant financial, structural and strategic investment in community services is required. Deinstitutionalized patients need to access comprehensive services in the community where they reside, or they will suffer adverse effects, including homelessness, re-institutionalization into detention facilities and community-based virtual asylums, and emergency room "boarding".

Clinical needs, disability support and stable accommodation are inter-independent, and should meet the social welfare/income needs, housing, employment and clinical follow-up needs of deinstitutionalized patients and of newly diagnosed people who should not be admitted to hospitals in the first place.
The health sector must collaborate with the social and residential sectors, so that patients discharged from institutional care facilities find a place to live in the community, actively participate in society, and contribute to it. Patients discharged from hospitals must have access to mental health services in the community, and they also must have access to social services for housing, employment and community reintegration.

The approach for successful deinstitutionalization at a policy level should be multisectoral. Relevant stakeholders from the social sector should be actively involved in the design and implementation of mental health policy and strategies, and mental health must become an integral part of existing and future policies in other health and non-health areas.

Lack of resources is a major barrier to meeting the needs of persons with mental disorders. The shortage of mental health professionals, including psychiatrists, psychiatric nurses, psychologists and social workers, hinders treatment and care. Solving these problems would improve mental health in the population, particularly in LMICs. WHO recommends that resources and efforts be allocated to education (at both pre- and postgraduate level) and training of primary care health workers, who must acquire (or improve) knowledge and skills to better deliver mental health and social care services.

Social determinants of mental health

There is good evidence that common mental disorders (depression and anxiety) are distributed across society in a gradient of economic disadvantage (Campion et al, 2013), and that the poor and disadvantaged suffer disproportionately from common mental disorders and their adverse consequences (Blas and Kurup, 2010; Fryers et al, 2004; Patel and Kleinman, 2003). We should address these disparities across their entire spectrum, since health inequalities exist along a social class gradient, and most people suffer some level of avoidable health inequity. Actions and interventions to reduce disparities in mental health should be proportionate to the level of need across the gradient, instead of being limited to vulnerable and disadvantaged groups defined according to spurious (and likely unfair) cut-offs.

Furthermore, social determinants play an important role also in all humanitarian crises. Indeed, humanitarian crises not only affect individuals but communities and social institutions, which can lead to the breakdown of families, social networks, and community bonds – exacerbating the negative impact of the situation. The response to mental health needs during emergencies is typically deployed in the same site and settings, or in near proximity to the location and places where the emergency occurred, i.e. in the community rather than within pre-existing large psychiatric hospitals. During humanitarian emergencies, the commitment of the health workforce, including psychiatrists, mental health leaders, and health workers who assume mental health functions, and those who are currently employed in mental health institutions, can be a great asset to promote the provision of mental health care in community settings.

POLICY OPTION 24

Actions to support mental health in emergency settings should seek to address the social environment as well as the psychological factors affecting populations. During humanitarian emergencies, the goal is to concentrate efforts and the response where needs are greatest, while rapidly and effectively restoring "normality". Furthermore, this collective mobilization of the mental health workforce can be used to demonstrate the feasibility, appropriateness and effectiveness of models of care alternative to psychiatric hospitals; models in which the role of the mental health workforce itself remains central and critical. Ultimately, despite their detrimental impact on individual and society, humanitarian emergencies can tighten and strengthen social ties and cohesiveness, and can be a powerful opportunity to build collective commitment and political support at the highest and broadest level to better develop the mental health system.

Innovation in deinstitutionalization

The WHO and the GGMHP conducted a survey in 2014 that identified five overarching principles for deinstitutionalization, and gave several practical examples:

Community-based services must be in place: Community-based services can be initiated by institutions, by reallocating resources to mobile teams, outpatient, and day-care facilities, group homes and rehabilitation programmes. Initial efforts made by institutions to strengthen community-based services may garner additional funding and reduce long-stay beds and reallocations in successive waves. Secondary care (e.g. mental health specialists working at general hospitals or community mental health centres) can provide essential supervision and support to primary health-care providers, conduct a range of other community-based services, and prevent (re)institutionalization by providing acute psychiatric care. Although community-based services are essential, their existence does not necessarily lead to deinstitutionalization. Targeted efforts at reducing long-stay beds are necessary.

The health workforce must be committed to change: The health workforce can either be a great asset or a great liability in deinstitutionalization. Mental health leaders usually need to be convinced of the benefits of deinstitutionalization. General health workers who assume mental health functions also must be persuaded. Health workers (and their professional associations) should be consulted widely and involved in planning and implementing deinstitutionalization and community-based care. Those employed in institutions deserve special attention. They usually have valuable information about discharge and care planning for institutional residents, and their involvement in the process helps mitigate concerns they might have about losing or changing employment, losing professional status, or changing familiar ways of working.

Political support at the highest level is crucial: Building support across broad groups of stakeholders helps overcome resistance and foster momentum for change. Support is needed from government officials and political leaders, and from academic leaders, health professionals, communities, service users and their families. Building support requires more than informing people about the need for deinstitutionalization and describing what it entails. It also is the process of using information in deliberate and strategic ways to change perceptions and to sway decision-making. Mobilizing people means creating commitment by asking them to become part of the solution. Gaining this type of political support is a skill, and it can be taught and learned.

Timing is key: Moments of openness, such as emergency situations and changes in political leadership, provide opportunities to rally support and introduce reform. During emergencies, attention and resources are turned towards the psychological welfare of broad groups of affected people, while decision-makers are willing to consider options beyond the status quo. Similarly, changes in political leadership are opportunities for deinstitutionalization because new administrations often welcome signature issues to define their tenure. Success is not invariably ensured in these moments; political skill is required to recognize these and other openings, and to act effectively upon them.

Additional financial resources are needed: Deinstitutionalization is not a cost-saving process. Comprehensive community-based services accessible to an entire population are usually more expensive than institutional care provided to a relative few. Although it is important to direct savings from deinstitutionalization to community-based mental health services, these “ring fenced” funds do not typically match the operational costs of providing community-based mental care across an entire district or country, as many more people will be served. More funds are needed in most cases. In addition to ongoing operating costs, time-limited expenditures on training, supervision and infrastructure are often needed to help establish community-based mental health care. A period of double funding for both institutions and community-based services enables establishment of community-based care before institutions are downsized or closed. If resources are limited, it is useful to start work with available funds, while strongly advocating for more support.

