mhGAP Mental Health Gap Action Programme

Scaling up care for mental, neurological, and substance use disorders

World Health Organization

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Foreword

Mental health is fundamental to health. This is reflected by the definition of health in the WHO Constitution as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". Research conducted in recent years has brought to our attention that mental health inherently affects physical health and physical health affects mental health. The two are inseparable in terms of achieving a more complete state of wellness.

Mental health is paramount to personal well-being, family relationships, and successful contributions to society. It is related to the development of societies and countries. Mental ill-health and poverty interact in a negative cycle: mental ill-health impedes people's ability to learn and to engage productively in their economies, and poverty in turn increases the risk for developing mental disorders, and reduces people's ability to gain access to health services.

The sheer numbers of people affected, the associated disability due to mental, neurological and substance use disorders, and the fact that effective treatment is available emphasizes the importance of addressing them in primary care. Our goal is to see that mental health is integrated into health care systems across the globe.

Much more effort is required to change policy, practice and service delivery systems to ensure mental health needs and concerns receive the level of priority necessary to reduce the burden associated with mental, neurological and substance use disorders. There should be no more excuses for marginalizing funding for the delivery of mental health services. We need to ensure that the area of mental health receives its fair share of public health resources.

WHO's *Mental Health Gap Action Programme* (*mhGAP*) makes a case for enhancing the political commitment of governments, international organizations and other stakeholders. *mhGAP* identifies the strategies to scale up coverage of key interventions for priority conditions in resource-constrained settings.

I invite partners to join WHO in making *mhGAP* a success.

Dr Ala Alwan
Assistant Director-General
Noncommunicable Diseases and Mental Health

Preface

Mental, neurological, and substance use disorders are highly prevalent and burdensome worldwide. The violations of human rights directed towards people with these disorders compound the problem. The resources that have been provided to tackle the huge burden are insufficient, inequitably distributed, and inefficiently used, which results in a large majority of people with these disorders receiving no care at all.

The World Health Organization (WHO) has recognized the need for action to reduce the burden, and to enhance the capacity of Member States to respond to this growing challenge. The WHO mental health Global Action Programme was endorsed by the 55th World Health Assembly in 2002. The programme has led to advocacy initiatives along with providing normative guidance to Member States in improving their health systems to deliver care to people with mental, neurological and substance use disorders. Mental health is now on the global public health agenda!

However, the task is far from complete. The gap between what is urgently needed and what is available to reduce the burden is still very wide. The next phase, *Mental Health Gap Action Programme (mhGAP),* presented in this document reflects the continued commitment of WHO to closing the gap. *mhGAP* is the WHO action programme developed for countries especially with low and lower middle incomes for scaling up services for mental, neurological, and substance use disorders. The essence of *mhGAP* is partnerships to reinforce and to accelerate efforts and increase investments towards providing services to those who do not have any.

I am pleased to present *mhGAP* to the global health community and look forward to the directions and actions that it will inspire.

Dr Benedetto Saraceno
Director
Department of Mental Health and Substance Abuse

Executive summary

Mental, neurological, and substance use (MNS) disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality. 14% of the global burden of disease, measured in disability-adjusted life years (DALYs), can be attributed to MNS disorders. The stigma and violations of human rights directed towards people with these disorders compounds the problem. The resources that have been provided to tackle the huge burden of MNS disorders are insufficient, inequitably distributed, and inefficiently used, which leads to a treatment gap of more than 75% in many countries with low and lower middle incomes.

In order to reduce the gap and to enhance the capacity of Member States to respond to the growing challenge, the World Health Organization (WHO) presents the *Mental Health Gap Action Programme (mhGAP)*. *mhGAP* provides health planners, policy-makers, and donors with a set of clear and coherent activities and programmes for scaling up care for MNS disorders.

The objectives of the programme are to reinforce the commitment of all stakeholders to increase the allocation of financial and human resources for care of MNS disorders and to achieve higher coverage with key interventions especially in the countries with low and lower middle incomes that have large proportions of the global burden of these disorders.

Since countries with low and lower middle incomes have most of the global burden, and because they have limited human and financial resources, a strategy that focuses on these countries has the potential for maximum impact. *mhGAP* provides criteria to identify the countries which contribute most to the burden of MNS disorders and which have a high resource gap.

This programme is grounded on the best available scientific and epidemiological evidence about MNS conditions that have been identified as priorities. It attempts to deliver an integrated package of interventions, and takes into account existing and possible barriers for scaling up care. Priority conditions were identified on the basis that they represented a high burden (in terms of mortality, morbidity, and disability); caused large economic costs; or were associated with violations of human rights. These priority conditions are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. The *mhGAP* package consists of interventions for prevention and management for each of these priority conditions, on the basis of evidence about the effectiveness and feasibility of scaling up these interventions. *mhGAP* provides a template for an intervention package that will need to be adapted for countries, or regions within countries, on the basis of local context.

The obstacles that hinder the widespread implementation of these interventions must also be considered, together with the options that are available to deal with them. *mhGAP* provides a framework for scaling up the interventions for MNS disorders, taking into account the various constraints that might exist in the country.

Success in implementation of the programme rests, first and foremost, on political commitment at the highest level. One way to achieve this is to establish a core group of key stakeholders who have multidisciplinary expertise to guide the process. Assessment of needs and resources by use of a situation analysis can help to understand the needs related to MNS disorders and the relevant health care, and thus to guide effective prioritization and phasing of interventions and strengthening of their implementation. Development of a policy and legislative infrastructure will be important to address MNS disorders and to promote and protect the human rights of people with these disorders.

Decisions will need to be made as to how best to deliver the chosen interventions at health facility, community, and household levels to ensure high quality and equitable coverage. Adequate human resources will be needed to deliver the intervention package. The major task is to identify the people who will be responsible for the delivery of interventions at each level of service delivery.

Most countries with low and middle incomes do not assign adequate financial resources for care of MNS disorders. Resources for delivery of services for these disorders can be mobilized from various sources – e.g. by attempts to increase the proportion allocated to these conditions in national health budgets; by reallocation of funds from other activities; and from external funding, such as that provided through developmental aid, bilateral and multilateral agencies, and foundations.

The *mhGAP* framework also includes plans for monitoring and evaluation of programme planning and implementation. Selection of inputs, processes, outcomes, and impact indicators, together with identification of tools and methods for measurement, are an integral part of the process.

The essence of *mhGAP* is to establish productive partnerships; to reinforce commitments with existing partners; to attract and energize new partners; and to accelerate efforts and increase investments towards a reduction of the burden of MNS disorders. Scaling up is a social, political, and institutional process that engages a range of contributors, interest groups, and organizations. Successful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community. An urgent commitment is needed from all partners to respond to this public health need. The time to act is now.

The challenge and the need

Mental, neurological, and substance use (MNS) disorders are prevalent in all regions of the world and are major contributors to morbidity and premature mortality. Worldwide, community-based epidemiological studies have estimated that lifetime prevalence rates of mental disorders in adults are 12.2–48.6%, and 12-month prevalence rates are 8.4–29.1%. 14% of the global burden of disease, measured in disability-adjusted life years (DALYs), can be attributed to MNS disorders. About 30% of the total burden of noncommunicable diseases is due to these disorders. Almost three quarters of the global burden of neuropsychiatric disorders is in countries with low and lower middle incomes. The stigma and violations of human rights directed towards people with these disorders compounds the problem, increasing their vulnerability; accelerating and reinforcing their decline into poverty; and hindering care and rehabilitation. Restoration of mental health is not only essential for individual well-being, but is also necessary for economic growth and reduction of poverty in societies and countries (Box 1). Mental health and health security interact closely. Conditions of conflict create many challenges for mental health (Box 2).

Box 1: Mental health and human development

Mental health is crucial to the overall well-being of individuals, societies, and countries. The importance of mental health has been recognized by WHO since its origin, and is reflected by the definition of health in the WHO constitution as "not merely the absence of disease or infirmity", but rather, "a state of complete physical, mental, and social well-being". Mental health is related to the development of societies and countries. Poverty and its associated psychosocial stressors (e.g. violence, unemployment, social exclusion, and insecurity) are correlated with mental disorders. Relative poverty, low education, and inequality within communities are associated with increased risk of mental health problems.

Community and economic development can also be used to restore and enhance mental health. Community development programmes that aim to reduce poverty, achieve economic independence and empowerment for women, reduce malnutrition, increase literacy and education, and empower the underprivileged contribute to the prevention of mental and substance use disorders and promote mental health.

Box 2: Mental health and health security

Health security is threatened at the individual, community, national, and international levels by conditions of rapid urbanization, natural disasters, violence, and conflicts. Rapid urbanization creates conditions in which the use of alcohol and other psychoactive substances increases. Violence and conflicts often increase harmful use of alcohol or drugs and, vice versa, alcohol and drug use disorders are associated with violence and criminal behaviour. In many emergencies – whether caused by natural disasters, violence, or war – the prevalence of mental distress and disorders rises and the capacity of formal and non-formal systems of care decreases markedly, which results not only in enormous suffering and disability but also in delayed recovery and rebuilding efforts.

Mental, neurological, and substance use disorders are linked in a complex way with many other health conditions. These disorders are often comorbid with, or act as risk factors for, noncommunicable diseases (e.g. cardiovascular disease and cancer), communicable diseases (e.g. HIV/AIDS and tuberculosis), sexual and reproductive health of mothers (e.g. increased gynaecological morbidity, sexual violence, maternal depression, and childhood development), and injuries (e.g. violence and road traffic accidents). Depression and substance use disorders also adversely affect adherence to treatment for other diseases.

