WHO Mental Health Forum 2019

14-15 October 2019
WHO headquarters Geneva
Executive Board Room

World Health Organization

Enhancing Country Action on Mental Health

Summary report

Table of Contents

Context

The World Health Organization (WHO) is leading the effort for achieving the objectives of the Mental Health Action Plan 2013-2020, adopted by the World Health Assembly in May 2013 and extended to 2030 at the 72nd World health Assembly in 2019. The WHO Mental Health Forum (WHO MH Forum, previously "mhGAP Forum") is a partnership event organized by WHO every year in Geneva, coinciding with World Mental Health Day (10 October). The WHO MH forum offers a platform by which to exchange information on the implementation of the Mental Health Action Plan and to strengthen collaboration among partners.

The eleventh meeting of the WHO MH Forum took place at the World Health Organization, Geneva on 14 and 15 October 2019. The primary focus of the 2019 WHO MH Forum was on "Enhancing Country Action on Mental Health". The second focus centred on the theme of the 2019 World Mental Health Day: "Suicide Prevention".

The forum was attended by approximately 297 participants. These included 72 country representatives from 49 Member States, 14 participants from 11 WHO Collaborating Centres, 35 representatives from all regions of WHO, 11 participants from other UN agencies, and 159 participants representing 115 organisations (including academic institutions, NGOs, mental health service user groups). The programme and list of participants are attached as Annex A.

SESSION 1: Opening Plenary

1.1 Welcome

The forum was opened by Dr Ren Minghui (WHO Assistant Director-General, Universal Health Coverage/Communicable and Noncommunicable Diseases). He emphasised the importance of the 2019 MH forum due to the launch of the WHO Special Initiative on Mental Health in May 2019, a priority for the WHO Director General and WHO. He also highlighted the landmark political declaration on Universal Health Coverage at the United Nations General Assembly where heads of state reaffirmed their commitment to spending on essential health services to a billion more people. This included commitments to implement measures to promote and protect mental health and wellbeing.

Reflecting on the past 12 months since the 2018 forum, Dr Ren highlighted the global momentum, noting many important events and the increased global awareness thanks to a number of initiatives. He noted that the World Health Organization Special Initiative on Mental Health will serve as a further catalyst to the development of this important area of public health. The exchange of lessons learned, at the 2019 forum was highlighted as being particularly important in guiding the implementation of mental health services and policies in countries.

1.2 Supporting Country Action on Mental Health

The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health

Dévora Kestel (Director, Department of Mental Health and Substance Abuse, WHO), introduced the section on Supporting Country Action on Mental Health, noting that the forum has changed its name from the mhGAP Forum to the WHO Mental Health Forum, to encapsulate the breadth of WHO's work in the field of mental health, extending beyond, but inspired by, the WHO mental health Gap Action Programme.

Dévora Kestel emphasised that the 2019 WHO MH forum has a special focus on implementation and highlighted the high level of participation from representatives of Member States, that will help ensure that the global agenda for mental health can progress successfully in countries. She introduced key updates from this year's efforts of the department:

- The WHO Mental Health Action Plan which was endorsed by Member States in 2013 and due to finish in 2020, was approved for extension to 2030 during this year's World Health Assembly.

- The WHO Secretariat have been asked to provide a menu of policy options of cost-effective interventions for consideration by next year's World Health Assembly. An update of the WHO-CHOICE interventions, updating original models and including new models on the cost effectiveness of pesticide bans for suicide prevention and school-based social-emotional learning interventions in adolescents to promote mental health and prevent suicide.

- The WHO Secretariat was asked to provide updates to the appendices of the WHO Mental Health Action Plan in consultation with Member States and taking into account the views of key stakeholders.

- Appointment of Cynthia Germanotta, co-founder of the Born This Way Foundation, as the first ever WHO Goodwill Ambassador for Mental Health.

- The first ever Technical Briefing on Mental Health at the World Health Assembly

The WHO Special Initiative for Mental Health (2019 – 2023): Universal Health Coverage for Mental Health

Dévora Kestel then introduced the WHO Special Initiative for Mental Health (2019-2023). Launched at the World Health Assembly, the Initiative focuses on universal health coverage for mental health, and forms a primary theme for this year's WHO mental health forum. The Special Initiative has a goal of supporting universal health coverage by ensuring access to quality and affordable care for mental health conditions in 12 priority countries to 100 million more people.

Strategic actions of the special initiative:

- Strategic Action 1 is about advancing mental health policies, advocacy and human rights
- Strategic Action 2 is about scaling up interventions and services across community-based, general health and specialist settings. It will be implemented in 12 priority countries covering all 6 WHO regions through partnership efforts with Member States, local and interventional implementation partners it will adopt a 'whole of WHO' approach, bringing together country, regional and HQ offices to support the Initiative. The WHO Special Initiative will look to advancing mental health policies and mental health reform at multiple levels.

To achieve this novel work which emphasises the sustainability of programmes for mental health, the Special Initiative will require US$ 60 million of catalytic funding, with US$ 1 million, per country, per year.

Finally Dévora Kestel noted that in the recent UN General Health Assembly, Member States endorsed a political declaration for Universal Health Coverage. WHO MSD intends to contribute to this through the work of the Special Initiative.

Updates from the WHO Department of Mental Health & Substance Use

Dzmitry Krupchanka (WHO), speaking on behalf of Vladimir Poznyak (WHO), introduced updates of the key areas of work from the Management of Substance Abuse Unit of the Department of Mental Health and Substance Abuse, WHO:

- The WHO SAFER Initiative launched in 2018.
- Provision of the Global Status Report on Alcohol and Health

- A request for WHO to report on the implementation of the aforementioned global strategy to the WHO Executive Board and 73rd World Health Assembly, in consultation with Member States.
- In 2019, WHO and UNODC will launch the multisite implementation study on community management of opioid overdose being conducted in three central Asian countries (Stop-Overdose-Safely programme, SOS).
- A tool to support health workers in perinatal care to identify, diagnose and manage substance use during pregnancy has been created to increase dissemination of guidelines on substance use in pregnancy.
- The Unit was involved in the development of the ICD 11 chapter on disorders due to substance use and addictive behaviours, where field testing in 12 countries will be conducted to pave the way toward better implementation.
- Multiple projects exist, to generate and disseminate new evidence. For example, there is a dedicated section for substance use in the WHO Global Health Observatory, resources for the prevention and treatment of substance use disorders in the WHO Atlas and a Global Information System on Alcohol and Health (WHO GISAH).

