Technical Report

Report on the tenth WHO Mental Health Gap Action Programme (mhGAP) Forum

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Introduction

The tenth meeting of the Mental Health Gap Action Programme (mhGAP) Forum was held at the World Health Organization (WHO) headquarters in Geneva on October 11 and 12, 2018. As a WHO Collaborating Center for Research and Training in Suicide Prevention, the Japan Support Center for Suicide Countermeasures (JSSC) takes part in the forum each year. In this paper, we will provide an overview of the forum and specifically report on the contents of the discussion related to suicide countermeasures.

WHO Mental Health Gap Action Programme

Mental disorders are global public health issues; they account for more than 10% of the global burden of disease, [1] and no fewer than 800,000 people die each year as a result of suicide. [2] On the other hand, access to mental health services is inadequate and unequally distributed, and a substantial gap exists between the mental health services that are needed and those that are actually available (mental health gap) in many developing regions. [1)]

In 2008, WHO established the mhGAP with the aim of scaling up the mental health services by governments, international organizations and other stakeholders and expanding the use of basic mental health services in low- and middle-income countries. The mhGAP has designated depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to illicit drug use and mental disorders in children as priority conditions and offers integrated packages of interventions to address each condition. [3] To promote mental health services in non-specialized health settings, mhGAP provides the necessary tools and resources, such as Intervention Guides in non-specialized health settings, Training Manuals to train trainers, supervisors, and health-care providers, and an Operations Manual for health care administrators, etc. [4]

The mhGAP Forum

The mhGAP Forum has been held annually since 2009 as a platform by which to, among other things, exchange information on the implementation and evaluation of mhGAP-related projects, discuss ways to accelerate preventive measures in each country, draw up proposals for the WHO secretariat and strengthen cooperation among stakeholders.

The main theme of the 2018 mhGAP Forum was “accelerating country action on mental health” and the second theme was “young people and mental health in a changing world.” The forum this time was attended by around 200 persons, including government representatives as well as participants from international organizations, WHO Collaborating Centers, academic research institutions, NGOs, etc. [5]

The forum consisted of four large sessions and two small group discussions. Small group discussions were held on specific themes. After group agendas for each small group discussion were introduced to the whole participants, each participant joined the group which he or she was interested in and the group drew

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up the key feedback messages resulting from the discussions.

Small group discussion on suicide countermeasures

In the small group discussion on "consultation on accelerating suicide prevention in countries," presentations were made on suicide-related trends in the international community and on innovative approaches to the problem in Canada, Japan and Ireland, followed by lively discussions on ways to accelerate suicide prevention measures. The substance of these discussions is summarized below.

First, Ms. Louise Bradley, president and CEO of the Mental Health Commission of Canada, introduced a 2014 campaign to exchange ideas on suicide prevention. A series of public meetings were carried out using a grassroots approach that involved a total of 308 parliament members and community stakeholders. As a result, guidelines were drawn up to address ways to prevent suicide in which the community plays the main role. In collaboration with the Mental Health Commission of Canada, WHO edited these guidelines so that could be used in other countries and published them as a document entitled "Preventing suicide: a community engagement toolkit." [6]

Next, Professor Yutaka Motohashi, director of the JSSC, gave an overview of Japan's national suicide prevention strategy and the results it has achieved. In accordance with the philosophy of the Basic Law on Suicide Countermeasures, Japan's suicide prevention measures are implemented comprehensively as social initiatives. He explained that the success of these efforts can be construed as being reflected in the steady decline in recent years in the number of deaths by suicide. As a result of the revision of the Basic Law in 2016, local governments have enacted their own plans, and the national government has developed and distributed tools to support them, including profiles of the actual local suicide conditions, local suicide countermeasure policy packages, a database of innovative approaches to suicide prevention, etc. Professor Motohashi went on to describe, the documents and regulations related to Japan's suicide countermeasures, the basic philosophy behind the Basic Law, the key points of the General Principles of Suicide Prevention Policy, the contents of the profiles of the actual local suicide conditions, and the process of combining the basic package with a priority package, and processes to work out an effective local suicide prevention plan.

Professor Ella Arensman, director of research at Ireland's National Suicide Research Foundation, provided an introduction to the process of formulating Ireland's national suicide reduction strategies, "Reach Out" (2005–2014) and "Connecting for Life" (2015–2020), their basic strategies and policy evaluation processes as well as an introduction to Ireland's national self-harm registry. The "Connecting for Life" strategy has seven key goals: to improve the nation's understanding of and attitudes to suicidal behavior, mental health and wellbeing; to support local communities' capacity to prevent and respond to suicidal behavior; to target approaches to reduce suicidal behavior and improve mental health among priority groups; to enhance accessibility, consistency and care pathways of services for people vulnerable to suicidal behavior; to ensure safe and high-quality services for people vulnerable to suicide; to reduce and restrict access to means of suicidal behavior; and to improve surveillance, evaluation and high quality research relating to suicidal behavior. This strategy is promoted through: whole-of-Government engagement and collaboration, and multi-agency approach to suicide prevention; a focus on formal accountability, adequate response, informed evidence and openness for change in line with emerging evidence-based initiatives; systematic approach to evaluation and research with regard to suicidal behavior by tracking the progress of the strategy implementation against set indicators over the next five years; national and regional Connecting for Life implementation plans. Moreover, in regard to

evaluation, in addition to the suicide mortality rate and the rate of presentations of self-harm in the whole population and amongst specified priority groups, which are the primary outcome indicators for the strategy as a whole, strategic objectives and intermediate indicators are set for each goal, and the National Office for Suicide Prevention implements them in cooperation with an advisory group composed of experts. The presentation also provided the results of the most recent evaluation.