Despite the prevalence and burden of MNS disorders, a large proportion of people with such problems do not receive treatment and care. A large multicountry survey supported by WHO showed that 35–50% of serious cases in developed countries and 76–85% in less-developed countries had received no treatment in the previous 12 months. A review of the world literature found treatment gaps to be 32% for schizophrenia, 56% for depression, and as much as 78% for alcohol use disorders. Many population-based studies have shown that more than 95% of people with epilepsy in many resource-poor regions do not receive adequate treatment. Country examples also illustrate the seriousness of the situation: only 11% of severe cases of mental disorder in China had received any treatment in the previous 12 months; and only 10% of treated people in Nigeria had received adequate treatment.

WHO has recognized the need for action to reduce the burden of MNS disorders worldwide, and to enhance the capacity of Member States to respond to this growing challenge. In 2001, the general public, national and international institutions and organizations, the public health community, and other stakeholders were reminded of the issue of mental health. Through the World Health Day, World Health Assembly, and World Health Report (*Mental Health: New Understanding, New Hope*), WHO and its Member States pledged their full and unrestricted commitment to this area of public health.

The WHO mental health Global Action Programme followed from these events to provide a coherent strategy for closing the gap between what is urgently needed and what is available to reduce the burden of mental disorders worldwide. The programme was endorsed in 2002 by the 55th World Health Assembly (WHA 55.10), which urged Member States to increase investments in mental health both within countries and in bilateral and multilateral cooperation.

The four core strategies identified by the programme were information, policy and service development, advocacy, and research. Comprehensive and sustained efforts by WHO and partners have substantially increased the available information about the prevalence, burden, resources, and evidence for interventions related to MNS disorders. Awareness about the importance of mental disorders for public health has greatly increased, and has put mental health on the policy agenda. Many countries have developed or revised their policies, programmes, and legislation related to these disorders.

Figure 1: Burden of mental disorders and budget for mental health

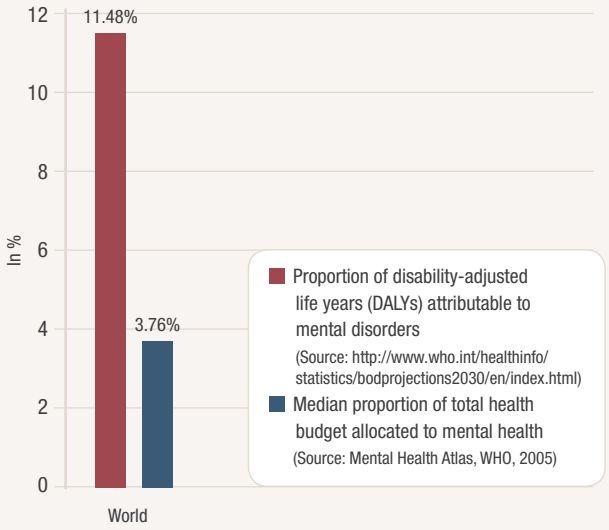
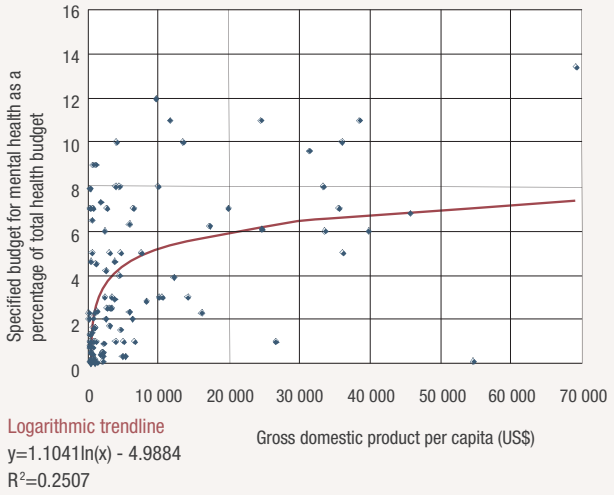


Figure 2: Association between specified budget for mental health as a proportion of total health budget and GDP per capita for 101 countries



(Source: *Mental Health Atlas*, WHO 2005)

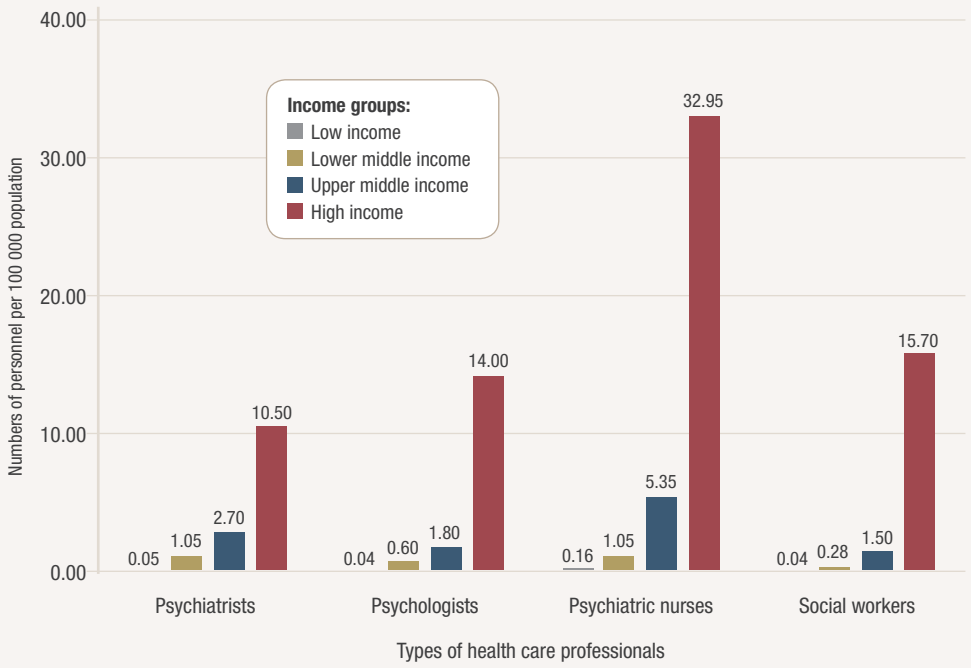
However, the resources provided to tackle the huge burden of MNS disorders have remained insufficient. Almost a third of countries still do not have a specific budget for mental health. Of the countries that have a designated mental health budget, 21% spend less than 1% of their total health budgets on mental health. Figure 1 compares the burden of mental disorders with the budget assigned to mental health; it shows that countries allocate disproportionately small percentages of their budgets to mental health compared with their burdens.

The scarcity of resources is further compounded by inequity in their distribution. Data from WHO's Atlas Project illustrate the scarcity of resources for mental health care in countries with low and middle incomes. Although most countries assign a low proportion of their health budgets to mental health, for countries with low gross domestic product (GDP), this proportion is even smaller (figure 2).

The scarcity of resources is even greater for human resources; figure 3 presents the distribution of human resources for mental health across different income categories.

There is also inefficiency in the use of scarce and inequitably distributed resources. For example, many middle-income countries that have made substantial investments in large mental hospitals are reluctant to replace them with community-based and inpatient facilities in general hospitals, despite evidence that mental hospitals provide inadequate care and that community-based services are more effective.

Figure 3: Human resources for mental health care in each income group of countries, per 100 000 population



(Source: *Mental Health Atlas*, WHO 2005)

Progress to organize services for people with MNS disorders thus needs to be accelerated; and allocation of more resources to these areas will be critical to this process.

WHO has received an increasing number of requests from countries for assistance and country-specific action. The need for – and relevance of – an economic perspective in planning, provision, and assessment of services, and for scaling up care for MNS disorders is another reason to revise the focus of the mental health strategy. Moreover, a comprehensive programme for action can inspire stakeholders and accelerate progress by bringing together partners with a common purpose.

Another stimulus for revision of the mental health strategy has been the recent publication of a *Lancet* series on global mental health, which addressed mental health issues in countries with low and middle incomes. The series culminated in a call for action to the global health community for scaling up services for mental health care in these countries. The series concluded that the evidence and solutions for dealing with the global burden of mental health are at hand. What is needed is political will, concerted action by a range of global health stakeholders, and the resources to implement them. The situation is similar for neurological and substance use disorders.

Mental Health Gap Action Programme

WHO aims to provide health planners, policy-makers, and donors with a set of clear and coherent activities and programmes for scaling up care for mental, neurological and substance use disorders through the *Mental Health Gap Action Programme (mhGAP).*

Objectives

- To reinforce the commitment of governments, international organizations, and other stakeholders to increase the allocation of financial and human resources for care of MNS disorders.
- To achieve much higher coverage with key interventions in the countries with low and lower middle incomes that have a large proportion of the global burden of MNS disorders.

Strategies

This programme is grounded on the best available scientific and epidemiological evidence on priority conditions. It attempts to deliver an integrated package of interventions, and takes into account existing and possible barriers to scaling up care.

Priority conditions

A disease area can be considered a priority if it represents a large burden (in terms of mortality, morbidity or disability), has high economic costs, or is associated with violations of human rights. The area of mental, neurological and substance use consists of a large number of conditions. The priority conditions identified by the above criteria for *mhGAP* are depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. These disorders are common in all countries where their prevalence has been examined, and they substantially interfere with the abilities of children to learn and with the abilities of adults to function in their families, at work, and in broader society. Because they are highly prevalent and persistent, and cause impairment, they make a major contribution to the total burden of disease. Disability is responsible for most of the burden attributable to these disorders; however, premature mortality – especially from suicide – is also substantial. The economic burden imposed by these disorders, includes loss of gainful employment, with the attendant loss of family income; the requirement for caregiving, with further potential loss of wages; the cost of medicines; and the need for other medical and social services. These costs are particularly devastating for poor populations. Annex 1 summarizes the burden created by these disorders and the links with other diseases and sectors. Moreover, MNS disorders are stigmatized in many countries and cultures. Stigmatization has resulted in disparities in the availability of care, discrimination and in abuses of the human rights of people with these disorders.