Key Messages from the Netherlands Summit on Mental Health and Psychosocial Support in Crisis Situations

H.E. Nathalie Olijslager (Ambassador, Permanent Representation of the Kingdom of the Netherlands) showed an inspiring video of the Netherlands Summit of Mental Health and Psychosocial Support in Crisis Situations, which took place the week before the WHO MH Forum. The summit focussed on people living in crisis situations, with the aim of making the 'the invisible, visible'. During the Summit, eight challenges were defined for the improvement of global MHPSS:

1. Fighting ignorance, denial, stigma and shame concerning mental health conditions
2. Engaging affected people and communities from the start
3. Building emergency preparedness
4. Choosing the right MHPSS tools for the situation
5. Building accessible MHPSS resources from the bottom up
6. Being clear about aims and claims
7. Adequate training and supervision
8. Emotional support for MHPSS providers

The Ambassador ended by emphasising the need to consider a person-centred approach throughout this work.

The French Ministerial Summit in Paris, 2020

Frank Bellivier, (Délégué ministériel à la santé mentale et à la psychiatrie, Ministère des Solidarités et de la Sante), announced the next and third ministerial summit for mental health to take place in Paris on the 9th and 10th October, 2020. Frank Bellivier indicated that mental health is a top health priority for France. The French Government is proud to host the next Summit and are actively defining the theme for next year's Summit. Three objectives have been identified for the Paris Summit: to maintain pressure on the global mental health agenda; to encourage sharing practices between countries; and to consolidate the global deliverables and the mobilization of key partners, including financial.

The WHO Special Initiative for Mental Health - USAID

Ann Willhoite (Senior Mental Health Advisor, USAID) commended the work by the Department and the global mental health community. She noted the important role USAID play as the largest bilateral funder of Global Mental Health in Development and MHPSS in Emergencies. The WHO Mental Health Special Initiative makes a statement to the rest of the world that there is no health without mental health. Ann Willhoite announced the beginning of a partnership between USAID and WHO on the Special Initiative for Mental Health. USAID, through its Victims of Torture Fund, is contributing 3 million dollars over the coming three years to support scaling up of services.

The WHO Special Initiative for Mental Health - Swiss Development Coorporation

Enrichetta Placella (Deputy Head, Global Program Health, Swiss Agency for Development and Cooperation- SDC) showed a video of a mental health programme in Bosnia, supported by the SDC. She reflected that the SDC's experiences in Moldova and Ukraine have the opportunity to be leveraged and replicated in other countries through the WHO Special Initiative. Enrichetta Placella noted the affinity in strategic outlook between the work of the SDC and the WHO Special Initiative, for example both build the case for investment in mental health and both look towards shaping norms at the global and country level, in terms of capacity building, and re-shaping services in primary care for mental health. This affinity encourages the SDC to support the WHO Special Initiative and in turn Erika Placella highlighted the hope that this would encourage more donors for the Special Initiative.

Mental Health and Human Rights

Dainius Pkras (UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health) stated that human rights based approach should be mainstreamed in mental health care. Challenges raised: there are widespread violations of human rights for those who use mental health services; the main principles in the Convention on the Rights of Persons with Disabilities (CRPD) are largely not addressed; institutionalisation in mental health services remains; excessive use of biomedical interventions in many areas continues; and diversity, human misery and the effects of social determinants on mental health (inequalities, poverty, violence, discrimination) are pathologised. To overcome these, recommendations included a shift in policies and services away from investments in systems with prevailing patterns of institutionalisation, coercion and exclusion; the removal of obstacles to empowerment, participation, non-discrimination inclusion; take targeted, concrete measures to radically reduce coercive practices; seek technical assistance from the WHO QualityRights initiative to improve the quality of mental health care; address power asymmetries by involving users of services and non-psychiatric professionals in all levels of decision making; and prioritise and scale up investment in non-coercive mental health services and support models.

Global Campaign for Mental Health (Update)

Sarah Kline (Deputy CEO, United for Global Mental Health; UGMH) outlined the advocacy, communications, campaign and financing work of UGMH:

- The Blueprint Group: aims to encourage greater global collaboration on mental health advocacy and communications. It includes over 280 representatives of

governments, international organizations, NGOs, trusts and foundations, academia and the private sector. So far this group has jointly agreed messaging for mental health, organized influential events with key stakeholders, successfully advocated for the inclusion of mental health in the UHC political declaration; inputted into the Netherlands ministerial summit.

- Social media messaging promoted by the group (#TimeToAct #MentalHealth) at key events including UNGA 2018, the UK Ministerial Summit 2018 and the World Economic Forum meeting in 2019.
- Speak Your Mind campaign: formally launched at the UN General Assembly this year, the campaign strives to improve the accessibility and quality of mental health services nationally and globally.
- Raising the profile of World Mental Health Day, where this year they joined forces with campaign partners: WHO, WFMH and IASP in promoting a call to action for suicide prevention which was this year's theme #40seconds. UGMH also launched the 'museum of lost and found potential' to highlight personal stories of mental health.

1.3 Statements by Member States

Seventeen Member States provided statements during the opening of the 2019 WHO MH Forum, presented in Annex B.

SESSION 2: Plenary – Recently Released WHO Products and Launch of Community mhGAP Toolkit

2.1 Recently released products on dementia, epilepsy, physical health, and mental disorders

Moderator Shekhar Saxena (Professor for the Practice of Global Mental Health, Harvard University) introduced the session by highlighting WHO's role in providing strong technical guidance. Tarun Dua (WHO) then provided an overview of four products launched in the past year: 1) Epilepsy: A Global Health Imperative, 2) WHO Dementia Risk Reduction Guidelines, 3) iSupport for dementia caregivers, and 4) WHO guidelines for management of physical health conditions in severe mental disorders. These products offer guidelines for supporting not only people struggling with mental and brain health conditions, but also their families and caregivers.

2.2 Launch of the mhGAP Community Toolkit

Tarun Dua (WHO) and Neerja Chowdhary (WHO) presented the mhGAP Community Toolkit, a community platform for delivering mental health promotion, prevention, service activities, and interventions. The toolkit was developed based on a scoping review and consultations at the 2018 mhGAP Forum. It is written for a wide range of audiences from different backgrounds and is divided into two main parts. Part 1 is a guide for programme managers and part 2 is a community provider manual that includes practical and actionable information for anyone in the community who wishes to provide support to people with mental health conditions.

Next steps for the toolkit include field-testing for feasibility and acceptability, collecting case studies, and gathering additional tools and resources to help communities build capacity to provide mental health care.

