Setting the WHO agenda for mental health

Department of Mental Health
Social Change and Mental Health
World Health Organization
Geneva
Setting the WHO Agenda for Mental Health

Final Report on a WHO Consultative Meeting
Geneva, 28-29 April 1999

This document reports on a brainstorming meeting called by the Director-General of WHO in order to help setting the WHO agenda for mental health and presents its conclusions. The speech delivered by the Director General on that occasion is also included.

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INTRODUCTION

In order to determine the best strategies for WHO to pursue in its efforts to address the rising burden of mental health problems, the Director-General of WHO, Dr Gro Harlem Brundtland, invited fifteen eminent mental health experts from around the world (see List of Participants in Annex 1) to an open brainstorming session at WHO Headquarters in Geneva, 28-29 April 1999. The aim of this consultative meeting was to review the current understanding of mental health challenges and to discuss ideas and options for the most effective strategies for WHO to pursue.

Dr Brundtland has identified mental health as a priority for WHO’s work and attention in the coming years. In her addresses to the Governing Bodies since she took office in July 1998, she has emphasized the need to increase the attention given to the rising disability and burden resulting from mental health conditions in developing and developed countries alike. She has stressed that more attention needs to be given to the causes and their prevention as well as the best practices for treatment of mental health conditions, such as depression.

Mental health has been highlighted as an area of particular importance in the proposed WHO programme budget for 2000-2001, submitted to the Executive Board in January 1999 and approved by the 51st World Health Assembly in May 1999.

After the Director-General’s opening speech (in Annex 2), and presentations made by Dr Y. Suzuki, Executive Director, Social Change and Mental Health Cluster, and Dr B. Saraceno, Director, Department of Mental Health, four technical presentations were made in line with the meeting themes and questions previously prepared (see Annex 3). These presentations covered the following areas:

- Best evidence of the mental disease burden (Presenter: Dr H. Whiteford)
- Best evidence for primary and secondary prevention including early treatment (Presenter: Prof. F. Lieh-Mak)
- Best evidence for diagnosis and clinical practice (Presenter: Dr D. Regier)
- How WHO can contribute (Presenter: Prof. A. Kleinman)

In addition to these presentations, Prof. N. Sartorious also made a presentation on the historical background of the WHO Department of Mental Health. Each theme presentation led to group and plenary discussion enriched by the full time attendance and participation of Dr Brundtland and several other senior WHO officers.
Further to the very stimulating and productive discussions, in a friendly and participatory atmosphere, a set of recommendations was drafted and later circulated among the participants for comments.

As a general rule, when there was no agreement on a specific topic, it was not included in the final recommendations. In a few instances however, it was felt that disagreements on certain topics were a clear sign that those topics deserved further attention. In these cases they were maintained in the final recommendations trying to balance all views on them, particularly when some participants wanted to strengthen a view that others wanted to be removed.

The revised final version of the recommendations of this consultative meeting are found in the pages that follow.
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RECOMMENDATIONS

Theme 1: Best evidence for disease burden

- There is general agreement that the DALY\(^1\) is a useful epidemiological and outcome measurement tool that represents a substantial advance on traditional epidemiological measures such as prevalence and incidence rates.

- The assessment of the burden of disease using the DALY has brought to the fore the public health importance of mental and neurological disorders: in 1990, these disorders represented 10.5% of the disease burden worldwide and it is estimated that they will account for 15% of the DALYs in 2020.

- In spite of the usefulness of the DALY, additional tools are needed to measure, e.g.:
  - the strong relationship between mental illness and factors such as gender, social class, social status and poverty;
  - the psychosocial and biological problems underlying mental illness, which need to be addressed in intervention and treatment strategies;
  - other types of burden, such as stigma and human rights violations and the emotional, social and economic costs to families, governments and communities;
  - other criteria useful to determine priorities.

- Other relatively frequent and disabling mental and neurological problems - such as mental retardation and vascular dementia - should be included in the list of conditions contributing to the burden related to mental problems.

Theme 2: Best evidence for primary and secondary prevention including early treatment

- There is evidence for the effectiveness of a number of primary prevention strategies, particularly in the areas of mental retardation, epilepsy, vascular dementia and behavioural problems. Less substantial evidence exists at this stage concerning the prevention of

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\(^1\) DALY (Disability-Adjusted Life Years) is a measure that combines the burden from premature mortality and that from living with disability of specified severity and duration. By indicating years of productive life lost from either premature death or years lived with a disability, it both provides information on the potential years of productive life which can be gained from effective prevention or treatment, and helps in establishing the cost effectiveness of mental health interventions to reduce this burden (and loss of human capital).
schizophrenia and some other major mental disorders; for some other disorders (e.g. Alzheimer’s disease) no primary prevention is possible, although new discoveries are promising.