Intervention package

Considerable information about the cost effectiveness of various interventions for reduction of the burden of MNS disorders is now available. Although it is useful to determine which interventions are cost effective for a particular set of disorders, this is not the end of the process. Other criteria need to be considered in decisions about which interventions to deliver, such as the severity of different disorders (in terms of suffering and disability), the potential for reduction of poverty in people with different disorders, and the protection of the human rights of those with severe MNS disorders.

The package consists of interventions for prevention and management for each of the priority conditions, on the basis of evidence about the effectiveness and feasibility of scaling up these interventions. In this context, an intervention is defined as an agent or action (biological, psychological, or social) that is intended to reduce morbidity or mortality. The interventions could be directed at individuals or populations, and were identified on the basis of their efficacy and effectiveness, cost effectiveness, equity, ethical considerations including human rights, feasibility or deliverability, and acceptability.

Interventions cannot be provided as freestanding activities, but should instead be delivered in a variety of packages and through different levels of a health system. Delivery of interventions as packages has many advantages, and is the most cost-effective option in terms of training, implementation, and supervision. Many interventions go naturally together because they can be delivered by the same person at the same time – e.g. antipsychotics, and family and community interventions for treatment of schizophrenia.

Table 1 presents a template for interventions for each of the priority conditions which can be adapted to the situation in different countries.

This template will need to be adapted for countries or regions on the basis of the prevalence and burden of each of the priority conditions; evidence about efficacy, feasibility, cost, and acceptability of the interventions

Table 1: Evidence-based interventions to address the priority conditions

Condition	Evidence-based interventions	Examples of interventions to be included in the package
Depression	• Treatment with antidepressant medicines • Psychosocial interventions	• Treatment with older or newer antidepressants by trained primary health-care professionals. • Psychosocial interventions such as cognitive behaviour therapy or problem solving. • Referral and supervisory support by specialists.
Schizophrenia and other psychotic disorders	• Treatment with antipsychotic medicines • Family or community psychosocial interventions	• Treatment with older antipsychotics by trained primary health-care professional within community setting. • Community-based rehabilitation. • Referral and supervisory support by specialists.
Suicide	• Restriction of access to common methods of suicide • Prevention and treatment of depression, and alcohol and drug dependence	• Multisectoral measures that relate to public health, such as restriction of availability of most toxic pesticides, and storage of supplies in secure facilities. • See examples of interventions for depression, disorders due to use of alcohol, and disorders due to use of illicit drugs.

Condition	Evidence-based interventions	Examples of interventions to be included in the package
Epilepsy	• Identification and treatment with antiepileptic medicines	• Treatment with first-line antiepileptic medicines by trained primary health-care professionals. • Referral and supervisory support by specialists.
Dementia	• Interventions directed towards caregivers	• Basic education about dementia and specific training on management of problem behaviours by trained primary health-care professionals.
Disorders due to use of alcohol	• Comprehensive policy measures aimed at reduction of harmful use of alcohol • Interventions for hazardous drinking and treatment of alcohol use disorders with pharmacological and psychosocial interventions	• Policy and legislative interventions including regulation of availability of alcohol, enactment of appropriate drink-driving policies, and reduction of the demand for alcohol through taxation and pricing mechanisms. • Screening and brief interventions by trained primary health-care professionals. • Early identification and treatment of alcohol use disorders in primary health care. • Referral and supervisory support by specialists.
Disorders due to illicit drug use	• Pharmacological and psychosocial interventions, including agonist maintenance treatment for opioid dependence	• Psychosocially assisted pharmacotherapy of opioid dependence using opioid agonists such as methadone or buprenorphine. • Early identification and provision of prevention and treatment interventions for drug use disorders by trained primary health-care professionals. • Referral and supervisory support by specialists.
Mental disorders in children	• Prevention of developmental disorders • Pharmacological and psychosocial interventions	• Measures within health sector such as provision of skilled care at birth, effective community-based services for maternal and child health care, prenatal screening for Down's syndrome, and prevention of alcohol abuse by mothers. • Multisectoral measures that relate to public health such as fortification of food with iodine and folic acid, and interventions to reduce child abuse. • Identification and initial care in primary health-care settings. • Referral and supervisory support by specialists.

in specific contexts; health system requirements for implementation (including financial and human resource implications); and cultural choices, beliefs, and health-seeking behaviours in specific communities. The priorities and the methods used will inevitably vary between settings. Thus the intervention packages and the delivery of the packages might differ between countries, and even between different areas in the same country. For example, in many low-income countries, more than three quarters of the population live in rural areas. Few services,

including human resources, reach such areas. The shortage of human resources thus demands pragmatic solutions. Community workers – after specific training and with necessary back-up, e.g. phone consultations with general practitioners – can deliver some of the priority interventions.

Identification of countries for intensified support

Most of the global burden of mental, neurological, and substance use disorders occurs in countries with low and lower middle incomes. These countries not only have the highest need to tackle this burden but also the fewest resources available to do so. The conceptual principle of *mhGAP* is that since a small number of low-income and lower middle-income countries contribute most to the global burden, and have comparatively few human and financial resources, a strategy that focuses on mental health care in these countries has the potential for maximum impact. *mhGAP* thus aims to provide criteria to identify the countries with low and lower middle incomes which have the largest burdens of MNS disorders and the highest resource gap, and to provide them with intensified support. It should be noted, however, that the framework *mhGAP* provides for country action is adaptable and can be used in any country where the possibility for technical support exists. Therefore, this process does not mean denial of support to other countries.

Selection of countries for intensified support could use many criteria. One criterion could be the burden of MNS disorders. The approach used in the Global Burden of Disease project was to use DALYs as a summary measure of population health across disease and risk categories. For example, total DALYs can be used as a measure of disease burden to identify the countries with low and lower middle incomes which have the highest burdens of priority conditions. DALYs per 100 000 population can also be used to measure disease burden. This criterion is useful to ensure that countries with small populations but high rates of MNS burdens are included. Another criterion could be gross national income (GNI) per capita, which is indicative of the relative poverty of countries.

Annex 2 provides a list of countries with low and lower middle incomes that have been identified for intensified support by use of these criteria. The countries were selected from three lists of countries for each of the six WHO regions. The first list rank-ordered countries by the total number of lost DALYs. The top four contributing countries from each of the six WHO regions were selected from this list. The second list rank-ordered countries by MNS burden rate. Any country from the top four contributing countries from each of the six WHO regions, which was not already selected from the previous list, was included. The third list rank-ordered countries by their GNI per capita. Any country from the top four poorest countries from each of the six WHO regions, which was not already selected from the previous lists, was included. Most of the identified countries, also have few resources available for health and a large resource gap, as evident from the scarcity of health providers and mental health professionals in these countries.

Another criterion could be the country's readiness for scaling up. Although "hard" indicators to measure a country's readiness do not exist, "soft" indicators could include any request for support from the country for scaling up activities in the area of MNS disorders; any previous or ongoing collaboration between WHO and the country; or any donor interest.

Scaling up

Scaling up is defined as a deliberate effort to increase the impact of health-service interventions that have been successfully tested in pilot projects so that they will benefit more people, and to foster sustainable development of policies and programmes. However, pilot or experimental projects are of little value until they are scaled up to generate a larger policy and programme impact. Until now, practical guidance about how to proceed with scaling up has been inadequate. *mhGAP* aims to identify general approaches and specific recommendations for the process of scaling up.

Scaling up involves the following tasks:

- identification of a set of interventions and strategies for health-service delivery, and planning of a sequence for adoption of these actions and of the pace at which interventions can be implemented and services expanded;
- consideration of obstacles that hinder the widespread implementation of the selected interventions, and the options that are available to deal with these obstacles; and
- assessment of the total costs of scaling up and sustaining interventions in a range of generalizable scenarios.

These tasks require a clear understanding of the type and depth of constraints that affect a country's health system. Such constraints could operate at different levels, such as community and household, health-service delivery, health-sector policy and strategic management, cross-sectoral public policies, and environment and context. One paper in the recently published *Lancet* series on global mental health reviewed barriers to development of mental health services through a qualitative survey of international mental health experts and leaders (box 3).

However, the barriers discussed in box 3 refer only to constraints on scaling up the supply of mental health services, whereas uptake is equally important for efficient delivery of services. Evidence suggests that demand-side barriers can deter patients from accessing available treatment, especially if they are poor or vulnerable. Barriers to uptake of mental health services include costs of access; lack of information; and gender, social, and cultural factors.

Box 3: Barriers to development of mental health services

The greatest barrier to development of mental health services has been the absence of mental health from the public health priority agenda. This has serious implications for financing mental health care, since governments have allocated meagre amounts for mental health within their health budgets, and donor interest has been lacking.

Another barrier identified was organization of services. Mental health resources are centralized in and near big cities and in large institutions. Such institutions frequently use a large proportion of scarce mental health resources; isolate people from vital family and community support systems; cost more than care in the community; and are associated with undignified life conditions, violations of human rights, and stigma. However, both downsizing mental hospitals and making care available in the community will entail challenges.

The third barrier to development of mental health services, which relates to organization of services, is the complexity of integrating mental health care effectively with primary care services. The systems that provide primary health care are overburdened; they have multiple tasks and high patient loads, little supervision and few functional referral systems, and a discontinuous supply of essential medicines. Limitations in human resources also contribute to this barrier, because low numbers and types of health professionals have been trained and supervised in mental health care.

Finally, a major barrier is likely to be the lack of effective public health leadership for mental health in most countries.

Source: Saraceno B et al. Barriers to the improvement of mental health services in low-income and middle-income countries. *Lancet,* 2007; 370:1164–1174.

Framework for country action

mhGAP aims to provide a framework for scaling up interventions for mental, neurological, and substance use disorders. The framework takes into account the various constraints which might exist in different countries. However, the programme is only intended as a guide for action, and should be flexible and adaptable enough to be implemented according to the situation in different countries.

The approach described in *mhGAP* has been designed to be consultative and participatory, to take account of national needs and resources, and to build on existing programmes and services. More specifically, it aims to provide guidance on the main steps in framework development.