2.3 Plenary Discussion on mhGAP Community Toolkit

During the plenary discussion that followed, attendees expressed enthusiasm for the Community Toolkit and asked additional questions. WHO explained that the toolkit is designed to apply to a broad range of settings and to guide users to adapt it to their local context. It is currently available only in English, but WHO would be interested in further translations. Attendees were invited to submit case studies, use the toolkit, and provide feedback on how to contextualize it. A number of important issues were raised including the importance of community involvement, doctors working collaboratively with the community, using the toolkit both in LMICs and marginalized communities in HICs; creating community systems that can manage important issues such as confidentiality and safety; doing robust and systematic research on the toolkit, and using SDGs as a framework for selecting a set of outcomes to assess.

2.4 Upcoming Products from WHO MSD

To conclude Session 2, Dévora Kestel (WHO) briefly reviewed upcoming WHO resources and tools expected to be released in the coming year. These included:

- Quality Rights Training Package
- WHO position paper on integrated care for brain health
- Other publications in brain health (e.g. dementia-related toolkits, Parkinson's discussion paper)
- Global scales for early childhood development
- Caregiving skills training toolkit
- Helping Adolescents Thrive (HAT) guidelines and toolkit
- Global report on developmental delays, disorders and disabilities
- Advocacy booklet on mental health and neglected tropical diseases.
- e-learning course for mhGAP
- Several evidence-based, scalable psychological interventions
- EQUIP (Ensuring Quality in Psychological support) training and implementation platform.
- An updated Mental Health Atlas

LUNCHTIME SEMINAR- Suicide prevention: a month long campaign.

Kenneth Carswell (WHO) opened the floor reporting statistics concerning suicide and highlighted world suicide day. Alexandra Fleischman (WHO) stated that 38 countries have suicide prevention strategies and noting the work needed to reach the SDG targets. Alison Brunier (Department of Communications at the Office of the Director-General, WHO) described some of the media used around the world on suicide precvention including South China, Brazil, India and the UK, the WHO 40 seconds of action social media campaign which involved celebrities (e.g. Talinda Bennington) and Facebook Messenger's set of 'story filters' and "stickers" for World Mental Health Day. WHO released products including a

resource for pesticide regulators (available in English, French and Spanish), and resources (video and one-pager) for professionals (journalists, police officers, teachers, emergency responders, employers and prison officers). Partners including United for Global Mental Health, WFMH and IASP were thanked for their work.

A variety of comments were raised from the floor including the importance of translation. Lebanon shared some of their campaign activities including putting messages of hope on cars. Dévora Kestel closed the session by giving thanks to the team and highlighted that while the current advocacy is welcomed, much more work is needed in the area of suicide prevention.

SESSION 3: Small Group discussions- Impact through implementation: How are WHO tools being used in countries?

Group 1: Implementation of Policy

The aim of the session was to explore how WHO tools are being used in countries to implement mental health policies, and to discuss impact, successes and challenges in using these tools. The session was moderated by Martin Vandendyck (WHO).

Simon Njuguna (Director of Mental Health, Ministry of Health, Kenya) reported on the rollout of the WHO QualityRights initiative country-wide.

Zipporah Angyu (Mental Health Desk Officer, Federal Ministry of Health, Nigeria) and Mary Dewan (WHO) outlined some of the key challenges in reforming the national mental health act, and discussed 2019 efforts to revise the law in line with the WHO standards and the UN CRPD.

Mani Chandran (Senior Consultant Geriatric Psychiatrist, Hamad Medical Corporation, Qatar) gave an overview of the development of the National Dementia Action Plan, highlighted some of the key achievements and lessons learned from the process, and outlined the aims and key actions of the Plan.

Gonzalo Soto Brandt (Professor, University of Chile) presented the evaluation of the implementation of mhGAP in Colombia, Belize and Dominican Republic using WHO AIMS, WHO Atlas and WHO Training report. He gave a brief overview of results of the evaluation and proposed a number of recommendations for future work in this area.

Frances Prescilla Cuevas (Ministry of Health, Philippines) discussed the recently endorsed National Mental Health Act, described the translation and high level launch of the Filipino version of the WHO QualityRights e-training platform (including challenges, solutions and lessons learned) and highlighted the importance of this platform in supporting the operationalization of the new Act.

Dita Protopopová (Coordinator of mental health reform projects, Ministry of Health, Czech Republic) described the QualityRights assessment which led to the upcoming rollout of QualityRights e-training nationwide. She described other Mental Health Care Reform efforts in the country including the development and implementation of the national Mental Health Action Plan, the National Action Plan for Alzheimer's disease and related illnesses and the National Suicide Prevention Action Plan.

KEY MESSAGES

Challenges to implementation include: fragmented individual initiatives for policy and law reform that do not lead to buy-in from government health sector, lack of community based services that promote recovery and human rights and policies and laws that do not align with the UN Convention on the Rights of Persons with Disabilities (CRPD) and other standards.

Solutions to challenges include: creation of solid partnerships involving government and civil society with a strong voice of people with lived experience; establish a vision for community based services which reflects national resource contexts, allows for the phasing out of institutions and promotes community inclusion; create national policies, laws and services that align with the CRPD and other human rights standards.

Recommendations include: participation of a broader range of stakeholders in Special Initiative actions, in particular the meaningful involvement of people with lived experience; ensure that commitment to deinstitutionalization and the principles of the CRPD are criteria for selecting Special Initiative countries and that it is the basis for all action through the Initiative; ensure that the leadership for the Special Initiative in countries is at the highest possible level and that the Initiative is also supported by local level champions in order to ensure maximum visibility and commitment.

3.2 Implementation of Mental Health Interventions to Adult Populations

The objectives of this session were to identify challenges and recommendations on the implementation of mental health interventions to adult populations. The session was moderated by Carmen Martínez (WHO).

Rabih El Chammay (Head of the National Mental Health Programme, Ministry of Public Health, Lebanon) presented the Mental Health Strategy 2015-2020 in Lebanon, which included the opening of 12 community mental health centres by 2021, Interpersonal Psychotherapy (IPT) training, psychiatric emergency training for health care providers working in emergency, testing (and implementation if effective) a guided digitial Self-Help intervention, and QualityRights. Key challenges and solutions were discussed.

Hilda Kanaka Fatma Jansen (Interim Mental Health Coordinator, Ministry of Health, Vanuatu) presented mhGAP implementation 2016-2019 in primary care health settings in Vanuatu after the 2015 tropical cyclone Pam. A multi-sectoral approach was taken. The mhGAP implementation included training and supervision in clinical and non-clinical settings. Key challenges and solutions were discussed.

Jasmine Kalha (Program Manager and Research Fellow, Centre for Mental Health, Law & Policy, India) presented implementation research on mental health and human rights across systems-based and community interventions in Gujara. Activities included building local capacity, improvements in social environment, introducing family and peer-support groups, and making improvement plans. Key challenges and solutions were discussed.

