EMRO Technical Publications Series 47

# Mental health atlas 2017

## Resources for mental health in the Eastern Mediterranean Region

World Health Organization
Regional Office for the Eastern Mediterranean

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Ministry of health mental health focal points were the key project collaborators, who provided information and responses to the Atlas survey questionnaire and responded to the many requests for clarification that arose from the data. A full list of collaborators is provided in Annex 1 of this report.

Dr Richard Gater (Senior Lecturer in Psychiatry, University of Manchester, United Kingdom) was the lead consultant in collating data, validating information and responses, liaising with Member State focal points, analysing data and preparing this report.

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Designed by Punto Grafico

# Contents

# Executive summary

The World Health Organization (WHO) mental health atlas project started in 2000, when a first assessment of available mental health resources in WHO Member States was carried out *(1)*. Three updates have been published subsequently *(2,3,4)*.

*Mental health atlas 2017 (5)* continues to provide up-to-date information on the availability of mental health services and resources globally, including on planning, legislation, collaborations, financial allocations, human resources, specialized facilities for mental health, and promotion and prevention programmes. This information was obtained by a questionnaire sent to designated focal points in each WHO Member State. Key findings for the WHO Eastern Mediterranean Region are presented in Box 1.

**Box 1. Key findings**

Global reporting on core mental health indicators

- 20 out of the Eastern Mediterranean Region's 22 countries (91%) at least partially completed the atlas questionnaire.
- 14 countries of the Region reported that mental health data have been compiled in the last two years either as part of a general health statistics report or a mental health specific report. 10 countries of the Region have compiled and produced a report on mental health specific data, covering at least the public sector, in the last two years.
- 14 countries of the Region were able to report on a set of five core indicators that covered mental health policy and law, promotion and prevention programmes, service availability and mental health workforce.

Mental health system governance

- 15 countries of the Region have a stand-alone policy or plan for mental health, and a further three have mental health policy or plans integrated into general or public health policy. Ten have a plan or strategy for child or adolescent mental health and eleven have a stand-alone mental health law.
- 16 countries of the Region have updated their policy and plan, and six have revised their mental health law in the previous five years.
- Mental health policies and plans are fully in line with human rights instruments in 10 countries of the Region, and laws are in line in eight countries.
- Financial resources have been allocated for implementation of the mental health plan in line with estimated resource needs in three countries.
- 6 countries of the Region reported that indicators are available and used to monitor implementation of most or all of the components of their mental health policies or plans.

Financial and human resources for mental health

- Median public expenditure on mental health is US$ 3.43 per capita, and more than half of this goes on mental hospitals. Public expenditure in the best-resourced countries of the Region is far higher than the least well-resourced countries; based on very small numbers of reporting countries, the median expenditure was over 100 times greater in well-resourced group 1 countries than in the least well-resourced group 3 countries.
- 15 countries of the Region delivered a total of 3807 mental health training courses for 75 000 health care workers in non-specialized/general health care settings in the previous year, although 90% of these were in one country. This resulted in training for a median of 0.32% of all general health care doctors and nurses.
- The median number of mental health workers in countries of the Region is 5.6 per 100 000 population, but there is wide variation from 0.7 per 100 000 population in group 3 countries to 18.6 in group 1 countries. Nurses make up half of the mental health workforce; doctors (mainly psychiatrists) form a quarter, followed by psychologists (14%) and social workers (9%).

### Mental health service availability and uptake

- The median number of mental health beds per 100 000 population ranges from 0.8 in group 3 countries to 11.2 in group 1 countries; even larger disparities exist for outpatient services, child and adolescent services, and social support.
- Only six countries of the Region reported having child and adolescent mental health beds, the greatest provision being 1.1 beds per 100 000 population, with the majority having 0.2 or less per 100 000. 12 countries of the Region reported they have some child and adolescent mental health outpatient facilities.

### Mental health promotion and prevention

- 13 countries of the Region have at least two functioning mental health promotion and prevention programmes, and eight countries have at least two functioning national mental health promotion and prevention programmes. Out of 46 reported functioning programmes, 35% were aimed at improving mental health literacy or combating stigma, and 7% were aimed at suicide prevention. Only two countries of the Region have a national suicide prevention strategy.

The atlas is being used to track progress in the implementation of *WHO's Mental Health Action Plan 2013–2020*. *Mental health atlas 2014* provided baseline values for agreed Action Plan targets and the new edition of the mental health atlas enables monitoring of progress towards meeting these targets by 2020 (see Table 1).

