

mhGAP FORUM 2018

“Accelerating Country Action on Mental Health”

Tenth Meeting of the mhGAP Forum

Hosted by WHO Geneva on 11 and 12 October 2018

Summary Report

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Context

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

The tenth meeting of the mhGAP Forum took place at the World Health Organization, Geneva on 11 and 12 October 2018. The primary focus of the 2018 mhGAP Forum was on “Accelerating Country Action on Mental Health”. The second focus centred on the theme of the 2018 World Mental Health Day: “Young People and Mental Health in a Changing World”.

The forum was attended by approximately 201 participants. Participants were 32 participants from 18 Member States, including Ambassadors. There were participants from partner UN organizations, participants from 15 WHO Collaborating Centres, and participants representing 94 civil society organizations, academic institutions, and mental health service user groups. The programme and list of participants are attached as Annex A.

SESSION 1: OPENING PLENARY

1.1 Welcome

The forum was opened by Dr Soumya Swaminathan, WHO Deputy Director-General for Programmes, who welcomed all participants on behalf of the WHO Director-General. It was noted that the forum is in its tenth year, and part of a landmark moment for turning the tide for mental health. This is in context of the heightened political importance for mental health, the universal health coverage agenda, and the personal commitment made by several key leaders around the world, such as during the Global Ministerial Summit, London. Additionally, the UN Secretary-General, António Guterres, has been committed to advancing mental health both globally and within the UN and the WHO Director-General, Dr. Tedros Adhanom Ghebreyesus, has made a personal commitment to expanding and strengthening mental health within WHO's General Programme of Work-13, where mental health will be one of the highest priorities for WHO over the next five years. Dr Swaminathan described the need for equality between mental health and physical health and whilst high level leadership and commitment is essential for moving towards equality, there must be an assurance that this interest is converted to action, in order to improve the lives of people who suffer from mental health conditions. Mental health was described as an area of health where all countries must step up their action, given that the treatment gap affects all contexts regardless of income status. The former director of the WHO Department of Mental Health and Substance Abuse, Shekhar Saxena, was thanked for his efforts in placing mental health high up on the agenda both globally and within WHO. Dr Swaminathan welcomed the newly appointed incoming Director, Dévora Kestel, who will be joining headquarters after leading the Mental Health and Substance Abuse Unit at the Pan American Health Organization and WHO Regional Offices of the Americas.

Mark van Ommeren, Director a.i. of the Department of Mental Health and Substance Abuse, chaired the opening plenary. He described the forum as an opportunity to learn from each other and to discuss how to accelerate action in countries. An invitation to provide inputs on WHO's Mental Health Action Plan 2013-2020 was given. Noting the soon approaching end of the period in which the Plan was developed for, mhGAP forum participants were encouraged to look beyond 2020, to help shape the direction in which WHO should proceed with the mental health agenda.

1.2 Raising Mental Health on the Political Agenda

Mental health and the High Level Commission on NCDs and the Third High-level Meeting of the General Assembly on the Prevention and Control of NCDs in New York

Dr Svetlana Akselrod, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health, opened by thanking the United Kingdom for their leadership in hosting the Global Mental Health Ministerial Summit and thanked the Netherlands for hosting this event in 2019. Dr Akselrod reviewed the work by the High Level Commission on NCDs which was established by the WHO Director-General. Civil society were thanked for their involvement in raising the importance of mental health on the political agenda. The report indicated that as part of the action against NCDs, mental health must be placed at a high level of priority and there remains a critical need to prevent and treat mental health conditions. The WHO's position on universal health coverage was considered essential to the successful implementation of the NCD agenda. Building upon the WHO Mental Health Action Plan 2013-2020, and the WHO tools such as mhGAP and QualityRights was advocated. The high level commission recommended that heads of state and government- not just ministers of

health- should oversee the progress in creating ownership at the national level for NCDs and mental health; that one bold step forward would be heads of state taking personal ownership on NCDs and mental health; and to involve service users in order to end discrimination and human rights violations and to inform effective planning of mental health services. At the Third High-level Meeting of the UN General Assembly on the Prevention and Control of NCDs in New York, heads of state and government came together to adopt a declaration which reaffirmed previous commitments for NCDs and for the first time included new commitments for mental health. Dr Akselrod reflected that these commitments from heads of state represent unprecedented progress for the NCD and mental health agenda, and contribute to the strong political foundation on which to progress mental health services around the world.

The Alliance of Champions for Mental Health and Wellbeing

Anna Romano (Director-General, Public Health Agency of Canada), presented an overview of the Alliance of Champions for Mental Health and Wellbeing. Canada played a leading role in launching the Alliance in May 2018 and to date 13 Member States have joined. Improving the mental health of Canadian citizens is a top priority for Canada. Interventions to prevent suicide and violence, address stigma and provide support to survivors of gender-based violence are needed. The importance of understanding mental health protective factors was emphasized. It was highlighted that international multi-sectoral partnerships are essential for progressing mental health promotion, prevention and treatment, which remain among the key challenges.

The Netherlands' initiative on mental health and psychosocial support in emergencies

Monique Kamphuis (First Secretary / Senior Policy Advisor for Health, Permanent Mission of the Kingdom of the Netherlands), introduced the Netherlands' initiative on mental health and psychosocial support in emergencies. The Netherlands recognizes the urgency to prioritize mental health and psychosocial support (MHPSS) for both Dutch citizens and for populations living in areas affected by conflicts and disasters. Monique Kamphuis reflected on the remarkable resilience shown by women, girls, men and boys in the face of traumatic experiences, yet cautioned us to not forget that traumatic experiences increase the risk of mental health conditions. Monique Kamphuis noted that consequently, a significant increase in the access to care through a massive scale-up of services was required. The Netherlands promotes a holistic approach to humanitarian support that includes MHPSS as an integral component given its capacity to help individuals, families and communities to heal. MHPSS in emergencies is about alleviating suffering, dignity, respect and prevention of mental disorders and helping communities in recovery including economic recovery. MHPSS is typically not prioritized despite the availability of tools such as mhGAP. On behalf of Minister Sigrid Kaag, Minister for Foreign Trade and Development Cooperation, the Netherlands presented an urgent call to all government policy makers and donors, to integrate MHPSS into humanitarian aid right from onset, not as is so often seen, a few months after the fact; to integrate MHPSS across sectors especially in health, education, social and child protection; to invest in local capacity; to bear in mind the Humanitarian Development Nexus and to address psychosocial wellbeing of staff and carers. The Netherlands is working closely with experts in this area to develop this initiative in order to achieve the maximum impact for addressing MHPSS in emergencies in a timely and culturally appropriate manner. The Ministry for Foreign Trade and Development Cooperation will host the second Global Ministerial Summit for mental health in Amsterdam on or near World Mental Health Day in 2019. The summit will focus on MHPSS in emergencies. Finally, a call to join forces was issued, to step up and address mental health problems and tackle discrimination against people affected by these conditions.