Ashley Nemiro (MHPSS Advisor, The MHPSS Collaborative), presented the implementation of Problem Management plus (PM+) in three settings: Ethiopia, Syria and Honduras. The case-studies showed PM+ integration into existing mental health and psychosocial support programs; the use of remote supervision to implement PM+; and the implementation of PM+ with volunteer workforce. Key challenges and solutions were discussed.

KEY MESSAGES

Challenges to implementing adult mental health interventions include: limited resources (financial, human, time and skills/training); lack of buy-in from governments; difficulty sustaining and scaling-up services.

Solutions include: a structured supervision system; additional mental health coordination support/resources at district level; pre-service training within academic courses; engagement of community and intersectoral actors.

Recommendations for WHO include: adopting a whole system approach (health, educational, social); provide support for service planning, monitoring and evaluation; address comorbidities and related conditions such as dementia under mental health services.

3.3 Implementation of Mental Health and Brain Health Interventions to Children and Adolescents

The session was opened by moderator Dan Chisholm (WHO) and organizer Chiara Servili (WHO).

Matias Irarrazaval (Director, Department of Mental Health, Ministry of Health, Chile) outlined a number of mental health initiatives in Chile, such as “Chile Grows With You”, a policy that aims to help all children reach their full potential for development; mhGAP training; WHO Caregiver Skills Training Programme for Families of Children with Developmental Disorders or Delays; and a training plan for Psychological First Aid (PFA).

Fareed Minhas (Professor of Psychiatry/Director, WHO Collaborating centre - Rawalpindi Medical College, Pakistan) presented the country’s experiences with technology assisted task-shifting (e.g. interactive voice response system for identification of cases) using ‘Family Volunteers’ to Implement mhGAP and the Caregivers Skills Training (CST).

Nikolay Negay (General Director, Republican Scientific and Practical Center of Mental Health, Ministry of Health, Kazakhstan) presented the country’s work implementing mental health screening and awareness raising in schools, and training of school staff to recognise those in need of support. Technology aided implementation of this work (e.g. through online training, electronic screening). An achievement of the program had been the successful decrease in adolescent suicide rate. mhGAP implementation was reported to be going well.

Benedict Dossen (Country Program Lead - Mental Health Program, Carter Centre, Liberia), presented mental health programs in the country: a 6 month post-basic training for clinicians, mhGAP-HIG, and training teachers and school staff in mental health and brain health. The

goals of Liberia's Mental Health Strategic Plan for 2016-2021 were discussed. Challenges to implementation included lack of mental health knowledge, stigma and lack of resources.

Charlotte Hanlon (WHO Collaborating Centre, Addis Ababa University, Ethiopia) joined online and presented the field testing of Caregivers Skills Training (CST) for families of children with developmental disorder in Ethiopia. Results suggest that CST was well-received during pre-pilot, and it is being integrated and delivered hospitals and training for psychiatrists and clinical psychologists.

KEY MESSAGES

Challenges to implementation of mental health and brain health interventions for children and adolescents include: inadequate human resource capacity; not enough time for assessment and management of MH conditions at PHC care; sustainability.

Solutions include: training (preservice training, competency-based training, continuous quality improvement, supervision and monitoring, and the use of digital technologies to support training); multidisciplinary teams; provide evidence on investment case; schools, which are an important platform for delivery (but specific strategies may be required for out-of-school children); the use of family volunteers; innovative financing; whole-government approach.

Recommendations include: Take time to understand the context well (including availability of human resources, and complex heterogeneous needs of children and families); engage schools; whole government approaches and innovative financing.

3.4 Implementation of Mental Health Interventions in Humanitarian Settings

The session was organized by Fahmy Hanna (WHO) and Inka Weissbecker (WHO), and moderated by Florence Baingana (WHO).

Fahmy Hanna provided an overview of new WHO estimates for mental health conditions following conflict, the scarcity of human resources and WHO MHPSS tools (e.g. IASC MHPSS guidelines, the mhGAP-HIG).

Claire Whitney (Sr. Global Mental Health & Psychosocial Advisor, International Medical Corps) presented on WHO and UNHCR needs assessment and gave a case study of it applied to Yemen. Implementation of PM+ in the Middle East was described.

Yutaro Setoya (WHO) presented on humanitarian hazards in the Pacific islands. An overview of the use of mhGAP, IASC guidelines, and MoH ToTs applied to the 2016 cyclone Winston in Fiji and the 2018 cyclone Gita in Tonga was given.

Selma Sevkli (Mental Health Technical Advisor, International Medical Corps) outlined the implementation of mhGAP-HIG (integrated with other tools) in Libya. Initial phases focused on identifying human resources, followed by development and adaptation of toolkit,

assessments, implementation and supervision. The presence of a strong local team (especially the inclusion of local psychiatrists) was a key asset to the success of the project.

Inka Weissbecker (WHO) showed a video clip of a mhGAP-HIG training programme in collaboration with IMC. It can be accessed from the following link: (https://www.youtube.com/watch?v=B9_Ik_Tf2N8&feature=youtu.be&fbclid=IwAR10l7go2zDfItWkKcfCLn3ACVkoKcGODlf4_ucshcEQqj231Sw4Y-3U15M).

Joseph Mogga (WHO) described South Sudan's work with the building back better framework and Self Help + (SH+). Tools (e.g. mhGAP operations manual) were operationalised through the MoH with support of WHO and led to 52 health workers being trained for the treatment of around 600 people, and the decrease of patients in prison.

Emeka Nwefoh (Mental Health Advisor, CBM) spoke about CBM work in North East Nigeria. CBM continued an intervention they had begun in November 2018 into December 2021 with funding from the German Ministry of Foreign Affairs. They conducted various ToTs with focus on supervision, clearer referral pathways, and the rebuilding of health facilities.

Alisa Ladyk-Bryzghalova (WHO) presented the Building Back Better (BBB) framework in Ukraine. Key components of the programme are de-institutionalisation and integration of mental health within PHC through the use of mhGAP. The overall program aims to have approximately 2 million people covered by mhGAP services across the country.

Giovanni Sala (Mental Health Programme Coordinator, COOPI) described the MHPSS program of COOPI Niger, inspired by BBB framework. The program aims to provide emergency response through community and public health integration in PHC. Activities include testing of group PM+ and awareness raising to reduce stigma and ease referrals from communities (e.g. radio stations, mobile cinemas).

KEY MESSAGES

Challenges to implementing mental health interventions in humanitarian settings included sustainability, mental health needs of humanitarian workers, and coordination issues (Governments, NGOs).