**Table 1.** Extent to which the global targets of the *Comprehensive Mental Health Action Plan 2013–2020* have been met in 2017

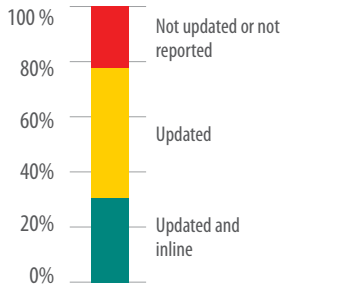
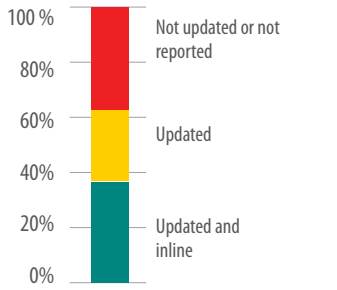
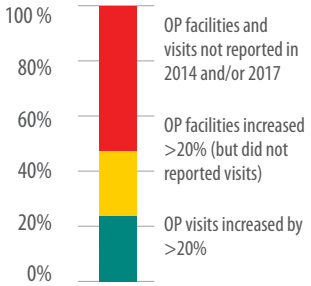
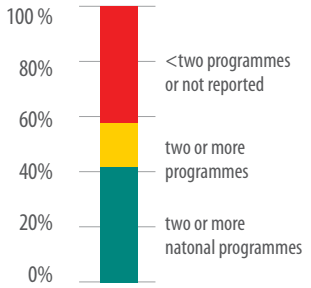
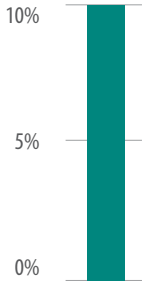
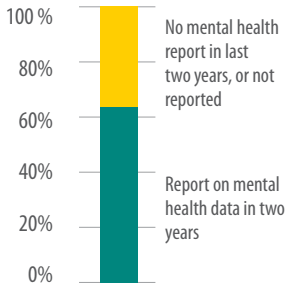
| Targets set out in the *Comprehensive Mental Health Action Plan 2013–2020* to be achieved by 2020 | Status of the Eastern Mediterranean Region in *Mental health atlas 2017* | Progress towards achieving the 2020 target |
|---|---|---|
| 1.1. Policy: 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments | 15 (68%) countries of the Region have updated their mental health policies/plans in the past five years<br>10 (45%) countries of the Region reported their mental health policies/plans are in line with all five international human rights standards |  |
| 1.2. Legislation: 50% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments | 14 (64%) countries of the Region have mental health legislation<br>8 (36%) countries of the Region reported their mental health legislation is in line with all five international human rights standards |  |

**Table 1. Extent to which the global targets of the *Comprehensive Mental Health Action Plan 2013–2020* have been met in 2017** *(Continued)*

| Targets set out in the *Comprehensive Mental Health Action Plan 2013–2020* to be achieved by 2020 | Status of the Eastern Mediterranean Region in *Mental health atlas 2017* | Progress towards achieving the 2020 target |
|---|---|---|
| 2. Coverage: service coverage for severe mental disorders will have increased by 20% | Insufficient comparable service coverage data reported in 2014 and 2017. As a proxy measure, outpatients facilities per 100 000 increased by more than 20% in 10 (45%) countries of the Region, and outpatient visits per 100 000 increased by more than 20% in five (23%) countries |  |
| 3.1. Prevention and promotion: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes | 13 (59%) countries of the Region have two or more functioning mental health promotion or prevention programmes<br>9 (41%) countries of the Region have two or more functioning national mental health promotion and prevention programmes |  |
| 3.2. Suicide: the rate of suicide in countries will be reduced by 10% | Median age-standardized suicide rate for the whole Region has reduced by 28% between 2010 and 2017. 15 (79%) countries in the Region with estimated suicide rates in 2010 and 2017 had reductions of more than 10% |  |
| 4. Mental health information: 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 | 14 (64%) countries of the Region reported that mental health data have been compiled and reported in the last two years<br>14 (64%) countries of the Region reported on a defined set of five core mental health indicators in *mental health atlas 2017*<br>12 (55%) countries of the Region reported on a defined set of six core mental health indicators in *mental health atlas 2017* |  |

# Introduction

## Context[1]

WHO first produced an atlas of mental health resources in the world in 2001 *(1)*, with updates produced in 2005, 2011 and 2014 *(2,3,4)*. The atlas project has become a valuable resource on global information on mental health and an important tool for developing and planning mental health services within countries.