Key messages from the UK's Mental Health Summit

Tim Kendall (National Clinical Director for Mental Health, NHS England, United Kingdom), shared key messages from the UK's Mental Health Summit, which took place on the 9-10 October in London, U.K, and was organized with technical support from the World Health Organization and OECD. The summit was seen as an opportunity to bring global stakeholders to share their achievements, and formulate solutions and recommendations, celebrate results, and bring momentum to mental health that would lead to enhancing access to care and increasing research in this area of work. Specific attention was paid to the actions societies need to implement in order to bring mental health into equality with physical health conditions. The Duke and Duchess of Cambridge attended the summit, together with 586 participants from 61 countries, including 20 Ministers, international organizations and a large number of caregivers and service users. The summit concluded with a set of recommendations for Ministers to achieve equality for mental health in the 21st century, and with a summit declaration. The summit also hosted the launch of the Lancet Commission on Global Mental Health and Sustainable Development, the seminal synthesis of knowledge on how to promote mental wellbeing, prevent mental health problems and enable recovery.

Political implications of The Lancet Commission on Global Mental Health and Sustainable Development

Shekhar Saxena, former Director of Mental Health and Substance Abuse at WHO and Visiting Professor, Harvard TH Chan School of Public Health, presented on the work of 28 experts from around the world, across three years, to produce the *Lancet Commission on Global Mental Health and Sustainable Development*. The report includes seven recommendations and goes beyond what has been discussed previously in the global mental health field.

Key messages for policy makers include the reframing of mental health as a global public good, whereby mental health should no longer signify only mental disorders, but also signify positive mental health- such that all people are viewed as existing on a spectrum. This dimensional approach is suited for a public health approach to mental health, and is relevant for youth. Mental health is a critical contributor to human capital. A second message for policy makers is that mental health should be considered an essential component of universal health coverage. The scaling up of care can be achieved through innovative techniques such as task-sharing or using technology. Innovations within UHC should be context-dependent using resources available within each country. The third message includes the importance of paying attention to social determinants, particularly for protecting mental health. Government departments other than health should hold mental health in mind in the development of their policies e.g. alleviating poverty, promoting nutrition, education, enhancing equity, gender equality, preventing violence. The fourth message advocates for public engagement to be strengthened, such that mental health is as discussable as physical health, for evidence-based interventions to reduce stigma to be implemented, and to engage civil society in a meaningful way. The fifth message highlights the need to invest more in mental health. Mental health has traditionally been underfunded, with approximately 1% of the health budget allocated in LMIC and 3% in HIC. The Lancet Commission advocates for the allocation of at least 5% of the health budget in LMIC and at least 10% of the health budget in HIC. Crucially, resources need to be used more efficiently and effectively and bilateral and multilateral development assistance needs to include an increase of spending for mental health. Finally, in indicating a shift from health to sustainable development, all parties should be aware that there is *no sustainable development without mental health*.

The emerging global campaign for mental health

Elisha London (CEO, United For Mental Health) reported on how the Global Campaign for Mental Health (now renamed as United for Mental Health) was established in the last year to address the need for a united effort to galvanize the history of work in mental health. Elisha London noted the excellent commitment for mental health from the UN Secretary General, the Director-General of WHO and the Executive Director of UNICEF. Elisha London described some of the advocacy work which United for Mental Health has conducted including during the United Nations General Assembly with UN Friends of Mental Health and Wellbeing and at the UK ministerial summit. Elisha London advocated that experts by experience and the broader community must be included in joint actions and advocacy efforts. United for Mental Health will continue advocacy efforts in the next 12 months to work with the Alliance of Champions and Friends of Mental Health and Wellbeing.

A short film, directed by Aardman's Danny Capozzi titled 'New Mindset' was shown. The 'new mindset' animation underlines how mental ill health is a global issue that affects everyone, everywhere, and was created to help the global mental health community to win support for change in how mental health is funded and treated.

1.3 Statements by Member States

Ten Member States provided statements during the opening of the 2018 mhGAP forum, presented in Annex B.

SESSION 2: SMALL GROUP DISCUSSION

2.1 Consultation on achieving universal health coverage for mental health

The objectives of this session were to highlight the foundational elements critical to delivering quality mental health services and achieving universal health coverage (UHC) with innovative approaches from the field.

The session was moderated by Tarun Dua (WHO) who set the stage by describing WHO's mandate for UHC as reflected in the Sustainable Development Goals, the GPW13 and commitments made at the UN General Assembly high level meeting on NCDs.

Dan Chisholm (WHO) highlighted the key issues in health system financing for better inclusion of mental health in UHC i.e. sufficiency, efficiency, equity and sustainability, and described WHO's recent work in this area. Phiona Koyiet (World Vision) described the Kenya experience in workforce development for psychological interventions with the main learning being that real scale up is feasible but it demands predictable funding over long periods to achieve sustained systemic change. Meredith Fendt-Newlin (WHO) presented the epilepsy scale up programme in Myanmar highlighting how key challenges in policy commitment, medicine supply and data collection and reporting were overcome. Integration of mental health in other health programmes was presented by Pamela Collins (University of Washington) using task shifting approaches in HIV programmes as an illustrative example. Mark Jordans (War Child Holland) presented a set of core service coverage indicators that can be used to routinely monitor mental health in low- and middle- income settings. Rahul Shidhaye (Public Health

Foundation of India) described how research can influence policy by presenting the state-wide scale up of PRIME in India.