Next, Dr. Alexandra Fleischmann of WHO's Department of Mental Health and Substance Abuse, gave a progress report on global suicide prevention measures based on the following perspectives: the United Nations' Sustainable Development Goals (SDGs); the WHO's 13th General Programme of Work, 2019–2023 (GPW13); and the WHO Mental Health Action Plan 2013–2020. In these plans and goals, The suicide mortality rate is used as an main outcome indicator in these plans and goals: For example, suicide mortality rate is an indicator (3.4.2) within SDGs Target 3.4 to reduce by one third premature mortality from non-communicable diseases by 2030; the GPW13 target No. 28 is a 15% reduction in suicide mortality rate in 5 years; and the Mental Health Action Plan's global target 3.2 is a 10% reduction in the rate of suicide by 2020. Since the global age-standardized suicide mortality rate (per 100,000 population), for example, has already dropped by 8% from 11.4 in 2013 to 10.5 in 2016, we are well on our way to achieving this goal. [7]

A lively discussion then ensued on how to accelerate national suicide prevention measures, and the following key messages were made.

- "Reducing stigma is key, including in structures and institutions, otherwise suicide remains a silent crisis in public health. Everyone needs to know the help available"
- "Acceleration will come from sharing learnings between all countries – regardless of their stage of implementation of national suicide prevention strategies"
- "Evaluation of national suicide prevention strategies is key to accelerating progress. Only three countries have done this"

Feedback from small group discussions

The key feedback points generated in each small group discussion were reported to all forum participants during the plenary discussion period. Some of the points reported by other groups that were considered important for suicide prevention measures as well included interventions based not on the medical model but on a more comprehensive biopsychosocial model that includes social-cultural factors and life course perspectives; multidisciplinary cooperation and the clarification of role sharing at all stages from project planning to implementation; sustainable initiatives spearheaded by local leaders; improvement in the quality of services through the upgrading of guidelines and pre-service education; greater efficiencies through coordination with health programs such as those for other non-communicable diseases and for HIV/AIDS. Reports were also given at this meeting on the current development status of the 11th revision of the International Classification of Diseases (ICD-11); the Programme for Improving Mental Health Care (PRIME); Africa Focus on Intervention Research for Mental Health (AFFIRM); and Emerging mental health systems in low- and middle-income countries (Emerald), etc.; the results of mhGAP-related initiatives around the world; the launch of the Lancet Commission on Global Mental Health and Sustainable Development; and the state of progress, etc., on WHO's Mental Health Action Plan. Finally, in light of the impending revision of that Plan in 2020, discussions were held on the course of action for future mental health initiatives.

Comments

We would like to describe key insights from participating in this mhGAP Forum. First of all, we had a real sense of the enormous differences in the circumstances surrounding the mental health services that each country is facing. In the small group

discussion introduced in this paper, we exchanged ideas on ways to accelerate national suicide prevention measures, but since conditions in each country vary, this meeting was not the place for discussions focused on a specific topics, for example, evaluation systems, detailed intervention techniques, etc. The issues raised by the participants and the demands on the international community were wide-ranging, and WHO and other stakeholders must have devoted a great deal of effort in summarizing them. Among the issues discussed, funding and human resources were not necessarily raised as main factors behind the lack of progress in suicide countermeasures. Actually, one of the key points in the discussion was that unless the stigma is eliminated, the topic of suicide will not even come up as a social problem. This issue was raised by a Canadian participant, so stigma is not simply a problem for developing countries; it is a major factor in various regions in holding back progress in suicide reduction. Furthermore, in the plenary discussion, reports from other groups on different mental health topics also called attention to the issue of stigma; thus, it is understandable that reducing stigma is an important global issues related to mental health. Since Professor Yutaka Motohashi, was asked to be one of the key speakers at the small group discussion, it was thought that the Japanese participants were expected to play a leadership role in communicating Japan's innovative approaches to suicide prevention to the rest of the world. On the other hand, it was also an extremely valuable opportunity for us to learn about the advanced efforts being made in other countries. In particular, in regard to evaluations of suicide prevention policy, according to Professor Arensman, whom we mentioned earlier, several countries around the world are implementing such assessments, but only three have reported the results: Finland, Scotland and Northern Ireland. In Japan, the Ministry of Health, Labour and Welfare's Office for Promotion of Suicide Countermeasures is at the stage of establishing a framework for evaluating Japan's suicide countermeasure policy; and the JSSC is also greatly involved in this work. The National Strategy to Reduce Suicide in Ireland has much in common with Japan's comprehensive public health approaches, and it is conceivable that learning about their evaluation system, specific evaluation indicators and the experience of evaluation there would be very useful in advancing suicide countermeasures in Japan.

Conclusions

Participating in the mhGAP Forum informed us with key issues underlying global mental health promotion and suicide prevention, such as the magnitude of the problem in the international community and the differences in the points at issue, Japan's standing in regard to suicide prevention measures and the current status of innovative examples in other countries.

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