Political commitment

Success in implementation of the programme rests, first and foremost, on achievement of political commitment at the highest level, and acquisition of the necessary human and financial resources. One way to achieve these prerequisites could be to establish a core group of key stakeholders who have multidisciplinary expertise to guide the process. Existing mechanisms to bring together relevant stakeholders should be assessed before the decision to set up a new group. Key stakeholders who need to be involved in the process include policy-makers, programme managers from relevant areas (such as essential medicines and human resources), communication experts, and experts from community development and health systems. The programme will need inputs from psychiatric, neurological, and primary care health professionals; social scientists; health economists; key multilateral and bilateral partners; and nongovernmental organizations (NGOs). Service users are also important stakeholders and their inputs will be essential.

Assessment of needs and resources

A situation analysis should provide a thorough understanding of the needs related to MNS disorders and the relevant health care, and help to guide effective prioritization and phasing of interventions and strengthening their implementation. Although available data might be limited (e.g. they may not be nationally representative or might vary in quality) information should be collected using existing sources as far as possible.

The situation analysis involves several tasks:

- describe the status of the burden of MNS disorders for the country, region, or selected population;

- identify human, financial and material resource requirements taking into account existing health sector plans and development strategies (box 4);
- examine the coverage and quality of essential interventions, and any reasons for low or ineffective coverage;
- describe any current policies that are relevant to MNS disorders and the status of their implementation, any current spending on these disorders, and the principal partners involved; and
- synthesize the information to highlight important gaps that must be addressed for scaling up care for MNS disorders. SWOT analysis, to identify strengths, weaknesses, opportunities, and threats, is a useful approach for this task.

Development of a policy and legislative infrastructure

A supportive policy environment aids the process of scaling up interventions for MNS disorders because policies define a vision for the future health of the population, and specify the framework to be put in place to manage and prevent priority MNS disorders. Policies need to be grounded in the principles of respect for human rights, and of fulfilment, promotion, and protection of those rights. When clearly conceptualized, a policy can coordinate essential services and activities to ensure that treatment and care are delivered to those in need, and that fragmentation and inefficiency in the health system are prevented. The Mental Health Policy and Service Guidance Package that has been developed by WHO consists of a series of practical, interrelated modules, designed to address issues related to the reform of mental health systems. This Guidance Package can be used as a framework to assist countries to create policies and plans, and then to put them into practice.

Actions required:

- draft or revise policy to set out its vision, values, and principles, its objectives, and key areas for action;
- incorporate existing knowledge about improvement of treatment and care and prevention of MNS disorders;
- involve all relevant stakeholders;
- work with other relevant sectors, and review other relevant policies; and
- develop means for implementation of the policy.

Mental health legislation is also essential to address MNS disorders. Mental health law codifies and consolidates the fundamental principles, values, aims, and objectives of mental health policies and programmes. It provides a legal framework to prevent violations, to promote human rights, and to address critical issues that affect the lives of people with mental disorders. WHO has developed the *Resource Book on Mental Health, Human Rights and Legislation*, which describes international standards for the rights of people with mental disorders; key issues that need to be considered and included in national mental health law; and best-practice strategies for development, adoption, and implementation of mental health law.

Box 4: WHO assessment for mental health systems

WHO has developed a tool, the WHO *Assessment Instrument for Mental Health Systems* (WHO-AIMS), to collect essential information on the mental health system of a country or region. This instrument has been developed for the specific needs of countries with low and middle incomes. It includes many input and process indicators and ordinal rating scales that facilitate the data collection process, since data are often not available for outcome indicators in many of these countries. WHO-AIMS produces comprehensive assessments and covers links with other sectors. For example, WHO-AIMS assesses the services and supports that are provided in primary care for people with mental disorders, and includes items which are highly relevant to countries with low and middle incomes such as paraprofessional primary health care workers and traditional healers. The instrument can also be easily adapted to collect data for neurological and substance use disorders.

Source: http://www.who.int/mental_health/evidence/WHO-AIMS/en/index.html

Delivery of the intervention package

Decisions about how best to deliver the chosen interventions at health facility, community, and household levels are critical to ensure maximum impact, high quality, and equitable coverage of the interventions. Delivery of the package depends on the capacity of health services, available financial, human, and material resources, and the community context. Key considerations for delivery of services include:

- design of responsibility for implementing interventions at different levels of the health system;
- integration into existing services;
- development of implementation strategies for community, primary, and referral facility levels that will achieve high coverage of the chosen interventions;
- strengthening of health systems;
- improvement of links between communities and the health system;
- development of strategies to reach populations with special needs; and
- development of strategies to deal with special situations, such as emergencies.

mhGAP calls for mental health to be integrated into primary health care. Management and treatment of MNS disorders in primary care should enable the largest number of people to get easier and faster access to services; many already seek help at this level. Integration of mental health into primary health care not only gives better care; it also cuts wastage resulting from unnecessary investigations and from inappropriate and non-specific treatments.

Health systems will need additional support to deliver the interventions. The drugs, equipment, and supplies that need to be available at each level of service delivery need to be identified, and mechanisms for their sustained supply need to be developed. Appropriate referral pathways and feedback mechanisms between all levels of service delivery will need to be strengthened.

An epilepsy project in rural China has demonstrated delivery of services through existing systems, and integration of the model of epilepsy control into local health systems. The results confirmed that epilepsy patients could be treated with phenobarbital through local primary care systems by town clinic physicians and rural doctors with basic training. The methods used in this project should be suitable for extension in rural areas of China, and perhaps in other developing countries. In fact, after the success of the initial study, the project was extended with support from the central Government to include 34 counties in China, with 19 million people. 1500 local physicians have been trained and more than 10 000 people with epilepsy have been treated.

Delivery of a package of interventions will require fostering of community mobilization and participation, and of activities that aim to raise awareness and improve the uptake of interventions and the use of services.

Planning for delivery of the intervention package also needs to incorporate populations with special needs (e.g. different cultural and ethnic groups or other vulnerable groups such as indigenous populations). The approach used for delivery of services must be gender sensitive. Gender differences create inequities between men and women in health status. In addition, gender differences result in differential access to and use of health information, care, and services (e.g. a woman might not be able to access health services because norms in her community prevent her from travelling alone to a clinic).

Implementation should be planned to encompass specific situations such as emergencies. Given the very limited capacity of the mental health system in countries with low and middle incomes, provision of such assistance to populations affected by disasters is a difficult task. People with severe pre-existing mental disorders are particularly vulnerable in emergency situations. However, emergencies can also catalyse mental health reforms, since the consequences of emergencies for the mental health and psychosocial well-being of people have gained the interest of the media, professionals, and the general public. Professionals

have become aware of increased rates of mental disorders after emergencies, and the public, including politicians, have become concerned about mental health consequences after emergencies. This tends to provide unprecedented opportunities for development of mental health systems in the months and years after an emergency, and improvements in service organization can occur very rapidly in these contexts.

Strengthening of human resources

Human resources with adequate and appropriate training are necessary for scaling up all health interventions, and especially for MNS conditions, since care for these conditions relies heavily on health personnel rather than on technology or equipment. Most countries with low and middle incomes have few trained and available human resources, and often face distribution difficulties within countries or regions (e.g. too few staff in rural settings or too many staff in large institutional settings). The problem has been exaggerated by migration of trained professionals to other countries. Moreover, staff competencies might be outdated or might not meet the population's needs. The available personnel might not be used appropriately and many might be unproductive or demoralized. Infrastructure and facilities for continuous training of health workers in many low-income countries are lacking. Development and upgrading of human resources are the backbone of organizational capacity building and one of the primary challenges of scaling up. The goal for human resources is simple but complex to reach – to get the right workers with the right skills in the right place doing the right things.

For each intervention package, a specific category of health personnel should be identified to take responsibility for delivery of the interventions at each level of service delivery. For example, primary health care professionals can treat most cases of epilepsy with first-line antiepileptic medicines, whereas complex cases need to be referred to a specialist. Access to health services can be improved by involving multiple cadres at various levels of the health system. Where doctors and nurses are in short supply, some of the priority interventions can be delivered by community health workers – after specific training and with the necessary supervision. For many priority conditions, delivery should be implemented with a stepped-care model, which consists of clearly defined roles for each level of care from primary to highly specialized care. This requires relevant training for each level of health professional.

Identification of additional skills that might be required by each category of health professional is also necessary. Skills might need to be strengthened, and new skills might need to be acquired. For example, primary health-care professionals could need training in psychosocial interventions for schizophrenia. The next step is to decide how these additional skills will be built.

Key actions include:

- appropriate pre-service and in-service training of different cadres of health professionals with curricula that are needs-based and fit-for-purpose;
- improvement of access to information and knowledge resources;
- development of supportive supervision; and
- development of simplified diagnostic and treatment tools.

In the short to medium term, in most countries, investment in in-service training will be needed. At the same time, early efforts should be made to strengthen the basic curriculum (pre-service training).

Strategies are needed to develop specialists, to manage and treat complex cases, to provide ongoing supervision and support to non-specialists, and to teach and train other health professionals.

Mobilization of financial resources

Most countries with low and middle incomes do not assign adequate financial resources for care of MNS disorders. Mobilization of the necessary financial resources for scaling up is therefore an important task. Accurate costing is a necessary first step, to set

Box 5: Cost of scaling up mental health care in countries with low and middle incomes

A recent study assessed the resource needs and costs associated with scaling up a package of essential interventions for mental health care over 10 years. The core package for this project comprised pharmacological and psychosocial treatments of three mental disorders – schizophrenia, bipolar disorders, and depression – and brief interventions for one risk factor – hazardous alcohol use.

Scaling up of cost-effective interventions was modelled within an overall service framework in which most users of mental health care were treated at primary care level, with referral of complex cases to more specialist services. The target coverage was set at 80% for schizophrenia and bipolar disorders, and at 25% and 33% for hazardous alcohol use and depression, respectively. The need for human resources to deliver the package was based on previous studies that assessed this requirement.