A lively discussion ensued that was moderated by Khalid Saeed (WHO). The main points raised were issues around screening versus case detection, a lack of mental health indicators in routine health information systems, care across the life course, and attention to social determinants and gender equity.

KEY MESSAGES

“Task sharing including leveraging community based platforms is essential for promotion, prevention, treatment and care for mental health”

“Integration with other health programmes such as HIV, NCDs and maternal and child health: entry points to address shared goals of equitable access, improved health outcomes and stigma reduction”

“No measurement of sustainable development without strengthening mental health information systems”

2.2 Promoting people-centered, recovery and human rights oriented care in policy, law services and practice – a consultation on WHO’s QualityRights initiative

The QualityRights group consultation was well attended by a range of different experts from diverse backgrounds, including health practitioners, persons with lived experience, academics working at country and community-level; as well as representatives from mental health services, advocacy groups, civil society, disabled persons’ organizations and countries’ permanent missions. Participants shared experiences from a wide range of countries and settings from Ethiopia, France, Argentina, Finland, UK, among others.

Michelle Funk and Natalie Drew (WHO) updated participants on the QualityRights initiative, WHO’s global initiative to improve quality of care and promote rights of people with mental health conditions and psychosocial, intellectual and cognitive disabilities. Natalie Drew presented some of the existing tools developed by the team including the current QualityRights face-to-face training, e-training and assessment tools. Natalie Drew also introduced resources currently being developed, such as the update of a guidance document and checklist aiming to assist policy-makers in aligning their policy and law with the UN Convention on the Rights of Persons with Disabilities. Finally, Natalie Drew updated participants on the implementation of the QualityRights initiative across countries, highlighting results in Gujarat and Indonesia, and the more recent project to roll-out and launch QualityRights capacity-building programmes throughout Ghana.

Carmen Valle (CBM), Dan Chisholm (WHO) and Simon Vasseur-Bacle (WHO Collaborating Centre for Research and Training in Mental Health, Lille) discussed the implementation of QualityRights in the field, notably in South-East Asia and Europe, emphasizing that QualityRights is gaining considerable momentum at country level. In South East Asia, Carmen Valle presented the community-level work being done in Thailand, the Philippines, and Nepal, and shared the enthusiasm and considerable impact generated by the training. Dan Chisholm shared results from the WHO European region’s assessments of mental health services using the QualityRights assessment toolkit and methodology in 25 European countries. Dan Chisholm also shared the current efforts of 14 countries to address the gaps identified in the assessments through the development of improvement plans for mental health services using the *QualityRights module on implementing improvement plans for service change* and through national capacity-building efforts using the QualityRights face to face and e-training tools. Simon Vasseur-Bacle outlined the experience of the WHO Collaborating Centre

in Lille in conducting the QualityRights assessments of mental health services in France, and the Centre's efforts to integrate QualityRights tools into the required continuous professional training for doctors and medical/paramedical practitioners in France.

Michelle Funk provided an in depth outline of the upcoming WHO QualityRights Best Practice Guidance on community-based mental health services that promote human rights and recovery. This document will identify, describe and provide evaluation data for community-based services that operate without coercion, are responsive to people's needs, and promote autonomy and inclusion in line with international human rights standards. Michelle Funk informed the participants of the methodology used for developing the guidance.. Early results from preliminary data collection and screening stages were shared and an overview of the general timeframe for this work were provided.

Group discussions focused initially on the QualityRights toolkits and the challenges faced by stakeholders in the implementation of the tools, including time constraints to provide face-to-face training, as well as political resistance to changing mindsets in the area of mental health. Participants reiterated the necessity to include persons with psychosocial, intellectual and cognitive disabilities in the delivery of QualityRights and the WHO team concurred, highlighting the critical role that people with lived experience and DPOs play in the design of its tools and in the initiative's methodology, values and principles. Creating a pool of QualityRights experts, in particular persons with lived experience will be critical for QualityRights implementation in countries as the project continues to gain momentum worldwide. The discussion also emphasized the pertinence of QualityRights in attempts to expand mental health in primary care by aiming to go beyond the biomedical model to encompass a holistic, human rights and recovery-oriented approach to providing primary mental health care. Discussions also centred around the Best Practice Guidance document, with experts emphasizing the need to ensure that the final document be representative of all countries, with considerations for cultural relevance, and transferability of the best practice services identified.

KEY MESSAGES

“QualityRights is WHO's global initiative to improve quality of care & promote rights of people with mental health conditions & psychosocial, intellectual & cognitive disabilities”

“Experts welcomed WHO's upcoming Best Practice Guidance on community-based mental health services that promote rights and recovery, which will supplement current QualityRights F2F, e-training & assessment tools”

“QualityRights is gaining momentum across different countries in Europe, Africa and South-East Asia”

2.3 Consultation on building mental health services during and after emergencies

Fahmy Hanna (WHO) introduced the topic with examples from WHO's work as documented in the WHO report: *Building Back Better Sustainable Mental Health Care after Emergencies*. Minimum standards of mental health and psychosocial response based on Sphere and IASC Mental Health and Psychosocial Support in Emergencies Guidelines was shared.

Pieter Ventevogel (UNHCR) shared examples from the field on using the WHO/UNHCR mhGAP- Humanitarian Intervention Guide in extremely low- resource settings in both camps and urban settings.

This was followed by a group discussion on the components of the absolute minimum response in low resource settings.

Inka Weissbecker (International Medical Corps, IMC), discussed crisis as an entry point for mental health system strengthening with examples from IMC's work in emergencies and provided an overview on IMC's newly developed toolkit for the Integration of Mental Health into General Health in Humanitarian Settings. This was followed by group discussion on knowledge and packages gaps.