Furthermore, the 2014 survey identified key methods to downsize psychiatric hospitals and improve community-based services:

- mobile clinical and outreach services
- psychiatric beds outside mental health hospitals
- discharge planning or hospital-to-community residence transfer programmes
- residential care in the community

- revision of hospital and services admission procedures
- tailored regional, local and even hospital level plans, in addition to but consistent with national policies and strategies
- support of the workforce and improved work conditions
- stimulate and support self-help and user groups in the community.

Integrating response to mental disorders and other chronic diseases

A 2008 WHO and World Family Doctors: Caring for People (Wonca) report, *Integrating mental health into primary care: A global perspective*, examined experiences with primary care integration across a range of countries and identified ten principles for successfully integrating mental health into primary care (WHO et al, 2008).

1. **Policy:** Government policy and plans need to incorporate primary care for mental health.
2. **Advocacy:** Advocacy is required to shift attitudes and behaviour.
3. **Training:** Adequate training of primary care workers is required.
4. **Roles:** Primary care tasks must be limited and doable.
5. **Support:** Specialist mental health workers and facilities must be available to support primary care.
6. **Medicines:** Service users must have access to essential psychotropic medications in primary care.
7. **Engagement:** Integration is a process, not an event.
8. **Coordination:** A mental health service coordinator is crucial.
9. **Collaboration:** Collaboration with other government non-health sectors, nongovernmental organizations, village and community health workers and volunteers is required.
10. **Resources:** Financial and human resources are needed.

These principles correspond closely with those that underlie WHO's (and others) push for renewing primary health care (Van Lerberghe, 2008). Translating these principles into action can be challenging, especially in resource-constrained settings. Stepped care and collaborative care (CC) are examples of more specific programmes and instances of successful integration.

Stepped care: Stepped care programmes for managing mental disorders are typically situated in primary care settings. Within a stepped care approach, patients are typically first treated with a low-intensity, low-cost intervention. Treatment results are monitored systematically, and patients move to higher intensity treatment only if needed. Programmes maximize efficiency by deploying available human resources according to need, reserving the most specialized and intensive resources for those with complex or severe problems.

Collaborative care: This is an evidence-based approach to improving management of mental disorders and comorbid chronic diseases in primary care settings. It aims to enhance quality of care and quality of life, consumer satisfaction and system efficiency for patients with complex, long-term problems cutting across multiple services, providers and settings (Kodner and Spreeuwenberg, 2002).

In general, patient-level integration is grounded in the belief that people are more than their disorders or health conditions. Focusing on people rather than diseases places patients at the centre of the health-care system. Services can be developed or redesigned to revolve around their needs. Most health systems are not yet designed around patients, but are structured to meet the needs of health

professionals and/or health-care administrators. Integration is important for all patients – especially so for those with multimorbid conditions.

Integrated care pathways can facilitate patient-level integration because they provide structured, multidisciplinary plans that focus on the patient's overall journey, rather than on the contributions of each specialism or service. They view service delivery from the patient's perspective, with the intent of providing a more integrated, seamless experience. Integrated care pathways have been increasingly extended, over the last 20 years, to a range of settings and disease areas, including mental health and other NCDs (Evans-Lacko et al, 2010; Vanhaecht et al, 2010). Because they are complex, however, we do not yet have solid evidence they are useful, especially in heavily resource-constrained health-care settings (Panella and Vanhaecht, 2010).

Patient-level integration also integrates support for self-management. Across the full range of chronic diseases, patients play essential roles in the daily management of their conditions. Major reviews have found that supporting self-management improves outcomes for chronic diseases (Bodenheimer et al, 2002; Ouwens et al, 2005; Weingarten et al, 2002). Self-management support can be provided in a range of venues and formats.

Older adults, children, homeless people, prisoners, migrants and minority ethnic group are at greater risk of mental illness and tend to have poor access to services. Community-based interventions are important in the prevention and management of multimorbid chronic conditions, particularly for these marginalized and vulnerable groups. Community-based interventions can be provided at small scale, can target a specific group or their community at large. These interventions are typically delivered by community health workers who can be trained to provide culturally appropriate interventions to prevent mental and other chronic diseases that share common determinants (see Objective 3). Importantly, community level integration extends beyond the clinical care to encompass social and economic needs and opportunities of people at risk or with mental disorders who live in deprived settings or in LMICs, where mental health services are scant or difficult to access.

POLICY OPTION 25

A promising and somewhat pragmatic approach to mental health integration is to use service delivery platforms that already exist for other chronic diseases (e.g. HIV/AIDS) as the basis for expanding mental health services. Many commonalities exist between mental disorders, other chronic NCDs, and HIV/AIDS, and further, they tend to co-occur. It therefore makes sense that mental health services could be better integrated into service delivery platforms for these other conditions. WHO's Integrated Management of Adult and Adolescent Illness (IMAI) initiative, for example, is a broadly disseminated health-care strategy that addresses the overall health of patients with HIV/AIDS and co-occurring tuberculosis. It emphasizes a person-centred approach to care and provides tools for evidence-based decision-making, patient monitoring, referral and back-referral to district hospitals, clinical team building, clinical mentoring and district planning. IMAI also promotes the inclusion of mental health into the overall care model for HIV/AIDS. As such, the mental health needs of many persons living with HIV/AIDS can be largely addressed with little duplication or waste, while simultaneously improving programme outcomes such as anti-retroviral drug adherence.

Promoting rights for children with psychosocial disabilities

Children form a vulnerable group in society. The CRPD and CRC provide a strong legal framework to promote the mental health of children, and the deinstitutionalization of children with psychosocial disabilities. These conventions have the legal force to influence the shaping of a national policy, and should be used by relevant stakeholders to hold all actors accountable to principles that have concrete impact on practices, and on the organization of services. Member States should be aware that institutionalizing children with psychosocial disabilities violates their human rights (see, for instance, Articles 2 and 23 of the CRC, and Article 7 of the CRPD). The Committee on the Rights of the Child states that "disability alone cannot justify institutionalization", so institutionalization cannot be a formal strategy in policies that regulate the support of children with psychosocial disabilities.

