

**MENTAL
HEALTH
ACTION PLAN
2013 – 2020**

WHO Library Cataloguing-in-Publication Data

Mental health action plan 2013–2020.

1.Mental health. 2.Mental disorders – prevention and control. 3.Mental health services.
4.Health planning. I.World Health Organization.

ISBN 978 92 4 150602 1

(NLM classification: WM 101)

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Printed by the WHO Document Production Services, Geneva, Switzerland

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FOREWORD



Mental well-being is a fundamental component of WHO's definition of health. Good mental health enables people to realize their potential, cope with the normal stresses of life, work productively, and contribute to their communities.

Mental health matters, but the world has a long way to go to achieve it. Many unfortunate trends must be reversed—neglect of mental health services and care, and abuses of human rights and discrimination against people with mental disorders and psychosocial disabilities.

This comprehensive action plan recognizes the essential role of mental health in achieving health for all people. It is based on a life-course approach, aims to achieve equity through universal health coverage and stresses the importance of prevention.

Four major objectives are set forth: more effective leadership and governance for mental health; the provision of comprehensive, integrated mental health and social care services in community-based settings; implementation of strategies for promotion and prevention; and strengthened information systems, evidence and research.

Although the targets of this action plan are ambitious, WHO and its Member States are committed to fulfilling them.

A handwritten signature in black ink that reads "M. Chan".

Dr Margaret Chan

Director-General

World Health Organization

SETTING THE SCENE

01 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.

02 This 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

03 The 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 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 action plan has been designed to create synergy with other relevant programmes of organizations in the United Nations system, United Nations interagency groups and intergovernmental organizations.

04 The 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 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.

05 In this 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 (ICD-10). 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 described, for example, in a WHO report on dementia issued in early 2012² and in the global strategy to reduce the harmful use of alcohol). Furthermore, the plan covers suicide prevention and many of the actions are also relevant to conditions such as epilepsy. The term "vulnerable groups" is used in the 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.

06 The 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, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society.

¹ Annex II provides 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 Alzheimer's Disease International. *Dementia: a public health problem*. Geneva, World Health Organization, 2012.

07 In the light of 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 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

08 Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: "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 affected 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

09 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. 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 do 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 2030.³

13 Mental disorders frequently lead individuals and families into poverty.⁴ Homelessness and inappropriate incarceration are far more common for people with mental disorders than for 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 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 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.

³ World Economic Forum, the Harvard School of Public Health. *The global economic burden of non-communicable diseases*. Geneva, World Economic Forum, 2011.

⁴ *Mental health and development: targeting people with mental health conditions as a vulnerable group*. Geneva, World Health Organization, 2010.

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-pharmaceutical 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 To improve the situation, and 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),⁵ information is available on cost-effective and feasible mental health interventions that can be expanded to a 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),⁶ in improving quality and respecting the rights of persons with mental disorders in health services (the WHO QualityRights toolkit),⁷ 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).⁸ 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, promoted and protected, 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, 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.

⁵ 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).

⁶ http://www.who.int/mental_health/policy/essentialpackage1/en/index.html (accessed 24 May 2013).

⁷ WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. Geneva, World Health Organization, 2012.

⁸ Inter-Agency Standing Committee. IASC guidelines on mental health and psychosocial support in emergency settings. Geneva, Inter-Agency Standing Committee, 2007.

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**:

1. **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.
2. **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.
3. **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.
4. **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.
5. **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.
6. **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.

34 The 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 within 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 support 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 mental health services of good quality 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 mental disorders (pre existing as well as emergency-induced) or psychosocial problems, including services 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: antidiscrimination 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.⁹

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 cause self-harm or commit suicide (including firearms, pesticides and availability of toxic medicines that 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.

⁹ 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.*

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 and 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 support 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.

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

The indicators for assessing progress towards meeting the global targets of the comprehensive mental health action plan represent a subset 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 the specific targets but can contribute to a varying extent towards reaching them jointly. As indicated under Objective 4 of the plan, the Secretariat will provide guidance, training and technical support 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 support 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 suicide deaths 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).

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
<p><i>Policy and law:</i> 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.</p>	<ul style="list-style-type: none"> • 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 in these mechanisms, for example, lawyers and people with mental disorders and psychosocial disabilities, 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.
<p><i>Resource planning:</i> 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.</p>	<ul style="list-style-type: none"> • 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
<p>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.</p>	<ul style="list-style-type: none"> • 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.
<p>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.</p>	<ul style="list-style-type: none"> • 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
<p>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.</p>	<ul style="list-style-type: none"> • 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.