Jasmine Vergara, (WHO), presented a summary of ongoing efforts by the Philippine National Department of Health, Regional and Provincial Health Office, supported by the WHO, in implementing mhGAP to ensure the clinical management of mental, neurological and substance use conditions in the province of Northern Samar, since the emergency response to Typhoon Haiyan in 2013.

Nazneen Anwar (WHO) shared updates on achievements and challenges facing WHO and actors in the mental health response for Rohingya refugees in Cox's Bazar. An overview was provided on outcomes of mhGAP training activities in Cox's Bazar. This was followed by group discussion on similar challenges and approaches for overcoming challenges and barriers based on participants' experiences.

Sarah Harrison (IFRC) shared an overview of challenges facing mental health and psychosocial technical working groups in countries with examples on limited access, challenges in multisectoral work, engagement with local actors and limitations of resources.

KEY MESSAGES

“Providing sustainable mental health services in humanitarian setting requires longer term development funding, encouraging local leadership & government sensitization and engagement, and should foster links to the community. It is important to conduct advocacy for reform or change and support MH champions in the community and health care system!”

“Integration of mental health into general health care using mhGAP promotes biopsychosocial model, not a narrow medical model. Therefore mhGAP programmes need to include contextual and cultural adaptation, engage key national stakeholders, staff and communities and implement psychological interventions”

2.4 Consultation on accelerating suicide prevention in countries

The session was attended by 35 participants. Louise Bradley (Mental Health Commission of Canada) shared the ways in which Canada has been facilitating conversations about suicide prevention between government and community stakeholders. The Community Engagement Toolkit contains resources for communities to begin implementing evidence-based suicide prevention strategies.

Yutaka Motohashi (WHO Collaborating Centre for Research and Training in Suicide Prevention, Japan) gave an overview of the history and successes of Japan's national response to suicide, including the role of communities. The response is founded on a vision of a society in which no one is driven to take their own life and programmes are both universal and targeted to specific high-risk groups.

Ella Arensman (WHO Collaborating Centre for Surveillance and Research in Suicide Prevention, Ireland) discussed the evaluation phase of Ireland's national suicide prevention strategy, as well as the national hospital-based self-harm registry. The evaluation is being carried out with an advisory group

comprised of various relevant stakeholders (e.g. central statistics office, individuals with lived experience). Both primary and intermediate outcomes will be measured, as well as process evaluation measures (e.g. programme fidelity). It was noted that very few countries had adopted an evaluation phase for their national strategies, and the participants exhibited great interest in the implementation plan required to conduct such evaluations.

Alexandra Fleischman (WHO) presented progress in suicide prevention from a global perspective, including UN SDGs, WHO General Programme of Work, and WHO Mental Health Action Plan indicators.

Break-out groups were held to facilitate small group discussions on how countries can accelerate suicide prevention. Participants were asked to address how example contexts could progress their implementation or development of their national suicide prevention strategy; and what role they perceived WHO should play in facilitating this. Feedback from small groups indicated that WHO could be well-positioned to develop implementation guidance, based on the experiences, successes, and how barriers have been overcome in different contexts when developing or implementing strategies. Common issues in progressing with national strategies were identified e.g. funding allocation and evaluation. Participants were particularly interested in learning from innovations in lower resourced settings. A large group discussion at the end of the sessions resulted in generating the following key feedback points:

KEY MESSAGES

“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”

RECEPTION AND NETWORKING

Station A: Step-by-Step e-mental health intervention for depression

This station was run by Eva Heim and Edith van 't Hof (WHO). The station presented information on an e-intervention called Step-by-Step.

Step-by-Step, is a guided, technology supported (app or website), intervention for depression. The intervention has an illustrated narrative approach and is mainly based on behavioural activation with additional therapeutic techniques such as stress management (slow breathing), identifying strengths, positive self-talk, increasing social support and relapse prevention. The intervention has been developed to be meaningful in communities exposed to adversity and can be easily adapted to different contexts. The intervention will be evaluated in an RCT in Lebanon with refugees and other people residing in Lebanon.

The workstation presented the Step-by-Step app and was well visited by attendees of the mhGAP-forum. A recently published concept paper on Step-by-Step was handed out to visitors at the work station, which can be accessed here: <http://mhealth.amegroups.com/article/view/20772/20394>

Station B: Mental Health Innovation Network (MHIN)

This station was run by Julian Eaton (London School of Hygiene and Tropical Medicine (LSHTM) and CBM). MHIN is based at the Centre for Global Mental Health at LSHTM and is a collaboration with the WHO's Department for Mental Health and Substance Abuse.

The Mental Health Innovation Network - <http://www.mhinnovation.net> - is an online community of mental health innovators and organisations, and is a platform for knowledge synthesis and exchange, providing information and resources to improve the quality and coverage of mental health care worldwide.

MHIN has currently more than 5,000 members, and 250 organizations who make use of online resources, manuals, toolkits, webinars, podcasts, and networking opportunities. There is now also an African Hub, and Latin America and Caribbean Hub.

SESSION 3: PLENARY SESSION

3.1 Launch of The Lancet Commission on Global Mental Health and Sustainable Development

The Lancet Commission on Global Mental Health and Sustainable Development was launched in plenary during the second day of the mhGAP Forum. Vikram Patel (Harvard Medical School) and Shekhar Saxena outlined mental health as a public health priority and presented how the Lancet Commission aims to use the recent UN Sustainable Development Goals as an opportunity for action to improve mental health and reduce global burden of poor mental health outlined in a blueprint.

The existing global mental health gap was demonstrated comprehensively and vividly. An increased burden of mental and substance use disorders by nearly 50% in the past 25 years and the continuing rise of social determinants such as climate change are challenging. These disorders now account for one in every ten years of lost health globally.

Across the life course there are two main surges: there is a peak of mental and substance disorders in young people, with mental health problems forming the leading killer in young adults around the world, and a rise in dementias among the increasingly ageing population.

The calculated economic burden is immense, yet the global expenditures do not meet the burden. Therefore, The Commission asked for a stronger financial commitment of 5% of a LMIC health budget and 10% for HIC. The question on how to unfreeze resources from institutions to community services was raised. To improve continuing support and care services for people with mental disorders, a reframing was proposed as a necessity: to establish mental health as a pillar of UHC, to apply a convergent understanding of mental health and a rights-based approach. After all there is *no sustainable development without mental health*.

