PDF version

Executive summary

1 At any given time about one person in every ten is suffering from a mental disorder, and about one in four families has a member with a mental disorder. Rates of mental disorder are even higher where there are complex emergencies. Despite the personal and economic costs and availability of cost-effective interventions, treatment rates for people with mental and substance use disorders are low, with treatment gaps of more than 35–50% of individuals with serious disorders in developed countries and 76–85% of individuals with serious disorders in less developed countries. Such gaps are mainly due to scarcity of human and financial resources, inequities in their distribution and inefficiencies in their use, as well as to the stigma associated with mental disorders

2 The Sixty-sixth World Health Assembly adopted a comprehensive mental health action plan 2013–2020 to address the challenge of bridging the treatment gap. The plan sets out a vision and roadmap for mental health for countries of the world to achieve by 2020. It identifies specific actions for Member States and for international and national partners with agreed targets and indicators.

3 In order to operationalize the vision and roadmap set out in the plan, a regional framework for scaling up action on mental health is proposed which identifies high impact, cost-effective, affordable, feasible strategic interventions across the domains of governance, health services, promotion and prevention, and surveillance, monitoring and research. It also provides a set of indicators to monitor progress in implementing these interventions. These domains correspond to the four objectives of the mental health action plan 2013–2020 and are guided by its underpinning principles.

4 Most countries in the Region report that they have a mental health policy (77%) Most countries report that they have mental health legislation (73%), but only one third are fully compliant with international human rights instruments and no country is fully implementing its existing policy while about 45% of countries are partially implementing the relevant legislation. The average mental health workforce in the Region is 14.6 personnel per 100 000 population. This is less than half the comparable global rate of 33.8 per 100 000 population. Furthermore, in about one third of countries, more than 85% of the mental health workforce is deployed in mental hospitals. With regard to availability of mental health services, a median of 6.1 beds per 100 000 population is available across the Region; 64.3% of psychiatric beds are located in

mental hospitals and 35.7% are located in community settings – general hospitals 18.3% and community residences 17.4%. In order to bridge the treatment gap and achieve the overall goal of the mental health action plan – “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” – the need is to focus on key strategic interventions to scale up holistic mental health care as outlined in the regional framework. The Regional Committee is invited to endorse the regional framework for scaling up action on mental health in countries of the WHO Eastern Mediterranean Region.

Introduction

5 Mental, neurological, and substance use disorders are a leading cause of the disease burden worldwide. (1). According to the World Health Report 2001, at any given time about one person in every 10 is suffering from a mental disorder, and about one in four families has a member with a mental disorder, 20% of children and adolescents worldwide suffer from disabling mental illness, and approximately 50% of mental disorders in adults begin before the age of 14 years (2). A recent systematic review estimated life-time prevalence rates of common mental disorders at 29.2% (25.9–32.6%) and a 12 month period prevalence rate of 17.6% (16.3–18.9%). A consistent gender effect was also observed with women having higher rates of anxiety (8.7:4.3%) and mood disorders (7.3:4.0%) (3). Rates of mental disorder are even higher where there are complex emergencies. Meta-analysis of the most robust epidemiological surveys in conflict-affected populations showed average prevalence of 15.4% for post-traumatic stress disorder (PTSD) and of 17.3 % for depression. These rates are substantially higher than the average 7.6% (any anxiety disorder, including PTSD) and 5.3% (any mood disorder, including major depressive disorder) reported from 17 countries which have participated in the world mental health survey (4).

6 Globally, mental and substance-use disorders account for 22.9% of non-fatal disease burden (measured as years lived with disability, YLD), and 7.4% of the global burden of disease (measured by disability adjusted life years (DALYs), a metric which encompasses years lived with disability as well as early death) (Table 1) (5).