The cost per year of scaling up the core package to target those in need was calculated as the product of five factors: total adult population × adult annual prevalence × service coverage × rate of use × unit cost of service. Other costs associated with programme management, training and supervision, and capital infrastructure were also calculated. For example, at existing level of service coverage, the annual expenditures for the healthcare package were estimated to be US$ 0.12 per person for Ethiopia and US$ 1.25 per person for Thailand. However, to reach the target coverage in 10 years' time, the total expenditure in Ethiopia would need to increase by 13 times (to US$ 1.58 per person) and by three times in Thailand (to US$ 4 per person).

The results suggested that the extra cost of scaling up mental health services over 10 years to provide extensive coverage of the core package should be feasible in absolute terms, although challenging.

Source: Chisholm D, Lund C, Saxena S. The cost of scaling up mental health care in low- and middle-income countries. *British Journal of Psychiatry,* 2007; 191: 528–535.

realistic budgets and to estimate resource gaps, before resources can be mobilized. Different types of cost estimates will be required for different purposes. WHO has developed a costing tool to estimate the financial costs of reaching a defined coverage level with a set of integrated interventions. A recent study calculated the resource needs and costs associated with scaling up a core package of interventions for mental health care in selected countries with low or middle incomes (box 5).

Although the estimated investments are not large in absolute terms, they would represent a substantial departure from the budget allocations currently accorded to mental health. If the total health budget remained unchanged for 10 years, delivery of the specified package for mental health care at target coverage would account for half of total spending on health in Ethiopia, and 8.5% of the total in Thailand. Thus health budgets need to be increased, especially in low-income countries.

Another important implication of this modelling exercise is that the delivery of mental health services needs to be changed. In particular, institutionally based models of care need to be replaced by community-based care, and more evidence-based interventions need to be introduced.

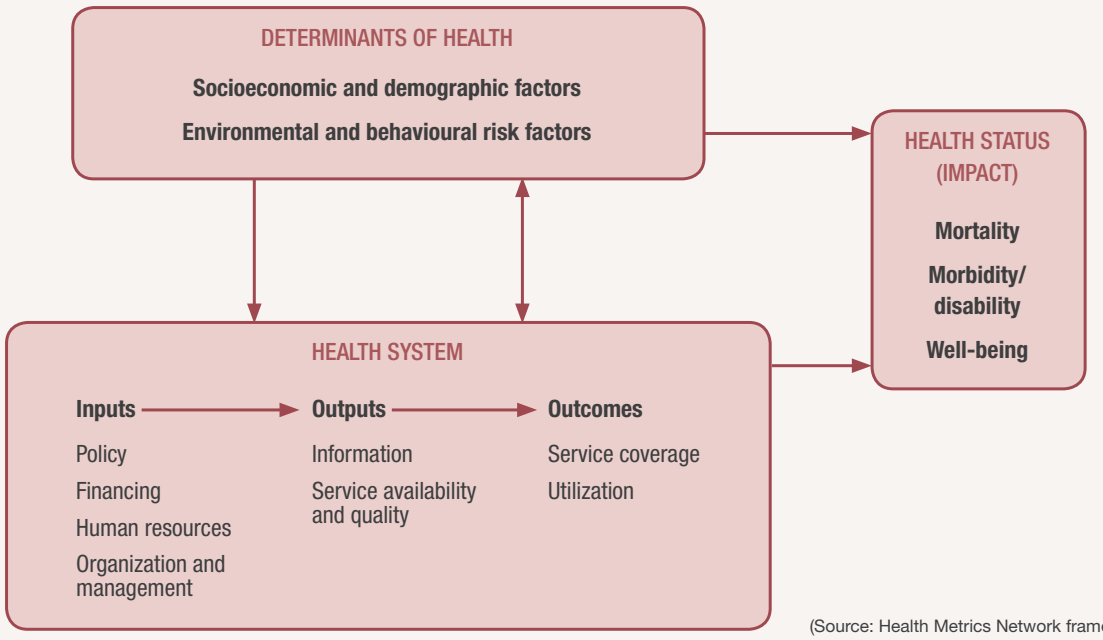
A further example is a study that estimated the avertable burden of epilepsy and the population-level costs of treatment with first-line antiepileptic medicines in developing countries across nine WHO subregions. It showed that extension of coverage of treatment with antiepileptic medicines to 50% of primary epilepsy cases would avert 13–40% of the existing burden, at an annual cost per person of 0.20–1.33 international dollars. At a coverage rate of 80%, the treatment would avert 21–62% of the burden. In all the nine subregions, the cost to secure one extra healthy year of life was less than the average income per person.

For sustainability, the marginal costs of strengthening the services for MNS disorders should be minimized by building on existing strategies and plans. Funding from governments will be required to deliver services for MNS disorders, and this will require that stakeholders argue their case determinedly. If strategies for MNS disorders could be integrated with the governmental development plans for other sectors, sustained investment and resources for this area could be secured.

Resources for delivery of services for MNS disorders can be mobilized from various sources:

- The proportion of the budget allocated to these conditions within national health budgets could be increased. The *Mental Health Atlas* has demonstrated that almost a third of countries do not have a specified budget for mental health. Even those countries which do budget for mental health, allocate only a small proportion of funds to this area – 21% of them spend less than 1% of their total health budgets on mental health. Advocacy to encourage countries to increase this proportion will be important.
- Funds could be reallocated to the intervention package from other activities. If, in the short term, the percentage of the health budget that is allocated to mental health cannot be increased, it might be possible to reallocate resources from mental hospitals to community-based services, since evidence has shown that they are more effective and cost effective than hospitals.
- External funding could be used. Since the health budgets of many countries with low or middle incomes are very low, scaling up of mental health care will typically require funding from external or donor sources. Countries can access additional sums through special funding initiatives such as those provided through developmental aid, bilateral and

Figure 4: Framework for measurement of health information



(Source: Health Metrics Network framework, 2007)

multilateral agencies, and foundations. Identification of external resources – ideally within a time frame that can maintain momentum and reduce delays – is a key task for the scaling-up process.

A strategy for mobilization of resources based on assessment of needs and resources and plan of action should be developed. WHO could support focal points for MNS disorders within countries to prepare proposals, to identify specific activities, and to fund the scaling up of services for MNS disorders.

Monitoring and evaluation

The phrase "what gets measured gets done" summarizes the importance of monitoring and evaluation for the planning and implementation of the programme. The scope of monitoring and evaluation reflects the scope of the implementation plan. The process should incorporate selection of indicators and identification of tools and methods for measurement. Each country will need to decide which indicators to measure and for what purpose; when and where to measure them; how to measure them; and which data sources to use. Countries will also need to plan for analysis and use of the data.

The indicators for measurement can be programme inputs and activities, programme outputs, outcomes, and impact/health status (figure 4).

Only a few universal indicators exist, and every scaling-up strategy needs to include its own indicators. Examples of input indicators include:

- the number of sites in the country that implement the scaling up strategy;
- the extent to which management methods and procedures are developed;
- the presence of an official policy, programme, or plan for mental health;
- a specified budget for mental health as a proportion of the total health budget; and
- the proportion of the total expenditure for mental health that is spent on community-based services.

Examples of output indicators include:

- the proportion of facilities for primary health that have trained health professionals for diagnosis and treatment of MNS disorders; and
- the proportion of facilities for primary health that have supplies such as essential medicines for MNS disorders.

An example of an outcome indicator is:

- the number of people treated each year for MNS disorders as a proportion of the total estimated yearly prevalence of MNS disorders.

Examples of impact/health status indicators include:

- the prevalence and burden (DALYs) of MNS disorders; and
- deaths from suicide and the rate of self-inflicted injuries.

Decisions about the frequency of measurement of the selected output indicators should be based on the implementation phase of activities. Generally, output indicators are measured on a continual basis and should be reviewed to readjust plans for activities every 1–2 years. Indicators of outcome and health status are measured periodically, usually at 3–5 years. Several methods could be used to obtain data that are needed for calculation of priority indicators. The data sources include reports from health facilities, supervisory visits, auditing of health facilities, national or district programme records, health facility or provider surveys, household surveys, and special studies to investigate specific issues.

Building partnerships

A programme is only as good as the effective action that it generates. Fundamental to *mhGAP* is the establishment of productive partnerships – i.e. to reinforce existing partners, attract and energize new partners, accelerate efforts, and increase investments to reduce the burden of mental, neurological, and substance use disorders. No one individual or organization can succeed in meeting the challenge; implementation of the programme thus calls for increased political will, public investment, awareness of health workers, involvement of families and communities, and collaboration between governments, international organizations, and other concerned parties.

WHO has an important role to play since it is the lead technical agency for health. Its structure is organized around staff who are based at headquarters, regional offices, and country offices. This structure is uniquely suited for implementation of country-based programmes. WHO's medium-term strategic plan (http://www.who.int/gb/e/e_amtsp.html) envisages unified objectives and strategies to achieve these objectives, and contributions from the distinctive but complementary capacities of various WHO offices. WHO is well placed to systematically implement key activities that have been identified in the framework of country action. WHO's Department of Mental Health and Substance Abuse, in consultation with their regional offices, has taken the lead in developing this strategy. Building partnerships among WHO programmes as well as with other stakeholders is key to the implementation of *mhGAP*.

Box 6: Inter-Agency Standing Committee *Guidelines On Mental Health And Psychosocial Support In Emergency Settings*

The guidelines were developed by 27 agencies and have been endorsed by the IASC, which consists of heads of UN agencies, intergovernmental organizations, Red Cross and Red Crescent agencies, and large consortia of NGOs. The process of development of the guidelines has greatly enhanced collaboration between agencies. The guidelines are founded on the principles of human rights, participation, building on available resources, integrated care, multilayered supports, and avoidance of harm. Many agencies are now applying these guidelines, and WHO encourages donors to use them as a key reference when deciding resource allocation. The guidelines are envisaged to lead to more effective use of resources for care of mental and substance use disorders. The guidelines use a multisectoral framework, and describe the first steps to protect mental health and psychosocial support during an emergency.