POLICY OPTION 26

The CRPD (Article 19) explicitly obligates States Parties to organize in-home, residential and other community-support services. A range of services and long-term financial support mechanisms for parents, day-care and education facilities must be available in community settings. Indeed, early child interventions are based on multidisciplinary services (psychosocial support, physical and occupational, speech and language therapy, nutrition etc.), with active involvement of parents/caregivers. Interventions must be designed, and staff must be trained to work with and train parents/caregivers, not merely to deliver their treatment/intervention. Most of these interventions do not require institutionalization, but must be adapted to be practised in the community. In addition, because community services require much greater involvement from parents, for community-based services to be scalable, programmes to support parents must be combined with health and social services (employment, housing, education).

Building the knowledge and skills of general and specialized health workers is crucial. Under- and postgraduate curricula and training of health workers in the field should be shaped considering (also) that all staff must be aware of the legislation (national and international) that protects disabled people from violence and torture. There may be a need to define and specify what constitutes torture and violence. Education of health workers is crucial also because, in some countries, health-care staff may, with the best of intentions, encourage parents to place children in institutions. This practice must change because detrimental consequences of institutionalization include violence, constriction and poor health. However, more staff are needed, with adequate training, to make the practice of psychosocial care adequate. Once the financial aids are in place, all health and social staff who work with children with psychosocial disabilities must be able to inform and assist parents to obtain them. This may require information rather than training, but may change practice, because the health specialist must consider their role in the health-care pathway, and know it well.

Improving access to and appropriate use of medicines

The demand for psychotropic medicines can be affected by the geographical distance of the patient from health-care providers. This distance may affect diagnosis and initiation of treatment, and may contribute to poor adherence to treatment. Due to the long-term nature of many severe mental disorders, treatment is often lengthy. If treatment is not locally accessible, and side-effects are not adequately dealt with, demand for medicines will likely decline over time. Poor adherence may create the impression that treatment is ineffective, and perpetuate the vicious cycle of demand constraints and barriers.

POLICY OPTION 27

A qualified procurement and supply management team is needed to translate national medicine policy into operational planning for the distribution system. The supply system should dynamically support the planned transformation of the health system and reorganization of its services. The shift from long-stay hospitals to non-specialized health settings covers more area; and larger population coverage requires a more capillary storage and broader distribution of medicines, so that high quality medicines are easy to obtain. However, the availability of medicines throughout a decentralized mental health system is not enough. Promoting information and education for staff and health service users on the medicines' selection process can improve the appropriate use of medicines for mental health. Training for staff and users should focus on: critical appraisal of evidence and appropriate use of medicines. Critical appraisal skills should be part of undergraduate (health) curricula, and/or continuing education, to improve prescribing habits. Actual everyday clinical activities may involve "journal clubs" and applied critical appraisal. Interactive, practical pedagogical approaches seem to have greater impact on practice. Pedagogical resources should adapt to the "practice", context, setting and contingency at national or regional level, and practice should be first assessed and analysed to design courses with the desired changes and improvements in mind.

Prohibitive costs to end users contribute to exacerbate inequalities in access to medicines, and marginalized groups, including unemployed, older adults, young children, women, ethnic minorities and immigrants, may be at greater risk of poor mental health because of their living circumstances, and typically have poor access to services. Therefore, access to medicines may be particularly problematic for vulnerable groups in the absence of financial protection or health insurance.

POLICY OPTION 28

The costs of medicines can be reduced through the implementation and use of standard treatment guidelines, and the utilization of policies on the use of generic medicines. Further, reduced taxation of medicines and vouchers for vulnerable groups can significantly reduce costs to end users, and improve access and adherence to treatment.

Finally, access to and use of psychotropic medications during humanitarian crises pose specific challenges. In the 1980s WHO launched (and standardized) the "pre-packed kits" (of medicines and medical devices) in emergencies. The Interagency Emergency Health Kit (IEHK) for the primary health-care needs of up to 10 000 people, contains psychotropic medicines.

POLICY OPTION 29

Each country should ensure that their IEHK conforms to WHO recommendations and that the delivery system guarantees access to the IEHK in emergency situations.

Key lessons from the Gulbenkian Mental Health Platform workshops

Brazil – The workshop held in Rio de Janeiro was a unique opportunity to consider several aspects and features of the Brazilian reform of mental health services. For instance, there was general agreement that deinstitutionalization in the country was made possible thanks to the steady and progressive investment in and scale up of mental and social care services in community-based settings, which guarantee continuity of care of discharged patients, and where new hospital admissions are regulated.

India – The integration of physical and mental health care must be promoted not only at the primary but also at the secondary level of the health system. The workshop held in India in 2015 provided the opportunity to elucidate some existing misconceptions that task-shifting (sharing) models should be promoted across all levels of the health system, in particular in community-based settings.

Portugal – Social care services should be provided to those in adverse socioeconomic circumstances, to promote well-being, prevent mental disorders, and integrate mental health care and interventions in those with mental disorders. At the Portuguese workshop, there was an opportunity to consider the extent to which an economic crisis can disrupt both social and health-care services and their cohesiveness and integration, particularly at the primary level of care, and in community-based settings.

Georgia – All actions aimed at halting all forms of human rights violations against people with mental disorders must comply with the CRPD legal framework. National policies, laws and services are under the direct responsibilities of governments and must be consistent with international human rights instruments. However, an informed civil society can substantially influence and actively participate in governance too. These and other relevant remarks emerged during the workshop held in Tbilisi in 2016.

Cabo Verde – Irrational and inappropriate prescribing, dispensing and use of medicines is a common problem in all world regions. At the Gulbenkian workshop held in Cabo Verde in 2017 participants agreed that rational selection, availability and affordability of quality medicines are essential, but education and training initiatives for health staff on the use and monitoring of psychotropic medications are indispensable, in order to provide appropriate medicines to people with mental illnesses in community-based services. Health professionals remarked that appropriate use is further enhanced by public education about the importance, benefits, limits and side-effects of medicines, which contributes to shape correct expectations that people with mental disorders receive and use medicines appropriate to their clinical needs.