The latest edition of the mental health atlas, carried out in 2017, assumes new importance as a repository of mental health information on WHO Member States, because it provides much of the baseline data against which progress towards the objectives and targets of the *Comprehensive Mental Health Action Plan 2013–2020* is to be measured. A total of six global targets have been established for the four objectives of the Action Plan to measure collective action and achievement by Member States towards the overall goal of the Action Plan (see the left-hand section of Table 2 below).

As stated in the Action Plan, the indicators underpinning the six global targets represent only a subset of the information and reporting needs that Member States require to be able to adequately monitor their own mental health policies and programmes. Thus, in addition, the WHO Secretariat prepared and proposed a more complete set of indicators for Member States for data collection and reporting to WHO.

The final proposed set of indicators shown below represents the culmination of the consultation and field-testing process, and is made up of the already agreed Action Plan indicators (shown in green in the table) and a complementary set of service development indicators (shown in blue). These 14 indicators became the basis for the mental health atlas questionnaire and formed the baseline measurement for the *Comprehensive Mental Health Action Plan 2013–2020*, with the data published in 2014. The mental health atlas survey carried out during 2017, which reflects countries in 2016, will be followed by another survey in 2020, so that progress towards meeting the targets of the Action Plan can be measured over time.

[1] This section is adapted from *Mental health atlas 2017 (5)*.

**Table 2.** Core mental health indicators, by mental health action plan objective and target

| Action Plan objectives | Action Plan targets | Action Plan indicators | Service development indicators |
|---|---|---|---|
| **Objective 1. To strengthen effective leadership and governance for mental health** | Target 1.1. 80% of countries will have developed or updated their policies or plans for mental health in line with international and regional human rights instruments (by the year 2020). | 1.1. Existence of a national policy/ plan for mental health that is in line with international and regional human rights instruments | 2a. Financial resources: Government health expenditure on mental health<br>2b. Human resources: Number of mental health workers<br>2c. Capacity-building: Number and proportion of general health care staff trained in mental health |
| | 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). | 1.2. Existence of a national law covering mental health that is in line with international and regional human rights instruments | |
| **Objective 2. To provide comprehensive, integrated and responsive mental health and social care services in community-based settings** | Target 2. Service coverage for severe mental disorders will have increased by 20% (by the year 2020). | 2. Number and proportion of persons with a severe mental disorder who received mental health care in the last year | 2d. Stakeholder collaboration: Number and type of formal collaborations with other departments, services and sectors, including service users and family or caregiver advocacy groups<br>2e. Service availability: Number of mental health care facilities at different levels of service delivery |
| **Objective 3. To implement strategies for promotion and prevention in mental health** | Target 3.1. 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020) | 3.1. Functioning programmes of multisectoral mental health promotion and prevention in existence | 2f. Inpatient care: Number and proportion of admissions for severe mental disorders to inpatient mental health facilities that a) exceed one year and b) are involuntary |
| | Target 3.2. The rate of suicide in countries will be reduced by 10% (by the year 2020). | 3.2. Number of suicide deaths per year | 2g. Service continuity: Proportion of persons with a severe mental disorder discharged from a mental or general hospital in the last year who were followed up within one month by community-based health services<br>2h. Social support: Number of persons with a severe mental disorder who receive disability payments or income support |
| **Objective 4. To strengthen information systems, evidence and research for mental health** | 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). | 4. Core set of mental health indicators routinely collected and reported every two years | |

# Methods[1]

The mental health atlas project required a number of administrative and methodological steps, starting from the development of the questionnaire and ending with the statistical analyses and presentation of data. The sequence of steps followed for the 2014 and 2017 surveys was in line with that pursued in 2011, and is briefly outlined below.

## Stage 1. Questionnaire development and testing

As described above, indicators included in the 2014 questionnaire were based on consultations with Member States, and were developed in collaboration with WHO regional offices, as well as experts in the area of mental health care measurement. The questionnaire was drafted in English and translated into French, Russian, Spanish and Portuguese. The questionnaire in 2017 was modified for some questions, such as those on social care and continuity of care after discharge, based on the response rate for variables and feedback from Member States and WHO regional and country offices.

