World Health Organization

SIXTY-SIXTH WORLD HEALTH ASSEMBLY
Provisional agenda item 13.3

A66/10 Rev.1
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Draft comprehensive mental health action plan 2013–2020

Report by the Secretariat

1. The Executive Board at its 132nd session noted an earlier version of this report and approved the process for finalizing the draft comprehensive mental health action plan 2013–2020.[1] A short web-based consultation was held from 1 to 28 February 2013, allowing Member States to provide additional comments and feedback. The draft action plan has been revised accordingly.

2. The burden of mental disorders continues to grow with significant impacts on health and major social, human rights and economic consequences in all countries across the world.

3. In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It urged Member States inter alia to develop and strengthen comprehensive policies and strategies that address the promotion of mental health, prevention of mental disorders, and early identification, care, support, treatment and recovery of persons with mental disorders. It also requested the Director-General, inter alia, to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.

4. A "zero draft" of the action plan, covering the period 2013–2020, was written and used as the basis for consultation with Member States, civil society and international partners. Consultations were held through five regional meetings, a Global Forum on Mental Health (Geneva, 10 October 2012), a web-based consultation (from 27 August to 19 October 2012) and an informal consultation with Member States (Geneva, 2 November 2012). Feedback was received from 135 Member States, 60 WHO collaborating centres and academic centres, 76 nongovernmental organizations, as well as 17 other organizations and individual experts. The informal consultation with Member States was also used as an opportunity to present and discuss the feedback received through the previous consultations and to receive direction on the final draft of the action plan.

5. Pursuant to resolution WHA65.4, the draft comprehensive mental health action plan 2013–2020, (see Annex), addresses the disease, social and economic burdens and human rights consequences of mental disorders. It proposes clear actions for Member States and international, regional and national-level partners, as well as actions for the Secretariat. It also contains proposed indicators and targets that can be used to evaluate levels of implementation, progress and impact.

[1] See document EB132/8 and the summary record of the third meeting of the Executive Board at its 132nd session.

ACTION BY THE HEALTH ASSEMBLY

6. The Health Assembly is invited to note the report and to consider the following draft resolution:

The Sixty-sixth World Health Assembly,

PP1 Having considered the report by the Secretariat on the draft comprehensive action plan 2013–2020, including the Annex,[1]

1. ADOPTS the comprehensive mental health action plan 2013–2020;

2. URGES Member States to implement proposed actions for Member States in the comprehensive mental health action plan 2013–2020;

3. INVITES international, regional and national partners to take note of the comprehensive mental health action plan 2013–2020;

4. REQUESTS the Director-General to implement actions for the Secretariat in the comprehensive mental health action plan 2013–2020 and to submit reports on the progress achieved in implementing the action plan, through the Executive Board, to the Sixty-eighth, Seventy-first and Seventy-fourth World Health Assemblies.

[1] Document A66/10 Rev.1.

ANNEX

DRAFT COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020

1. In May 2012, the Sixty-fifth World Health Assembly adopted resolution WHA65.4 on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level. It requested the Director-General, inter alia, to develop a comprehensive mental health action plan, in consultation with Member States, covering services, policies, legislation, plans, strategies and programmes.

2. This draft comprehensive action plan has been elaborated through consultations with Member States, civil society and international partners. It takes a comprehensive and multisectoral approach, through coordinated services from the health and social sectors, with an emphasis on promotion, prevention, treatment, rehabilitation, care and recovery. It also sets out clear actions for Member States, the Secretariat and international, regional and national level partners, and proposes key indicators and targets that can be used to evaluate levels of implementation, progress and impact. The action plan has, at its core, the globally accepted principle that there is "no health without mental health".[1]

3. The draft action plan has close conceptual and strategic links to other global action plans and strategies endorsed by the Health Assembly, including the global strategy to reduce the harmful use of alcohol, the global plan of action for workers' health, 2008–2017, the action plan for the global strategy for the prevention and control of noncommunicable diseases, 2008–2013, and the draft global action plan for the prevention and control of noncommunicable diseases (2013–2020). It also draws on WHO's regional action plans and strategies for mental health and substance abuse that have been adopted or are being developed. The draft action plan has also been designed to create synergy with other relevant programmes of organizations in the United Nations system, United Nations interagency groups and intergovernmental organizations.

4. The draft action plan builds upon, but does not duplicate, the work of WHO's mental health gap action programme (mhGAP). The focus of the latter was to expand services for mental health in low-resource settings. The draft action plan is global in its scope and is designed to provide guidance for national action plans. It addresses, for all resource settings, the response of social and other relevant sectors, as well as promotion and prevention strategies.

5. In this draft action plan, the term "mental disorders" is used to denote a range of mental and behavioural disorders that fall within the International Statistical Classification of Diseases and Related Health Problems (Tenth revision). These include disorders that cause a high burden of disease such as depression, bipolar affective disorder, schizophrenia, anxiety disorders, dementia, substance use disorders, intellectual disabilities, and developmental and behavioural disorders with onset usually occurring in childhood and adolescence, including autism. For dementia and substance use disorders, additional prevention strategies may also be required (as, for example, described in a WHO report on dementia issued in early 2012[2] and the global strategy to reduce the harmful use of alcohol).

[1] See the WHO web site (http://www.who.int/mental_health/mhgap/consultation_global_mh_action_plan_2013_2020/en/index.html) for: a glossary of main terms; links to other global action plans, strategies and programmes; international and regional human rights treaties; and selected WHO technical materials and resources on mental health.

[2] WHO, Alzheimer's Disease International. *Dementia: a public health problem.* Geneva, World Health Organization, 2012.

Furthermore, the plan covers suicide prevention and many of the actions are also relevant to conditions like epilepsy. The term "vulnerable groups" is used in the draft action plan to refer to individuals or groups of individuals who are made vulnerable by the situations and environments that they are exposed to (as opposed to any inherent weakness or lack of capacity). The term "vulnerable groups" should be applied within countries as appropriate to the national situation.

6. The draft action plan also covers mental health, which is conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, and to build social relationships, as well as the aptitude to learn and acquire an education, ultimately enabling their full active participation in society.

7. In light of the widespread human rights violations and discrimination experienced by people with mental disorders, a human rights perspective is essential in responding to the global burden of mental disorders. The draft action plan emphasizes the need for services, policies, legislation, plans, strategies and programmes to protect, promote and respect the rights of persons with mental disorders in line with the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of Persons with Disabilities, the Convention on the Rights of the Child and other relevant international and regional human rights instruments.