Objective 3: To implement strategies for promotion and prevention in mental health

Mental health promotion and prevention of mental disorders should form an integral part of national mental health policy. Promotion and prevention should combine universal and targeted strategies and interventions aimed at reducing stigma and discrimination and promoting the human rights of people with mental disorders. They should also increase public knowledge and understanding about mental health and its determinants.

Social determinants of mental health

A dominant hypothesis linking social status and mental disorders focuses on the level, frequency and duration of stressful experiences and the extent to which they are buffered by social supports in the form of emotional, informational or instrumental resources provided by or shared with others, and by individual capabilities and ways of coping. Mental health promotion and the prevention of mental disorders should encompass actions and interventions to tackle health inequalities that are appropriate for different stages of life. Most NCDs and mental disorders have a long induction (between exposure to the putative cause and the beginning of the disease) and latency periods (when the disease is detected or diagnosed), duration and timing, which remain largely unknown. A focus on early childhood and development is particularly important because there is strong evidence that several mental and physical health conditions that emerge and become clinically overt in adulthood originate in early life (Fryers and Brugha, 2013; Shonkoff et al, 2012). Stressors or suboptimal conditions experienced in sensitive developmental periods during early childhood may affect the function and structure of organs and systems, of neuronal mechanisms that regulate stress responses in the brain, and the expression of genes (Taylor, 2010). Social support and stable relationships with a caring adult can buffer the effect of stress on these systems (Shonkoff et al, 2009; Taylor, 2010). Therefore, social support in the family and the wider community is of fundamental importance, not only to reduce the exposure and long-term effects of unfavourable conditions and stressors, but also to favour the progressive making of the individual's resilience to future adverse events or circumstances, and the ability to cope actively in response to life challenges and stressors.

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Taking a life-course perspective recognizes that the influences that operate at each stage of life can change the vulnerability and exposure to harmful processes, or stressors. Social arrangements and institutions, like preschool, school, the labour market and pension systems have a significant impact on the opportunities that empower people to choose their own course in life. These social arrangements and institutions differ enormously and their structures and impacts are, to greater or lesser extent, influenced or mitigated by national and transnational policies. Further, investing in maternal education likely produces benefits for both mothers and infants and should be prioritized at a policy level through funding of home- and health facility-based antenatal and postnatal care. With the correct training and supervision of primary and community health-care workers, interventions implemented in LMICs can improve the mental health of mothers. Interventions may also benefit mothers by creating better employment opportunities for women and higher levels of income.

Integrating response to mental disorders and other chronic diseases

Determinants are factors that account for the underlying causes of a health condition. Mental disorders, other NCDs and communicable conditions share common determinants, including genetic and biological (genetics, family history, age, gender), cognitive and behavioural (low self-esteem, impulsivity, unhealthy diet, physical inactivity, tobacco use, substance abuse, unsafe sex) and social and environmental (low socioeconomic status, adverse life events, social exclusion). In turn, physical chronic conditions, including cancer, heart disease, diabetes and HIV/AIDS, are strongly associated with depression also, because of their associated psychological burden. For instance, depression, diabetes and HIV/AIDS, three prominent chronic conditions, share key risk factors, including inherited risk (a family history of the disease), the influence of behaviour on disease incidence, and the effect of socioeconomic position or deprivation on health status.

The existence and identification of common determinants of mental disorders and other chronic conditions, and the importance of exposure in early life have important implications for mental health promotion and for prevention, including the focus on reduction of exposure to risks throughout the life course, and the identification of population subgroups at higher risk who may be the target of tailored interventions aimed at preventing diseases or improving early detection of mental disorders in those with diagnosed NCDs, and vice versa.

The integration of mental and NCDs care and treatment holds the promise to improve both mental health outcomes and the detection and treatment of comorbid NCDs in those with mental disorders.

Improving access to and appropriate use of medicines

The mantra "start low go slow" describes the appropriate use of psychotropic medications. In general, pharmacological interventions should be started with a low dose within the therapeutic range and increase slowly to the lowest effective dose, to obtain benefit while reducing side-effects, and to optimize adherence. Here, prevention refers to reducing side-effects and to achieving the intended treatment outcome. For example, in the case of major depression, treatment should not be discontinued until the person is symptom free for 9–12 months. Monitoring once every three months as the person's symptoms improve is recommended; follow-up should continue to prevent new episodes. Close monitoring is also crucial to detect a manic episode in time, and antidepressants must be stopped immediately because they may trigger a manic episode in untreated bipolar disorder.

> Suicide contributes substantially to mortality, particularly among the youth, and it has a significant impact on the lives and mental health of very many families, communities and society at large. Although suicide is largely preventable, too often governments and policy-makers continue to consider suicide a low priority in their agendas. In fact, because several social, psychological, cultural and health-related factors interact with suicidal behaviour it is essential that governments develop and implement a suicide prevention strategy that outlines specific actions at multiple levels through the active involvement of the health, social and other relevant sectors.

In most countries, poor understanding, little awareness, and the persistence of stigma related to suicide are major obstacles to suicide prevention efforts.

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It is crucial that, within national suicide prevention strategies, governments and key stakeholders take action to raise awareness and mental health literacy in the general population, and to reduce stigma of suicidal behaviours. In 2014, WHO published the comprehensive global report *Preventing suicide: A global imperative*, which leveraged these research and public health advancements on suicide prevention (WHO, 2014e). With this report, WHO sent two important messages: suicide has enormous and ubiquitous impact, and it can be effectively prevented (see Appendix 2).

Key lessons from the Gulbenkian Mental Health Platform workshops

Brazil – The expansion of psychiatric wards in general hospitals was a key recommendation made at the Gulbenkian workshop held in Rio de Janeiro in 2015. This can encourage early detection of mental disorders and improve care and treatment outcomes. Further, the concomitant expansion of community-based services can substantially contribute to effective prevention programmes for mental disorders in all those who use primary and secondary health services.