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 support.
- 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.

Actions	Options for implementation
<p><i>Mental health in humanitarian emergencies (including isolated, repeated or continuing conflict, violence, and disasters):</i> 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.</p> <p><i>Resource planning:</i> 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.</p>	<ul style="list-style-type: none"> • 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 the guidelines mentioned above. • 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. <ul style="list-style-type: none"> • 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 eLearning 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.

Actions	Options for implementation
<p>Address disparities: Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.</p>	<ul style="list-style-type: none"> • 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
<p>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.</p>	<ul style="list-style-type: none"> • 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. • 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 support. • 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.

Actions	Options for implementation
<p><i>Suicide prevention:</i> 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.</p>	<ul style="list-style-type: none"> • 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. • 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
<p>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).</p> <p>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.</p>	<ul style="list-style-type: none"> • 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. <ul style="list-style-type: none"> • 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.

Overview of the Mental Health Action Plan 2013 - 2020

Vision

A world in which mental health is valued, promoted, and protected, 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.

Cross-cutting Principles

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.

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.

Objectives and Targets

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)

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).

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).

Goal

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

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.

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).

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

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).

RESOLUTION OF THE SIXTY-SIXTH WORLD HEALTH ASSEMBLY (MAY 2013)***WHA66.8 Comprehensive mental health action plan 2013–2020***

The Sixty-sixth World Health Assembly,

Having considered the report by the Secretariat on the draft comprehensive action plan 2013–2020, including the Annex¹,

1. ADOPTS the comprehensive mental health action plan 2013–2020;
2. URGES Member States to implement the proposed actions for Member States in the comprehensive mental health action plan 2013–2020 as adapted to national priorities and specific national circumstances;
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 the 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.

(Ninth plenary meeting, 27 May 2013
Committee A, fourth report)

RESOLUTION OF THE SIXTY-FIFTH WORLD HEALTH ASSEMBLY (MAY 2012)***WHA65.4 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level***

The Sixty-fifth World Health Assembly,

Having considered the report on the global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level;²

Recalling resolution WHA55.10, which, inter alia, urged Member States to increase investments in mental health, both within countries and in bilateral and multilateral cooperation, as an integral component of the well-being of populations;

Recalling further United Nations General Assembly resolution 65/95, which recognized that mental health problems are of major importance to all societies and are significant contributors to the burden of disease and the loss of quality of life, and have huge economic and social costs, and which also welcomed the WHO report on mental health and development that highlighted the lack of appropriate attention to mental health and made the case for governments and development actors to reach out to people with mental disorders in the design of strategies and programmes that include those people in education, employment, health, social protection and poverty reduction policies;

Noting the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (New York, 19 and 20 September 2011), at which it was recognized that mental and neurological disorders, including Alzheimer's disease, are an important cause of morbidity and contribute to the global noncommunicable disease burden, necessitating provision of equitable access to effective programmes and health-care interventions;

Recognizing that mental disorders can lead to disabilities, as reflected in the United Nations Convention on the Rights of Persons with Disabilities, which also notes that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others, and that the World Report on Disability 2011 charts the steps that are required to improve the participation and inclusion of people with disabilities, including those with mental disabilities;

¹ Document A66/10 Rev. 1

² Document A65/10

Recognizing also that mental disorders fall within a wider spectrum that includes neurological and substance-use disorders, which also cause substantial disability and require a coordinated response from health and social sectors;

Concerned that millions of people worldwide are affected by mental disorders, and that in 2004, mental disorders accounted for 13% of the global burden of disease, defined as premature death combined with years lived with disability, and also that, when taking into consideration only the disability component of the burden of disease calculation, mental disorders accounted for 25.3% and 33.5% of all years lived with a disability in low- and middle-income countries, respectively;

Concerned also that exposure to humanitarian emergencies is a potent risk factor for mental health problems and psychological trauma, and that social structures and ongoing formal and informal care of persons with severe, pre-existing, mental disorders are disrupted;

Recognizing further that the treatment gap for mental disorders is large all over the world, that between 76% and 85% of people with severe mental disorders in low- and middle-income countries receive no treatment for their mental health conditions, and that the corresponding figures for high income countries, although lower – between 35% and 50% - are also high;