OVERVIEW OF THE GLOBAL SITUATION

8. Mental health is an integral part of health and well-being, as reflected in the definition of health in WHO's Constitution: "health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". Mental health, like other aspects of health, can be impacted by a range of socioeconomic factors (described below) that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery in a whole-of-government approach.

Mental health and disorders: determinants and consequences

9. Determinants of mental health and mental disorders include not only individual attributes such as the ability to manage one's thoughts, emotions, behaviours and interactions with others, but also social, cultural, economic, political and environmental factors such as national policies, social protection, living standards, working conditions, and community social supports among others. Exposure to adversity at a young age is an established preventable risk factor for mental disorders.

10. Depending on the local context, certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may (but not necessarily) include members of households living in poverty, people with chronic health conditions, infants and children exposed to maltreatment and neglect, adolescents first exposed to substance use, minority groups, indigenous populations, older people, people experiencing discrimination and human rights violations, lesbian, gay, bisexual, and transgender persons, prisoners, and people exposed to conflict, natural disasters or other humanitarian emergencies. The current global financial crisis provides a powerful example of a macroeconomic factor leading to cuts in funding despite a concomitant need for more mental health and social services because of higher rates of mental disorders and suicide as well as the emergence of new vulnerable groups (for example the young unemployed). In many societies, mental disorders related to marginalization and impoverishment, domestic violence and abuse, and overwork and stress are of growing concern, especially for women's health.

11. People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely than the general population, owing to physical health problems that are often left unattended (such as cancers, cardiovascular diseases, diabetes and HIV infection) and suicide. Suicide is the second most common cause of death among young people worldwide.

12. Mental disorders often affect, and are affected by, other diseases such as cancer, cardiovascular disease and HIV infection/AIDS, and as such require common services and resource mobilization efforts. For example, there is evidence that depression predisposes people to myocardial infarction and diabetes, both of which conversely increase the likelihood of depression. Many risk factors such as low socioeconomic status, alcohol use and stress are common to both mental disorders and other noncommunicable diseases. There is also substantial concurrence of mental disorders and substance use disorders. Taken together, mental, neurological and substance use disorders exact a high toll, accounting for 13% of the total global burden of disease in the year 2004. Depression alone accounts for 4.3% of the global burden of disease and is among the largest single causes of disability worldwide (11% of all years lived with disability globally), particularly for women. The economic consequences of these health losses are equally large: a recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16.3 million million between 2011 and 2030.[1]

13. Mental disorders frequently lead individuals and families into poverty.[2] Homelessness and inappropriate incarceration are far more common for people with mental disorders than the general population, and exacerbate their marginalization and vulnerability. Because of stigmatization and discrimination, persons with mental disorders often have their human rights violated and many are denied economic, social and cultural rights, with restrictions on the rights to work and education, as well as reproductive rights and the right to the highest attainable standard of health. They may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities. They are often denied civil and political rights such as the right to marry and found a family, personal liberty, the right to vote and to participate effectively and fully in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care. As such, persons with mental disorders often live in vulnerable situations and may be excluded and marginalized from society, which constitutes a significant impediment to the achievement of national and international development goals. The Convention on the Rights of Persons with Disabilities, which is binding on States Parties that have ratified or acceded to it, protects and promotes the rights of all persons with disabilities, including persons with mental and intellectual impairments, and also promotes their full inclusion in international cooperation including international development programmes.

Health system resources and responses

14. Health systems have not yet adequately responded to the burden of mental disorders; as a consequence, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorder in low-income and middle-income countries; the corresponding range for high-income countries is

[1] World Economic Forum, the Harvard School of Public Health. *The global economic burden of non-communicable diseases.* Geneva, World Economic Forum, 2011.

[2] *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

also high: between 35% and 50%. A further compounding problem is the poor quality of care for those receiving treatment. WHO's *Mental Health Atlas 2011* provides data that demonstrate the scarcity of resources within countries to meet mental health needs, and underlines the inequitable distribution and inefficient use of such resources. Globally, for instance, annual spending on mental health is less than US$ 2 per person and less than US$ 0.25 per person in low-income countries, with 67% of these financial resources allocated to stand-alone mental hospitals, despite their association with poor health outcomes and human rights violations. Redirecting this funding towards community-based services, including the integration of mental health into general health care settings, and through maternal, sexual, reproductive and child health, HIV/AIDS and other chronic noncommunicable disease programmes, would allow access to better and more cost-effective interventions for many more people.

15. The number of specialized and general health workers dealing with mental health in low-income and middle-income countries is grossly insufficient. Almost half the world's population lives in countries where, on average, there is one psychiatrist to serve 200 000 or more people; other mental health-care providers who are trained in the use of psychosocial interventions are even scarcer. Similarly, a much higher proportion of high-income countries than low-income countries reports having a policy, plan and legislation on mental health; for instance, only 36% of people living in low-income countries are covered by mental health legislation compared with 92% in high-income countries.

16. Civil society movements for mental health in low-income and middle-income countries are not well developed. Organizations of people with mental disorders and psychosocial disabilities are present in only 49% of low-income countries compared with 83% of high-income countries; for family associations the respective figures are 39% and 80%.

17. Finally, the availability of basic medicines for mental disorders in primary health care is notably low (in comparison to medicines available for infectious diseases and even other noncommunicable diseases), and their use restricted because of the lack of qualified health workers with the appropriate authority to prescribe medications. In addition, the availability of non-pharmacological approaches and trained personnel to deliver these interventions is also lacking. Such factors act as important barriers to appropriate care for many persons with mental disorders.

18. What is being done to improve this situation? In addition to the data on mental health resources in countries (from WHO's Mental Health Atlas 2011, as well as the more detailed profiling obtained through use of WHO's Assessment Instrument for Mental Health Systems),[1] information is available on cost-effective and feasible mental health interventions that can be expanded to larger scale to strengthen mental health care systems in countries. WHO's Mental Health Gap Action Programme, launched in 2008, uses evidence-based technical guidance, tools and training packages to expand service provision in countries, especially in resource-poor settings. It focuses on a prioritized set of conditions and, importantly, directs its capacity building towards non-specialized health care providers in an integrated approach that promotes mental health at all levels of care.