Solutions proposed were: engagement of humanitarian and development partners towards common outcome in line with national agenda; integration of MHPSS support for humanitarian workers; better coordination through MHPSS Technical Working Groups (national partners, authorities, ministries and other decision makers to be engaged).

Recommendations were: Building Back Better- Build capacity using tools such as mhGAP HIG, Operations Manual, PM+ and others; healthy humanitarian workers are needed for scale up of MHPSS; and establish MHPSS Technical Working Groups and engage with governmental stakeholders.

SESSION 4: WHO Special Initiative: Suggestions from the field

4.1 Introduction

Dévora Kestel opened the session and introduced Mark van Ommeren (WHO) and Alison Schafer (WHO).

Mark van Ommeren (WHO) introduced the aim of the Special Initiative project, "By 2023 universal health coverage (UHC) ensures access to quality and affordable care for mental health conditions in 12 priority countries to 100 million more people." This will be done through 2 strategic actions: 1) Advancing mental health policy, advocacy and human rights, and 2) Scaling up interventions and services across community-based, general health and specialist settings. By make substantial investments for 5 years in 12 priority countries the aim is to have enough structure in country to sustain the services. Most of the money for the project will be spent in countries and a better balance will be created in distribution of technical staff in WHO country, regional and HQ offices. The aim is to have implementing staff in country offices. Selection of countries is still underway.

Alison Schafer (WHO) introduced a small activity for participants. She asked all participants to write down their ideas and thoughts to answer the following sentence:

"My one suggestion for WHO's Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health is…"

The top three themes were:

1. Working at a community level (involvement of community health workers, schools, faith centres) was the most common suggestion (n=23)
2. A focus on research and quality of services (using scientific evidence, M & E, research, inclusion of academia, publishing results) (n=12)
3. Integration of mental health across levels, services and populations (engaging different sectors, using a system change approach) (n=10).

Additional themes submitted by five or more people were:

1. getting government buy-in (n=9)
2. running awareness campaigns (n=8)
3. involving people with lived experience (n=8)
4. engaging in advocacy (n=6)
5. focus on children and adolescents (n=6)
6. involvement of other health sectors (e.g. family medicine, PHC) (n=5)
7. involvement of vulnerable populations (e.g. refugees, migrants, people with disabilities) (n=5)
8. supervision systems in place (n=5)
9. tackling stigma (n=5).

4.2 Summary of small group discussions and country presentations on mental health system reform

Summaries of small group discussions can be found in “Key messages” boxes in Session 3 above.

4.3 Country presentations on mental health system reform

Rabih el Chammay (Head of the National Mental Health Programme, Ministry of Public Health, Lebanon) described the reform of the Lebanese mental health system. The importance of leadership governance and inter-sectoral policy work was emphasised. Main challenges were (i) building all the blocks of the system at the same time and (ii) funding. Recommendations to overcome these included (i) having a road map (Mental Health strategy), having a highly skilled team centrally and leveraging other agendas (e.g. UHC, NCDs,), and (ii) use humanitarian funding for system strengthening, create a collaborative governance model and to identify actors willing to invest in system strengthening.

Jacob Bernard (Federal Coordinator of the Belgian mental health care reforms, Federal Public Service – Health, Belgium) described the mental health reform in Belgium, which focused on the integration of psychiatric care into existing community networks and resources. For healthcare systems reform, a global approach is needed with consensus at all political levels, and links with employment, justice, and education system. A lot of time was also needed (at least 10 years in Belgium). It is important to have stakeholders involved, a strong national strategic plan that is in line with regional plans and having a regional coordinator.

Yuri Cutipe (Director of Mental Health, Ministry of Health, Peru), outlined the mental health reform in Peru, which started in 2011 and focused on providing care through community mental health centers. In 2015 a finance program for mental health was created. By 2021 the aim is to have increased coverage from 10% to 28%. Key lessons learnt were: in addition to a legal mechanism for the operationalization of policies permanent intersectoral, national and regional buy-in is key; political advocacy and technical assistance of the national and international organizations is important; the need for partners in health and human rights reform; and the need for political support for community mental health policy from other sectors of the State and social actors. Having concrete financing mechanisms is essential in creating sustainability.

4.3 Plenary Discussion

Dévora Kestel closed the session by thanking all the presenters. She acknowledged that everyone has contributed a lot to these projects, the results are rewarding and that leadership is essential in making things happen.

SESSION 5: Small Group Discussions

5.1 Consultation: Strategies to scale up WHO QualityRights in and across Countries

The session was moderated by Sarah Kline, Deputy CEO, United for Global Mental Health.

Natalie Drew Bold (WHO) shared information on the the large scale implementation and evaluation of QualityRights in India. The momentum of scale-up has been encouraging for the team which has on-going collaborations with 10 countries.

The participants in the room represented around 8 countries which led to an intensive and concrete discussion on the possible ways to scale-up QualityRights: within countries and across countries.
Some of the strategies to scale-up included:

- Setting-up an implementing committee
- Having a mixed stakeholder group, policy makers, professionals, diverse civil society groups
- Establishing a group of national champions and video messages promoting the e-training through social media
- Involving ministers, people with lived experience, civil society reps, well known national personalities in the national launch event of QR e-training initiative
- High level participation- all stakeholder groups
- Social media strategy by national expert for ongoing rollout
- Complementary QR face to face training (ToT) for super coaches to feed forum discussions and respond to feedback
- QR assessment and improvement/transformation of mental health and social services

The session included questions on the feasibility of the intervention, where QualityRights had introduced and included updates on various innovative strategies being used across countries to implement QualityRights.

KEY MESSAGES

Suggestions for in-country strategies included integration of QualityRights into a number of areas (e.g. professional development curriculum, workplace settings, UN staff, in countries).

Suggestions for strategies across countries included: engaging national human rights institutions; challenging power hierarchies through representation from inter-sectoral partners such as education, social justice, social welfare and others, to ensure no group dominates; building mental health leadership within countries; demonstrating how countries can use QualityRights to achieve SDG 3.4; include QualityRights as an approach for donor funding in countries, in line with Article 32 of the UN CRPD.

5.2 Consultation: The development and implementation of a Minimum Services Package for mental health and psychosocial support in humanitarian settings

This session was led by Inka Weissbecker (WHO) and Zeinab Hijazi (Mental Health and Psychosocial Support Specialist, UNICEF).

Inka Weissbecker summarised the aims of the three year Minimum Services Package (MSP) project: to create a package of priority actions and interventions carried out by humanitarian actors to improve availability and quality of care in humanitarian settings. It will support coordinated MHPSS through integration across the sectors of health, child protection, and education and will be co-led by WHO and UNICEF with the support of UNHCR.