7 In addition to disabilities, mental disorders are associated with excess mortality, either because of being an independent risk factor for other health outcomes, such as suicide, or because of association with other risk factors for physical illnesses, particularly cardiovascular disease, including stroke, and cancer. Furthermore people with mental disorders are less likely to receive a timely and appropriate management of physical illness because of diagnostic overshadowing, even in countries with well established health care systems (6,7).

8 Mental disorders are not only of public health concern but of economic development and societal welfare concern as well. A study undertaken for the World Economic Forum estimated that the cumulative global effect of mental disorders in terms of lost economic output could amount to US$ 16 trillion by 2030. In high-income countries, expenditures incurred and loss of productivity from mental disorders, equate to about 4% of gross national product (GNP) and it is predicted that the cost of mental disorders will more than double by 2030 across all countries (8). An integrated package of cost-effective mental health care and prevention interventions can be delivered in community-based settings for US$ 1–2 per capita per year in low- and lower-middle income countries, and US$ 3–5 in upper-middle income countries (9). The median government mental health spending per capita for low, lower-middle and upper-middle income country groups globally is very low (less than US$ 2), and much of the reported expenditure is allocated to inpatient care, particularly to mental hospitals (10).

9 Despite the personal and economic costs and availability of cost-effective interventions, treatment rates for people with mental and substance use disorders are low with treatment gaps of 35–50% of individuals with serious disorders in developed countries and 76–85% of individuals with serious disorders in less developed countries (11). Even in developed countries, treatment is typically provided many years after the disorder begins. The main reasons for this are scarcity of human and financial resources, inequities in their distribution and inefficiencies in their use (12), as well as the stigma associated with mental and substance use disorders.

Situation analysis

Magnitude of the problem in the Region

10 Epidemiological data on the prevalence of mental disorders in the Region is limited. Where data are available, the range of instruments used and the methodological differences across the surveys are wide (12). The global burden of disease study has shown that the prevalence of mental disorders, specifically depressive illness and anxiety disorders, is the highest in countries of the Region and is almost wholly accounted for by the complex emergency situations prevailing across most of the countries (13).

11 Community screening surveys report rates of psychological distress between 15.6% (United Arab Emirates) and as high as 51.8% (Palestine). The screening surveys conducted with children and adolescents in Oman, Gaza Strip (Palestine) and Mosul (Iraq) show much higher rates of psychological disorders in Palestine and Iraq than in Oman, but since the assessment methods were different they cannot be directly compared. It is nevertheless interesting that these studies show the least difference in rates between males and females (14).

12 As mentioned above, the prevalence of mental disorders as determined by diagnostic

interviews in the Region vary widely because of the different methodologies and instruments used. The diagnostic breakdown suggests a picture similar to the global picture, with depression and anxiety the most common mental disorders. However, in addition there are high rates of post-traumatic stress disorder in Afghanistan, specific phobias in Egypt and Oman, and obsessive compulsive disorder in Islamic Republic of Iran. All the surveys of adult populations consistently report rates of mental disorder much higher in females than males, with an average female to male ratio of 2.3 among the surveys of adults (14).

13 The annual regional age-standardized suicide rate for the Region is 6.4 per 100 000 population (7.5 for males and 5.2 for females) compared with an annual global age-standardized suicide rate of 11.4 per 100 000 population (15.0 for males and 8.0 for females). Regional suicides account for only 3.7% of global suicides while the regional population accounts for 8% of the total global population (15).

14 Countries in the Region typically spend about 2% of their health budget on mental health, which compares with the 5–10% required to match the spending on mental health in the United Kingdom, Canada and European Union countries. The median per capita expenditure of US$ 0.15 on mental health per person is well short of the US$ 1–2 needed for a selective package of cost-effective mental health interventions in low-income countries and up to US$ 3–5 in high-income and middle-income countries. Furthermore, centralized and institutionalized care consumes a disproportionate amount of mental health expenditure (9,16).