Alongside the questions, a glossary and a guide based on frequently asked questions were developed to help standardize terms and to ensure that the conceptualization or definition of resources was understood by all respondents. The completion guide and glossary were integrated into the online data collection platform.

## Stage 2. Questionnaire dissemination and submission

For each country, WHO requested ministries of health or other responsible ministries to appoint a focal point to complete the atlas questionnaire. The focal point was encouraged to contact other experts in the country to obtain information relevant to answering the survey questions.

Close contact with the focal points was maintained during the course of their nomination and through questionnaire submission. A WHO staff member was available to respond to enquiries, provide additional guidance, and assist focal points in completing the atlas questionnaire. The questionnaire was also available online, and countries were strongly encouraged to use this method for submission. However, a Word version of the questionnaire was available whenever preferred.

## Stage 3. Data clarification, cleaning and analysis

Once a completed questionnaire was received, it was screened for incomplete and inconsistent answers (particularly in comparison to 2014 responses). To ensure quality of data, respondents were re-contacted and were asked for clarification and to correct their responses as appropriate. Subsequently a draft country profile was shared with each of the Member States for their further review and input.

Upon receipt of the final questionnaires, data were aggregated by WHO region and this regional review presents the results for the individual countries of the Eastern Mediterranean Region and by country group (see Table 3). Since the countries of the Eastern Mediterranean Region vary widely in terms of their health outcomes, resources, and stability, the WHO Regional Office for the Eastern Mediterranean has developed a classification of countries into three groups that each have broadly similar health system characteristics. Frequency distributions and measures of central tendency were calculated as appropriate for these country groupings. Rates per 100 000 population were calculated for certain data points, using official United Nations population estimates for 2015.

The data reported in this regional review are based on the same data as *Mental health atlas 2017*, but includes additional data for occupied Palestinian territory and some data not reported in the global report that have been included here because of their regional relevance.

### Limitations

A number of limitations should be kept in mind when examining the results. While best attempts have been made to obtain information from countries on all variables, some countries could not provide data for a number of indicators. The most common reason for the missing data is that such data simply do not exist within the countries. In some situations, the data required to complete a question may be available at a specific facility, district or regional level but not aggregated nationally at central level. Also, in some cases it was difficult for countries to report the information in the manner requested in the atlas questionnaire. For example, some countries had difficulty in reporting data on involuntary admission at hospitals and data on capacity-building

[1] Most of this section is adapted from *Mental health atlas 2017 (5)*, except the specific references to the Eastern Mediterranean Region.

programmes for mental health at primary health care level. The extent of missing data can be determined from the number of countries that have been able to supply details. Each individual table or figure contains the number of responding countries.

A further limitation is that most of the information provided relates to the country as a whole, thereby overlooking potentially important variability within countries concerning, for example, the degree of policy implementation, the availability of services, and the existence of promotion or prevention programmes in rural versus urban areas or remote versus central parts of the country. Similarly, few of the reported data can provide a breakdown by age or gender, despite the importance that equality of access and universal health coverage has in the articulation of the *Comprehensive Mental Health Action Plan 2013–2020*. This makes it difficult to assess resources for particular populations within a country such as children, adolescents or the elderly.

Although a large number of countries submitted questionnaires for both atlas 2014 and atlas 2017, the list of countries completing different data points within each of the questions was sometimes different. This adds some constraints for comparisons of data over time between the atlases. Additionally, based on the response rate for some of the variables and feedback from Member States, and WHO regional and country offices, some questions were modified, such as those on social care and continuity of care after discharge. While this has contributed to the improvement of completion rates for these questions in 2017 compared to 2014, these changes limit the ability to make comparisons over time.

Finally, it is important to acknowledge the limitations associated with self-reported data, particularly in relation to qualitative assessments or judgements (often being made by a single focal point). For example, respondents were asked to provide an informed categorical response concerning the implementation of mental health policies and laws, and their conformity with international (or regional) human rights instruments. For some of these items it is possible to compare self-reported responses to publicly available information (such as a published mental health policy or budget for a country), but in other cases the opportunity for external validation is more limited.

The mental health atlas is an ongoing activity of WHO. As more accurate and comprehensive information covering all aspects of mental health resources becomes available, and the concept and definition of resources become more refined, it is expected that the database will also become better organized and more reliable. While it is clear that, in many cases, country information systems are weak, the mental health atlas may serve as a catalyst for further development by demonstrating the utility of such systems.