19. The Secretariat has elaborated other technical tools and guidance in support of countries in developing comprehensive mental health policies, plans and laws that promote improved quality and availability of mental health care (such as the WHO mental health policy and service guidance package);[2] in improving quality and respecting the rights of persons with mental disorders in health

[1] *WHO-AIMS version 2.2: World Health Organization Assessment Instrument for Mental Health Systems*, Geneva, World Health Organization, 2005 (document WHO/MSD/MER/05.2).

[2] http://www.who.int/mental_health/policy/essentialpackage1/en/index.html (accessed 10 December 2012).

services (the WHO QualityRights toolkit);[1] and for disaster relief and post-disaster mental health system reconstruction (including the Inter-Agency Standing Committee Guidelines in mental health and psychosocial support in emergency settings).[2] Knowledge, information and technical tools are necessary but not sufficient; strong leadership, enhanced partnerships and the commitment of resources towards implementation are also required in order to move decisively from evidence to action and evaluation.

STRUCTURE OF THE COMPREHENSIVE ACTION PLAN 2013–2020

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

21. Its overall **goal** is to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

22. The action plan has the following **objectives**:

(1) to strengthen effective leadership and governance for mental health

(2) to provide comprehensive, integrated and responsive mental health and social care services in community-based settings

(3) to implement strategies for promotion and prevention in mental health

(4) to strengthen information systems, evidence and research for mental health.

The global targets established for each objective provide the basis for measurable collective action and achievement by Member States towards global goals and should not negate the setting of more ambitious national targets, particularly for those countries that have already reached global ones. Indicators for measuring progress towards defined global targets are provided in Appendix 1.

23. The action plan relies on six **cross-cutting principles and approaches**:

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

[1] *WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities*. Geneva, World Health Organization, 2012.

[2] Inter-Agency Standing Committee. *IASC guidelines on mental health and psychosocial support in emergency settings*. Geneva, Inter-Agency Standing Committee, 2007.

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

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

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

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

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

24. The framework provided in this action plan needs to be adapted at regional level in order to take into account region-specific situations. The actions proposed for Member States are to be considered and adapted, as appropriate, to national priorities and specific national circumstances in order to accomplish the objectives. There is no blueprint action plan that fits all countries, as countries are at different stages in developing and implementing a comprehensive response in the area of mental health.

PROPOSED ACTIONS FOR MEMBER STATES AND INTERNATIONAL AND NATIONAL PARTNERS AND ACTIONS FOR THE SECRETARIAT

25. To achieve the plan's stated vision, goal and objectives, specific actions are proposed for Member States and for international and national partners. In addition, actions for the Secretariat have been identified. Although actions are specified separately for each objective, many of these will also contribute to the attainment of the other objectives of the action plan. Some possible options to implement these actions are proposed in Appendix 2.

26. Effective implementation of the global mental health action plan will require actions by international, regional and national partners. These partners include but are not limited to:

- development agencies including international multilateral agencies (for example, the World Bank and United Nations development agencies), regional agencies (for example, regional development banks), subregional intergovernmental agencies and bilateral development aid agencies;

- academic and research institutions including the network of WHO collaborating centres for mental health, human rights and social determinants of health and other related networks, within developing and developed countries;

- civil society, including organizations of persons with mental disorders and psychosocial disabilities, service-user and other similar associations and organizations, family member and carer associations, mental health and other related nongovernmental organizations, community-based organizations, human rights-based organizations, faith-based organizations, development and mental health networks and associations of health care professionals and service providers.

27. The roles of these three groups are often overlapping and can include multiple actions across the areas of governance, health and social care services, promotion and prevention in mental health, and information, evidence and research (see actions listed below). Country-based assessments of the needs and capacity of different partners will be essential to clarify the roles and actions of key stakeholder groups.

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

28. Planning, organizing and financing health systems is a complex undertaking involving multiple stakeholders and different administrative levels. As the ultimate guardian of a population's mental health, governments have the lead responsibility to put in place appropriate institutional, legal, financing and service arrangements to ensure that needs are met and the mental health of the whole population is promoted.

29. Governance is not just about government, but extends to its relationship with nongovernmental organizations and civil society. A strong civil society, particularly organizations of people with mental disorders and psychosocial disabilities and families and carers, can help to create more effective and accountable policies, laws and services for mental health in a manner consistent with international and regional human rights instruments.

30. Among the key factors for developing effective policies and plans addressing mental health are strong leadership and commitment by governments, involvement of relevant stakeholders, clear elaboration of areas for action, formulation of financially-informed and evidence-based actions, explicit attention to equity, respect for the inherent dignity and human rights of people with mental disorders and psychosocial disabilities, and the protection of vulnerable and marginalized groups.

31. Responses will be stronger and more effective when mental health interventions are firmly integrated within the national health policy and plan. In addition, often it is necessary to develop a dedicated mental health policy and plan in order to provide more detailed direction.

32. Mental health law, whether an independent legislative document or integrated into other health and capacity-related laws, should codify the key principles, values and objectives of policy for mental health, for example by establishing legal and oversight mechanisms to promote human rights and the development of accessible health and social services in the community.

33. Policies, plans and laws for mental health should comply with obligations under the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.[1]

[1] Major international and regional human rights instruments are listed in the WHO web site: http://www.who.int/mental_health/mhgap/consultation_global_mh_action_plan_2013_2020/en/index.html.

34. Inclusion and mainstreaming of mental health issues more explicitly within other priority health programmes and partnerships (for instance, HIV/AIDS, women's and children's health, noncommunicable diseases and the global health workforce alliance) as well as into other relevant sectors' policies and laws, for example those dealing with education, employment, disability, the judicial system, human rights protection, social protection, poverty reduction and development, are important means of meeting the multidimensional requirements of mental health systems and should remain central to leadership efforts of governments to improve treatment services, prevent mental disorders and promote mental health.

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

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

Proposed actions for Member States

35. *Policy and law*: Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

36. *Resource planning*: Plan according to measured need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon evidence-based mental health plans and actions.

37. *Stakeholder collaboration*: Motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.

38. *Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations*: Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policies, laws and services.

Actions for the Secretariat

39. *Policy and law*: Compile knowledge and best practices for – and build capacity in – the development, multisectoral implementation and evaluation of policies, plans and laws relevant to mental health, including codes of practice and mechanisms to monitor protection of human rights and implementation of legislation, in line with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

40. *Resource planning*: Offer technical assistance to countries in multisectoral resource planning, budgeting and expenditure tracking for mental health.