Zeinab Hijazi explained that the MSP focusses initially on child protection, education and health, with future focus on different aspects (e.g. GBV, disabilities).

Peter Ventevogel (Senior Mental Health Expert, UNHCR), used the Rohingya crisis as an example, to outline the need for the MSP to provide a more predictable, faster and credible response for humanitarian crisis.

Koen Sevenants, (UNICEF) outlined the need for the MSP to support organisations to organise and co-ordinate responses, in particular for enhancing services in child protection.

Sarah Harrison, (Global MHPSS Technical Advisor, International Federation of Red Cross and Red Crescent Societies) highlighted the absence of existing data on financial costs (per child or person in need) of MHPSS in humanitarian crises. It is hoped that the MSP will fill this gap. The need for the MSP was emphasised, using Ebola response in DRC as a case example.

Margi Bhatt (Coordinator, Education Policy, Inter-Agency network for Education in Emergencies), highlighted the need for MHPSS to be integrated in education. Linking to a case study in Syria, challenges included linking child protection and education, no clear way to co-ordinate the response, being unsure of the costs involved. The MSP can help overcome these challenges.

Discussion from the floor included the support for more transparent costing to allow for better coordination (although this will not be easy); the importance of having different entry points for MHPSS (e.g. child protection, health); localisation and adaptation of MSP; and ensuring the MSP is simple and accessible.

KEY MESSAGES

There is the need to better integrate MHPSS services, care and pathways across sectors, including health and child services.

A Minimum Service Package for MHPSS may allow for better coordination between donors; include tools that can be used for advocacy within organizations and with partners; include elements related to disability, child protection and nutrition; enhance accountability and research.

Challenges for the MSP include difficulties producing cost estimates; ensuring that the language is simple and understandable; identifying who should be responsible for MHPSS (i.e. which actors and sectors); including people with complex mental health needs.

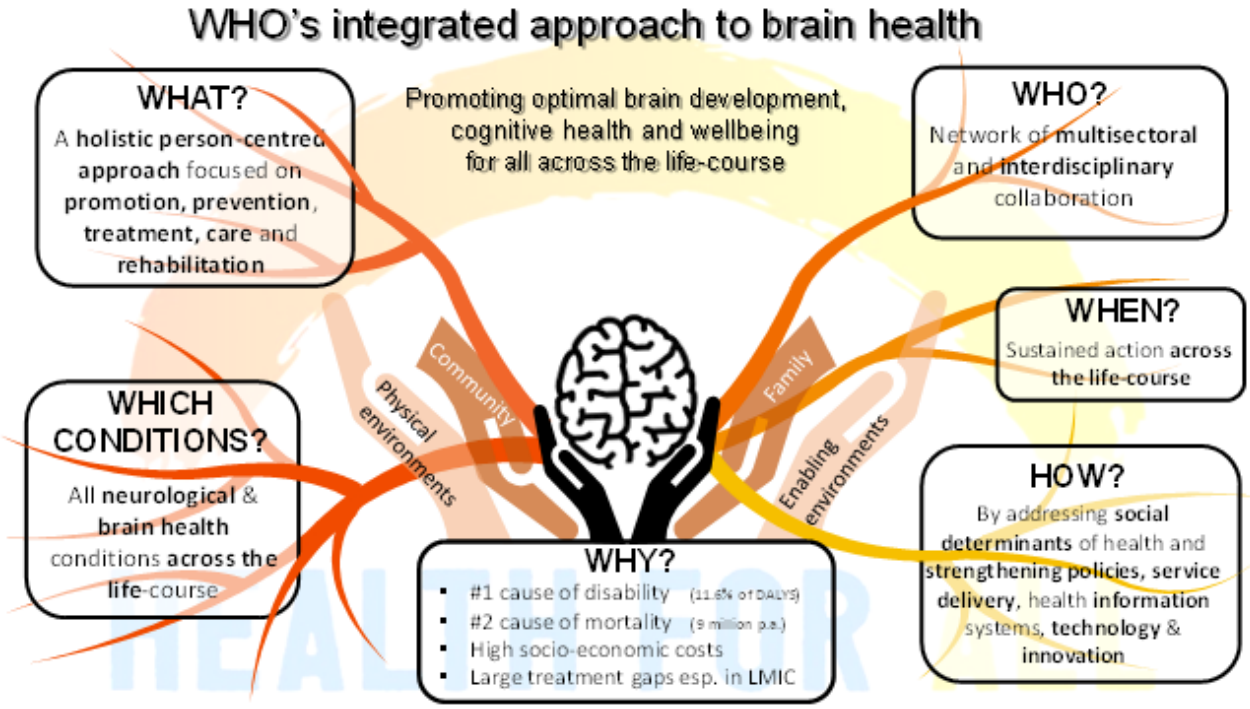
The importance of ensuring that MHPSS is aligned with global guidelines in health and child protection, and is being recognized at the policy level.

5.3 Consultation: Integrated approach to Brain Health

The objective of this session was to discuss and obtain feedback on WHO's integrated approach to brain health. The session was moderated by Dan Chisholm (WHO).

Tarun Dua (WHO) introduced WHO's vision for an integrated approach to brain health (see Figure 1).

Figure 1. WHO's integrated approach to brain health.



Kate Swaffer (Chair, CEO and co-founder, Dementia Alliance International) highlighted the need for brain health education across the life-course, starting with children. She also stressed the importance of a rehabilitative, rights-based approach focusing on mental, physical and emotional health.

Alla Guekht (Director, Moscow Research and Clinical Center for Neuropsychiatry, Russian Federation) emphasized the importance of personalized and multidisciplinary care, coordinating health care professions such as neurology, psychiatry, psychology and physiology, amongst others.

Raoul Bermejo (Coordinator, Care, UNICEF), introduced the Nurturing Care framework (WHO, UNICEF and others), and indicated that the pregnancy period, early development and adolescent years are important times to promote brain health, emphasizing that brain development can be nurtured.

Alarcos Cieza (WHO) shared WHO's rehabilitation perspective, which includes a focus on functioning, rehabilitation and action. The importance of measuring functioning, in addition to mortality and morbidity, was highlighted.

Benedict Dossen, (Country Program Lead - Mental Health Program, The Carter Centre, Liberia), spoke about the national assessment on mental health needs in young people carried out by the Government of Liberia in 2009, and subsequent training for teachers to raise awareness of brain health, which resulted in reduced stigma, reduced physical abuse, the establishment of referral routes to mental health clinicians.