**Table 3. Eastern Mediterranean Region country groups**[1]

| Description of group | Countries |
|---|---|
| **Group 1**<br>Countries where socioeconomic development has progressed considerably over recent decades, supported by high income, generally with the highest densities of health staff per population | ▪ Bahrain<br>▪ Kuwait<br>▪ Oman<br>▪ Qatar<br>▪ Saudi Arabia<br>▪ United Arab Emirates |
| **Group 2**<br>Largely middle-income countries that have developed extensive public health service delivery infrastructure, but face resource constraints, with mid-range densities of health staff per population | ▪ Egypt<br>▪ Iran (Islamic Republic of)<br>▪ Iraq*<br>▪ Jordan<br>▪ Lebanon<br>▪ Libya*<br>▪ Morocco<br>▪ Occupied Palestinian territory<br>▪ Tunisia<br>▪ Syrian Arab Republic* |
| **Group 3**<br>Countries which face major constraints in improving population health outcomes as a result of lack of resources for health, political instability and other complex development challenges, with the lowest densities of health staff per population | ▪ Afghanistan<br>▪ Djibouti<br>▪ Pakistan<br>▪ Somalia<br>▪ Sudan*<br>▪ Yemen* |

*Countries with WHO Grade 2 or Grade 3 emergencies at the time of the survey.

[1] Health systems strengthening in countries of the Eastern Mediterranean Region: challenges, priorities and options for future action. Regional Committee for the Eastern Mediterranean, Fifty-ninth session, Provisional agenda item 3 (EM/RC59/Tech.Disc.1). Cairo: WHO Regional Office for the Eastern Mediterranean; 2013.

# 1. Reporting on core mental health indicators

Considerable effort has been expended by the WHO Secretariat and Member States to complete and submit the mental health atlas questionnaire, particularly as atlas 2017 is the tool for measurement of progress towards the achievement of objectives and targets of the *Comprehensive Mental Health Action Plan 2013–2020*, against baseline values provided in the 2014 mental health atlas.[1]

In total, 20 (91%) out of 22[2] countries of the Eastern Mediterranean Region were able to at least partially complete the atlas 2017 questionnaire. This is fewer than the 100% of countries of the Region that were reported on in atlas 2014, but similar to the 91% of countries in the rest of the world that were reported on in atlas 2017. The two countries that were unable to submit questionnaires were from country groups 1 and 3.

The atlas 2017 questionnaire asked countries to rate the availability and status of mental health data reporting in their country. Fourteen (78%) out of the 18 countries of the Region responding to this question reported that mental health data have been compiled in the last two years either as part of a general health statistics report or a mental health-specific data report, compared with 83% of countries in the rest of the world (see Table 4 and Fig. 1). Ten (56%) countries have a mental health-specific data report compiled in the last two years for the public sector, or both public and private sectors, compared with 46% of countries in the rest of the world. Three countries have not compiled mental health data in a report for policy, planning or management purposes in the last two years – all three are group 3 countries; mental health data were only compiled in one (25%) of the four group 3 countries (see Fig. 1). The contrast with better-resourced countries is most stark when looking at those countries producing a mental health-specific data report in the last two years: 75% and 80% of group 2 and 3 countries, respectively, compared with 0% of group 3 countries.

Seventeen countries of the Region reported on the availability and status of mental health data reporting in both 2014 and 2017 atlases (see Fig. 2). The number of countries with specific reports focusing on mental health remains the same (9 out of 17, or 53%), but there has been a reduction by one in the number of countries reporting on both public and private sectors, and an increase by two in the number of countries that compiled no mental health data in the last two years.

With regard to the availability of mental health data, countries were asked about the availability of three health status and outcome indicators (see Fig. 3) and eight health system indicators (see Fig. 4). While 68% of countries of the Region who provided data indicated that there had been at least periodic or regular reporting of prevalence of mental disorders during the past year, lower rates of 54% and 55% were reported for suicide mortality rates and mental health status or outcomes for people using mental health services, respectively. There were substantial differences in rates of reporting according to country group, with 100% of group 1 countries reporting on prevalence and mental health status or outcomes compared with less than half of group 3 countries. Suicide mortality reporting was less than 65% across all country groups. The percentages of countries reporting mental health system indicators was between 69% and 93% across the eight indicators. All group 1 countries had at least periodic or regular reporting for six of the eight mental health system indicators in the past year, whereas 71–88% of group 2 countries and only 50% of group 3 countries had this frequency of reporting.