41. *Stakeholder collaboration:* Provide best practices and tools to strengthen collaboration and interaction at international, regional and national levels between the stakeholders in the development, implementation and evaluation of policy, strategies, programmes and laws for mental health, including

the health, judicial and social sectors, civil society groups, persons with mental disorders and psychosocial disabilities, carers and family members, and organizations in the United Nations system and human rights agencies.

42. *Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations*: Engage organizations of people with mental disorders and psychosocial disabilities in policy making at international, regional and national levels within WHO's own structures and provide support to organizations to design technical tools for capacity building, based on international and regional human rights instruments and WHO's own human rights and mental health tools.

Proposed actions for international and national partners

43. Mainstream mental health interventions into health, poverty reduction, development policies, strategies and interventions.

44. Include people with mental disorders as a vulnerable and marginalized group requiring prioritized attention and engagement within development and poverty-reduction strategies, for example in education, employment and livelihood programmes, and the human rights agenda.

45. Explicitly include mental health within general and priority health policies, plans and research agenda, including noncommunicable diseases, HIV/AIDS, women's health, child and adolescent health, as well as through horizontal programmes and partnerships, such as the Global Health Workforce Alliance, and other international and regional partnerships.

46. Support opportunities for exchange between countries on effective policy, legislative and intervention strategies for promoting mental health, preventing mental disorders and promoting recovery from disorders based on the international and regional human rights framework.

47. Support the creation and strengthening of associations and organizations of people with mental disorders and psychosocial disabilities as well as families and carers, and their integration into existing disability organizations, and facilitate dialogue between these groups, health workers and government authorities in health, human rights, disability, education, employment, the judiciary and social sectors.

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

48. In the context of improving access to care and service quality, WHO recommends the development of comprehensive community-based mental health and social care services; the integration of mental health care and treatment into general hospitals and primary care; continuity of care between different providers and levels of the health system; effective collaboration between formal and informal care providers; and the promotion of self-care, for instance through the use of electronic and mobile health technologies.

49. Developing good-quality mental health services requires the use of evidence-based protocols and practices, including early intervention, incorporation of human rights principles, respect for individual autonomy and the protection of people's dignity. Furthermore, health workers must not limit intervention to improving mental health but also attend to the physical health care needs of children, adolescents and adults with mental disorders, and vice versa, because of the high rates of co-morbid physical and mental health problems and associated risk factors, for example high rates of tobacco consumption, that go unaddressed.

50. Community-based service delivery for mental health needs to encompass a recovery-based approach that puts the emphasis on supporting individuals with mental disorders and psychosocial disabilities to achieve their own aspirations and goals. The core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise. In addition, a multisectoral approach is required whereby services support individuals, at different stages of the life course and, as appropriate, facilitate their access to human rights such as employment (including return-to-work programmes), housing and educational opportunities, and participation in community activities, programmes and meaningful activities.

51. More active involvement and support of service users in the reorganization, delivery and evaluation and monitoring of services is required so that care and treatment become more responsive to their needs. Greater collaboration with "informal" mental health care providers, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers and local nongovernmental organizations, is also needed.

52. Another essential requirement is for services to be responsive to the needs of vulnerable and marginalized groups in society, including socioeconomically disadvantaged families, people living with HIV/AIDS, women and children living with domestic violence, survivors of violence, lesbian, gay, bisexual and transgendered people, indigenous peoples, immigrants, asylum seekers, persons deprived of liberty, and minority groups among others within the national context.

53. When planning for humanitarian emergency response and recovery it is crucial to ensure that mental health services and community psychosocial supports are widely available.

54. Exposure to adverse life events or extreme stressors, such as natural disasters, isolated, repeated or continuing conflict and civil unrest or ongoing family and domestic violence, may have serious health and mental health consequences that require careful examination, particularly with regard to issues of diagnostic characterization (especially avoiding over-diagnosis and over-medicalization) and approaches to support, care and rehabilitation.

55. Having the right number and equitable distribution of competent, sensitive and appropriately skilled health professionals and workers is central to the expansion of services for mental health and the achievement of better outcomes. Integrating mental health into general health, disease-specific and social care services and programmes (such as those on women's health and HIV/AIDS) provides an important opportunity to manage mental health problems better, promote mental health and prevent mental disorders. For example, health workers trained in mental health should be equipped not only to manage mental disorders in the persons they see, but also to provide general wellness information and screening for related health conditions, including noncommunicable diseases and substance use. Not only does service integration require the acquisition of new knowledge and skills to identify, manage and refer people with mental disorders as appropriate, but also the re-definition of health workers' roles and changes to the existing service culture and attitudes of general health workers, social workers, occupational therapists and other professional groups. Furthermore, in this context, the role of specialized mental health professionals needs to be expanded to encompass supervision and support of general health workers in providing mental health interventions.

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

Proposed actions for Member States

56. *Service reorganization and expanded coverage:* Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient care, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.

57. *Integrated and responsive care*: Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing, and education) through service user-driven treatment and recovery plans and, where appropriate, with the inputs of families and carers.

58. *Mental health in humanitarian emergencies* (including isolated, repeated or continuing conflict, violence and disasters): Work with national emergency committees and mental health providers in order to include mental health and psychosocial support needs in emergency preparedness and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with (pre-existing as well as emergency-induced) mental disorders or psychosocial problems, including those for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.

59. *Human resource development:* Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human rights-oriented mental health and social care services, for children and adolescents inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, in order to identify people with mental disorders and offer appropriate treatment and support as well as to refer people, as appropriate, to other levels of care.

60. *Address disparities:* Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.

Actions for the Secretariat

61. *Service reorganization and expanded coverage:* Provide guidance and evidence-based practices for deinstitutionalization and service reorganization, and provide technical support for expanding treatment and support, prevention and mental health promotion through recovery-oriented community-based mental health and social support services.

62. *Integrated and responsive care*: Collate and disseminate evidence and best practices for the integration and multisectoral coordination of holistic care, emphasizing recovery and support needs for persons with mental disorders, including alternatives to coercive practices and strategies to engage service users, families and carers in service planning and treatment decisions, and provide examples of financing mechanisms to facilitate multisectoral collaboration.

63. *Mental health in humanitarian emergencies* (including isolated, repeated or continuing conflict, violence, and disasters): Provide technical advice and guidance for policy and field activities related to mental health undertaken by governmental, nongovernmental and intergovernmental organizations, including the building or rebuilding after an emergency of a community-based mental health system that is sensitive to trauma-related issues.