- In view of the fact that much primary prevention strategies have to be carried out by other professionals and health workers (for example, the distribution of iodine, perinatal care, life skills interventions in schools) mental health professionals must highlight the importance of engaging in these activities and provide technical specification of what needs to be done.

- There is insufficient knowledge of individual, non biological vulnerability and resiliency factors in childhood that predispose to or protect from the development of mental disorders among adults, that can be targeted by specific, tailored preventive interventions.

- Overall there is more evidence for secondary and tertiary prevention (which have more successfully organized services) than for primary prevention of severe mental illnesses.

**Theme 3: Best evidence for diagnosis and clinical practice**

- WHO has developed a significant number of assessment tools which are now widely used. Many of these instruments could be improved in terms of sensitivity in relation to culture, gender, age and population needs and/or health care seeking behaviour, and of a link with underlying psychosocial and biological factors and with treatment strategies. Also, these assessment tools could gain in feasibility by being more client and symptom oriented and if they provide rapid assessments suitable for use in direct care.

- A number of community-based programmes and case management cost-effective interventions are available for psychosis, depression, epilepsy, anxiety and other neuropsychiatric disorders. Treatment compliance and outcome assessment can be improved when a chronic-disease model of clinical case-management is followed.

- The treatment of the most prevalent mental disorders such as depressive disorders has been shown to be cost-effective. The Direct Observed Treatment Strategies (DOTS) approach for managing multidrug resistant tuberculosis could be appropriate for managing depression in primary care settings, as is the case for other chronic diseases such as diabetes and hypertension. Existing research suggests that primary care physicians can assume management responsibility at this level more easily if they have access to referral facilities and if there is a sustained access to essential medication. A WHO demonstration project on the treatment of depression in primary health care could represent an important step beyond cost-effectiveness, to highlight the generalizability and sustainability of this model.

- Evidence-based treatment strategies for schizophrenia and other psychoses should be implemented with attention to pharmacological and psychosocial treatment procedures of demonstrated efficacy and to recent developments in these areas. These procedures include the availability of adequate anti-psychotic medications, case management, self-help
and professional support of families, day-care centres, supported living facilities, vocational training, other social support services, primary health care, crises support, and inpatient hospitalization for acute symptomatic stabilisation. Implementation of these programmes requires community support through public education and action to reduce stigma and discrimination against people with mental illness. It has been possible to significantly improve the conditions and maintain patients with chronic mental illness in community settings in both developed and developing countries if psychosocial and psychopharmacological treatments are adequately provided.

- Patients’ human rights, both in treatment settings and in the community, should be monitored and enforced. Human rights issues relating to discrimination include the need for explicit legal guidelines to balance society’s requirements for compulsory treatment with a patient’s right to refuse treatment. Of equal importance is the right to parity in insurance or other financing of needed treatment for mental disorders with that available for other medical and surgical conditions.

- Existing community support services (such as those initiated by family and consumer groups) could be included as essential components of cost-effective mental health services; they should be identified, further developed, expanded and supported.

**Theme 4: How WHO can contribute.**

- WHO should strengthen its collaboration with countries, other international governmental and non-governmental organizations, professionals, scientists, the media etc., by encouraging the inclusion of mental health into their agendas.

- WHO should provide the information base indicating how efficacious interventions for mental health can be generalised successfully at the community or population level, including the linkage of mental health interventions to a health sector approach, thus firmly mainstreaming mental health into general health, and health in the context of human development. Differences between urban and rural areas, and the scarcity of professional human resources and care in developing countries deserve special attention. Cost-effective strategies to intervene effectively for both the ‘hidden burden’ such as stigma, discrimination and human rights violations and the burden measured by DALYs are still needed. The wide scale dissemination/implementation of efficacious interventions could be improved if these other types of burden is recognized and taken into account.

- WHO should provide leadership in the development of technology needed for the development of mental health programmes and policies integrated into the general health sector approach, including the reduction of discrimination and stigma. This technology includes:

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2 As spelled out in the United Nations General Assembly Resolution 46/119 of 17 December 1991, on “Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care”. 
good practice and quality assurance guidelines incorporating procedures for the
generalization of prevention and treatment of target diseases and conditions; and
advice to the health sector on organization, financing and structure.