Recognizing in addition that a number of mental disorders can be prevented and that mental health can be promoted in the health sector and in sectors outside health;

Concerned that persons with mental disorders are often stigmatized, and underlining the need for health authorities to work with relevant groups to change attitudes to mental disorders;

Noting also that there is increasing evidence on the effectiveness and cost-effectiveness of interventions to promote mental health and prevent mental disorders, particularly in children and adolescents;

Noting further that mental disorders are often associated with noncommunicable diseases and a range of other priority health issues, including HIV/AIDS, maternal and child health, and violence and injuries, and that mental disorders often coexist with other medical and social factors, such as poverty, substance abuse and the harmful use of alcohol, and, in the case of women and children, greater exposure to domestic violence and abuse;

Recognizing that certain populations live in a situation that makes them particularly vulnerable to developing mental disorders, and the consequences thereof;

Recognizing also that the social and economic impact of mental disorders, including mental disabilities, is diverse and far-reaching;

Taking into account the work already carried out by WHO on mental health, particularly through its Mental Health Gap Action Programme,

1. URGES Member States:

(1). according to national priorities and within their specific contexts, 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;

(2). to include in policy and strategy development the need to promote human rights, tackle stigmatization, empower service users, families and communities, address poverty and homelessness, tackle major modifiable risks, and as appropriate, promote public awareness, create opportunities for generating income, provide housing and education, provide health care services and community-based interventions, including de-institutionalized care;

(3). to develop, as appropriate, surveillance frameworks that include risk factors as well as social determinants of health to analyse and evaluate trends regarding mental disorders;

(4). to give appropriate priority to and to streamline mental health, including the promotion of mental health, the prevention of mental disorders, and the provision of care, support and treatment in programmes addressing health and development, and to allocate appropriate resources in this regard;

(5). to collaborate with the Secretariat in the development of a comprehensive mental health action plan;

2. REQUESTS the Director-General:

(1). to strengthen advocacy, and develop a comprehensive mental health action plan with measurable outcomes, based on an assessment of vulnerabilities and risks, in consultation with and for consideration by Member States, covering services, policies, legislation, plans, strategies and programmes to provide treatment, facilitate recovery and prevent mental disorders, promote mental health and empower persons with mental disorders to live a full and productive life in the community;

(2). to include, in the comprehensive mental health action plan, provisions to address:

(a). assessment of vulnerabilities and risks as a basis for developing the mental health action plan;

(b). protection, promotion and respect for the rights of persons with mental disorders including the need to tackle stigmatization of persons with mental disorders;

(c). equitable access to affordable, quality and comprehensive health services that integrate mental health into all levels of the health care system;

(d). development of competent, sensitive, adequate human resources to provide mental health services equitably;

(e). promotion of equitable access to quality health care including psychosocial interventions and medication and addressing physical health care needs;

(f). enhancement of initiatives, including in policy, to promote mental health and prevent mental disorders;

(g). access to educational and social services, including health care, schooling, housing, secure employment and participation in income-generation programmes;

(h). involvement of civil society organizations, persons with mental disorders, families and caregivers in voicing their opinions and contributing to decision-making processes;

(i). design and provision of mental health and psychosocial support systems that will enable community resilience and will help people to cope during humanitarian emergencies;

(j). participation of people with mental disorders in family and community life and civic affairs;

(k). design of mechanisms to involve the education, employment and other relevant sectors in Member States in the implementation of the mental health action plan;

(l). building upon the work already done and avoidance of duplication of action;

(3). to collaborate with Member States and, as appropriate, with international, regional and national nongovernmental organizations, international development partners and technical agency partners in the development of the mental health action plan;

(4). to work with Member States and technical agencies to promote academic exchange, through which to contribute to policy-making in mental health;

(5). to submit the comprehensive mental health action plan, through the Executive Board at its 132nd session, for consideration by the Sixty-sixth World Health Assembly.

(Ninth plenary meeting, 25 May 2012
Committee A, first report)

1. GLOSSARY OF MAIN TERMS

Mental health

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community.