64. *Human resource development:* Support countries in the formulation of a human resource strategy for mental health, including the identification of gaps, specification of needs, training requirements and core competencies for health workers in the field, as well as for undergraduate and graduate educational curricula.

65. *Address disparities*: Collect and disseminate evidence and best practices for reducing mental health and social service gaps for marginalized groups.

Proposed actions for international and national partners

66. Use funds received for direct service delivery to provide community-based mental health care rather than institutional care.

67. Assist the training of health workers in skills to identify mental disorders and provide evidence-based and culturally-appropriate interventions to promote the recovery of people with mental disorders.

68. Support coordinated efforts to implement mental health programmes during and after humanitarian emergency situations, including the training and capacity building of health and social service workers.

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

69. In the context of national efforts to develop and implement health policies and programmes, it is vital to meet not only the needs of persons with defined mental disorders, but also to protect and promote the mental well-being of all citizens. Mental health evolves throughout the life cycle. Therefore, governments have an important role in using information on risk and protective factors for mental health to put in place actions to prevent mental disorders and to protect and promote mental health at all stages of life. The early stages of life present a particularly important opportunity to promote mental health and prevent mental disorders, as up to 50% of mental disorders in adults begin before the age of 14 years. Children and adolescents with mental disorders should be provided with early intervention through evidence-based psychosocial and other non-pharmacological interventions based in the community, avoiding institutionalization and medicalization. Furthermore, interventions should respect the rights of children in line with the United Nations Convention on the Rights of the Child and other international and regional human rights instruments.

70. Responsibility for promoting mental health and preventing mental disorders extends across all sectors and all government departments. This is because poor mental health is strongly influenced by a range of social and economic determinants including income level, employment status, education level, material standard of living, physical health status, family cohesion, discrimination, violations of human rights and exposure to adverse life events, including sexual violence, child abuse and neglect. Mental health needs of children and adolescents who are exposed to natural disasters or civil conflict and unrest, including those who have been associated with armed forces or armed groups, are very high and require special attention.

71. Broad strategies for mental health promotion and the prevention of mental disorders across the life course may focus on: anti-discrimination laws and information campaigns that redress the stigmatization and human rights violations all too commonly associated with mental disorders; promotion of the rights, opportunities and care of individuals with mental disorders; the nurturing of core individual attributes in the formative stages of life (such as early childhood programmes, life skills and sexuality education, programmes to support the development of safe, stable and nurturing relationships between children, their parents and carers); early intervention through identification, prevention and treatment of emotional or behavioural problems, especially in childhood and adolescence; provision of healthy living and working conditions (including work organizational improvements and evidence-based stress management schemes in the public as well as the private sector); protection programmes or community protection networks that tackle child abuse as well as other violence at domestic and community levels and social protection for the poor.[1]

72. Suicide prevention is an important priority. Many people who attempt suicide come from vulnerable and marginalized groups. Moreover, young people and the elderly are among the most susceptible age groups to suicidal ideation and self-harm. Suicide rates tend to be underreported owing to weak surveillance systems, a misattribution of suicide to accidental deaths, as well as its criminalization in some countries. Nevertheless, most countries are showing either a stable or an increasing trend in the rate of suicide, while several others are showing long-term decreasing trends. As there are many risk factors associated with suicide beyond mental disorder, such as chronic pain or acute emotional distress, actions to prevent suicide must not only come from the health sector, but also from other sectors simultaneously. Reducing access to means to self-harm and commit suicide (including firearms, pesticides and availability of toxic medicines which can be used in overdoses), responsible reporting by the media, protecting persons at high risk of suicide, and early identification and management of mental disorder and of suicidal behaviours can be effective.

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

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

Proposed actions for Member States

73. *Mental health promotion and prevention*: Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.

74. *Suicide prevention*: Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.

[1] See *Risks to mental health: an overview of vulnerabilities and risk factors. Background paper by WHO Secretariat for the development of a comprehensive mental health action plan* (http://www.who.int/mental_health/mhgap/consultation_global_mh_action_plan_2013_2020/en/index.html; accessed 10 December 2012).

Actions for the Secretariat

75. *Mental health promotion and prevention*: Provide technical support to countries on the selection, formulation and implementation of evidence-based and cost-effective best practices for promoting mental health, preventing mental disorders, reducing stigmatization and discrimination, and promoting human rights across the lifespan.

76. *Suicide prevention*: Provide technical support to countries in strengthening their suicide prevention programmes with special attention to groups identified as at increased risk of suicide.

Proposed actions for international and national partners

77. Engage all stakeholders in advocacy to raise awareness of the magnitude of burden of disease associated with mental disorders and the availability of effective intervention strategies for the promotion of mental health, prevention of mental disorders and treatment, care and recovery of persons with mental disorders.

78. Advocate the rights of persons with mental disorders and psychosocial disabilities to receive government disability benefits, gain access to housing and livelihood programmes, and more broadly to participate in work and community life and civic affairs.

79. Ensure that people with mental disorders and psychosocial disabilities are included in activities of the wider disability community, for example, when advocating for human rights and in processes for reporting on the implementation of the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions.

80. Introduce actions to combat stigmatization, discrimination and other human rights violations towards people with mental disorders and psychosocial disabilities.

81. Be partners in the development and implementation of all relevant programmes for mental health promotion and prevention of mental disorders.

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

82. Information, evidence and research are critical ingredients for appropriate mental health policy, planning and evaluation. The generation of new knowledge through research enables policies and actions to be based on evidence and best practice, and the availability of timely and relevant information or surveillance frameworks enables implemented actions to be monitored and improvements in service provision to be detected. Currently, the research imbalance whereby most research is conducted in and by high-income countries needs to be corrected in order to ensure that low-income and middle-income countries have culturally appropriate and cost-effective strategies to respond to mental health needs and priorities.

83. Although summary mental health profiles are available through periodic assessments such as WHO's Project ATLAS, routine information systems for mental health in most low-income and middle-income countries are rudimentary or absent, making it difficult to understand the needs of local populations and to plan accordingly.