Findings of the mental health atlas questionnaire 2014

15 The high prevalence, disability and growing costs of mental disorders, taken together with the huge treatment gap despite availability wof cost-effective treatments, form a compelling case to reassess provision for mental health care. WHO took up this challenge with the comprehensive mental health action plan 2013–2020, which was adopted by the World Health Assembly in 2013. The plan sets out a new vision and goal for mental health to be articulated through four objectives and six measurable global targets to be achieved by 2020 (17).

16 In order to monitor progress in achieving these targets and to monitor other critical aspects of mental health systems development, a set of core mental health indicators was developed. All countries in the Region completed the mental health atlas 2014 questionnaire which is based on these indicators and which will serve as the baseline for monitoring progress towards meeting the targets of the global action plan.

17 Most countries report that they have a mental health policy (77%) and the proportion of group 1 and 3 countries having mental health policies is higher compared to group 2 countries (83% each of group 1 and 3 compared to 70% of group 2 countries). However, in relation to compliance with international standards, the rates are comparable across the three groups of countries (57%, 58% and 53% respectively). Most countries report that they have mental health legislation (73%), but only one third are fully compliant with international human rights instruments. However, the mental health laws in group 3 countries are more likely to be compliant with international human right standards (87% compared to 40% of group 1 countries). No country is fully implementing its existing policy while about 45% of countries are partially implementing the relevant legislation.

18 With regard to service user empowerment and participation, the Region has the lowest level of involvement of association of service users and their families. Group 2 countries have greater involvement of stakeholders, with an average of 40% of the domains (information, policy, early involvement, participation and resources) at least partially implemented, twice that for group 1 and group 3 countries.

19 With regard to investment in mental health, the government is the main provider of funds for care and treatment of severe mental disorders in 77% of countries. Four countries provided data on total government mental health expenditure, including at least one from each of the health system groups. The one group 1 country had an annual per capita government mental health spending of US$ 7.24, while the average spending for the two group 2 countries was US$ 1.35 and for the one Group 3 country less than US$ 0.01. A tentative estimate of median government spending on mental health in the Region is US$ 6.32 per person, which is very low in comparison with the global median of US$ 72.57.

20 The average mental health workforce in the Region is 14.6 personnel per 100 000 population. This is less than half the comparable global rate of 33.8 per 100 000 population. Furthermore, in about one third of countries, more than 85% of the mental health workforce is deployed in mental hospitals. There was a substantial increase in the mental health nursing workforce between 2011 and 2014 in group 1 and group 2 countries. The fall in numbers of psychiatrists per 100 000 in group 2 countries, with an increase in group 1 countries, suggests that sociopolitical and economic factors may be influencing the availability and mobility of mental health resources. Group 3 countries have the highest percentage of doctors, and nurses and midwives who have received training in mental health for at least 2 days in the last 2 years. The Region is slightly above the global median for training of primary care physicians (2.1%) and slightly below median for training of nurses and midwives (1.7%).

21 With regard to availability of mental health services, a median of 6.1 beds per 100 000 population is available across the Region; 64.3% of psychiatric beds are located in mental hospitals and 35.7% are located in community settings – general hospitals 18.3% and community residences 17.4%. There is a clear gradient across group 1 to group 2 and group 3 countries. This distribution is almost unchanged from that found in 2011. The median number of mental hospital beds per 100 000 in the Region is comparable with the global median of 6.5 per 100 000.

22 In the area of promotion of health and prevention of disease, globally 41% of countries have mental health promotion and prevention programmes, the same percentage as in the Region. Within the Region, 60% of group 2 countries have more than one functioning national mental health prevention or promotion programme, which is twice the rate in group 1 and group 3 countries. The three countries that have developed a national suicide prevention strategy are all in group 2.