The Commission is available at www.globalmentalhealthcommission.org

3.2 Results and lessons learned from multi-site mhGAP implementation research efforts

During this session, three multi-site mhGAP implementation experiences were presented:

- PRIME (Programme for Improving Mental Health Care) is a consortium of research institutions and Ministries of Health in five countries in Asia and Africa for research on priority mental disorders in primary and maternal health care in low resource settings.
- AFFIRM (Africa Focus on Intervention Research for Mental Health) is a research and capacity development hub implemented in 6 African countries.
- EMERALD (Emerging mental health systems in low- and middle-income countries) consists of 6 work packages which aim to improve mental health outcomes by enhancing health system performance.

Crick Lund (University of Cape Town), Charlotte Hanlon (Kings College London) and Joshua Ssebunnya (Butabika National Hospital) walked the audience through the development process, challenges and outcomes of these projects. They illustrated examples of positive impact and feasibility in different countries such as PRIME trainings as an incorporated part of the National Health Training Center curriculum in Nepal and the development of theory of change workshops to contextualise plans. Lessons learned included the importance of engagement of policy makers right from start, close monitoring and supervision on all levels, demand-side interventions and need for further research.

WHO was a partner in all 3 named implementation research efforts.

3.3 Pre-publication launch of ICD 11 chapters on mental, behavioural and neurological disorders

Tarun Dua (WHO) introduced the development process for ICD-11, followed by Geoffrey Reed's (WHO) review on the strategies applied to the development of the ICD-11 and major changes, improvements and innovations in the classification of Mental, Behavioural and Neurodevelopmental disorders as well as Diseases of the Nervous System. A pre-final version of the ICD-11 version for morbidity and mortality reporting was released to Member States on 18 June 2018 to allow them to begin preparing for implementation, including the preparation of translations and the training of health professionals. The ICD-11 will be presented to the World Health Assembly in May 2019 for approval. Statistical reporting by Member States based on the ICD-11 is scheduled to begin on 1 January 2022. MSD's focus in managing the revision of the classification of Mental, Behavioural and Neurodevelopmental disorders and Diseases of the Nervous System has emphasized the integration of current scientific evidence and improving the clinical utility and global applicability of the classification.

Innovations in the ICD-11 include a new chapter on Conditions Related to Sexual Health, inclusion of the concept of disorders due to addictive behaviours (gambling disorder and gaming disorder) in the classification, and expansion of the classes of substances identified in disorders due to substance use in line with current global use patterns. Gender identity disorder has been reconceptualized to gender incongruence and moved out of the chapter on mental disorders to the chapter on sexual health. Stroke is now primarily categorized in the Chapter on Disease of the Nervous System compared to previous listing in the circulatory system diseases. Other aspects highlighted included the elimination of mind-body dualism in Sleep-Wake Disorders and sexual dysfunctions and a move towards dimensional

classification in several areas. For example, subtypes of schizophrenia and specific personality disorders have been eliminated in favor of a dimensional approach. During discussion it was remarked that a dimensional approach may be particularly useful for public health approaches on a population level, while a categorical classification is still needed and relevant in clinical settings.

SESSION 4: SMALL GROUP DISCUSSIONS

4.1 Consultation on development of mhGAP Community Toolkit

The objectives of this session were to identify potential barriers and facilitators to implementation of mental health services via the community platform; highlight examples from partners scaling-up community-based mental health programmes; present the outline of the proposed mhGAP Community Toolkit; and gain feedback on its proposed components. The session was moderated by Neerja Chowdhary (WHO) who set the scene of how the community platform is an ideal place to address mental health throughout the life course, achieve universal health coverage and the Sustainable Development Goals with equitable access to quality care, fair financing, and human rights protection.

Mark Jordans (War Child Holland) presented the development and evaluation of the Community Informant Detection Tool (CIDT) to identify people with mental health conditions in community settings, that is effective in increasing help seeking and access to services in Nepal. Sarah Harrison (IFRC) described the unique volunteer workforce in International Federation of Red Cross and Red Crescent Societies who now receive brief psychological first aid training. 38 million volunteers globally offer a massive scope for an impact on mental health in their own communities. Carmen Valle (CBM) explained CBM's strategy of community based inclusive development for mental health and presented some of the challenges faced in communities around the world. Giorgio Cometto (WHO) presented WHO's guideline on health policy and system support to optimize community health worker programmes to illustrate the breadth and depth of the literature on community health workers that might inform the development of the mhGAP Community Toolkit. Cassie Redlich (WHO) presented the progress to date on the Toolkit. She gave an overview of the scoping review that identified the (a) settings, (b) people/providers, and (c) spectrum of care that characterise the community platform.

Dévora Kestel (WHO) led a dynamic discussion on community platforms and the long-term needs of health systems to address mental health in the community. Points raised included: community workers as generalists vs specialists and what their role might be in addressing mental health; risks in overburdening the professional workforce with competing health priorities; incentivising and motivating community workers, the role of social workers in promoting inclusion and social support; the role of peers; and measuring competencies.

KEY MESSAGES

“Involvement of mental health social workers and the wider community can help people to live better together – we now move beyond health workers to address social determinants of mental health”

“The community platform is an ideal place to address mental health throughout the life course: you just have to be a human being to receive care and support”

“Let communities find ways to support mental health by picking flowers from the bouquet of community-based interventions that are evidenced and available”

4.2 Consultation on mhGAP pre-service training: how to build a better future workforce now

The main aim of this session was to explore opportunities for the mhGAP-IG pre-service training in mental health. Pre-service education is the learning that takes place in preparation for a future professional role, for example, as a medical doctor or other health worker. In the past, the mhGAP-IG has almost exclusively focused on in-service training.