84. Crucial information and indicators that are needed for the mental health system include: the extent of the problem (the prevalence of mental disorders and identification of major risk factors and protective factors for mental health and well-being); coverage of policies and legislation, interventions

and services (including the gap between the number of people who have a mental disorder and those who receive treatment and a range of appropriate services, such as social services); health outcome data (including suicide and premature mortality rates at the population level as well as individual- or group-level improvements related to clinical symptoms, levels of disability, overall functioning and quality of life) and social/economic outcome data (including relative levels of educational achievement, housing, employment and income among persons with mental disorders). These data need to be disaggregated by sex and age and reflect the diverse needs of subpopulations, including individuals from geographically diverse communities (for instance, urban versus rural), and vulnerable populations. Data will need to be collected through *ad hoc* periodic surveys in addition to the data collected through the routine health information system. Valuable opportunities also exist to draw on existing data, for example, gathering information from the reports submitted to treaty-monitoring bodies by governments and nongovernmental and other bodies as part of the periodic reporting mechanisms.

Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).

Proposed actions for Member States

85. *Information systems*: Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including data on completed and attempted suicides) in order to improve mental health service delivery, promotion and prevention strategies and to provide data for the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).

86. *Evidence and research*: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.

Actions for the Secretariat

87. *Information systems:* Develop a core set of mental health indicators and provide guidance, training and technical assistance on the development of surveillance/information systems to capture information for the core mental health indicators, facilitate the use of these data to monitor inequities and health outcomes, and augment the information collected by WHO's Global Mental Health Observatory (as a part of WHO's Global Health Observatory) by establishing baseline data to monitor the global mental health situation (including progress on reaching the targets laid out in this action plan).

88. *Evidence and research:* Engage relevant stakeholders, including people with mental disorders and psychosocial disabilities and their organizations, in the development and promotion of a global mental health research agenda, facilitate global networks for research collaboration, and carry out culturally validated research related to burden of disease, advances in mental health promotion, prevention, treatment, recovery, care, policy and service evaluation.

Proposed actions for international and national partners

89. Provide support to Member States to set-up surveillance/information systems that: capture core indicators on mental health, health and social services for persons with mental disorders; enable an assessment of change over time; and provide an understanding of the social determinants of mental health problems.

90. Support research aimed at filling the gaps in knowledge about mental health, including the delivery of health and social services for persons with mental disorders and psychosocial disabilities.

Appendix 1

INDICATORS FOR MEASURING PROGRESS TOWARDS DEFINED TARGETS OF THE DRAFT COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020

These indicators for assessing progress towards meeting the global targets of the comprehensive mental health action plan represent a sub-set of the information and reporting needs that Member States require to be able to monitor adequately their mental health policies and programmes. Given that targets are voluntary and global, each Member State is not necessarily expected to achieve all these specific targets but can contribute to a varying extent towards jointly reaching them. As indicated under Objective 4 of the plan, the Secretariat will provide guidance, training and technical assistance to Member States, upon request, on the development of national information systems for capturing data on indicators of mental health system inputs, activities and outcomes. The aim is to build on existing information systems rather than creating new or parallel systems. Baselines for each target will be established early during the implementation phase of the global action plan.

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

Global target 1.1	80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).
Indicator	Existence of a national policy and/or plan for mental health that is in line with international human rights instruments *[yes/no]*.
Means of verification	Physical availability of the policy/plan and confirmation that it accords with international and regional human rights standards.
Comments/assumptions	Many policies and plans older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to policies/plans of the majority of states/provinces within the country. Policies or plans for mental health may be stand-alone or integrated into other general health or disability policies or plans.

Global target 1.2	50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments (by the year 2020).
Indicator	Existence of a national law covering mental health that is in line with international human rights instruments *[yes/no]*.
Means of verification	Physical availability of the law and confirmation that it accords with international and regional human rights standards.
Comments/assumptions	Laws older than 10 years may not reflect recent developments in international human rights standards and evidence-based practice. For countries with a federated system, the indicator will refer to the laws of the majority of states/provinces within the country. Laws for mental health may be stand-alone or integrated into other general health or disability laws.

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

Global target 2	Service coverage for severe mental disorders will have increased by 20% (by the year 2020).
Indicator	Proportion of persons with a severe mental disorder (psychosis; bipolar affective disorder; moderate-severe depression) who are using services *[%]*.
Means of verification	*Numerator*: Cases of severe mental disorder in receipt of services, derived from routine information systems or, if unavailable, a baseline and follow-up survey of health facilities in one or more defined geographical areas of a country. *Denominator*: Total cases of severe mental disorder in the sampled population, derived from national surveys or, if unavailable, subregional global prevalence estimates.
Comments/assumptions	Estimates of service coverage are needed for all mental disorders, but are restricted here to severe mental disorders to limit measurement effort. Health facilities range from primary care centres to general and specialized hospitals; they may offer social care and support as well as psychosocial and/or pharmacological treatment on an outpatient or inpatient basis. To limit measurement effort, and where needed, countries may restrict the survey to hospital-based and overnight facilities only (with some loss of accuracy, due to omission of primary care and other service providers). The baseline survey will be undertaken in 2014, with follow-up at 2020 (and preferably also at mid-point in 2017); the survey questionnaire can be supplemented in order also to investigate service readiness and quality, as desired. The Secretariat can provide guidance and technical assistance to Member States regarding survey design and instrumentation.

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

Global target 3.1	80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020).
Indicator	Functioning programmes of multisectoral mental health promotion and prevention in existence *[yes/no]*.
Means of verification	Inventory or project-by-project description of currently implemented programmes.
Comments/assumptions	Programmes may – and preferably should – cover both universal, population-level promotion or prevention strategies (e.g. mass media campaigns against discrimination) and those aimed at locally identified vulnerable groups (e.g. children exposed to adverse life events).

Global target 3.2	The rate of suicide in countries will be reduced by 10% (by the year 2020).
Indicator	Number of completed suicides per year per 100 000 population.
Means of verification	Routine annual registration of deaths due to suicide (baseline year: 2012 or 2013).
Comments/assumptions	Effective action towards this target requires joint action from multiple sectors outside health/mental health sector. Obtaining accurate surveillance data is difficult and owing to more accurate reporting of suicides, population ageing and other possible factors, total recorded suicides may not decrease in some countries; however, the rate of suicide (as opposed to total suicides) best reflects improved prevention efforts.

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

Global target 4	80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).
Indicator	Core set of identified and agreed mental health indicators routinely collected and reported every two years *[yes/no]*.
Means of verification	Reporting and submission of core mental health indicator set to WHO every two years.
Comments/assumptions	Core mental health indicators include those relating to specified targets of this action plan, together with other essential indicators of health and social system actions (e.g. training and human resource levels, availability of psychotropic medicines, and admissions to hospital). The data need to be disaggregated by sex and age groups. Where needed, surveys can also be used to complement data from routine information systems. The Secretariat will advise countries on a set of core indicators to be collected in consultation with Member States. Data will be collected, analysed and reported by WHO on a global and regional basis (as part of WHO's Global Health Observatory).