Website: http://www.humanitarianinfo.org/iasc/content/products/docs/Guidelines%20IASC%20Mental%20Health%20Psychosocial.pdf

UN agencies

Many international organizations have a health agenda – e.g. UNICEF. Scaling up needs partnerships across the different agencies so that scarce financial resources are fairly allocated. One such example is mental health in emergencies. Aid for mental health in emergencies probably needs authoritative guidelines and interagency collaboration more than any other area. Therefore, in 2007, WHO initiated and co-chaired a taskforce that developed the Inter-Agency Standing Committee (IASC) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (box 6).

Government ministries

The most important partners for country action are government ministries. Each government needs to take responsibility for the planning and implementation of their strategic plan. Since WHO is a multinational organization, it can bring together countries which share geographical, social, and cultural ties, and which also have similar issues or difficulties with MNS disorders, to join forces and learn from each other's experiences. The Pacific Island Mental Health Network (PIMHnet) is an example of such an innovative partnership (box 7).

Donors

Both multilateral and bilateral donors are increasingly funding the health sector. Strong advocacy is needed to place MNS disorders on the priority agenda of donors for health assistance to countries with low and middle incomes, and to provide a substantial increase in resource allocation for these disorders. However, an increase in finances is not enough. These resources need to be distributed equitably and used efficiently. Public health bodies and other professional communities in countries with low and middle incomes need to be active partners in enabling this distribution to happen.

Box 7: Pacific Island Mental Health Network (PIMHnet) – forging partnerships to improve mental health care

The WHO Pacific Islands Mental Health Network (PIMHnet), which was launched during the Pacific Island meeting of health ministers in Vanuatu in 2007, has brought together 16 nations of the Pacific Islands. Working together, network countries are able to draw on their collective experience, knowledge, and resources to promote mental health and develop systems for mental health that provide effective treatment and care in these nations.

In consultation with countries, PIMHnet has identified several priority areas of work, including: advocacy; human resources and training; mental health policy, planning, legislation, and service development; access to psychotropic medicines; and research and information. Network countries meet every year to develop workplans that outline major areas for action to address these priorities. These workplans need to be officially endorsed by ministers of health. Formally appointed focal points in all countries provide coordination and liaison between the PIMHnet members and with the network secretariat and the in-country team.

An important strategy of PIMHnet has been the forging of strategic partnerships with NGOs and other agencies working in the Pacific Region to reduce the existing fragmentation of activities for mental health; to develop coordinated and effective strategies to address the treatment gap; to improve mental health care; and to put an end to stigma, discrimination, and violations of human rights for people with mental disorders.

Website: http://www.who.int/mental_health/policy/country/pimhnet/en/index.html

NGOs and WHO collaborating centres

NGOs that operate locally, nationally, and internationally can contribute in many ways to the implementation of this programme (box 8). For example, bodies of health professionals can contribute by ensuring that basic education and training for all health workers includes management of MNS disorders. Other important partners involved in implementation of this programme are the network of WHO collaborating centres.

Box 8: ILAE/IBE/WHO *Global Campaign Against Epilepsy*

About 50 million people worldwide have epilepsy, and many more are affected by its consequences as relatives, friends, employers, and teachers. 80% of those with epilepsy live in developing countries, of whom 80% are not appropriately treated despite the availability of interventions that are both effective and inexpensive.

The need for a global effort against this universal disorder is compelling. The three leading international organizations that work in the area of epilepsy (International League Against Epilepsy [ILAE], International Bureau for Epilepsy [IBE], and WHO) joined forces in 1997 to create the *Global Campaign Against Epilepsy.* The campaign aims to improve provision of information about epilepsy and its consequences, and to assist governments and those concerned with epilepsy to reduce its burden.

So far, over 90 countries are connected with the campaign. As part of general efforts to raise awareness, regional conferences have been organized, and regional declarations developed and adopted. Regional reports have been developed to define the current challenges and offer appropriate recommendations. The assessment of country resources has been undertaken within the Atlas Project and *Atlas Epilepsy Care in the* World, which summarized the data for available resources for epilepsy care from 160 countries.

One activity to assist countries in the development of their national programmes for epilepsy is demonstration projects. The ultimate goal of these projects is the development of various successful models of epilepsy control that can be integrated into the health care system of the participating country.

The success of *Global Campaign Against Epilepsy* is largely attributable to the collaboration of NGOs, such as ILAE and IBE, with WHO.

Website: http://www.who.int/mental_health/management/globalepilepsycampaign/en/index.html

Civil society

Civil society including service users, caregivers, and family members are key partners for improving services. The involvement of users/patients and their caregivers is an important aspect of the care and treatment extending across health and social care. Stakeholders in the social sector should assist with the provision of social supports for people with MNS disorders, building on local resources and generating external resources as needed. The involvement of service users and their families in the planning and delivery of services for MNS disorders has gathered considerable momentum over the last decade. The voices of user movements are instrumental in campaigning for, and bringing about, changes in attitudes towards those experiencing these illnesses. An example is the *Global Forum for Community Mental Health* (box 9).

Box 9: *Global Forum for Community Mental Health*

The progress made towards the establishment of community services for mental health is generally agreed to have been rather slow, despite evidence that these services are the most effective for fostering of mental health and respect for human rights. WHO has convened the *Global Forum for Community Mental Health* to give extra impetus to this area. The mission of the *Global Forum for Community Mental Health* is to provide a caring and supportive network for all those interested in promotion of services for community mental health for people with serious mental illnesses. This forum provides a foundation for sharing information, and providing mutual support and a sense of belonging for users, families, providers, and all those who are interested in shifting mental health care from long-term institutions to effective community-based care. The forum is organized on a partnership basis; the existing partners include BasicNeeds, the Christian Blind Mission, and the World Association for Psychosocial Rehabilitation. The UK Department of Health is actively assisting the forum. User and family groups have also been strongly involved.

The first *Global Forum for Community Mental Health* meeting was organized in May, 2007, in Geneva. Two regional workshops are planned every year, in addition to the global meeting. The regional workshops will provide opportunities to small NGOs to derive the necessary support for their tasks related to mental health care in the community and to generate best practices to be implemented by others.

Website: http://www.gfcmh.com/

The time to act is now!

Mental, neurological, and substance use disorders are prevalent and cause a substantial public health burden. They are associated with poverty, marginalisation, and social disadvantage. Stigma and violations of human rights of people with MNS disorders add to the problem. Effective interventions to reduce this burden are available and can be implemented even in settings where resources are scarce.

Coverage of service for MNS disorders in all countries, but particularly in countries with low and middle incomes, needs to be scaled up so that the available care is proportionate to the amount of need. *mhGAP* aims to put mental health on the global priority agenda for public health. *mhGAP* envisages scaling up care for a set of priority conditions with use of an intervention package that is both evidence based and feasible. It advocates for committed sustained support and coordinated efforts to help countries to improve the coverage and quality of services. It provides vision and guidance about how to respond to this public health need.

Scaling up mental health care is a social, political, and institutional process that engages many contributors, interest groups, and organizations. Governments, health professionals for MNS disorders, civil society, communities, and families, with support from the international community, are all jointly responsible for successfully undertaking this scaling up process. The way forward is to build innovative partnerships and alliances. Commitment is needed from all partners to respond to this urgent public health need. The time to act is now!

Annex 1:

Public health burden associated with priority conditions included in *mhGAP*

For priority conditions included in *mhGAP,* the table summarizes the MNS burden, and its links with other diseases and sectors.

Priority condition	Burden	Links with other diseases	Links with other sectors
Depression	Single largest contributor to non-fatal burden and is responsible for a high number of lost DALYs worldwide. Fourth leading cause of disease burden (in DALYs) globally and is projected to increase to second leading cause in 2030. Lifetime estimate of prevalence for either major depressive disorder or dysthymia is 4.2–17% (weighted mean 12.1%).	A risk factor for suicide and many noncommunicable diseases such as stroke, coronary heart disease, and type 2 diabetes. Comorbid depression is a predictor of adverse outcome – e.g. increased mortality after myocardial infarction. Infection with HIV-1 is associated with increased occurrence of depression; adherence to antiretroviral therapy is adversely affected by comorbid depression. Adherence to antiretroviral therapy has been shown to improve when comorbid depression is treated. Comorbid depression also affects adherence to treatment for other health conditions such as diabetes and tuberculosis. Postpartum depression has negative consequences for the early relationship between mother and infant and for the child's psychological development. Maternal depression is a risk factor for infant stunting. Mothers suffering from depression may delay seeking help for their child with potentially serious illnesses.	
Schizophrenia and other psychotic disorders	Lifetime risk for schizophrenia is 0.08–0.44%, and 0.64–1.68% for non-affective psychoses. Lifetime prevalence estimate for non-affective psychoses is 0.3–1.6%. 1.1% of total DALYs lost are because of schizophrenia. 2.8% of total years lived with disability are due to schizophrenia, since the disorder is associated with early onset, long duration, and severe disability.	Risk factor for suicide. Substance use commonly occurs with schizophrenia. Maternal schizophrenia is consistently associated with preterm delivery and low birth weight.	Schizophrenia is one of the most stigmatizing disorders, resulting in violations of human rights and discrimination in areas such as employment, housing, and education.