The organizers of this session sought to bring together professionals who are both responsible for, and involved in, pre-service mental health training, to provide updates on current mhGAP-IG implementation efforts, and to explore future opportunities to use mhGAP in pre-service training. The session was moderated by Norbert Skokauskas (WHO) who emphasized the benefits of pre-service training and presented the principles and approaches to strengthening and enhancing pre-service training with mhGAP. Fahmy Hanna (WHO) highlighted that mhGAP-IG is an accessible and practical tool, used in more than 106 countries in all WHO regions, and translated into more than 20 languages, however mhGAP-IG pre-service training is a missed opportunity in the majority of countries where mhGAP-IG is implemented.

Janice Cooper (Carter Center, Liberia) spoke about mhGAP-IG in Liberia, emphasising the need for expansion of training at a pre-service level with guidance on integration and presented on Liberia's next steps towards adequate preservice level inclusion– such as the requirement of mhGAP training completion in order to receive board certifications. José Luis Ayuso-Mateos (WHO Collaborating Centre for Mental Health Services Research and Training, Spain), spoke about opportunities and challenges for mhGAP-IG pre-service in several Spanish speaking countries as discussed at the recent meetings dedicated to medical education on mental health in Spain and Mexico. An example of pre-service training integration in Somalia was shared by Khalid Saeed (WHO) and Peter Hughes (Royal College of Psychiatrists, United Kingdom).

A dynamic discussion ensued, that was moderated by Norbert Skokauskas and summarized by Myron Belfer (Harvard Medical School), by stating that that mhGAP-IG in pre-service training is a primary training approach and not a secondary opportunity. Key messages from the consultation included:

KEY MESSAGES

“Pre-service education is the learning that takes place in preparation for a future professional role, for example, as a medical doctor or other health worker. Medical educators and decision makers need to be informed about mhGAP-IG pre-service benefits and impacts”

“While mhGAP IG has been widely used, the uptake in preservice training remains limited. This was a missed opportunity to expand the number of knowledgeable service providers not only in low and middle income countries”

“Each country has a particular approach to education, with each teaching institution, tailored to the professional resources available and the populations' needs: mhGAP-IG in pre-service aims to enhance and strengthen a pre-service curriculum and not to change it”

“Following three mhGAP pre service consultations in 2018, the first mhGAP pre service ToT course will be held in November 2018 in Kiev, Ukraine. Countries interested in integrating mhGAP-IG into pre-service education are encouraged to collaborate with other interested countries and the WHO to promote the sharing of evidence-based knowledge and any further development of the mhGAP-IG materials”

4.3 Consultation on designing a prevention and promotion intervention package: Helping Adolescents Thrive (HAT)

The session was attended by around 40 participants. There were five presentations delivered followed by questions and comments from the participants.

Chiara Servili (WHO) provided an overview of the Helping Adolescents Thrive (HAT) project, a joint collaboration between WHO (MSD and, Maternal, Newborn, Child and Adolescent Health) and UNICEF. End products of HAT will be i) WHO guidelines for universal, targeted and indicated promotive and preventive interventions and ii) an open-access evidence-based universal and targeted intervention package to promote mental health and prevent mental disorders, risk behaviours, and self-harm in adolescents. Based on literature review findings, the HAT package will be a low intensity intervention focusing on enhancement of a few core competencies such as interpersonal skills, emotional regulation and problem solving, in the context of broader actions for facilitating safe and nurturing environments. HAT will provide guidance for implementation across sectors (e.g. education and social) applicable to less-resourced settings.

Cristina De Carvalho Eriksson (UNICEF) presented and discussed which at-risk groups of adolescents will be targeted by HAT interventions. HAT will develop targeted interventions for adolescents exposed to adversities (e.g. violence, extreme poverty, forced displacement due to natural disasters or conflict), pregnant adolescents and adolescent parents, and adolescents living with HIV/AIDS. Indicated interventions will be developed for adolescents with emotional problems and adolescents with disruptive/oppositional behaviours in order to prevent progression into diagnosable mental and conduct disorders, self-harm, and other risk behaviours. Christina emphasized the importance of including youth in the development of the package and a need to ensure stigma reduction.

Felicity Brown (War Child Holland) presented the organization's strategies for developing a multi-sectoral comprehensive, stepped- care system with input from country-level stakeholders and engagement of families. Felicity outlined War Child's promotion, prevention and treatment programmes designed to be scalable, context sensitive and systematically adapted to the cultural context.

Khalid Saeed (WHO) discussed demand from countries. He emphasized the need to develop interventions for the wide continuum of needs and contexts within regions, as well as the importance of identifying the common core intervention elements that link with a life-course approach that will be applicable across diverse settings.

Adrian Sell (CitiesRISE) presented the efforts of CitiesRISE to improve mental health of young people through collective action in major cities that catalyse systemic change, building on evidence-based strategies and exchange of learning among communities. Their approach to bringing about systematic change is one of youth leadership and empowerment.

Comments from the participants included: The need to consider digital interventions (and the limitations to this), the age range, gender issues, and a need for advocacy and evaluation tools.

The group summarized the discussion in the following key messages:

KEY MESSAGES

“Involve multiple stakeholders (e.g. adolescents, end-users and policy makers) in all phases, from intervention design to adaptation and delivery”

“Social determinants of mental health need to be addressed, along with individual resilience and skills”

“A life-course and gender-responsive approach is required, taking into account specific social-cultural contexts and different risk constellations”

4.4 Consultation on care pathways for people with dementia – Leaving no one behind

In line with the vision and goal of the global dementia action plan¹, the aim of this small group session was to discuss stakeholder needs across the continuum of dementia care, service availability as well as implementation mechanisms at country-level and to map these against any existing WHO tools or guidelines on dementia, healthy ageing, human rights and rehabilitation to identify gaps and particular further requirements for WHO guidance.

The session was attended by over 30 representatives from Member States, non-State actors, WHO colleagues all 3 levels of the organization, professionals of multiple disciplines including public health experts, psychiatry, geriatrics, neuropsychology, occupational therapy, neuroimaging and health economics.