Appendix 2

OPTIONS FOR THE IMPLEMENTATION OF THE COMPREHENSIVE MENTAL HEALTH ACTION PLAN 2013–2020

The actions proposed in this document for Member States convey what can be done to achieve the objectives of the action plan. This Appendix sets out some options for how these actions could be realized, recognizing the diversity of countries, particularly in terms of the level of development of mental health, health and social systems and resource availability. These options are neither comprehensive nor prescriptive, but provide illustrative or indicative mechanisms through which actions can be undertaken in countries.

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

Actions	Options for implementation
Policy and law: Develop, strengthen, keep up to date and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.	• Set up a functional mental health unit or coordination mechanism in the health ministry, with responsibility for strategic planning, needs assessment, multisectoral collaboration and service evaluation • Sensitize national policy-makers to mental health and human rights issues through the preparation of policy briefs and scientific publications and the provision of leadership courses in mental health. • Mainstream mental health and the rights of persons with mental disorders and psychosocial disabilities into all health and other sector policies and strategies including poverty reduction and development. • Improve accountability by setting up mechanisms, using existing independent bodies where possible, to monitor and prevent torture or cruel, inhuman and degrading treatment and other forms of ill treatment and abuse; and, involve appropriate stakeholder groups, for example lawyers and people with mental disorders and psychosocial disabilities, in these mechanisms, in a manner consistent with international and regional human rights instruments. • Repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities. • Monitor and evaluate the implementation of policies and legislation to ensure compliance with the Convention on the Rights of Persons with Disabilities and feed this information into the reporting mechanism of that Convention.
Resource planning: Plan according to measured or systematically estimated need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon, evidence-based mental health plans and actions.	• Use – and if indicated, collect – data on epidemiological and resource needs in order to inform the development and implementation of mental health plans, budgets and programmes. • Set up mechanisms for tracking expenditure for mental health in health and other relevant sectors such as education, employment, criminal justice and social services. • Identify available funds at the planning stage for specific culturally-appropriate, cost-effective activities so that implementation can be assured. • Join with other stakeholders to effectively *advocate* increased resource allocation for mental health.

Actions	Options for implementation
Stakeholder collaboration: Engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.	• Convene, engage with and solicit consensus from all relevant sectors and stakeholders when planning or developing policies, laws and services relating to health, including sharing knowledge about effective mechanisms to improve coordinated policy and care across formal and informal sectors. • Build local capacity and raise awareness among relevant stakeholder groups about mental health, law and human rights, including their responsibilities in relation to the implementation of policy, laws and regulations.
Strengthening and empowerment of people with mental disorders and psychosocial disabilities and their organizations: Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.	• Provide logistic, technical and financial support to build the capacity of organizations representing people with mental disorders and psychosocial disabilities. • Encourage and support the formation of independent national and local organizations of people with mental disorders and psychosocial disabilities and their active involvement in the development and implementation of mental health policies, laws and services. • Involve people with mental disorders and psychosocial disabilities in the inspection and monitoring of mental health services. • Include people with mental disorders and psychosocial disabilities in the training of health workers delivering mental health care.

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

Actions	Options for implementation
Service reorganization and expanded coverage: Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped care principles as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient, and outpatient care in general hospitals, primary care, comprehensive mental health centres, day care centres, support of people with mental disorders living with their families, and supported housing.	• Develop a phased and budgeted plan for closing long-stay psychiatric institutions and replacing them with support for discharged patients to live in the community with their families. • Provide outpatient mental health services and an inpatient mental health unit in all general hospitals. • Build up community-based mental health services, including outreach services, home care and support, emergency care, community-based rehabilitation and supported housing. • Establish interdisciplinary community mental health teams to support people with mental disorders and their families/carers in the community. • Integrate mental health into disease-specific programmes such as HIV/AIDS and maternal, sexual and reproductive health programmes. • Engage service users and family members/carers with practical experience as peer support workers. • Support the establishment of community mental health services run by nongovernmental organizations, faith-based organizations and other community groups, including self-help and family support groups. • Develop and implement tools or strategies for self-help and care for persons with mental disorders, including the use of electronic and mobile technologies. • Include mental health services and basic medicines for mental disorders in health insurance schemes and offer financial protection for socioeconomically disadvantaged groups.

Actions	Options for implementation
Integrated and responsive care: Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health care needs and facilitates the recovery of persons of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing and education) through service user-driven treatment and recovery plans, and where appropriate, with the inputs of families and carers.	• Encourage health workers to link people with services and resources available from other sectors as a routine part of care (for example, livelihood opportunities, education and employment). • Advocate with other sectors (for example, housing, education, employment, social welfare) for the inclusion of people with psychosocial disabilities in their services and programmes. • Cultivate recovery-oriented care and support through awareness-building opportunities and training for health and social service providers. • Provide information to people with mental disorders, their families and carers on causes and consequences of disorders, treatment and recovery options, as well as on healthy lifestyle behaviours in order to improve overall health and well-being. • Foster the empowerment and involvement of persons with mental disorders, their families and caregivers in mental health care. • Procure and ensure the availability of basic medicines for mental disorders included in the WHO List of Essential Medicines at all health system levels, ensure their rational use and enable non-specialist health workers with adequate training to prescribe medicines. • Address the mental well-being of children when parents with severe illnesses (including those with mental disorders) are presenting for treatment at health services. • Provide services and programmes to children and adults who have experienced adverse life events, including ongoing domestic violence and civil unrest or conflict, that address people's trauma, promote recovery and resilience, and avoid re-traumatizing those who seek assistance. • Implement interventions to manage family crises and provide care and support to families and carers in primary care and other service levels. • Implement the use of WHO QualityRights standards to assess and improve quality and human rights conditions in inpatient and outpatient mental health and social care facilities.
Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence, and disasters): Work with national emergency committees to include mental health and psychosocial support needs in emergency preparedness, and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for persons with (pre-existing as well as emergency-induced) mental disorders or psychosocial problems, including for health and humanitarian workers, during and following emergencies, with due attention to the longer term funding required to build or rebuild a community-based mental health system after the emergency.	• Work with national emergency committees on emergency preparedness actions as outlined in the Sphere Project's minimum standard on mental health and the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings. • Prepare for emergencies by orienting health and community workers on psychological first aid and providing them with essential mental health information. • During emergencies, ensure coordination with partners on the application of the Sphere Project's minimum standard on mental health and above mentioned guidelines. • After acute emergencies, build or rebuild sustainable community-based mental health systems to address the long-term increase in mental disorders in emergency-affected populations.