India – The relationship between mental and physical health is bidirectional and is underpinned by common determinants, which modulate risk and influence prognosis. The recommendations made at the Indian workshop highlighted policy options and specific actions to promote the integration of mental disorders and other chronic diseases into health-care systems. Most of these recommendations are likely to improve primary, secondary and tertiary prevention of mental disorders acting at the susceptibility (risk reduction), subclinical or early clinical (improved prognosis), and the overtly clinical stage of mental illnesses (optimized function through effective rehabilitation).

Portugal – In other sections of this report we have emphasized the critical role that social determinants play in modulating the risk of mental disorders. Social interventions, including loans, money transfer, housing and employment programmes, have potent effects on mental well-being. A key message that emerged from the Gulbenkian workshop, during which the detrimental effects on mental health of the economic crisis were critically discussed, was that a strong education system is a powerful resource to promote better health for all, and prevent mental disorders.

Georgia – The Gulbenkian workshop held in Georgia provided the opportunity to reaffirm the importance of stopping institutionalization of children. If and when children cannot stay with their family and in their community, foster care was recommended as an alternative to placement in institutions. Foster care for children with disabilities has been used for therapeutic purposes in few countries. However, a strong system of accredited foster carers can play a crucial role to prevent suboptimal development and short- and long-term effects on mental health for all children who require non-permanent placement outside their family.

Cabo Verde – The appropriate use of medicines favours treatment adherence also thanks to better monitoring of side-effects. Several recommendations were made at the Gulbenkian workshop held in Cabo Verde, including the importance of regulating the availability, ensuring the quality, and monitoring the use of psychotropic medicines to help prevent adverse events, which negatively influence demand from those in need of pharmacological treatment. Effective prevention of adverse events can play a key part in breaking the cycle of poor demand, which leads to poor supply and availability of psychotropic medicines.

Objective 4: To strengthen information systems, evidence and research for mental health

Systematic monitoring and evaluation of progress are integral parts of the WHO comprehensive MHAP. Active surveillance systems with core indicators of health and social system actions, related to pre-specified targets of the plan, are indispensable to generating country level data and information on mental health needs and determinants. Systematic data collection is the basis of informed action to improve mental health service delivery and reform, and to provide appropriate, evidence-based care and treatment.

Monitoring and surveillance – As part of the MHAP, WHO encourages and prompts countries to report and submit core mental health indicators every two years to monitor progress and to allow comparisons between countries. The collective goal is to reduce the global burden of mental health through a coordinated and systematic health system response.

Research and evidence – Over the last few decades, evidence on the distribution and impact of mental disorders has accumulated. However, studies are skewed disproportionately towards high-income countries. Lacking are data on LMICs, where health and social systems are often inadequate to respond to the population's mental health needs. WHO encourages countries to establish academic collaborations, to invest in and improve their research capacity, and to conduct high-quality, ethical research to help them develop, implement and monitor mental health services in ways that respect the human rights of persons with mental disorders.

Social determinants of mental health

To implement action to prevent and ameliorate mental disorders at the local and national level, it is necessary to build systems and processes that collect data and that appropriately use and provide information. Different actions require different kinds of information, including on social, economic and environmental circumstances and stressors. Community engagement at the local level enables the local population to actively help identify sources of psychological distress, and assets and resources in their neighbourhoods, communities or regions. Information about how local educational, health-care and social services influence mental health and its social distribution is necessary to inform interventions designed to improve the social environment and reduce social inequalities and/or their effect on mental health. Local participatory processes may also enable community members to identify solutions, implement interventions, and contribute to the creation and maintenance of routine information systems and data collection for monitoring purposes.

Research and evidence on social determinants of common mental disorders, and on interventions and programmes aimed at preventing mental disorders, have expanded widely in recent years. This large corpus of research has benefited from the experience gained in, and the success of a large community of social and health scientists in the field of social determinants of health. Their work and successes have now been fully extended to mental health. The WHO/Gulbenkian paper *Social determinants of mental health*, published in 2014 (WHO, 2014c), is an important companion to the work and publications of the

WHO Commission of Social Determinants of Health, and the *WHO Review of social determinants of health and the health divide*. The current consensus, grounded in a significant body of good quality research conducted in both high-income countries and LMICs, is that the social circumstances into which a person is born, grows and ages are strongly associated with risk of mental disorders (Fryers et al, 2005; Lund et al, 2010). There is convincing evidence that the negative effects of unfavourable social circumstances on mental health can be effectively counteracted and modified through scalable actions that target individuals at risk, communities and the general population (Campion et al, 2013).

Innovation in deinstitutionalization

Deinstitutionalization requires, as a prerequisite, collection of data on individual residents in institutions to understand their problems and the resources available to them. This will help clarify how easy or difficult it will be for individuals to leave the institution and live in the community. Similarly, community services can only function if an efficient system guarantees rapid and accurate communication between multisectoral services and across the health system levels. Referral from primary to secondary to tertiary levels must run smoothly, for example, because specialists play a key role in supporting and supervising primary care health and social workers. At the system level, standardized mental health indicators can be used to integrate combined, routinely collected health and socio-demographic data with detailed mental health data from primary, secondary and tertiary services. This makes it possible to monitor the progress of deinstitutionalization. Disaggregating data by sex, age and other relevant socio-demographic characteristics provides crucial information to monitor and improve mental health services.

Integrating response to mental disorders and other chronic diseases

As discussed above (see Objective 2), it is pragmatic to integrate mental health into existing service delivery platforms for other chronic conditions, especially to meet the mental health-care needs of people with comorbid somatic and mental health diseases. Structural integration at community and primary care levels should aim to establish a single entry point to manage multiple diseases. This will require strengthening clinical information systems that track individuals and populations.

Improving access to and appropriate use of medicines

The use of routinely collected ecological and patient-level data (cross-linking different existing databases) can provide important information and be used to monitor use of psychotropic medicines. However, it should be stressed that aggregate data may be prone to “ecological fallacies” and that hypothesis-driven research initiatives are the optimal approach to establish whether use of medicines at a patient level is appropriate, safe and efficacious.