Based on the actual data submitted through atlas 2017 to WHO, an assessment of countries' ability to report on a defined set of core mental health indicators was also made. The included indicators were: 1) stand-alone mental health policy or plan (yes or no); 2) stand-alone mental health law (yes or no); 3) mental health workforce (available data for at least some types of worker); 4) service availability (data for at least some care settings); and 5) mental health promotion and prevention (completion of inventory, including if no programmes present). A total of 14 countries (64% of all countries in the Region) reported on all five items. This is the same percentage as the 64% of countries that self-reported on their ability to report either separately or as part of the general health statistics, and is similar to the 62% of countries that reported on all five items globally. The addition of a sixth key indicator to the defined core set (service utilization for certain severe mental disorders) reduces substantially the number of countries able to report to 12 or 55% of all

[1] This paragraph and subsequent paragraphs introducing sections of this regional review are directly adapted from *Mental health atlas 2017 (5)*.

[2] The total number of 22 countries includes occupied Palestinian territory, which is not included in the 21 Member States reported on in the global report presented in *Mental health atlas 2017 (5)*.

countries of the Region. However, this is slightly higher than the 45% of countries of the Region that self-reported on their ability to regularly compile mental health specific data covering at least the public sector, and is also higher than the 46% of countries that reported on all six items globally.

**Table 4.** Mental health data availability and reporting

| Mental health data availability and reporting | Countries |
|---|---|
| No mental health data have been compiled in a report for policy, planning or management purposes in the last two years | ▪ Pakistan<br>▪ Sudan<br>▪ Yemen |
| Mental health data (either in the public system, private system or both) have been compiled for general health statistics in the last two years, but not in a specific mental health report | ▪ Afghanistan<br>▪ Morocco<br>▪ Occupied Palestinian territory<br>▪ Oman |
| A specific report focusing on mental health activities in the public sector only has been published by the Health Department or any other responsible government unit in the last two years | ▪ Bahrain<br>▪ Iran (Islamic Republic of)<br>▪ Iraq<br>▪ Lebanon<br>▪ Qatar<br>▪ Saudi Arabia<br>▪ Syrian Arabic Republic<br>▪ United Arab Emirates |
| A specific report focusing on mental health activities in both the public and private sector has been published by the Health Department or any other responsible government unit in the last two years | ▪ Egypt<br>▪ Jordan |

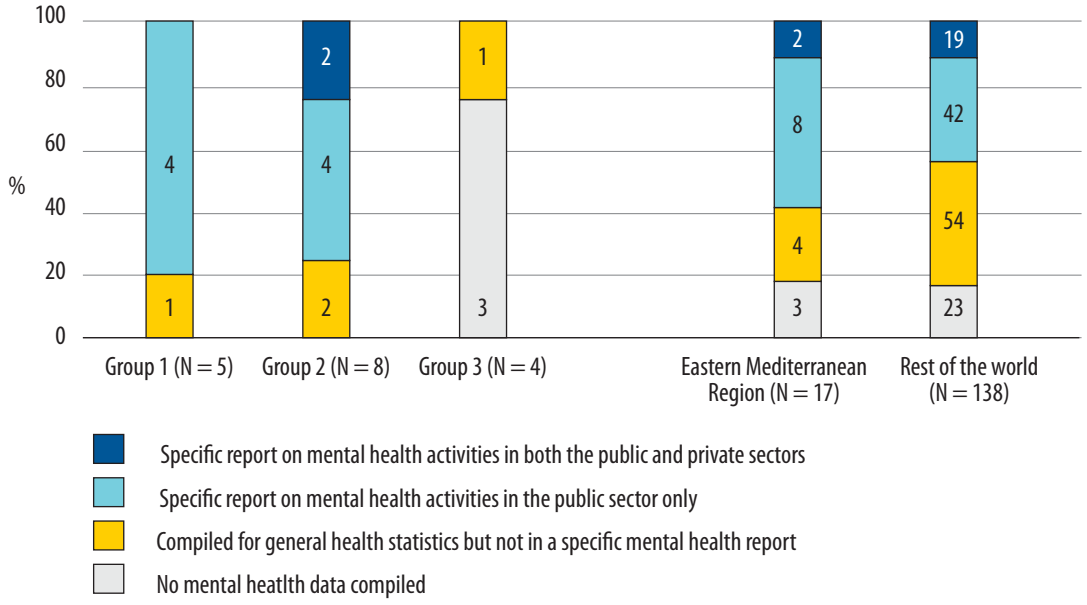



**Fig. 1.** **Mental health data availability and reporting by country group, Eastern Mediterranean Region and the rest of the world**