23 In the area of information systems, although 19 countries have produced reports on mental health data, almost half of the countries have not published a specific mental health information report in the past 2 years. Group 2 countries have the most advanced profile for publication of mental health information. All but one (or 90%) of group 2 countries have published a specific report focusing on mental health in the past 2 years whereas, only half of group 1 countries and no group 3 country have published a specific mental health report in the same time period. Although the Region compares favourably with other regions, the current information systems may not be in line with the target indicators of the mental health action plan.

A framework for scaling up action on mental health in the Eastern Mediterranean Region

24 The Sixty-sixth World Health Assembly adopted a comprehensive mental health action plan 2013–2020. The plan sets out a vision and roadmap for mental health for countries of the world to achieve by 2020. It identifies specific actions for Member States and for international and national partners with agreed targets and indicators. In order to operationalize the vision and roadmap set out in the plan, a regional framework for scaling up action on mental health is proposed which identifies key strategic interventions across the domains of governance, health care, promotion and prevention, and surveillance, monitoring and research. It also provides a set of indicators to monitor progress in implementing these interventions. The domains correspond to the four objectives of the mental health action plan 2013–2020 and are guided by its underpinning principles. However, given that a disproportionately high number of countries of the Region are experiencing complex emergencies, the regional framework also suggests strategic interventions across its first three domains, which can help countries prepare for, and minimize, the damaging effects of complex emergencies on mental health.

A. Governance

25 The key governance responsibilities are in the development and oversight of implementation of mental health policies and plans, mental health legislation and finances. These form the supporting framework in which mental health services will be delivered. It is crucial that they complement and support each other. For example, mental health laws should codify the fundamental principles, values, aims and objectives of mental health policies and plans, and budgets need to be allocated to achieve the national mental health plan targets.

Key strategic interventions

Establish/update a multisectoral national policy/strategic action plan for mental health.

Review legislation related to mental health in line with international human rights covenants/instruments and establish a mechanism to independently monitor the implementation of updated legislation.

Integrate priority mental conditions in the basic health delivery package of the government and social/private insurance reimbursement schemes.

Embed mental health and psychosocial support in national emergency preparedness and recovery plans.

B. Health care

26 WHO has proposed the service organization pyramid for an optimal mix of services for mental health (17). At successively higher levels of the pyramid the mental health needs of the individual require more intensive professional assistance with commensurate higher costs of care. This balanced approach involves scaling up of community-based mental health services, including integration of mental health into primary care and other priority health care programmes, such as making pregnancy safer, the Expanded Programme on Immunization and integrated child care programmes on the one hand and scaling down of mental institutions on the other (18–27).

Key strategic interventions

Reorient the mental health services by:

providing people with mental health conditions and their families access to self-help and community-based interventions;

downsizing the existing long-stay mental hospitals and ensuring protection of the rights of people with mental health conditions;

establishing mental health services in general hospitals for outpatient and short-stay inpatient care;

integrating delivery of cost effective, feasible and affordable evidence-based interventions for mental conditions in primary health care and other priority health programmes.

Implement best practices for mental health and psychosocial support in emergencies.

C. Promotion and prevention

Mental health promotion and prevention interventions can improve the mental health of the population by mitigating risk factors, enhancing protective factors for good mental and physical health, and contributing to lasting positive effects on a range of social and economic outcomes. Evidence suggests the following interventions as having the most potential for the Eastern Mediterranean Region (15,28–36).

Key strategic interventions

Integrate recognition and management of maternal depression and parenting skills training in maternal and child health programmes.

Integrate life skills education in school curricula, using a whole school approach.

Reduce access to means of suicide.

Train emergency responders to provide psychological first aid.

Employ evidence-based methods to improve mental health literacy and reduce stigma.

D. Surveillance, monitoring and research

28 The lifeblood of planning and development is evidence, including both evidence about the local needs and services, and research evidence about new innovations. The mental health action plan requires relevant high quality mental health and service indicators to be collected and reported. Some of these indicators can be incorporated into routine national data collection, and others may need to be supplemented by periodic surveys. Similarly, mental health research is critical, to guide rational policy development, strategic programme planning and the reorganization of mental health services. Prioritizing mental health research, particularly implementation research, can generate enormous returns in terms of reducing disability and preventing premature death (37).