After a brief introduction to the global dementia action plan and its action area focusing on dementia diagnosis, treatment, care and support, the floor was given to partners and stakeholders to share their views on dementia care pathways, including Kate Swaffer (Dementia Alliance International), DY Suharaya (Alzheimer’s Disease International), Anna Romano and Tina Raimondo (Policy perspective from Canada and the Philippines), Sebastiana Nkomo da Gama (WHO), and Elanie Marks (WHO). Their statements emphasized the need for early diagnosis followed by holistic and *integrated* care and management that are adaptable to different cultural settings and based on human rights, equity, evidence and sustainability. The importance of empowering people with dementia to keep up intrinsic/functional capacity for as long as possible was highlighted. Such a positive approach focusing on abilities rather than disabilities would enable people with dementia and reduce stigma.

Statements were followed by an interactive group exercise, during which participants mapped out the corner stones and requirements of an integrated dementia care pathway along the continuum of a person’s dementia (i.e. from before symptom onset to the end of life). Participants were encouraged to creatively work on said continuum, add their own ideas reflecting personal needs or professional experiences and engage in discussions with each other.

The outcome of this rich exchange of ideas was summarized in a poster and the following two tweets:

¹ [Global action plan on the public health response to dementia 2017-2025](http://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/), available at: http://www.who.int/mental_health/neurology/dementia/action_plan_2017_2025/en/

Vision: A world in which dementia is prevented and people with dementia and their carers live well and receive the care and support they need to fulfil their potential with dignity, respect, autonomy and equality. **Goal:** To improve the lives of people with dementia, their carers and families, while decreasing the impact of dementia on them as well as on communities and countries

KEY MESSAGES

“Life is not over because of #dementia. We need a positive approach to #dementiapathways. Dementia diagnosis should open doors and empower. #livingwell #HealthForAll”

“The big C’s of creating coordinated #dementiapathways: Compassion, Caring, Capacity-building, Case-detection, Collaboration, Cultural adaptability.”

SESSION 5: CELEBRATING WORLD MENTAL HEALTH DAY 2018

Introduction

The session was opened and introduced by Dr. Alberto Trimioli from the World Federation for Mental Health (WFMH). In his statement he reflected on the right of youth to having access to mental health services, which is often a right unrealised. Dr. Trimioli affirmed the commitment of the WFMH to prioritising and advocating for youth mental health services, acknowledging the unique stressors for this age group in a changing world and the importance of ensuring preventative actions, early detection and treatment of disorder.

The Panel

Alison Brunier from WHO Communications introduced a panel of speakers, which included:

- Dr. Tedros (WHO Director General).
- Two students from the Geneva International School (Lucy and Catherine),
- Mr. Jim Williams, principal of the Geneva International School,
- Druv Puri, WHO Intern,
- Ms. Phiona Koyiet, World Vision International.

In response to the question “What are some of the main challenges you see for young people today?”, the unique role that social media plays in the lives of youth was emphasized. Depression, anxiety and substance abuse were challenges identified, alongside the pressures for high grades, degrees, careers and social belonging. Demands placed on youth and on social connections in an increasingly globalised world are playing a huge role.

It was emphasized that youth in low, middle income and conflict contexts have challenges, and that research is further emphasising the need to prioritise this age group, which are not seen to be currently benefiting from traditional aid and development approaches targeting ‘children’.

Many youth primarily seek support from friends or families. However, for ‘bigger issues’ it is often difficult to seek out support because it required youth to be strong enough to personally admit their own difficulties. Online information was cited as an important resource, but also acknowledged as being potentially risky if knowledge on how to vet information was not understood. Contacts at school for support have been helpful to many, and the school has had success with a student mentor programme, where students can each meet with a dedicated staff member for regular support;

Dr. Tedros commented on the importance of listening to youth and their challenges. He thanked the panel for their participation and the support offered this year by the WFMH who prioritised this important topic as the feature of this year’s World Mental Health Day. Dr. Tedros spoke of stigma and the need for people with mental health problems to be fully supported with accessible and effective treatment, and for continued advocacy around the topic. *“But for that to change, we need to keep up the conversation. We have to keep the candle on and we have to discuss about it in our families, our societies, in our institutions, everywhere.”* He quoted statistics about the impacts of

mental disorder, including depression and lives lost each year to suicide, particularly amongst youth. He restated that we need to recognise the enormity of the problem and begin addressing it in earnest.

SESSION 6: PLENARY DISCUSSION

6.1 Reports from small groups

Each small group consultation presented two to three key messages, summarising the main learning points from each session. These have been summarised as ‘Key Messages’ throughout this document.

6.2 Summarizing implementation of the Mental Health Action Plan 2013-2020: Results of Mental Health Atlas 2017

Tarun Dua (WHO) reminded participants of the four objectives of the Mental Health Action Plan 2013-2020: strengthening leadership and governance, providing care in community based settings, prevention and promotion implementation and strengthening information systems, evidence and research. WHO has been using the WHO Atlas as a mechanism for looking at the information on country resources. This started in 2001, together with publication of the first World Health Report on Mental Health. Since then five Atlas’ have been published. The 2014, and 2017 Atlas serve as the vehicle for monitoring the implementation of the comprehensive action plan. The 2017 Atlas represents progress values for 2016.

Fahmy Hanna (WHO) explained that there are 14 core mental health indicators which are designed to measure the targets of the mental health action plan (6) and the service development indicators (8). Submission rates by WHO Member States indicated good commitment from ministries of health, where 177 of 194 Member States submitted responses for Atlas. This represents 91% of the WHO member states and 97.5% of the global population. It was noted that some countries are submitting for the first time. A summary of progress on targets was presented:

- First target: 80% of WHO Member States will have developed or updated their policies or plans for mental health by 2020 in line with international human rights instruments. The baseline was 45% in 2014 and this increased to 48% in 2017.
- Second target: 50% of WHO Member States will have developed or updated their law for mental health. In 2014, this was 34%, increasing to 39% in 2017. Fahmy reflected that this shows that more than half the world does not have policies, plans or laws in line with international human rights instruments. Though more than 120 countries have updated their policy plan and 77 have updated their laws, not all have updated in line with human rights instruments.
- Third target: 20% increase in service coverage for severe mental disorders. There was no computable data from Atlas for 2014 or 2017, predominantly due to incomplete or incomprehensible data for this indicator.
- Fourth target: 80% of WHO Member States will have at least two functioning mental health promotion and prevention programmes. In 2014 this was 41% increasing to 64% in 2017. This is a remarkable improvement. It is possible that this reflects better reporting of this indicator.