Source: Promoting mental health: concepts, emerging evidence, practice. WHO, 2004
http://www.who.int/mental_health/evidence/en/promoting_mhh.pdf

Mental disorders

Mental disorders comprise a broad range of problems, with different symptoms. However, they are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others. These disorders are included and described in chapter V: Mental and behavioural disorders (F00-F99) of WHO's International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). The area of disorders covered are as follows: F00-F09 Organic, including symptomatic, mental disorders; F10-F19 Mental and behavioural disorders due to psychoactive substance use; F20-F29 Schizophrenia, schizotypal and delusional disorders; F30-F39 Mood (affective) disorders; F40-F48 Neurotic, stress-related and somatoform disorders; F50-F59 Behavioural syndromes associated with physiological disturbances and physical factors; F60-F69 Disorders of adult personality and behaviour; F70-F79 Mental retardation; F80-F89 Disorders of psychological development; F90-F98 Behavioural and emotional disorders with onset usually occurring in childhood and adolescence; and F99 Unspecified mental disorder.

Source: International Statistical Classification of Diseases and Related Health Problems 10th Revision Version for 2010. WHO, 2010.
<http://apps.who.int/classifications/icd10/browse/2010/en#/V>

Disability

Disability is an umbrella term for impairments, activity limitations and participation restrictions, denoting the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors).

Source: World report on disability 2011. WHO, 2011.
http://whqlibdoc.who.int/publications/2011/9789240685215_eng.pdf

Mental health policy and mental health plan

A mental health policy is the official statement of a government which defines the vision and details an organized set of values, principles, objectives and areas for action to improve the mental health of a population. A mental health plan details the strategies, activities, timeframes and budgets that will be implemented to realize the vision and achieve the objectives of the policy as well as the expected outputs, targets and indicators that can be used to assess whether implementation has been successful.

Source: Mental health Atlas 2011. WHO, 2011.
http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf

Source: Mental Health policy, plans and programmes. WHO 2005
http://www.who.int/mental_health/policy/services/essentialpackage1v1/en/index.html

Mental health legislation

Mental health legislation, or mental health provisions integrated into other laws (e.g. anti-discrimination, general health, disability, employment, social welfare, education, housing, and other areas), may cover a broad array of issues including access to mental health care and other services, quality of mental health care, admission to mental health facilities, consent to treatment, freedom from cruel, inhuman and degrading treatment, freedom from discrimination, the enjoyment of a full range of civil, cultural, economic, political and social rights, and provisions for legal mechanisms to promote and protect human rights (e.g. review bodies to oversee admission and treatment to mental health facilities, monitoring bodies to inspect human rights conditions in facilities and complaint mechanisms).

Source: Mental health Atlas 2011. WHO, 2011.

http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf

Source: Drew, N., Funk, M., Tang, S. et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. The Lancet, 378 (9803), 1664 - 1675, 2011.

Mental health services

Mental health services are the means by which effective interventions for mental health are delivered. The way these services are organized has an important bearing on their effectiveness. Typically, mental health services include outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community, and mental hospitals.

Source: Organization of services for mental health. WHO, 2003.

http://www.who.int/mental_health/policy/services/essentialpackage1v2/en/index.html

Mental Health Atlas 2011. WHO, 2011. http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf

Recovery

From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding of one's abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life and a positive sense of self. Recovery is not synonymous with cure. Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery – hope, healing, empowerment and connection – and external conditions that facilitate recovery – implementation of human rights, a positive culture of healing, and recovery-oriented services.

Source: WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities. WHO, 2012.

http://whqlibdoc.who.int/publications/2012/9789241548410_eng.pdf

Psychosocial disabilities

Refer to people who have received a mental health diagnosis, and who have experienced negative social factors including stigma, discrimination and exclusion. People living with psychosocial disabilities include ex-users, current users of the mental health care services, as well as persons that identify themselves as survivors of these services or with the psychosocial disability itself.

Source: Drew, N., Funk, M., Tang, S. et al. Human rights violations of people with mental and psychosocial disabilities: an unresolved global crisis. The Lancet, 378 (9803), 1664 - 1675, 2011.

<http://download.thelancet.com/pdfs/journals/lancet/PIIS014067361161458X.pdf?id=40bade4753939e7f2e5f8cf2.13a9c2030d0:54121351243806649>

Vulnerable groups

Certain groups have an elevated risk of developing mental disorders. This vulnerability is brought about by societal factors and the environments in which they live. Vulnerable groups in society will differ across countries, but in general they share common challenges related to their social and economic status, social supports, and living conditions, including:

- Stigma and discrimination;
- Violence and abuse;
- Restrictions in exercising civil and political rights;
- Exclusion from participating fully in society;
- Reduced access to health and social services;
- Reduced access to emergency relief services;
- Lack of educational opportunities;
- Exclusion from income generation and employment opportunities;
- Increased disability and premature death.