Priority condition	Burden	Links with other diseases	Links with other sectors
Suicide	Suicide is the third leading cause of death worldwide in people aged between 15 and 34 years, and it is the 13th leading cause of death for all ages combined. About 875 000 people die from suicide every year. Suicide worldwide represents 1.4% of the disease burden (in DALYs).	High rates of suicide are associated with mental disorders such as depression and schizophrenia and with alcohol and drug dependence.	Childhood adversities including physical, emotional, and sexual abuse are associated with high risk for suicide. Suicide results from many complex sociocultural factors and is most likely to occur during situations of socioeconomic, family, and individual crisis (e.g. loss of a loved one, loss of employment, partner abuse, or domestic violence). Easy access to lethal means such as pesticides is related to high rates of suicide.
Epilepsy	The prevalence of active epilepsy globally is 5–8 per 1000 population. Epilepsy affects about 50 million people worldwide, about 80% of whom live in developing countries. The risk of premature death in people with epilepsy is two to three times higher than it is for the general population.	Prenatal or perinatal causes (obstetric complications, prematurity, low birth weight, and neonatal asphyxia) are risk factors for development of epilepsy. Other causes include traumatic brain injuries, infections of the central nervous system, cerebrovascular disease, brain tumours, and neurodegenerative diseases.	Epilepsy imposes a hidden burden associated with stigmatization, discrimination, and violations of human rights against people in the community, workplace, school, and home.
Dementia	About 24.3 million people have dementia worldwide, and this number is predicted to double every 20 years. 60% of people with dementia live in developing countries. Studies in developing countries have shown that the prevalence of dementia ranges from 0.84% to 3.5%. Family caregivers provide great support for people with dementia, who can have substantial psychological, practical, and economic difficulties. In the USA, the yearly cost of informal care was $18 billion per year (in 1998).	Treatment of underlying disease and risk factors for cardiovascular disease can help prevent future cerebrovascular disease that could lead to multi-infarct dementia. Other disorders, such as hypothyroidism or vitamin B12 deficiency, which could lead to or aggravate dementia, are easily treatable, and the costs of treatment are much lower than are the costs of dementia care.	Dementia presents employment issues for caregivers and a burden to the welfare sector.

Priority condition	Burden	Links with other diseases	Links with other sectors
Disorders due to use of alcohol	4.4% of the worldwide burden of disease is attributable to alcohol consumption. Neuropsychiatric disorders due to alcohol use, including alcohol dependence, account for 34% of the burden of disease and disability that is attributable to alcohol. In some countries of the Americas and Eastern Europe, the estimated prevalence of disorders from alcohol use is around 10%. Even though most high-risk drinkers worldwide are men, women are seriously affected by alcohol abuse, (e.g. domestic violence related to alcohol).	Alcohol consumption is causally related to more than 60 international classification of disease codes, including liver damage, pancreatic damage, suicides, unintentional injuries, and hormonal disturbances.	Disorders due to the use of alcohol affect social services, fiscal sector, services for law enforcement and criminal justice, fire services, transport, traffic regulations, the alcohol industry, the agricultural sector, tourism, hospitality and the entertainment industry.
Disorders due to use of illicit drugs	200 million people worldwide were estimated to have used illicit drugs in 2005–06. In developed countries, the economic cost of illicit-drug use has been estimated to be 0.2–2% of gross domestic product. Illicit use of opioids was estimated to account for 0.7% of global DALYs in 2000. The estimated number of injecting drug users worldwide is about 13 million. Cannabis is the most widely used illicit drug – 3.8% of the global population older than 15 years use this drug. Despite the fact that cannabis use accounts for about 80% of illicit drug use worldwide, the mortality and morbidity that is attributable to its use are not well understood, even in developed countries.	Dependent heroin users have an increased risk of premature death from drug overdoses, violence, suicide, and causes related to alcohol. 5–10% of new HIV infections worldwide are attributable to use of injection drugs because of sharing of contaminated equipment. Disorders due to use of illicit drugs are associated with an increased risk of other infectious diseases such as hepatitis B and C.	Disorders due to use of illicit drugs affect social services, criminal justice systems, educational sectors, and road traffic safety.

Priority condition	Burden	Links with other diseases	Links with other sectors
Mental disorders in children	Mental disorders in young people tend to persist into adulthood. Conversely, mental disorders in adults often begin in childhood or youth. Roughly 50% of mental disorders in adults begin before the age of 14 years. The burden of mental disorders in children and adolescents has not been adequately identified in terms of DALYs. A study done in Sudan, the Philippines, Colombia, and India showed that between 12% and 29% of children aged 5–15 years had mental health problems. In a study of Nigerian children and adolescents, 62.2% of new referrals to the clinic had had substantial psychosocial stressors in the year before presentation. A prevalence of 17.7% of behavioural disorders in children has been reported in western Ethiopia. The prevalence of intellectual disabilities (mental retardation) from developing countries has been reported to vary from 0.09% to 18.3%.	Children and adolescents who are orphans due to the death of their parents from HIV/AIDS, or who are infected themselves, are at risk for development of neuropsychological consequences. Other concerns associated with poor mental health among children and adolescents are violence, and poor reproductive and sexual health. Alcohol and drug use are major risk factors for mental disorders in adolescents. The most important preventable causes of intellectual disability are protein or energy malnutrition, iodine deficiency, birth trauma, and birth asphyxia.	Armed conflict is known to affect child and adolescent mental health. Displacement from homes, families, communities, and countries because of war or other emergencies can lead to depression, suicide, substance use, or other problems in children. Child soldiering and prostitution can hinder the psychological development of children. Education, social services, foster and residential care, and the criminal justice system are all burdened by mental disorders in children.

Annex 2:

Burden attributable to mental, neurological, and substance use disorders and the available human resources in countries with low and lower middle incomes

Countries with low and lower middle incomes by WHO region	World Bank income category	Gross national income per capita (US$ 2006)	Population in thousands (2002)	MNS disorders DALYs (in thousands)	MNS disorders DALYs per 100 000	Mental health professionals (per 100 000)	Health providers (per 1000)
African Region							
Algeria	LM	3030	31 266	431	1377.5	3	3.36
Angola	LM	1980	13 184	212	1605.2	<0.001	1.27
Benin	Low	540	6558	94	1440.6	1.27	0.88
Burkina Faso	Low	460	12 624	175	1388.1	0.5	0.6
Burundi	Low	100	6602	118	1787.2	1.72	0.22
Cameroon	LM	1080	15 729	225	1432.5	0.33	1.79
Cape Verde	LM	2130	454	7	1547.3	2	1.36
Central African Republic	Low	360	3 819	66	1741.1	0.17	0.52
Chad	Low	480	8 348	113	1347.9	0.03	0.32
Comoros	Low	660	747	10	1324.4	0.55	0.89
Congo	LM	950	3 633	62	1708.2	0.39	1.16
Côte d'Ivoire	Low	870	16 365	323	1976.3	0.5	0.73
Democratic Republic of the Congo	Low	130	51 201	888	1734.7	0.48	0.64
Eritrea	Low	200	3 991	65	1622.2	0.21	0.63
Ethiopia	Low	180	68 961	954	1382.8	0.48	0.25
Gambia	Low	310	1 388	19	1346.7	0.16	1.43
Ghana	Low	520	20 471	372	1818.0	2.15	1.07
Guinea	Low	410	8359	118	1410.0	0.04	0.67
Guinea-Bissau	Low	190	1449	20	1353.4	<0.001	0.82
Kenya	Low	580	31 540	551	1745.5	2.41	1.28
Lesotho	LM	1030	1 800	31	1729.6	1.54	0.67
Liberia	Low	140	3 239	48	1490.0	0.06	0.33
Madagascar	Low	280	16 916	233	1378.9	0.43	0.61
Malawi	Low	170	11 871	188	1585.3	2.5	0.61
Mali	Low	440	12 623	179	1417.5	0.24	0.61
Mauritania	Low	740	2 807	40	1432.4	0.28	0.74

Countries in **bold** meet criteria for intensified support (see page 13).

Countries with low and lower middle incomes by WHO region	World Bank income category	Gross national income per capita (US$ 2006)	Population in thousands (2002)	MNS disorders DALYs (in thousands)	MNS disorders DALYs per 100 000	Mental health professionals (per 100 000)	Health providers (per 1000)
Mozambique	Low	340	18 537	316	1706.4	0.11	0.35
Namibia	LM	3230	1 961	34	1743.2	12.2	3.35
Niger	Low	260	11 544	163	1409.0	0.16	0.25
Nigeria	Low	640	1 20 911	2 152	1779.9	4.13	1.98
Rwanda	Low	250	8 272	129	1555.0	1.13	0.48
Sao Tome and Principe	Low	780	157	2	1486.1	3.301	2.36
Senegal	Low	750	9 855	130	1323.6	0.295	0.38
Sierra Leone	Low	240	4 764	74	1547.0	0.12	0.39
Swaziland	LM	2430	1 069	19	1749.6	10.3	6.46
Togo	Low	350	4 801	67	1400.7	0.24	0.47
Uganda	Low	300	25 004	377	1508.5	7.6	0.81
United Republic of Tanzania	Low	350	36 276	516	1421.1	2.245	0.39
Zambia	Low	630	10 698	172	1604.7	5.1	2.13
Zimbabwe	Low	340	12 835	219	1704.5	5.8	0.88
Region of the Americas							
Bolivia	LM	1100	8 645	232	2677.8	5.9	4.42
Colombia	LM	2740	43 526	1 329	3054.3	2	1.9
Cuba	LM	NA	11 271	303	2686.4	33.7	13.35
Dominican Republic	LM	2850	8 616	212	2463.0	4.6	3.71
Ecuador	LM	2840	12 810	386	3009.5	31.74	3.13
El Salvador	LM	2540	6 415	181	2817.5	31.7	2.03
Guatemala	LM	2640	12 036	283	2354.7	1.35	4.94
Guyana	LM	1130	764	28	3646.5	1.2	2.77
Haiti	Low	480	8 218	200	2436.4	0	0.36
Honduras	LM	1200	6 781	166	2454.3	1.52	1.89
Jamaica	LM	3480	2 627	67	2558.5	10.7	2.5
Nicaragua	LM	1000	5 335	141	2644.1	2.845	1.45
Paraguay	LM	1400	5 740	156	2720.9	1.88	2.89
Peru	LM	2920	26 767	726	2711.4	13.06	1.84
Suriname	LM	3200	432	13	3027.6	17.07	2.07

Countries in **bold** meet criteria for intensified support (see page 13).