Evidence-based medicine (EBM) practice is the WHO-promoted approach to improving mental health globally. All actors involved in the provision of mental health care within and between the health and social sectors should be aware of the provenance and evidence-based approach of guidelines and recommendations. In addition, there should be a centralized (governmental) policy to support “pragmatic” randomized controlled trials (RCTs) – studies that attempt to answer to questions perceived as “urgent and relevant” at a clinical level, and are conducted in parallel with the usual clinical activities, and in the same settings and circumstances. The results of multi-centre RCTs have greater external validity,

and can better and more comprehensively inform practice at national and international level. However, participation in experimental research is still insufficient in LMICs. Participants should be encouraged to take part in large, international multi-centre RCTs that have the greatest potential to generate results relevant both for the local context and for the advancement of knowledge and understanding within the wider scientific community.

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The translation of results from research to clinical practice, and the transfer of knowledge from academia to services settings are often slow, inefficient and under-resourced. Resources should be allocated to train health professionals on critical appraisal of the scientific evidence, also to avoid the potentially biased continuing education funded by pharmaceutical companies. Access to unbiased information is crucial, and should be promoted "centrally" with appropriate policy decisions, and funding. Initiatives include the WHO Hinari Access to Research for Health Programme for LMICs (www.who.int/hinari/en), and the Plain Language Summaries of Cochrane Reviews – making research easy to understand, and easily and freely accessible. Once resources exist, health workers must be informed and their use of these resources encouraged and monitored.

Key lessons from the Gulbenkian Mental Health Platform workshops

During the intense, highly interactive discussions of all five Gulbenkian workshops it was clear to all that there is an urgent need for more and better data and evidence regarding several central questions and themes of mental health policy. Evidence on the cost-effectiveness of the shift from long-stay care to community-based services is lacking for most world regions. Data on violations of human rights rely primarily on case series or even case reports, rather than systematic, registry-based sources and monitoring systems. Although progress has been made in recent years, and funders are more prone to support implementation research, there is still limited evidence on social interventions aimed at promoting mental health, and preventing illnesses. New paradigms in the delivery of mental health services require sound, well-designed research programmes to prove effectiveness. For instance, preliminary evidence suggests that "housing first" for people with severe mental illnesses (whereby intensive case management programmes and interventions are preceded by ensuring housing provision, to first exit homelessness or expedite deinstitutionalization) can be beneficial to reduce homelessness in people with mental disorders. However, the cost-effectiveness and scalability of "housing first" remains largely uncertain, and there is still little dissemination of the positive and negative aspects, experiences and findings of the various kinds of "housing first" models.

The Gulbenkian trialogs highlighted the importance of constructive interactions amongst the various stakeholders in order to arrive at agreed recommendations and commitments aimed at improving the mental health of the population. However, formal evaluation and operational research of programmes and plans relevant for all recommendations made during the Gulbenkian workshops will be indispensable to monitor progress towards the implementation of the WHO MHAP.

The WHO's Global Health Observatory includes several mental health indicators and, in conjunction with the *Mental health atlas* (WHO, 2014d), is the most comprehensive surveillance system and source of information of the global health and mental health situation. WHO has also taken a leading role in setting research priorities in global mental health, with the aim to harmonize and promote the efficiency of global and national research agendas (see Appendix 2).

APPENDIX 1
WHO RESOURCES AND NORMATIVE PRODUCTS

In recent years, WHO has produced several documents and resources that policy-makers, public health professionals and relevant stakeholders worldwide can access, consult and use to implement the comprehensive MHAP. All mental health publications can be downloaded from the WHO website (http://www.who.int/mental_health/publications/en/), and hard copies can be ordered from the WHO bookshop. Here, we briefly describe the most relevant WHO normative products, and provide links to WHO electronic resources.

WHO Mental Health Gap Action Programme (mhGAP)

WHO's Mental Health Gap Action Programme (mhGAP) is intended to scale up care for MNS disorders. mhGAP is WHO's flagship programme in mental health; it probably has the most impact and provides tangible aid for countries attempting to provide universal health coverage for people affected by MNS disorders.

The *mhGAP-Intervention Guide* (mhGAP-IG) is a resource that provides evidence-based guidelines for improving mental health services in non-specialized health-care settings. The mhGAP-IG modules organize conditions by priority, and cover assessment, management and follow-up. mhGAP-IG should be implemented as part of a systems approach. Ideally, public health experts and managers should coordinate, so that the proposed interventions are supported by necessary infrastructure/resources, including the availability of essential psychotropic medicines. A separate module summarizes key steps in implementing mhGAP-IG. Because the mhGAP-IG is a model guide, it must be adapted to meet the national or local needs of those who want to implement the guidelines.

Comprehensive information and additional resources related to the mhGAP are available on the WHO website (http://www.who.int/mental_health/mhgap/en/), including the latest version of the *mhGAP Intervention Guide* (http://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/), the 2015 *mhGAP Guideline Update* (http://www.who.int/mental_health/mhgap/guideline_2015/en/) and the mhGAP Evidence Resource Centre. The Evidence Resource Centre contains the electronic version of background material, process documents, evidence profiles and recommendations for mhGAP guidelines for MNS priority disorders (http://www.who.int/mental_health/mhgap/evidence/en/).

Mental health atlas 2014

The WHO *Mental health atlas* was published in 2000, and updated in 2005, 2011 and 2014. It is the most comprehensive source of standard information on mental health situations worldwide, and is the best global surveillance mechanism for monitoring progress towards the overall goal of the WHO MHAP (http://www.who.int/mental_health/evidence/atlas/mental_health_atlas_2014/en/).

The Atlas contains a set of mental health indicators for the global targets of each of the four objectives of the MHAP, and contains other core mental health indicators too. The Atlas 2014 questionnaire covers critical areas of mental health system development, including governance and financing, human resources, service availability and delivery, promotion and prevention, and surveillance (at a country level). The information in the Atlas is obtained via a questionnaire sent to designated focal points in each WHO

Member State. The latest edition of the Atlas, from a 2014 survey, contains “baseline information” on how far each country has come to meeting the objectives and targets of the MHAP. This information will be supplemented by periodic Atlas surveys, sent to country focal points, monitoring progress towards the goal of meeting all targets by 2020.