- WHO should advise Member States and communities on how to set up policies,
programmes, mobilise resources and funds from other sectors (e.g. labour, education) and
external funding bodies but also on how to make better use of intrinsic community
resources including the important resources provided by family members.

- WHO should target:

  (a) key areas where it can make a difference such as rehabilitation of schizophrenia,
treatment of depression and epilepsy in the primary care setting and suicide
prevention and
  (b) vulnerable populations, such as poor women, victims of violence, displaced
persons, the elderly and persons living in extreme poverty.

- Six steps are recommended to be part of the immediate WHO agenda. These are:

  - demonstration of a strong commitment by the Director-General of WHO;
  - better use of the UNDP resident coordinator system;
  - convening a meeting on the broader economic issues around mental health,
particularly mental health financing;
  - organization of a network of centres interested in mental health policy in the
international context;
  - provision of strong support to regional mental health advisers and country
officers; and
  - careful preparation for an International Year for Mental Health or the recognition
by WHO of a World Mental Health Day.

- Primary health care intervention protocols for mental disorders should be evaluated taking
into account, in addition to clinical outcome measures, indicators allowing an assessment
of their impact in terms of both the human and the social capital (i.e. social cohesiveness
and morale that are important determinants of the quality of life and willingness to
contribute to the society). Mental health promotion and the reduction of discrimination
against people with mental illness directly promote social capital, which is important for
healthy and economically productive societies.
ANNEX 1

Setting the WHO Agenda for Mental Health
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* Invited but unable to attend.
ANNEX 2

Setting the WHO Agenda for Mental Health
Geneva, 28-29 April 1999

Opening speech by

Dr Gro Harlem Brundtland
Director-General
World Health Organization

Colleagues,

It gives me great pleasure to welcome you to WHO on this very special occasion.

Today and tomorrow we are opening the doors of WHO to listen. When I took office last July there was one thing of which I was certain: WHO needed to devote considerable attention to the mounting challenges from mental health disorders.

As a physician, a politician and a Prime Minister, I had followed the evolution of new knowledge and evidence over the years, noting how mental health gradually – and often silently – was growing to become a substantial cause of the global burden of disease – in rich and poor countries alike.

In contrast to the dramatic improvements in physical health in most countries over the course of the current century - in particular, unprecedented improvements in mortality rates - the mental component of health has in many places not improved.

At the same time I noticed – in my own country as well as in the international debate -that there was considerable uncertainty in the way health authorities recommended to deal with the issue. Mental health covers a broad range of medical and social dimensions. In many countries the area is marked by social taboos and in the professional debate there are strong and often conflicting schools of thought, not making it any easier for primary health care workers – or for political decision-makers.

It was clear to me that WHO has a critical role to play in shaping the global focus on the mental health challenge and to develop further evidence and knowledge about best practices.

We have a pretty clear picture of the burden of disease coming from mental health disorders. Increasingly sophisticated methods to measure health and its burden, in particular the DALY (Disability Adjusted Life Year), have helped to provide a more balanced conception of needs and priorities.

What the DALY does is to quantify not only the number of deaths but also the impact of premature death and disability on a population. It combines them into a single unit of measurement of the overall burden of disease. Using the DALY as the basis for measurement, mental health problems have been found to be one of the most significant contributors to the global burden of disease.
In the World Health Report that we put out two weeks from now we bring updated figures.

Worldwide, mental disorders accounted for approximately 12% of all disability adjusted life years lost in 1998. Their contribution is higher in high-income countries (23%) than in low and middle income countries (11%).

Major depression was ranked fifth in the 10 leading causes of global disease burden and this condition is as relevant in developing countries. After major depression, the most important causes of neuropsychiatric burden are alcohol dependence, bipolar affective disorders and schizophrenia. In high-income countries, Alzheimer's and other dementias are the third leading cause of neuropsychiatric burden.

Major depression is closely linked with suicide, since most individuals who commit suicide are also clinically depressed. The burden attributable to major depression is 40% more than the direct burden, once suicide is taken into account.

Five of the ten leading causes of disability worldwide (major depression, schizophrenia, bipolar disorders, alcohol use and obsessive compulsive disorders) are mental problems. They are as relevant in developing countries as they are in high income countries.