Countries with low and lower middle incomes by WHO region	World Bank income category	Gross national income per capita (US$ 2006)	Population in thousands (2002)	MNS disorders DALYs (in thousands)	MNS disorders DALYs per 100 000	Mental health professionals (per 100 000)	Health providers (per 1000)
South-East Asia Region							
Bangladesh	Low	480	143 809	3 472	2414.4	0.113	0.57
Bhutan	LM	1410	2 190	52	2393.6	0.46	0.27
Democratic People's Republic of Korea	Low	NA	22 541	446	1977.9	0	7.41
India	Low	820	1 049 550	27 554	2625.3	0.31	1.87
Indonesia	LM	1420	217 131	4 165	1918.4	2.91	0.95
Maldives	LM	2680	309	6	1977.6	1.56	3.62
Myanmar	Low	NA	48 852	1 010	2067.5	1.11	1.34
Nepal	Low	290	24 609	572	2324.1	0.32	0.67
Sri Lanka	LM	1300	18 910	468	2474.9	2.09	2.28
Thailand	LM	2990	62 193	1 493	2400.7	4.1	3.2
Timor-Leste	Low	840	739	3	429.4	0	2.29
European Region							
Albania	LM	2960	3 141	64	2034.2	7	5.52
Armenia	LM	1930	3 072	62	2024.5	4.48	8.41
Azerbaijan	LM	1850	8 297	170	2049.9	9.4	11.83
Belarus	LM	3380	9 940	300	3014.3	36.84	16.71
Bosnia and Herzegovina	LM	2980	4 126	100	2422.0	12.33	5.76
Georgia	LM	1560	5 177	126	2442.5	30	7.85
Kyrgyzstan	Low	490	5 067	123	2430.7	18.6	9.17
Republic of Moldova	LM	1100	4 270	145	3388.6	40.7	8.93
Tajikistan	Low	390	6 195	141	2278.8	5.5	7.22
The former Yugoslav Republic of Macedonia	LM	3060	2 046	46	2238.4	35	8.09
Turkmenistan	LM	NA	4 794	109	2280.9	3	13.22
Ukraine	LM	1950	48 902	1 376	2813.2	43.36	11.08
Uzbekistan	Low	610	25 705	561	2183.4	10.65	13.38
Eastern Mediterranean Region							
Afghanistan	Low	NA	22 930	612	2670.9	0.196	0.4
Djibouti	LM	1060	693	11	1590.9	0.16	0.6
Egypt	LM	1350	70 507	1 194	1694.1	3.4	2.53

Countries in **bold** meet criteria for intensified support (see page 13).

Countries with low and lower middle incomes by WHO region	World Bank income category	Gross national income per capita (US$ 2006)	Population in thousands (2002)	MNS disorders DALYs (in thousands)	MNS disorders DALYs per 100 000	Mental health professionals (per 100 000)	Health providers (per 1000)
Iran, Islamic Republic of	LM	3000	68 070	1 676	2462.6	5	1.83
Iraq	LM	NA	24 510	402	1640.0	1.05	1.97
Jordan	LM	2660	5 329	100	1876.0	5.6	5.27
Morocco	LM	1900	30 072	490	1630.7	2.637	1.3
Pakistan	Low	770	149 911	3 435	2291.5	0.88	1.2
Somalia	Low	NA	9 480	148	1565.5	0.28	0.23
Sudan	Low	810	32 878	499	1518.1	0.56	1.14
Syrian Arab Republic	LM	1570	17 381	245	1411.5	1	3.34
Tunisia	LM	2970	9 728	168	1726.1	2.4	4.21
Yemen	Low	760	19 315	302	1563.2	1.83	0.99
Western Pacific Region							
Cambodia	Low	480	13 810	271	1962.4	0.88	1
China	LM	2010	1 302 307	29 421	2259.2	3.28	2.14
Fiji	LM	3300	831	15	1805.3	0.5	2.29
Kiribati	LM	1230	87	1	1553.1	1	2.65
Lao People's Democratic Republic	Low	500	5 529	154	2781.3	0.03	1.61
Marshall Islands	LM	3000	52	1	1870.9	4	3.45
Micronesia (Federated States of)	LM	2380	108	2	1683.6	4	4.5
Mongolia	Low	880	2 559	56	2178.8	16.7	6
Papua New Guinea	Low	770	5 586	106	1889.9	1.33	0.58
Philippines	LM	1420	78 580	1 599	2035.2	17.7	2.72
Samoa	LM	2270	176	3	1654.6	0.5	2.74
Solomon Islands	Low	680	463	7	1602.1	0.9	0.98
Tonga	LM	2170	103	2	1666.2	8	3.69
Vanuatu	LM	1710	207	3	1620.7	0	2.46
Viet Nam	Low	690	80 278	1 599	1991.6	0.68	1.28

Countries in **bold** meet criteria for intensified support (see page 13).

LM=lower middle

NA=Exact data not available, but estimated to be $905 or less for low-income countries, and $906 to $ 3 595 for countries with lower middle incomes.

Recommended reading

1. Chisholm D, Lund C, Saxena S. The cost of scaling up mental health care in low- and middle-income countries. *British Journal of Psychiatry,* 2007; 191: 528–535.
2. Chisholm D; WHO-CHOICE. Cost-effectiveness of first-line antiepileptic drug treatments in the developing world: a population-level analysis. *Epilepsia*, 2005;46:751–759.
3. Inter-Agency Standing Committee (IASC). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva, Switzerland, IASC, 2007 [in Arabic, English, French, and Spanish].
4. Jamison DT et al., eds. *Disease control priorities in developing countries*, 2nd ed. Washington, DC, USA, The World Bank and Oxford University Press, 2006.
5. Kohn R et al. The treatment gap in mental health care. *Bulletin of the World Health Organization*, 2004;82:858–866.
6. Lancet Global Mental Health Group. Series on global mental health. *Lancet*, published online Sept 4, 2007. (http://www.thelancet.com/online/focus/mental_health)
7. Lopez AD et al., eds. *Global burden of disease and risk factors*. Washington, DC, USA, The World Bank and Oxford University Press, 2006.
8. Mathers CD et al. *Global burden of disease in 2002: data sources, methods and results*. Geneva, Switzerland, World Health Organization, 2004 (GPE Discussion Paper No. 54, rev. February 2004).
9. Wang PS et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *Lancet*, 2007;370:841–850.
10. World Bank. *World Development Indicators database*. Washington DC, USA, The World Bank, September 2007 (http://siteresources.worldbank.org/DATASTATISTICS/Resources/GNIPC.pdfWB).
11. World Health Assembly Resolution WHA55.10. Mental health: responding to the call for action. In: *Fifty-fifth World Health Assembly, Geneva, 13–18 May, 2002.* Geneva, Switzerland, World Health Organization, 2002.
12. World Health Organization. The World Health Report 2001 – *Mental health: new understanding, new hope.* Geneva, Switzerland, World Health Organization, 2001.
13. World Health Organization. *mental health Global Action Programme: mhGAP*. Geneva, Switzerland, World Health Organization, 2002.
14. World Health Organization. *Investing in mental health*. Geneva, Switzerland, World Health Organization, 2003.
15. World Health Organization*. Atlas: Country resources for neurological disorders 2004*. Geneva, Switzerland, World Health Organization, 2004.
16. World Health Organization. *Neuroscience of psychoactive substance use and dependence*. Geneva, Switzerland, World Health Organization, 2004.
17. World Health Organization. *Mental Health Atlas 2005*. Geneva, Switzerland, World Health Organization. 2005.
18. World Health Organization. *WHO Resource book on mental health, human rights and legislation*. Geneva, Switzerland, World Health Organization, 2005.
19. World Health Organization. *World Health Organization Assessment Instrument for Mental Health Systems* (WHO-AIMS 2.2). Geneva, Switzerland, World Health Organization, 2005.
20. World Health Organization. *Mental Health Declaration for Europe: Facing the Challenges, Building Solutions*. World Health Organization Regional Office for Europe. Copenhagen, Denmark, 2005 (http://www.euro.who.int/mentalhealth/publications/20061124_1).
21. World Health Organization. *Disease control priorities related to mental, neurological, developmental and substance abuse disorders*. Geneva, Switzerland, World Health Organization, 2006.
22. World Health Organization. *Dollars, DALYs and Decisions*. Geneva, Switzerland, World Health Organization, 2006.
23. World Health Organization. *Framework and standards for country health information systems.* Geneva, Switzerland, World Health Organization, 2007.
24. World Health Organization. *Neurological disorders: public health challenges*. Geneva, Switzerland, World Health Organization, 2007.
25. World Health Organization. *WHO Mental Health Policy and Service Guidance Package (13 modules)*. Geneva, Switzerland, World Health Organization, 2007 (http://www.who.int/mental_health/policy/essentialpackage1/en/index1.html).

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Mental, neurological, and substance use disorders are highly prevalent and burdensome globally. The gap between what is urgently needed and what is available to reduce the burden is still very wide.

WHO recognizes the need for action to reduce the burden, and to enhance the capacity of Member States to respond to this growing challenge. *mhGAP* is WHO's action plan to scale up services for mental, neurological and substance use disorders for countries especially with low and lower middle incomes. The priority conditions addressed by *mhGAP* are: depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children. The *mhGAP* package consists of interventions for prevention and management for each of these priority conditions.

Successful scaling up is the joint responsibility of governments, health professionals, civil society, communities, and families, with support from the international community. The essence of *mhGAP* is building partnerships for collective action.

A commitment is needed from all partners to respond to this urgent public health need and the time to act is now!

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