ICD-11 (11th revision of the International Classification of Diseases)

The 11th revision of the ICD will be published in 2018 (http://www.who.int/classifications/icd/revision/en/). The WHO Department of Mental Health and Substance Abuse (MSD) took the lead in revising the International Classification of Diseases (ICD) chapter on mental and behavioural disorders. Its overarching goal was to develop a revised global classification system of mental, behavioural and neurodevelopmental disorders that maximizes scientific validity, clinical utility and global applicability (First et al, 2015). Clinical utility and global applicability are critical to the classification’s function as the interface between health encounters and global health information (Reed et al, 2013). The ICD is an essential tool for researchers, practitioners and policy-makers who understand, diagnose, treat and track mental health disorders around the world.

Excess mortality in persons with severe mental disorders

Excessive mortality among people with mental disorders has been consistently reported across studies: risk of death is two to three times higher than in the general population. Men and women diagnosed with severe mental disorders also live shorter lives, on average (20 years for men and 15 for women) (Wahlbeck et al, 2011). This large, unfair gap in life expectancy is both scandalous and largely avoidable. In 2015, WHO convened a consultation on excess mortality in persons with severe mental disorders, and reviewed the epidemiology, modifiable risk factors, programmes, guidelines and interventions. The consultation developed a policy and research agenda to decrease excess mortality in those with severe mental disorders. They built an intervention framework that focused on individual, health system and policy interventions (http://www.who.int/mental_health/evidence/excess_mortality_report/en/).

Mental health in humanitarian emergencies

The WHO resources and work on mental health in emergencies focuses mostly on resource-poor countries, where most populations exposed to natural disasters and war reside. At these times, the population’s need for basic services overwhelms local capacity, because local systems may have been interrupted by the emergency, or because the needs of adults and children affected by the emergency exceed what the system can provide. WHO has produced several documents on mental health in emergencies; all are available on the WHO website (http://www.who.int/mental_health/emergencies/en/) and some are described briefly below.

mhGAP Humanitarian Intervention Guide

The mhGAP Humanitarian Intervention Guide (mhGAP-HIG) is one of the key WHO documents for mental health and psychosocial support in humanitarian emergencies. The mhGAP-HIG gives specific and detailed instructions for reducing stress, and contains brief modules on assessing and managing a substantial and diverse range of MNS problems, including acute stress, grief, moderate-severe depressive disorder and post-traumatic stress disorder. The mhGAP-HIG is available in six languages on the WHO website (http://www.who.int/mental_health/publications/mhgap_hig/en/).

Scalable, low-intensity, psychological interventions

Often, people who live in urban slums, suffer through long-term humanitarian emergencies, live in camps for displaced people or experience other forms of adversity, do not have access to psychological interventions. Mental health professionals are scarce, and usually not trained in cognitive behavioural therapy (CBT) or interpersonal psychotherapy (IPT). The value of these psychological interventions is increasingly recognized. There is an expanding evidence base for programmes based on low-intensity, feasible interventions in least resources settings, and for the effectiveness of community-based services. For example, CBT and IPT, alone or in combination with pharmacological interventions, can effectively treat adult depression, and can successfully be delivered by general care providers.

WHO is giving more attention to and guidance for scalable psychological interventions, including recent manuals on simple CBT for perinatal depression, on group IPT for depression, and on a multi-component behaviour interventions (involving problem-solving counselling, behavioural activation, stress management, and strengthening social support) for common mental disorders among adults in communities affected by adversity (Problem Management Plus [PM+]).

WHO developed these manuals to respond to the urgent needs of tens of millions of people who live in extremely difficult circumstances and experience adversity that puts them at risk of developing mental health and social problems; these people face the greatest barriers to accessing health and social services and appropriate treatment.

Global strategy to reduce the harmful use of alcohol

The WHO's global strategy to reduce harmful use of alcohol (http://www.who.int/substance_abuse/activities/gsrhua/en/) adopted by the World Health Assembly in 2010, stresses the need for governments to adopt national, multisectoral policy options and interventions through their health ministries, bringing together all ministries and stakeholders.

Harmful use of alcohol kills about three million people a year. It takes a higher toll on the young and on those who are most vulnerable and disadvantaged. Harmful use of alcohol substantially increases the risk and worsens the prognosis of many other NCDs (cancer, cardiovascular, cirrhosis) and infectious diseases (HIV/AIDS, tuberculosis, sexually transmitted diseases). The relationship between harmful use of alcohol and mental and psychosocial disorders is complex. While some psychiatric symptoms may be alcohol-related, there are well-established alcohol-induced mental disorders, and any alcohol use can lead to alcohol use disorders.

Further, co-occurrence of alcohol use disorders and mental disorders is strongly associated with suicide and suicide attempts. Thus, WHO explicitly recommends coordinating alcohol prevention and treatment strategies with suicide prevention because alcohol consumption is related to suicide risks, and because coordinating joint policy and programme options and interventions generates synergistic opportunities. These interventions include actions to increase public and media awareness of the significance of the two problems, promoting responsible media reporting and attitudes, improving public information on access to and use of health services, improving health system response to alcohol-related health problems and suicidal behaviours, mobilizing community resources to assist and support families and acquaintances of those who drink, and of those who have attempted suicide or who are at greater individual risk of suicide.

Preventing suicide: A global imperative

Although mental health problems play a role that varies across different contexts, cultural factors and socioeconomic status are also very influential. It takes a wide-ranging effort across different sectors to prevent suicides, as well as coordination and support from government policy within an evidence-based conceptual framework. In most countries, poor understanding, little awareness and the persistence of stigma related to suicide are major obstacles to suicide prevention efforts. Therefore, it is crucial that, within national suicide prevention strategies, governments and key stakeholders take action to raise awareness and mental health literacy in the general population, and to reduce stigma of suicidal behaviours.

In 1996 WHO provided technical support and the United Nations published *Prevention of suicide: Guidelines for the formulation and implementation of national strategies* (WHO, 1996). For more than a decade, these guidelines inspired and guided more than 20 countries to develop national suicide strategies. Great advances have been made in the past years, and our knowledge of the suicide epidemiology, risk factors and interventions has significantly improved. In 2014, WHO published the comprehensive global report *Preventing suicide: A global imperative*, which leveraged these research and public health advancements on suicide prevention. With this report, WHO sent two important messages: suicide has enormous and ubiquitous impact, and it can be effectively prevented (http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/).