And the more we know about the present, the more we learn about the future. All predictions are that the future will bring an exponential increase in mental problems. The most important reasons include the ageing of the population, exacerbating social problems and unrest, including the rising number of persons affected by violent conflicts, civil wars and disasters and the growing number of displaced persons.

There can be no doubt: Mental health has to be given renewed and increased attention from WHO. That means a strengthened organizational emphasis and that we are doing. Our contribution has to look beyond what WHO funds can buy – it is a question of how we as the lead agency in health can help mobilize resources, attention and new knowledge and better advise governments on how to adapt and develop their policies.

We have completed our reorganization and you will learn more about our new structure during the day. As we target our strategies we have wanted to call on you – a distinguished group of experts - with the simple purpose of listening, understanding and seeking together with you the best way to pursue.

This is – to my knowledge - the first attempt of WHO to bring together a group of outstanding specialists to examine mental health issues in a comprehensive way and from an innovative perspective.

Meetings on mental health have indeed been organised in the past. The programme 'Nations for Mental Health' had expert consultations in '96 and in '97 and a Global WHO Mental Health Programme Coordinating Group meeting was convened every two years, each time in a different region, the last one in 1994 in Beijing. That meeting was an attempt to provide the WHO with a general perspective on mental health.

However, the focus of these meetings was to review and update existing workplans and strategies for WHO's mental health programme.
My intention is for this meeting to be more comprehensive and ambitious. Before reviewing the existing WHO workplan, we need to examine what is the best evidence for the mental health burden—what is the best evidence for assessment, treatment, prevention and health promotion. Then—at the end of these two days—we will be better placed to develop a forward-looking workplan for mental health and the best way for the WHO to contribute to an effective mental health response.

Beyond the striking figures related to those suffering from defined mental disorders, there exist a number of groups of people who, because of extremely difficult circumstances or conditions, are at special risk of being affected by the burden of mental problems. These include persons in extreme poverty (such as slum-dwellers); children and adolescents experiencing disrupted nurturing; abused women; abandoned elderly people; persons traumatized by violence such as forced migrants and refugees. The Kosovo tragedy tells all about it.

We are, today, in a position to make better use of a wealth of knowledge and technologies that allows us more effectively to manage, treat and prevent a wide range of mental health and neurological problems. It is time to review priorities and commitments and to recognize the substantial benefits that will accrue through investing in mental health.

WHO intends to respond to this challenge.

First of all, WHO has an essential role in assisting countries in the strengthening of the overall mental health system, assisting them in generating policies and improving the provision of services and treatment. We also need to strengthen the technical capacity of individuals working in the area of mental health to utilise effectively state-of-the-art information on mental health intervention.

In order to make cost-effective treatments available to the population, we must consider access to care, which no doubt needs to increase substantially. Almost 140 countries have now an updated list of essential drugs, including psychotropic drugs. But at the same time we know that one third of the global population has no access to these essential drugs. In Africa, 50% of the population is unable to access the required drugs; the situation is particularly pertinent in rural areas where antidepressants, anticonvulsants and antipsychotic drugs are rarely available.

In relation to the issue of access we need to make overall treatment for mental problems—not only drugs—available to the population. Mental health needs to be integrated into general health, especially into primary health care.

Secondly, we should promote operational research at country level to understand better the cost-effectiveness of implemented strategies. Cost-effectiveness should not be limited to treatment, rehabilitation and prevention strategies but should encompass the use of advocacy strategies and awareness-raising activities. Important work in the Social Sciences has led to the development of innovative models to maximise the impact of advocacy and awareness raising, and we should embrace these models in order to better plan, implement and evaluate.

However, a strategy based on health systems alone is not sufficient. In WHO as a whole, both at Headquarters and in the Regions, the objective is to place health sector development more squarely at the heart of the Organization's work. Health is one of the most politically and institutionally difficult sectors in any country and involves all the public and private institutions that have a stake in people's health.
We are working to become a more effective and reliable supporter of countries as they 
restructure and reform their health sectors. Sector-wide approaches offer a way of supporting 
health development to strengthen national ownership and help to build national systems.

Expanding our work in this area will require a strategy of reaching out to our many 
partners - in the scientific community, with professional and nongovernmental organisations, and 
with the broader family of development agencies, within and beyond the United Nations System.

Many WHO Collaborating Centers have contributed substantially to a number of 
achievements in mental health. Some notable examples include the Pilot Study on Schizophrenia, 
the development of the chapter on mental and behavioural disorders in the International 
Classification of Diseases, and the conception and design of the initiative Nations for Mental 
Health.