Source: Mental Health and Development report. WHO, 2010.

http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf

2. LINKS TO OTHER GLOBAL ACTION PLANS, STRATEGIES AND PROGRAMMES

The Global Mental Health Action Plan has close conceptual and strategic links to other global action plans which have been developed, including the following:

- Global strategy to reduce the harmful use of alcohol (2010) provides a portfolio of policy options and interventions that should be considered for implementation in each country and sets priority areas for global action that is intended to promote, support and complement relevant actions at local, national and regional levels. These directions and actions are reinforced in the Global Mental Health Action plan which is relevant for prevention, treatment and care for alcohol use disorders.

Full text available at: www.who.int/substance_abuse/msbalcstragegy.pdf

- Global Plan of Action on Social Determinants of Health (2012) covers better governance for health and development, increased participation in policy making and implementation, reorientation of the health sector towards reducing health inequities, strengthening global governance and collaboration, monitoring progress and increasing accountability, and social determinants. Many of the risks and vulnerabilities for mental health problems are common to other health problems. Implementation of the Global Mental health Action Plan addresses the key areas covered in the Action Plan on the Social Determinants of Health and not only contributes to improved mental health, but also makes a positive contribution in tackling the social determinants of health more generally.

Full text of Rio Political Declaration on Social Determinants of Health (2011) available at:

<http://www.who.int/sdhconference/declaration/en/index.html>

- Action plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases (2008-2013) outlines the proposed strategies and actions to tackle the growing public-health burden imposed by noncommunicable diseases with a focus on cardiovascular diseases, cancers, chronic respiratory diseases and diabetes. Given the considerable co-morbidity between mental health and physical problems, the Global Mental Health Action plan is expected to contribute to better health outcomes for people with the above four NCDs and vice versa. A new action plan for the period 2013-2020 is under development.

Full text available at: www.who.int/nmh/Actionplan-PC-NCD-2008.pdf

- Workers' health: global plan of action (2008-2017) provides the principles and objectives necessary for maintaining physical and mental health in the workplace, including preventing exposures to occupational hazards, delivering essential public health interventions, and providing access to health services. The global plan of action includes implementation options aimed at ensuring the safety and productivity of workers in all Member States.

Full text available at: http://www.who.int/entity/occupational_health/WHO_health_assembly_en_web.pdf

- Global campaign for violence prevention: plan of action for 2012-2020 presents a set of six goals for curbing the causes and ensuing repercussions of violence around the world. The first two goals aim to prioritize violence prevention within the global public health agenda; the next three aim to build strong foundations for on-going violence prevention efforts; and the last aims to focus support for violence prevention efforts on evidence-based prevention strategies (e.g. measures to improve parenting and parent-child relationships) with the potential to prevent multiple types of violence and other adverse childhood experiences, many of which may negatively affect the mental health status of individuals or communities.

Full text available at: http://www.who.int/entity/violence_injury_prevention/violence/global_campaign/gcnp_plan_of_action.pdf

The Global Mental Health Action plan will also build upon several WHO regional action plans and strategies for mental health and substance abuse that have been developed or are in the process of development. These include:

- Regional Strategy for Mental Health, Africa, 2000-2010,

Full text available at: <http://www.afro.who.int/en/clusters-a-programmes/dpc/mental-health-violence-and-injuries/mvi-publications.html>

- Regional NCD strategic Plan in the African Region, 2012-2016

Full text of Brazzaville Declaration on NCDs available at:

http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=6304

- Reduction of the Harmful Use of Alcohol: A Strategy for the WHO African Region (2010)

Full text available at: <http://www.afro.who.int/en/sixtieth-session.html>

- Strategy for mental health & substance abuse in the Eastern Mediterranean Region (2011)

Full text available at: http://www.emro.who.int/docs/RC_technical_papers_2011_5_14223.pdf

- Pan American Health Organization Strategy and Plan of Action on mental health (2009)

Full text available at: http://new.paho.org/hq/index.php?option=com_docman&task=doc_download&gid=3653&Itemid

- Pan American Health Organization Regional plan of action to reduce harmful use of alcohol (2011)

Full text available at: http://new.paho.org/hq/index.php?option=com_content&task=view&id=5723&Itemid=4139&lang=en

- Pan American Health Organization Regional plan of action on substance use and public health (2011)