Actions	Options for implementation
Human resource development: Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally-appropriate and human rights-oriented mental health and social care services, for children and adolescents inter alia, by introducing mental health into undergraduate and graduate curricula; and through training and mentoring health workers in the field, particularly in non-specialized settings, to identify and offer treatment and support to people with mental disorders as well as to refer people, as appropriate, to other levels of care.	• Develop and implement a strategy for building and retaining human resource capacity to deliver mental health and social care services in non-specialized health settings, such as primary health care and general hospitals. • Use WHO's *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized settings* (2010) and associated training and supervision materials to train health workers to identify disorders and provide evidence-based interventions for prioritized expanded care. • Collaborate with universities, colleges and other relevant educational entities to define and incorporate a mental health component in undergraduate and postgraduate curricula. • Ensure an enabling service context for training health workers including clear task definitions, referral structures, supervision and mentoring. • Improve the capacity of health and social care workers in all areas of their work (for example, covering clinical, human rights and public health domains), including e-learning methods where appropriate. • Improve working conditions, financial remuneration and career progression opportunities for mental health professionals and workers in order to attract and retain the mental health workforce.
Address disparities: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.	• Identify and assess the needs of different socio-demographic groups in the community and also vulnerable groups not using services (such as homeless people, children, older people, prisoners, migrants and minority ethnic groups, and people caught up in emergency situations). • Assess the barriers that "at risk" and vulnerable groups face in accessing treatment, care and support. • Develop a proactive strategy for targeting these groups and provide services that meet their needs. • Provide information and training to health and social care staff to help them better understand the needs of "at risk" and vulnerable groups.

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

Actions	Options for implementation
Mental health promotion and prevention: Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.	• Increase public knowledge and understanding about mental health, for instance through media awareness and campaigns to reduce stigmatization and discrimination and to promote human rights. • Include emotional and mental health as part of home- and health facility-based antenatal and postnatal care for new mothers and babies, including parenting skills training. • Provide early childhood programmes that address the cognitive, sensory-motor and psychosocial development of children as well as promote healthy child-parent relationships. • Reduce exposure to the harmful use of alcohol (by implementation of measures included in the Global strategy to reduce the harmful use of alcohol). • Introduce brief interventions for hazardous and harmful substance use. • Implement programmes to prevent and address domestic violence, including attention to violence related to alcohol use.

Actions	Options for implementation
	• Provide services and programmes to children and adults who have experienced adverse life events that address their trauma, promote recovery and resilience, and avoid re-traumatizing those who seek assistance. • Protect children from abuse by introducing or strengthening community child protection networks and systems. • Address the needs of children with parents with chronic mental disorders within promotion and prevention programmes. • Develop school-based promotion and prevention, including: life/skills programmes; programmes to counter bullying and violence; awareness raising of the benefits of a healthy lifestyle and the risks of substance use; early detection and intervention for children and adolescents exhibiting emotional or behavioural problems. • Promote work participation and return-to-work programmes for those affected by mental and psychosocial disorders. • Promote safe and supportive working conditions, with attention to work organizational improvements, training on mental health for managers, the provision of stress management courses and workplace wellness programmes and tackling stigmatization and discrimination • Enhance self-help groups, social support, community networks and community participation opportunities for people with mental disorders and psychosocial disabilities and other vulnerable groups. • Encourage the use of evidence-based traditional practices for promotion and prevention in mental health (such as yoga and meditation). • Enhance the use of social media in promotion and prevention strategies. • Implement preventive and control strategies for neglected tropical diseases (for instance, taeniasis and cysticercosis) in order to prevent epilepsy and other neurological and mental health problems. • Develop policies and measures for the protection of vulnerable populations during financial and economic crises.
Suicide prevention: Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender persons, youth and other vulnerable groups of all ages based on local context.	• Increase public, political and media awareness of the magnitude of the problem, and the availability of effective prevention strategies. • Restrict access to the means of self-harm and suicide (for instance, firearms and pesticides). • Promote responsible media reporting in relation to cases of suicide. • Promote workplace initiatives for suicide prevention. • Improve health system responses to self-harm and suicide. • Assess and manage self-harm/suicide and associated mental, neurological and substance use disorders (as outlined in the *mhGAP intervention guide*). • Optimize psychosocial support from available community resources both for those who have attempted suicide as well as for families of people who have committed suicide.

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

Actions	Options for implementation
Information systems: Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and prevention strategies and to feed into the Global Mental Health Observatory (as a part of WHO's Global Health Observatory).	• Establish an active surveillance system for mental health and suicide monitoring, ensuring that records are disaggregated by facility, sex, age and other relevant variables. • Embed mental health information needs and indicators, including risk factors and disabilities, within national population-based surveys and health information systems. • Collect detailed data from secondary and tertiary services in addition to routine data collected through the national health information system. • Include mental health indicators within information systems of other sectors.
Evidence and research: Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by persons with mental disorders, including the establishment of centres of excellence with clear standards, with the inputs of all relevant stakeholders including persons with mental disorders and psychosocial disabilities.	• Develop a prioritized national research agenda in the area of mental health, based on consultation with all stakeholders. • Improve research capacity to assess needs and to evaluate services and programmes. • Enable strengthened cooperation between universities, institutes and health services in the field of mental health research. • Conduct research, in different cultural contexts, on local understandings and expressions of mental distress, harmful (for instance, human rights violations and discrimination) or protective (for instance, social supports and traditional customs) practices, as well as the efficacy of interventions for treatment and recovery, prevention and promotion. • Develop methods for characterizing mental health disparities that occur among diverse subpopulations in countries including factors such as race/ethnicity, sex, socioeconomic status and geography (urban versus rural). • Strengthen collaboration between national, regional and international research centres for mutual interdisciplinary exchange of research and resources between countries. • Promote high ethical standards in mental health research, ensuring that: research is conducted only with the free and informed consent of the person concerned; researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting people to participate in the research; research is not undertaken if it is potentially harmful or dangerous; and all research is approved by an independent ethics committee functioning according to national and international norms and standards.

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