Key strategic interventions for surveillance and information systems

Integrate the core indicators within the national health information systems (see Annex 1).

Enhance the national capacity to undertake and utilize prioritized implementation research.

Baseline comparison with the targets set out in the mental health action

plan

29 This section provides the current baseline and the projections for achieving the targets set out in the mental health action plan.

30 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). Although 55% of countries of the Region have updated their mental health policies in the past 5 years, 32% (seven countries) are compliant with all the international standards identified and therefore meet the action plan target. If this target is to be achieved, policies need to be updated in line with human rights instruments in at least 11 more countries by 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). While 73% of countries of the Region have mental health legislation (either stand-alone or integrated in other legislation), only 27% (six countries) are compliant with all five measured components of human rights standards and therefore meet the action plan target. If this target is to be achieved, mental health legislation needs to be updated and enacted in five more countries by 2020.

Global target 2: Service coverage for severe mental disorders will have increased by 20% (by the year 2020). In order to monitor and assess this indicator a current baseline of service coverage needs to be established. Current information in the Region does not properly establish this baseline. First, the denominator for calculating coverage is the total population at risk, rather than the total population in need. Second, the reporting of numbers of people with severe mental disorders treated is available only for 13 countries at the level of the mental hospital, 9 at general hospital and 8 at mental health outpatient levels. If the treated prevalence in mental health outpatient facilities, currently at the level of 1158 per 100 000 population (based on 8 countries) is to increase by 20% by 2020, then the target is 1390 per 100 000 population.

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). According to the responses to atlas 2014, to meet the target by 2020, the nine countries with two or more programmes must continue to have eligible programmes, and a further nine countries must establish two or more national promotion or prevention programmes.

Global target 3.2: the rate of suicide in countries will be reduced by 10% (by the year 2020). The annual regional age-standardized suicide rate for the Region is 6.4 per 100 000 population (7.5 for males and 5.2 for females). A reduction by 10% suggests a target of 5.8 suicides per 100 000 per year. However, the currently reported rates may underestimate the true suicide rate due to possible social, religious and cultural factors. There is an urgent need to work towards establishing accurate suicide reporting in countries of the Region.

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). Although 19 countries have produced reports on mental health data (either dedicated reports or reports on mental health in general health statistics), it is clear from the responses to the 2014 atlas questionnaire that the extent of mental health information is limited in most countries and a current baseline against which to monitor and assess this indicator is difficult to establish on the basis of available data.

Conclusion

31 The key evidence informed strategic interventions identified which would be considered as “best buys” and “good buys” have been brought together in the proposed regional framework for scaling up action on mental health with the aim of facilitating implementation of the mental health action plan 2013–2020 (Annex 1). The framework is supported by a set of WHO tools and guidelines. Furthermore, a set of indicators is proposed to monitor progress towards implementation of the strategic interventions. These indicators are in line with the indicators of the action plan, in order to avoid duplication of efforts in monitoring progress towards the targets of the action plan. The information needed to report on the set of indicators in the regional framework can be gathered either routinely through incorporation of the indicators into the health management and other information systems of the countries, or can be collected by periodic surveys.

32 All the strategic interventions identified under the four main domains provide synergy to each other.

33 The Regional Committee is invited to endorse the regional framework for scaling up action on mental health.

References

1. Murray CJL, Vos T, Lozano R, Naghavi M, Flaxman AD, Michaud C, et al. Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet. 2012;380(9859):2197–223. PMID:23245608

2. The world health report 2001 – Mental health: new understanding, new hope. Geneva: World Health Organization; 2001 (http://www.who.int/whr/2001/en/, accessed 28 May 2015).