Full text available at: http://new.paho.org/hq/index.php?option=com_docman&task=doc_view&gid=14583&Itemid=2146&lang=en

- Regional Strategy for Mental Health, Western Pacific Region, 2002

Full text available at: http://www.wpro.who.int/publications/pub_9290610077/en/index.html

- European action plan to reduce the harmful use of alcohol 2012-2020

Full text available at: http://www.euro.who.int/_data/assets/pdf_file/0006/147732/RC61_wd13E_Alcohol_111372_ver2012.pdf

- Maternal, child, and adolescent mental health for the Eastern Mediterranean Region (2011)

Full text available at: <http://applications.emro.who.int/dsaf/dsa1214.pdf>

- European Mental Health Strategy, - under development

The global action plan has a number of synergies with programmes of other United Nations agencies, International Governmental Organizations (IGOs), and interagency groups with IGO membership as described below:

1. The Department of Economic and Social Affairs (DESA) of the United Nations promotes mainstreaming of the rights of persons with disabilities, including persons with mental and psychosocial disabilities into development responses. <http://www.un.org/disabilities/>

2. The Inter-Agency Standing Committee (IASC) has issued Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007). An IASC Reference Group on Mental Health and Psychosocial Support has been created to follow-up on the implementation of these guidelines.

<http://www.humanitarianinfo.org/iasc/pagelader.aspx?page=content-subsidi-default&mainbodyid=2&publish=0>

3. The International Labour Organization (ILO) seeks to address psychosocial factors through health promotion in the workplace. http://www.ilo.org/safework/events/courses/WCMS_126657/lang--en/index.htm

4. The International Organization for Migration (IOM) works to strengthen the capacity of mental health and psychosocial services offered to migrants and crisis-affected populations in emergency and post-emergency situations.

<http://www.iom.int/cms/en/sites/iom/home/what-we-do/migration-et-sante/mental-health-and-psychosocial-support.html>

5. The United Nations Population Fund (UNFPA) integrates mental health as part of the outputs of its strategic plan. UNFPA considers mental health an emerging issue. <http://www.unfpa.org/public/global/pid/910>

6. The Constitution of the United Nations Educational, Scientific and Cultural Organization (UNESCO) – as part of the Interagency Network of Education (INEE) in Emergencies - integrates concern for psychosocial well-being into emergency education programmes. www.ineesite.org/

7. UNICEF integrates a psychosocial perspective in its child protection and education activities. UNICEF, through the protection sector, has been the United Nations system's largest funder of community-based psychosocial support activities during and after emergencies.

http://www.unicef.org/protection/57929_57998.html

8. The United Nations Relief and Works Agency for Palestine refugees in the Near east (UNRWA) provides mental health and psychosocial support to Palestinian refugees in two of its five fields. In 2011, UNRWA and WHO signed a cooperation agreement for a Joint Programme on Community Mental Health Care for Palestine Refugees.

<http://www.unrwa.org/etemplate.php?id=70#health>

9. The United Nations High Commissioner for Refugees (UNHCR) aims for full integration of mental health concerns within UNHCR's health services' operations for refugees.

<http://www.unhcr.org/pages/49c3646cdd.html>

<http://www.unhcr.org/4e26c9c69.html>

10. The United Nations Office on Drugs and Crime (UNODC) promotes the prevention, treatment and care of drug dependence and reintegration of people with drug abuse problems. In 2008, UNODC and WHO signed a cooperation agreement for a Joint Programme on Drug Dependence Treatment and Care.

<http://www.unodc.org/unodc/en/frontpage/unodc-and-who-launch-joint-drug-dependence-treatment-programme.html>

11. The United Nations University (UNU), a think-tank for the United Nations system, has an International Institute for Global Health, which plans to build a partnership for global mental health. <http://iigh.unu.edu/?q=node/152>

12. The United Nations Fund for Action Against Sexual Violence in Conflict (UN Action) funds United Nations agencies to collaborate to improve coordination and accountability, amplify advocacy, and support country efforts to prevent sexual violence and respond more effectively to the social, physical, and mental needs of survivors. <http://mptf.undp.org/factsheet/fund/UNA00>

13. The United Nations Development Programme (UNDP) is moving towards incorporation of non-communicable conditions, including mental disorders, in country-level United Nations Development Assistance Framework (UNDAF) programme planning. <http://www.undg.org/?P=232>

3. INTERNATIONAL AND REGIONAL HUMAN RIGHTS TREATIES

The constitution of the World Health Organization recognizes that the enjoyment of the highest attainable standard of health is a fundamental right of every human being. It defines health as a state of complete physical, mental and social well-being, and not merely as the absence of disease or infirmity. It thus recognizes mental health as an essential element of health.