We are currently reviewing the policy and the working mechanisms of our WHO 
Collaborating Centers in order to improve further our collaboration and to maximise input which 
iso consistent with the goals of the WHO. Excellent collaborations have also been established with 
many professional organizations and NGOs, - the World Psychiatric Association, the World 
Federation of Mental Health, Alzheimer's Disease International, the World Federation of 
Neurology, the International League against Epilepsy and the International Association for 
Suicide Prevention - just to name a few.

The UN system is a huge family of agencies with different mandates many of which could 
encompass mental health. With the International Labour Office we have established close links 
in the field of vocational rehabilitation and mental health in the workplace; with the UNHCR we have 
common projects concerning the mental health of refugees, and with ECOSOC we have 
collaborated on issues related to the human rights of people with mental disorders, an activity now 
broadened to include the UN human rights agency.

A closer working relationship with these organizations can contribute to mainstreaming 
of mental health within the UN system; thereby increasing the impact of mental health activities 
at country level.

Finally, even within the WHO, partnerships should be strengthened. There are many 
departments and clusters, dealing directly or indirectly with mental health issues. Only if we work 
towards a 'one WHO', can we have a unique, strong and effective WHO mental health policy.

Distinguished experts,

I thank you for agreeing to attend this meeting, to share with us your valuable knowledge 
and experience and to help WHO set the agenda for its response to an increasingly important 
public health issue.

I invite you to engage actively during these two days of brainstorming and to share with 
us your insight and knowledge.

Thank you.
ANNEX 3

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Questions and issues to be addressed

Each of the themes and related questions below should be considered within the context of a cross-cultural and gender sensitive perspective embracing mental health service delivery and the public health approach.

Theme 1:  Best evidence of the mental disease burden

Guiding questions/issues

1. How broad are most current conceptions of mental health?
   (a) Should the notion be more broad or more narrowly defined?
   (b) What should be the essential elements?

2. How should the notion of mental disease burden relate to the notion of mental health?

3. How adequate is our current picture of the burden from mental illness? Are the burden of disease estimates to be published in WHR99 a reasonable start?

4. Would it be important or feasible to broaden the notion of mental disease burden to include:
   (a) the effects of stigma, discrimination, human rights violations?
   (b) conditions which generate mental health problems - not necessarily disease?
5. What information and data does the WHO need to collect in order to understand better the mental disease burden and needs of member states?
   (a) Who should collect this information
   (b) What level of complexity of information is required or is feasible

Theme 2: Best evidence for primary and secondary prevention of mental disease, including early treatment

Guiding questions/issues

1. What are the primary prevention strategies that are effective for the prevention of mental illness/problems and what evidence is there for their effectiveness/cost-effectiveness?

2. What are the secondary prevention strategies that are effective for the prevention of mental illness/problems and what evidence is there for their effectiveness/cost-effectiveness?

3. What is the role of treatment for mental illness in the area of suicide prevention?

4. What evidence is there for early treatment as an effective (and cost-effective) prevention strategy?

5. What is the relation between mental health promotion and the prevention of mental illness/problems?

6. What kind of data is needed to strengthen WHO’s response to the prevention of mental illness/problems?

Theme 3: Best evidence for diagnosis and clinical practice

Guiding questions/issues
1. What are the range of tools we have to make rapid and reliable diagnoses for use in the different health care settings, and what are their costs?

2. To what extent can (or should) outpatient management of patients through medication and psychosocial intervention replace long term inpatient care?

3. What are the available effective (including cost-effective) interventions for mental illness/problems and what evidence exists for their effectiveness in developing and developed countries?

4. How can we strengthen our data base of cost-effective interventions for mental problems/diseases?

5. When no cost-effective mental health interventions are available or when the complexity of the problem goes beyond a simple cost-effective mental health intervention what are the strategies and alliances that can be utilised?

6. How can WHO’s response to mental illness/problems be maximised, for example, through a disease oriented approach, through an approach emphasizing the strengthening of services or through other approaches? How might these approaches be different for developing and developed countries?
Theme 4: How WHO can contribute

Guiding questions/issues

1. How can WHO help place mental health more firmly on the public health agenda?

2. How should WHO approach the different agendas of the health sector, non-health sector, government and NGOs, the business community and international agencies?

3. What is WHO's role in collecting, standardizing and disseminating evidence on cost, effectiveness, and quality of preventive, curative and diagnostic interventions?