3. Steel Z, Marnane C, Iranpour C, Chey T, Jackson JW, Patel V, et al. The global prevalence of common mental disorders: a systematic review and meta-analysis 1980–2013. Int J Epidemiol. 2014;43(2):476–93. PMID:24648481

4. Tol WA, Barbui C, Galappatti A, Silove D, Betancourt TS, Souza R, et al. Mental health and psychosocial support in humanitarian settings: linking practice and research. Lancet. 2011;378(9802):1581–91. PMID:22008428

5. Whiteford HA, Degenhardt L, Rehm J, Baxter AJ, Ferrari AJ, Erskine HE, et al. Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. 2013;382(9904):1575–86. PMID:23993280

6. Bailey S, Thorpe L, Smith G. Whole-person care: from rhetoric to reality: achieving parity between mental and physical health. London: Royal College of Psychiatrists; 2013 (http://www.rcpsych.ac.uk/files/pdfversion/OP88xx.pdf, accessed 10 July 2015).

7. Scott KM, Ben Wu KS, Saunders K, Benjet C, He Y, Lepine JP, et al. Early-onset mental disorders and their links to chronic physical conditions in adulthood. In: Alonso J, Chatterji S, He Y, editors. The burdens of mental disorders: global perspectives from the WHO world mental health surveys. New York: Cambridge University Press; 2013.

8. Bloom DE, Cafiero ET, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, et al. The global economic burden of noncommunicable diseases. Geneva: World Economic Forum; 2011.

9. Investing in mental health: evidence for action. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/87232/1/9789241564618_eng.pdf, accessed 10 July 2015).

10. Mental health atlas 2014. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2015 (in press).

11. Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromet EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. Lancet. 2007;370(9590):841–50. PMID:17826169

12. Wang PS, Angermeyer M, Borges G, Bruffaerts R, Tat Chiu W, De Girolamo G, et al. Delay and failure in treatment seeking after first onset of mental disorders in the World Health Organization's World Mental Health Survey Initiative. World Psychiatry. 2007;6(3):177–85. PMID:18188443

13. Ferrari AJ, Charlson FJ, Norman RE, Patten SB, Murray CJL, Vos T, et al. Burden of depressive disorders by country, sex, age and year: Findings from the Global Burden of Disease Study 2010. PloS Medicine. 2013;10(11):e1001547.14.

14. Regional Strategy on mental health and substance abuse. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2012 (http://applications.emro.who.int/dsaf/EMROPUB_2012_EN_1067.pdf?ua=1, accessed 10 July 2015).

15. Preventing suicide: a global imperative. Geneva: World Health Organization; 2014 (http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/, accessed 10 July 2015).

16. Mental health atlas 2011: resources for mental health in the Eastern Mediterranean Region. Cairo: World Health Organization Regional Office for the Eastern Mediterranean; 2012 (http://applications.emro.who.int/dsaf/emropub_2013_1578.pdf?ua=1, accessed 10 July 2015).

17. Mental health action plan 2013–2020. Geneva: World Health Organization; 2014 (http://www.who.int/mental_health/publications/action_plan/en/, accessed 10 July 2015).

18. Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, et al. Treatment and prevention of mental disorders in low-income and middle-income countries. Lancet. 2007;370(9591):991–1005.

19. Thornicroft G, Tansella M. The balanced care model for global mental health. Psychol Med. 2013;43(4):849–63. PMID:22785067

20. World Health Organization and the Gulbenkian Global Mental Health Platform. Innovation in deinstitutionalization: a WHO expert survey. Geneva: World Health Organization; 2014 (http://apps.who.int/iris/bitstream/10665/112829/1/9789241506816_eng.pdf?ua=1, accessed 10 July 2015).