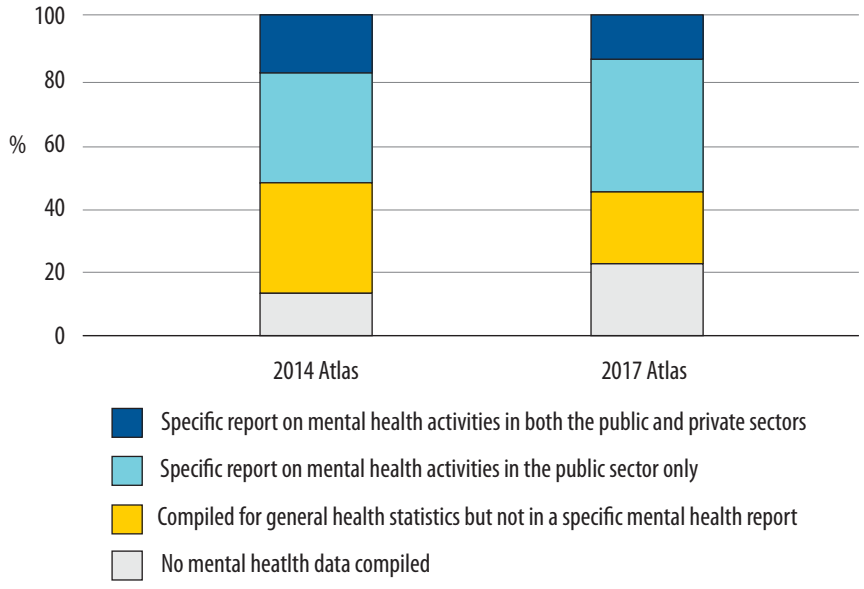



**Fig. 2.** **Mental health data availability and reporting in the last two years for the 17 countries of the Region that reported this indicator in both atlas 2014 and 2017**

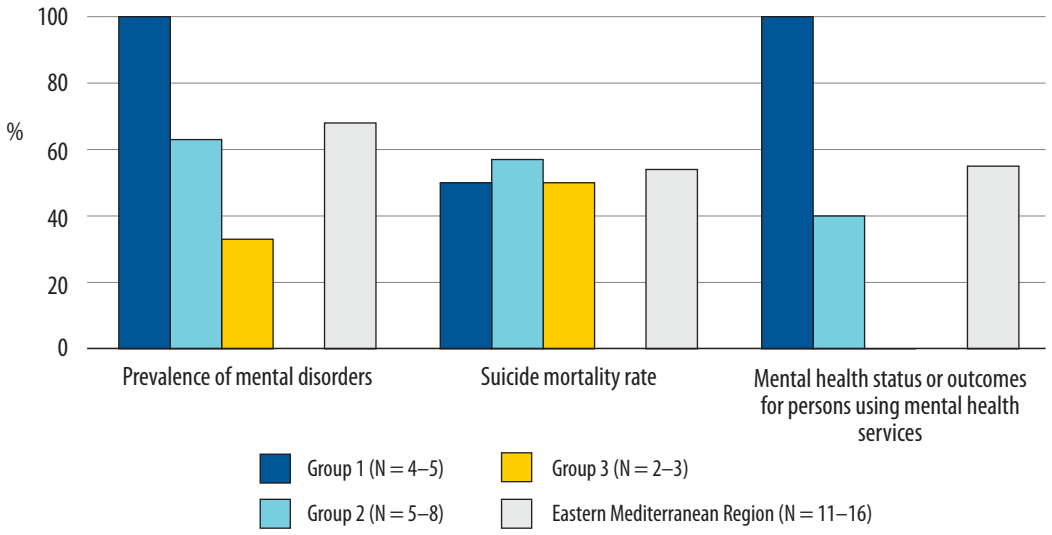



**Fig. 3.** **Mental health status and outcome reporting in the last year – percentage of countries with automatic/continuous/periodic/regular reporting of indicators by country group and for the Eastern Mediterranean Region**