The United Nations and regional human rights frameworks are an important means of promoting and protecting the rights of persons with mental disorders. By becoming parties to international treaties, States assume obligations and duties under international law to respect, to protect and to fulfill human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfill means that States must take positive action to facilitate the enjoyment of basic human rights.

The UN Convention on the Rights of Persons with Disabilities (CRPD), which came into force in 2008 and has been widely ratified by Member States, is the first legally binding instrument with comprehensive rights and protections for persons with disabilities. The CRPD sets out a full range of civil, cultural, economic, political and social rights historically denied people with mental disorders, including the right to equal recognition before the law, to liberty and security of person, to be free from torture or cruel, inhuman or degrading treatment or punishment, to live independently and be included in the community as well as the right to education, health, employment and social protection and participation in political and public life.

Key UN and regional human rights treaties

United Nations treaties	Regional treaties
<i>Convention on the Rights of Persons with Disabilities (CRPD)</i>	African Charter on Human and Peoples' Rights
<i>International Covenant on Economic, Social and Cultural Rights (ICESCR)</i>	American Convention on Human Rights
<i>International Covenant on Civil and Political Rights (ICCPR)</i>	Additional protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights
<i>Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)</i>	Inter-American Convention on all Forms of Discrimination Against Persons with Disabilities
<i>Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)</i>	Inter-American Convention to Prevent and Punish Torture
<i>Convention on the Rights of the Child (CRC)</i>	European Convention for the Protection of Human Rights and Fundamental Freedoms
	European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment

4. SELECTED WHO TECHNICAL MATERIALS AND RESOURCES ON MENTAL HEALTH**1. mhGAP**

http://www.who.int/mental_health/mhgap/en/

- Mental Health Gap action Programme; Scaling up care for mental, neurological, and substance use disorders, WHO, 2008 (English, French, Spanish)
- Mental Health Gap action Programme - Intervention Guide (mhGAP-IG), WHO, 2010 (English, French, Spanish)

2. Mental health and development

http://www.who.int/mental_health/policy/mhtargeting/en/index.html

- Report on Mental health and development; WHO, 2010

3. Policy, services and human rights

http://www.who.int/mental_health/policy/en/

- All 14 WHO policy modules
- Improving health systems and services for mental health; WHO, 2009
- Integrating mental health into primary care: a global perspective; WHO and WONCA, 2009
- WHO QualityRights tool kit: assessing and improving quality and human rights in mental health and social care facilities; WHO, 2012 (http://www.who.int/mental_health/policy/quality_rights/en/index.html)

4. Human rights and law

http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf

- WHO resource book on mental health, human rights and legislation. World Health Organization, 2005

5. Information and surveillance

- Mental Health Atlas 2011 (www.who.int/mental_health/publications/mental_health_atlas_2011)
- WHO-AIMS (http://www.who.int/mental_health/evidence/WHO-AIMS/en/)

6. Emergency mental health

http://www.who.int/mental_health/emergencies/en/

- WHO and IASC publications on emergency mental health: 9 in English and 8 in non- English

7. Epilepsy

http://www.who.int/mental_health/mhqap/evidence/epilepsy/en/

- Epilepsy Management at Primary Health Level in rural China, WHO, 2009
- A manual for Medical and Clinical Officers in Africa, WHO, 2002

8. Dementia

http://www.who.int/mental_health/publications/dementia_report_2012

- Dementia: a public health priority; WHO, 2012

9. Alcohol and substance use disorders (http://www.who.int/substance_abuse/en/)

- Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence, 2009
- Principles of Drug Dependence Treatment, 2008
- Basic Principles for Treatment and Psychosocial Support of Drug Dependent People Living with HIV/AIDS, 2006
- Substitution maintenance therapy in the management of opioid dependence and HIV/AIDS prevention; WHO/UNODC/UNAIDS position paper, 2004
- AUDIT - The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care (second edition), 2001 (English and Spanish)
- ASSIST questionnaire version 3
- The ASSIST package (Alcohol, Smoking and Substance Involvement Screening Test), including a self-help guide

The Mental Health Action Plan's 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.



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www.who.int/mental_health/en/

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ISBN 978 92 4 150602 1



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