Raad Shakir (Professor Neurology, European Academy of Neurology) emphasized the importance of considering issues such as stroke within the purview of neurological disorders, and highlighted the need for WHO to better engage neurologists and neurosurgeons.

Peter Yaro (Executive Director, Basic Needs- Ghana) highlighted the need to train and include traditional healers in order to overcome health human resource constraints in low- and middle-income countries. In Ghana this represented a key step to promoting epilepsy care, and there are now registers for traditional healers in both Ghana and South Africa.

KEY MESSAGES

There is a need to focus on: conceptual issues regarding brain health and mental health; a holistic approach to brain health that is evidence-based across the life-course; prevention, treatment, care and rehabilitation (including optimal functioning)

A systemic approach is required, which considers family dimensions, traditional healers, essential medicines, NCDs and assistive technologies.

There is the need to address social determinants of health and stigma.

It is important to respect societal and personal perspectives as well as country context.

There is an opportunity to mainstream brain health into universal health coverage and primary health care; and a need to integrate two pillars, or brain health paradigms: health promotion and disease-specific prevention, management and interventions.

Lunchtime Seminar: Promoting Human rights and Recovery-oriented Services and Supports for Persons with Psychosocial Disabilities.

The seminar, moderated by Alison Brunier (WHO) opened with a brief introduction by Michelle Funk (WHO) who highlighted the importance of creating community services that operate without coercion, support recovery and promote autonomy and inclusion. She then described the work currently underway to generate WHO good practice guidance in this area.

Seminar speakers Michael Njenga (CEO, Users and Survivors of Psychiatry in Kenya), Thurayya Zreik (Field Manager, QualityRights, National Mental Health Program, Ministry of

Public Health, Lebanon) and Arturo Cannarozzo (organizer of the International Activities, La Collina Social Cooperative, Italy), gave powerful testimonies about their lived experience of mental health and using mental health services. Each presenter spoke about initiatives they are undertaking to promote services that respect human rights and promote recovery.

Highlights of the seminar included Thurayya Zreik's vivid account of the positive changes she witnessed within a service after it had implemented QualityRights, Michael Njenga's strong call to end coercive practices, respect legal capacity and promote peer support as an essential part of the service package, and Arturo Cannarozzo's important reminder that all services have a duty to look at the whole life of the person, not just focusing on their symptoms, and to support them in achieving their goals and aspirations.

SESSION 5: Small Group Discussions (part 2)

5.4 Consultation: Implications of ICD 11 for health care practice and training

The objective of the session was to consult on the implications of ICD-11 for health care practices and training. The session was moderated by Jose Luis Ayuso-Mateos (Professor of Psychiatry, Universidad Autónoma de Madrid, Spain).

Geoffrey Reed (Professor of Medical Psychology, Global Mental Health Program, Columbia University, USA) outlined the major changes to ICD-11 (approved in May 2019, which come into effect January 2022)

(i) Elimination of mind-body dualism (e.g. new unified classifications of sleep-wake disorders which was previously divided into 'organic' and 'non-organic')
(ii) Move towards dimensional classification (stronger focus on current presentation, moving away from stable diagnoses)
(iii) Disorders due to Substance Use corresponds to global public health needs
(iv) Gender Identity disorders now called "gender incongruence" and moved to the new chapter on sexual health, no longer considered a mental disorder.

Raad Shakir (European Academy of Neurology) described how the changes in the ICD 11 would improve neurology. For example, stroke is classified as a brain disease in its own right in the ICD 11 (previously was under three classifications), leading to improved clarity and clinical usefulness.

Mariana Pinto da Costa (Chair, Early Career Psychiatrists, World Psychiatric Association) presented views of early career psychiatrists on International Classification Systems. For example, out of 202 early career psychiatrists 55% stated they were "very interested" in the ICD-11 and 37.6% were "very interested" in the DSM 5.

KEY MESSAGES

Clinical description and diagnostic guidelines (CDDG) are the best tool for training; therefore a priority should be set on the translation, publication and widespread dissemination of these guidelines.

There is a need to capacity build activities that incorporate novel technologies for health education.

There is a need to involve professional societies and national health authorities to identify the required activities for the adoption and implementation of ICD 11.

The incorporation of ICD 11 changes into undergraduate and graduate education should be facilitated and promoted.

The need and scope for a primary care version should be assessed and articulated, and an appropriate product developed, consistent with mhGAP and other recommendations from WHO's Mental Health and Substance Use Department.

5.5 Consultation: Planned EQUIP (Ensuring Quality in Psychological Support) training materials including training guidance and foundational skills training

Alison Schafer (WHO) opened the session by introducing the EQUIP (Ensuring Quality in Psychological Support) project. Jennifer Hall (WHO) facilitated an icebreaker to prepare the group for an interactive session, followed by Sarah Watts (WHO) who introduced the training package and competencies developed within the EQUIP project.

A participatory group activity followed, moderated by Jennifer Hall (WHO), Edith van't Hof (WHO), Sarah Watts (WHO) and Alison Schafer (WHO), to gather ideas from the group of activities for training pre-selected competencies. The EQUIP team selected 4 core competencies for the exercise on training activities: 1) Promotion of realistic hope for change, 2) Rapport building and self-disclosure, 3) Exploration, interpretation and normalisation of feelings, 4) Demonstration of empathy, warmth and genuineness. The consultation was very interactive and all groups gave valuable ideas on activities.

Main issues raised in the discussion were around the use of competency assessment tool ENACT, the link between competency based training and client outcomes, how to use the EQUIP tools in different contexts..

KEY MESSAGES

Competency based training can improve quality of training provided.

Consideration needs to be given to implementation of competency -based training, to ensure it can be used in different contexts, and a safe learning environment is maintained,

Suggestions for training competencies included role plays, group reflections and teaching the group mindfulness skills.

5.6 Consultation: The role of mental health and psychosocial support in emergency preparedness, climate change and disaster risk reduction

The objectives of this session were to consult on the role of mental health and psychosocial support in emergency preparedness, climate change and disaster risk reduction. The session was moderated by Brandon Gray (WHO).

Fahmy Hanna (WHO) highlighted the importance of MHPSS preparedness through a case study of a hurricane affecting the Bahamas. MHPSS preparedness can be linked to disaster risk reduction (DRR). The Sendai Framework for Disaster Risk Reduction also highlights that MHPSS needs to be a component of disaster risk management programming (DRM).

Jostacio Lapitan (WHO) highlighted the need for political commitment in order to have public health services that promote dignity, strengthen resilience, make scalable psychological interventions available and provide mental health integrated with general health care.