21. Patel V, Thornicroft G. Packages of care for mental, neurological, and substance use disorders in low- and middle-income countries: PLoS Medicine Series. PLoS Med. 2009;6(10):e1000160. PMID:19806180

22. Patel V, Belkin GS, Chockalingam A, Cooper J, Saxena S, Unützer J. Grand challenges: integrating mental health services into priority health care platforms. PLoS Med. 2013;10(5):e1001448. DOI: 10.1371/journal.pmed.1001448

23. Rahman A, Surkan PJ, Cayetano CE, Rwagatare P, Dickson KE. Grand challenges: integrating maternal mental health into maternal and child health programmes. PLoS Med. 2013;10(5):e1001442. doi: 10.1371/journal.pmed.1001442. Epub 2013 May 7.

24. World Health Organization and Calouste Gulbenkian Foundation. Integrating the response to mental disorders and other chronic diseases in health care systems. Geneva: World Health Organization; 2014 (http://apps.who.int/iris bitstam/10665/112830/1/9789241506793_eng.pdf?ua=1, accessed 10 July 2015).

25. IASC guidelines on mental health and psychos cial support in emergency settings. Geneva: Inter-Agency Standing Committee (IASC); 2007 (http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/, accessed 10 July 2015).

26. Van Ommeren M, Hanna F, Ventevogel P, Weissbecker I. Mental health and psychosocial support in humanitarian emergencies: key considerations and actions. East. Mediterr. Health J. 2015;21(6) (in press).

27. Building back better: sustainable mental health care after emergencies. Geneva: World Health Organization; 2013(http://apps.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf?ua=1, accessed 10 July 2015).

28. Walker SP, Chang SM, Powell CA, Grantham-McGregor SM. Effects of early childhood psychosocial stimulation and nutritional supplementation on cognition and education in growth-stunted Jamaican children: prospective cohort study. Lancet. 2005;366(9499):1804–7.

PMID:16298218

29. Knapp M, McDaid D, Parsonage M. Mental health promotion and prevention: the economic case. London: Personal Social Services Research Unit, London School of Economics and Political Science; 2011.

30. Reichow B, Servili C, Yasamy MT, Barbui C, Saxena S. Non-specialist psychosocial interventions for children and adolescents with intellectual disability or lower-functioning autism spectrum disorders: a systematic review. PLoS Med. 2103;10(12): e1001572. doi:10.1371/journal.pmed.1001572

31. Durlak JA, Weissberg RP, Dymnicki AB, Taylor RD, Schellinger KB. The impact of enhancing students' social and emotional learning: a meta-analysis of school-based universal interventions. Child dev. 2011;82(1):405–32. doi: 10.1111/j.1467-8624.2010.01564.x.

32. Weare K, Nind M. Mental health promotion and problem prevention in schools: what does the evidence say? Health Promot Int. 2011;26(Suppl 1):i29–69. 10.1093/heapro/dar075 PMID:22079935

33. van der Feltz-Cornelis CM, Sarchiapone M, Postuvan V, Volker D, Roskar S, Grum AT, et al. Best practice elements of multilevel suicide prevention strategies: a review of systematic reviews. Crisis. 2011;32(6):319–33. doi: 10.1027/0227-5910/a000109.

34. Jorm, AF. Mental health literacy: empowering the community to take action for better mental health. Am. Psychol. 2012;67(3):231–43. doi: 10.1037/a0025957.

35. Jorm AF, Kitchener BA, O'Kearney R, Dear KB. Mental health first aid training of the public in a rural area: a cluster randomized trial [ISRCTN53887541]. BMC Psychiatry. 2004;4:33 doi:10.1186/1471-244X-4-33

36. Clement S, Lassman F, Barley E, Evans-Lacko S, Williams P, Yamaguchi S, et al. Mass media interventions for reducing mental health-related stigma. Cochrane Database Syst Rev. 2013;7: CD009453.DOI: 10.1002/14651858.CD009453.pub2

37. Regan M, Patel V, Rahman A, Gater R. Mental health research: developing priorities and promoting its utilization to inform policies and services. East. Mediterr. Health J. 2015;21(6) (in press).