- Fifth target: 10% reduction in rate of suicide (per 100,000) in countries. In 2014 this was 11.4% and in 2017 was 10.5% - moving ever closer towards the target. This was not measured through Atlas and is an estimate for age standardised suicide rates.
- Sixth target: 80% of WHO Member States will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems. Considering only countries publishing mental health indicators in a separate report, in 2014 this was 33% , increasing to 37% in 2017. By adding countries with mental health indicators published as part of general health statistics, this indicator has increased only from 65% in 2014 to 66 % in 2017.

Regarding data on other mental health indicators, there was no change in the mental health workforce since the baseline. There remain large inequalities in the distribution of the workforce, with less than 2 per every 100,000 in low income countries and more than 70 in high income countries. More than 40% of the mental health workforce globally are composed of mental health nurses, and more than 45% of the world are living in areas with less than 1 psychiatrist for every 100,000.

Government spending on mental health remains varied. Middle income countries spend <US\$ 3 per capita per year on mental health and high income countries spend > US\$ 80. In all income groups, the majority of funding goes to mental health hospitals e.g. 40% in high income countries and 80% in middle income countries. Low income countries spend less than 10 US cents per capita on mental health.

With regards to functioning prevention and promotion programmes globally, 40% are for mental health awareness, 12% suicide prevention and 10% are school promotion programmes. For a programme to be considered functioning it should include at least two of: human resource, financial resource, a plan and at least one evaluation.

Participants were encouraged to read the Mental Health Atlas as it includes more data than was presented. Participants were informed that country profiles and regional reports will soon be made available. Tarun reflected that this is an example of three-level collaboration where all three levels of WHO work together to progress action on mental health. .

The issues of service coverage and its estimation are an important component of the new WHO strategic plan, 2019-2023, 'Triple Billion' targets. There is an indicator where WHO will be monitoring service coverage for severe mental health conditions. The target for mental health service coverage in the GPW is 50%. To reach this level increased service coverage, it requires commitment to deliver services but also have mechanisms to measure it better. Investing in the measures to evaluate progress is essential.

Mark van Ommeran announced that there will be some topics that the WHO DG will take forward in the next five years as part of the 'Flagship Programmes'- and one of them is mental health. Within this WHO MSD will be supporting country offices to build capacity in their staff for mental health, for example through training. Significant upcoming conferences in which WHO MSD will have a role were mentioned.

6.3 Beyond the current action plan: Campaigning and planning for the next decade

Shekar Saxena and Dévora Kestel, representing the former and incoming directors of the WHO Department of Mental Health and Substance Abuse presented on the next decade of aspirations, beyond the current Mental Health Action Plan 2013-2020. Whilst the implementation of the Mental

Health Action Plan is occurring, implementation has not been not adequate. Therefore, four questions were posed to participants as part of an open discussion:

- How can we accelerate the implementation of the action plan which is imminently due to finish?
- How can we accelerate actions on mental health through key WHO and UN meetings and processes?
- How can we work more effectively with civil society including people with lived experience?
- How can we encourage larger and more sustainable and coordinated investment in mental health, both at national and global levels?

Responses from civil society representatives, Member States, and WHO regional offices were summarised as follows:

Implementation of mhGAP at country level

- WHO to publish Atlas country profiles in a timely manner and to include qualitative information to make them more useful.
- WHO to strengthen its capacity at country level including appointing more technical staff and to train them well including by leadership courses
- WHO to publish leadership course material for many more mental health professionals to benefit
- WHO to leverage other activities and initiatives e.g. on pandemics (e.g Ebola, HIV) and conflicts and disasters to strengthen the case for mental health
- WHO to disseminate best practices, experience and examples from countries as learning material and also to reward good achievers

Utilizing other WHO and UN mechanisms and events

- To use the interest and commitment of the UN Secretary General more fully
- To work more closely with other UN organizations (e.g. UNICEF, UNHCR UNDP) and also with others (e.g. WB)
- To use the opportunity of initiatives – such as the Alliance, Friends and Summits formed/organized by member states - to achieve more momentum for mental health at the WHA.
- To insert mental health in other resolutions of UN and WHA
- To use the opportunity of events like G7, G20 and WISH, German health summits to advance the mental health agenda.
- To be ready to begin work on the next iteration of the mental health action plan, if directed by EB/WHA

Working closely with civil society including with people with lived experience

- To work more closely with global as well as regional and national advocacy movements especially those led by people with lived experience
- To recruit people with lived experience as staff in WHO
- To have stronger collaboration with international and more importantly, national professional and civil society associations and federations

To facilitate more investments

- To approach foundations and corporations (after proper due diligence for conflict of interest) for investments, especially those not yet funding mental health
- To approach development agencies

- To make better efforts at country level
- To use the currently available funds more efficiently and effectively

6.4 Conclusions

An lively internet facilitated evaluation of participants' evaluation of the 2018 mhGAP forum was led by Alison Schafer (WHO). Multiple suggestions were received on the role of WHO: in supporting countries, in developing resources in disseminating resources and suggestions for improving the mhGAP forum for next year.

Mark van Ommeren thanked WHO Department of Mental Health and Substance Abuse staff, consultants and interns for their work in organising and hosting the forum and the efforts of all participants who attended the meeting including Member States.

Svetlana Akselrod, WHO Assistant Director-General for Noncommunicable Diseases and Mental Health, offered closing remarks. Dr Akselrod looked forward to the role of WHO HQ in working with countries and highly welcomed the role of civil society in progressing the mental health agenda. Participants were reminded that poor mental health can affect all of us during our lifetime, and that reducing stigma and acknowledging mental health as relevant to all contexts, serves to contribute to the efforts in promoting mental health as a global priority.