Elena Villalobos-Prats (WHO) stated that climate change has been defined as the public health risk of the century and explained links between climate change and public health, such as i increased air pollution, extreme weather, and poverty.

Kasi Sekar (Professor and Registrar, National Institute of Mental Health and Neurosciences - NIMHANS, India) outlined the importance of a multi-sectoral MPHSS response through describing a project (implemented by National Institute of Mental Health and Neuroscience and UNDP funded by USAID) which aimed to develop community resilience in disaster prone areas in India. Preliminary studies showed that these materials were effective.

Martin Vandendyck (WHO) described how working with the MoH to provide psychological support, using a Building Back Better (BBB) approach, supported responses to two emergencies in the Western Pacific region last year (an earthquake in Papua New Guinea and flash-floods in Laos PDR, first national emergency in Laos).

Maria Ziegler (Operations Officer, Gender and Development, Caribbean Development Bank) outlined efforts to support DRR in the Caribbean, in particular in response to hurricanes, through raising awareness, community campaigns, capacity building (mhGAP-HIG, PFA) and creating a regional roster of mental health professionals available for mobilisation in case of emergency.

Anva Ratzon (protection coordinator and DRR countenance, IsrAID) summarised IsraAID approach to DRR, and highlighted the basis of the programme in Moshe Farchi's model to reduce acute stress reactions. Anva proceeded to describe a series of projects conducted in Guatemala and in other countries to integrate DRR and MHPSS in 31 schools.

Julian Eaton (Mental Health Director, CBM) presented on the work conducted in the Ebola crisis in Sierra Leone. Preparedness work previously conducted in Sierra Leone, such as capacity building for nurses, supporting front line workers, focus on children and persons with disabilities and set up of MHPSS systems, greatly helped Ebola response.

Brandon Gray (WHO) discussed a draft framework by the IASC MHPSS Reference Group that has been developed for integrating MHPSS into DRR and *vice-versa*. The framework will include practical tools (such as checklists on preparedness, tools on how to integrate MHPSS into DRR), a guidance note to understand how the IASC framework can be used on the ground and operationalised, and lessons learnt.

Maria Baena Álvarez (WHO) stated that more research is needed in the field of mental health and climate change, on both acute weather event and long-term implications of climate change.

Fiona Charlson (Senior Research Fellow, Queensland Centre for Mental Health Research, Australia) described the impact that climate change is having in Australia and in the Pacific and stated that that literature on climate change and mental health is largely restricted to discussion papers of proposed causal pathways and cultural impacts using qualitative research. Future research is needed.

KEY MESSAGES

It is important to be ready to respond and not waiting for an emergency to happen

The identification of links between disaster risk reduction and MHPSS.

The impact of climate change on mental health, and how these can be integrated in a holistic manner.

SESSION 6: Plenary Discussion and Close

6.1 Reports from small groups

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

6.2 Updates from WHO Regional Advisors

Florence Baingana (Consultant, WHO AFRO) provided updates from the AFRO region. She described the context: suicide and substance use are the main areas of burden, and the

majority of countries do not have mental health policies or plans. Challenges in reducing the treatment gap include: low prioritization of mental health, insufficient funding, weak health systems, lack of health information systems, lack of resource (health care workers, facilities, medicines) and poor quality of care. There were many achievements, including QualityRights support in Kenya, legislation review support in Nigeria and support for developing mental health strategic plan in South Sudan. Plans for 2020/2021 include: regional programme managers' meeting with all 47 Member States, regional dementia meeting for 20 Member States; implementing QualityRights in francophone countries, mental health capacity building for WHO country offices and national ministries of health.

Dan Chisolm and Alisa Ladyk-Bryzghalova (WHO) provided updates from the EURO region. More than 25 out of 50 Member States in EURO have explicitly included mental health in their work plan, however there continues to be an overdependence on institutionalized health. Challenges include meeting the needs of so many Member States. There are two strategic directions: (i) the promotion and protection of mental health and brain health over the life-course, including advocacy and mental health in old age and (ii) policy. Achievements include dementia policy and planning workshop in Malta, suicide prevention and mhGAP in central Asia (e.g. Tajikstan) and QualityRights implementation (e.g. in Latvia).

Alisa Ladyk-Bryzghalova provided an overview of Ukraine country-level activities, including support for developing a national mental health policy and action plan, financing for mental health , implementing mhGAP and QualityRights in Ukraine.

Carmen Martinez (WHO) provided updates from the AMRO region. These included developing mental health policies,; mhGAP and PM+; de-institutionalization of services; implementation of QualityRights; economic investment cases to develop evidence; caregiver skills training (CST) for families of children with developmental delays; suicide prevention strategies and plans; and aiming to develop a regional observatory for mental health by 2020;

Martin Vandendyck (WHO) outlined activities in the WPRO region. Key priorities included: noncommunicable diseases and ageing, health security, climate change and environment – mental health and dementia are included under all three priorities. 19 of 27 Member States requested support on mental health. China, the Philippines and Vietnam are currently developing national dementia plans. WPRO adopts a tailored support approach for the Western Pacific.

6.3. Evaluation of the Forum

Kenneth Carswell (WHO) led participants through an online evaluation of the Mental Health Forum 2019 in real time. Key results are shown below.

Suggestions made for making products easier to implement and use included:

- more accessible products (shorter, easier to read; n=25)
- Operational guidance, implementation workshops and training and supervision (n=19)
- Ensuring local adaptation and contextualisation and relevance to field (n=13)

29% stated they found the forum "extremely useful", 45% "very useful", 40 % "useful" and 4% "not useful"

88% stated that WHO should continue with the WHO MH Forum “more or less as it is”

Suggestions for improving the forum included:

- More time for discussion and interaction, less presentations, more group work, different talk formats, more question time, more participation from participants (n=56)
- Smaller sessions and smaller groups for group-work (n= 14)
- More service users and carers involvement (and possibly paying for their attendance) (n=13)

6.4. Conclusions and close

Dévora Kestel (WHO) expressed her gratitude to the Mental Health and Substance Abuse Department team for organizing the Mental Health Forum 2019, and also recognized the work of the photographers. Recognition was expressed to participating governments, nongovernmental organizations and other agencies. The Mental Health Forum 2019 represented an opportunity to learn about activities being undertaken at country-level. Dévora expressed that it is rewarding to witness progress unfolding but that there still remains much to accomplish. She thanked donors and partners for their intentions to support this agenda moving forward. Dévora mentioned that WHO will reflect on the feedback shared by participants during the Mental Health Forum 2019 and encouraged participants to collaborate in an ongoing manner. To close the session, Dévora indicated that WHO will continue to work hard to ensure that people with mental health needs receive the care and respect they deserve.