The report has been instrumental to developing and implementing national suicide prevention strategies that rely on effective and scalable, evidence-based actions and interventions, and a clear public health approach. The 2014 WHO report is a, comprehensive, evidence-based resource for policy-makers and other stakeholders who want to develop a timely and effective national response to lift the burden of suffering caused by suicide and suicide attempts from individuals, families, communities and society.

QualityRights Took Kit

Worldwide, people with mental disabilities, intellectual disabilities and substance abuse problems face poor-quality care and suffer violations of their human rights. Because mental health services often do not integrate evidence-based treatment and practices, recovery outcomes are poor. People with mental health conditions are stigmatized, excluded, rejected and marginalized. Stereotypes about those with mental disorders abound, and many members of the public (and even health-care workers) believe that those with mental health conditions cannot make decisions or take care of themselves, that they are dangerous to themselves or others, that they should be pitied, and that they rely on public welfare. These misconceptions deny them opportunities to work, get an education, and live fulfilling, independent lives in the community.

The WHO *QualityRights Tool Kit* offers countries practical information and tools for assessing and improving quality and human rights standards in mental health and social care facilities. The tool kit is inspired by and draws upon specific articles of the CRPD – the basis for human rights standards. The tool kit provides practical guidance on:

- The human rights and quality standards that should be respected, protected and fulfilled in both inpatient and outpatient mental health and social care facilities.
- Preparing for and conducting a comprehensive assessment of facilities.
- Reporting findings and making appropriate recommendations based on the assessment.

The electronic version of the WHO *QualityRights Tool Kit* can be downloaded from the WHO website (http://www.who.int/mental_health/publications/QualityRights_toolkit/en/). A paperback version (with CD-ROM) is also available.

MiNDbank

WHO created the world's largest database of resources covering mental health, substance abuse, disability, general health, human rights and development. MiNDbank (http://www.mindbank.info/) is part of the WHO QualityRights campaign to improve the quality of services and promote the rights of people with mental, psychosocial and intellectual disabilities. MiNDbank is a central easy access point for a wide range of national and international resources that span policies, strategies and laws, treaties, and United Nations and WHO resolutions. MiNDbank promote national resource sharing and best practices across countries, and reduces fragmentation and duplication of information and efforts across and within countries. Its multidisciplinary and holistic approach facilitates advocacy and promotes research, encompassing human rights, mental and physical health.

Maternal mental health

Mental disorders in women who have just given birth are very common, particularly in LMICs. Maternal mental disorders can and should be treated for the sake of both mother and child, since a mother's mental disorder can affect a child's growth and development. The WHO *Thinking healthy* manual (http://www.who.int/mental_health/maternal-child/thinking_healthy/en/) takes an evidence-based approach, describing how well-trained non-specialist health providers can deliver an effective intervention to reduce perinatal depression.

Child and adolescent mental health

Neuropsychiatric conditions and mental disorders in children and adolescents are common worldwide, and have a significant impact on child development. A comprehensive module in the mhGAP-IG covers assessing and managing developmental, behavioural and emotional disorders in children and adolescents. WHO also collaborated with Member States and partner agencies to respond to the largely unmet needs and promote the human rights of children with autism spectrum disorders and other developmental disorders (http://www.who.int/mediacentre/factsheets/autism-spectrum-disorders/en/). In 2014, the World Health Assembly adopted a resolution on "Comprehensive and Coordinated Efforts for the Management of Autism Spectrum Disorders". The clear set of actions set out in the resolution is explicitly linked to the WHO comprehensive MHAP. Members States, which unanimously approved the resolution, are urged to design and implement a wide range of interventions and to define a clear policy aimed at improving the provision of integrated health and social services to persons with autism spectrum disorders and their families.

iSupport (for caregivers of people with dementia)

iSupport is an online training programme for caregivers of persons with dementia. It helps caregivers understand dementia and quality of care, and it reduces the burden on informal caregivers. Detailed information about iSupport is on the WHO website (http://www.who.int/mental_health/neurology/dementia/isupport/en/). iSupport is currently being field tested (https://www.isupportfordementia.org/en).

Research prioritization

In addition to developing evidence-based guidelines, normative products and resources, WHO has taken a lead role in identifying challenges and setting global research priorities in the fields of intellectual disability (Tomlinson et al, 2009), global mental health (Collins et al, 2011), mental health in emergencies (Tol et al, 2011) and dementia (Shah et al, 2016). Research prioritization exercises are based on standard international procedures, including the Child Health and Nutrition Research Initiative (CHNRI) method (Rudan et al, 2008), where the collaboration between several hundred of stakeholders and experts from all world regions is orchestrated in a series predefined steps that elicit, consolidate, score and rank research questions.

The goal of prioritization exercises is to reduce disease burden in the most realistic, equitable and cost-effective way. Other goals include improving health system efficiency, scientific discovery, development and delivery of effective interventions, and, more widely, disseminating effective education materials about modifiable risks. Research prioritization exercises use standardized, evidence-based methods to advance knowledge and gather evidence. Research priorities draw attention to gaps, inform and harmonize global and national research agendas, so policy-makers and funders can plan investment and design policy efficiently and effectively.

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POLICY OPTIONS ON MENTAL HEALTH: A WHO-GULBENKIAN MENTAL HEALTH PLATFORM COLLABORATION

This is the final report of the six-year collaboration between the WHO Department of Mental Health and Substance Abuse and the Gulbenkian Global Mental Health Platform, an initiative of the Calouste Gulbenkian Foundation aimed at reducing the global burden of mental health through the development and application of evidence and good practices to global mental health. This final report constitutes a comprehensive and practical source of information and inspiration for national policy and decision-makers, legislators, justices, opinion shapers, and professional, formal and informal mental health workers willing to contribute to strengthening the response of all sectors to the still largely unmet needs of people with mental disorders, through the implementation of the WHO Mental Health Action Plan at national level. The report cross references the evidence assembled under the five key areas that were identified and prioritized by WHO and the Gulbenkian Mental Health Platform and the experience generated by country workshops conducted in Brazil, Cabo Verde, Georgia, India and Portugal. This report identifies 32 policy options to promote and strengthen the implementation of the WHO MHAP.

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