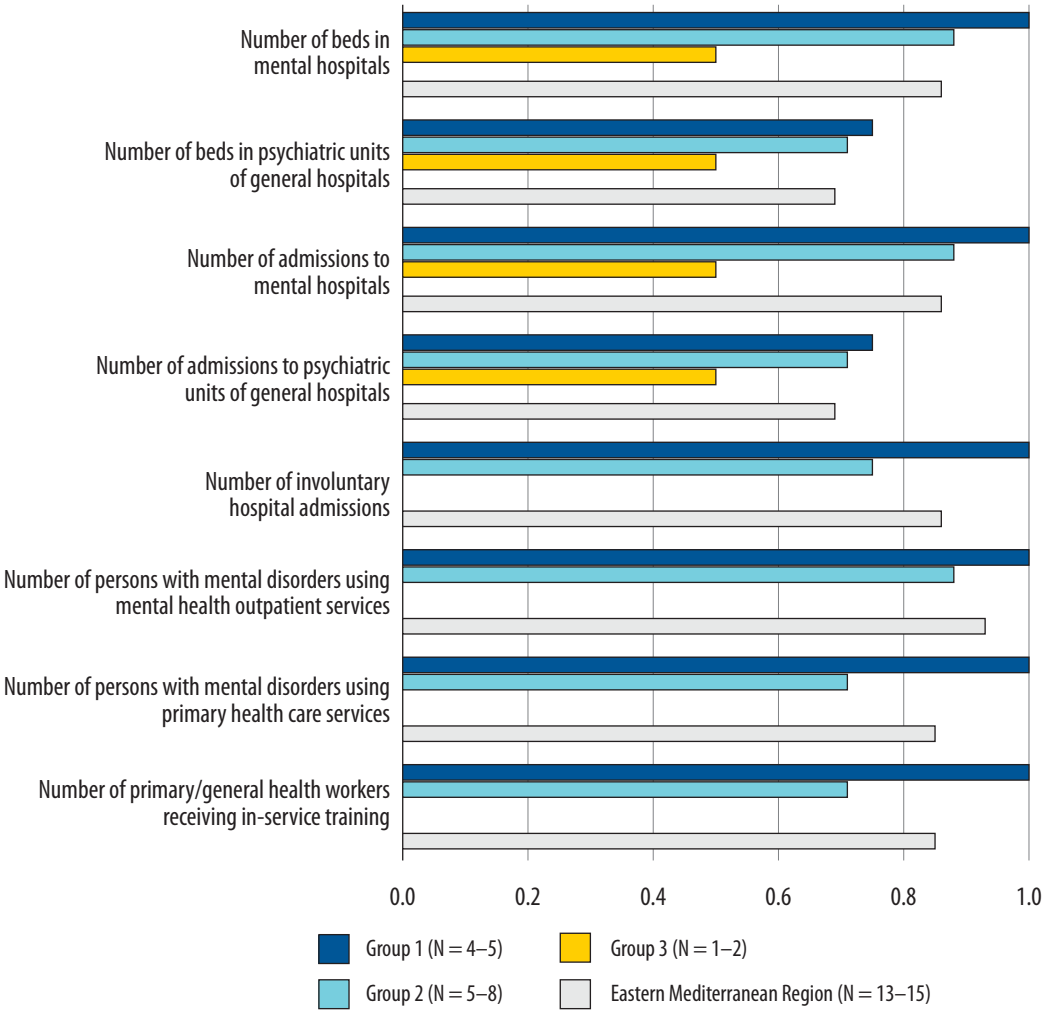



**Fig. 4.** **Mental health system reporting in the last year – percentage of countries with automatic/continuous/periodic/regular reporting of indicators by country group and for the Eastern Mediterranean Region (groups with <2 reporting countries are excluded)**

# 2. Mental health governance

## 2.1. Mental health policy and plans

Objective 1 of the *Comprehensive Mental Health Action Plan 2013–2020* relates to strengthened leadership and governance for mental health. The development and implementation of well-defined mental health policies and plans represent critical ingredients of good governance and leadership. The Action Plan recommends that policies, plans and laws for mental health should comply with obligations under the Convention on the Rights of Persons with Disabilities and other international and regional human rights conventions. The existence of an explicit mental health policy and plan helps improve the organization, quality and accessibility of mental health services and community care, as well as the engagement of people with mental disorders and their families.

A mental health policy can be broadly defined as an official statement of a government that conveys an organized set of values, principles, objectives and areas for action to improve the mental health of a population. A mental health plan is a detailed scheme for action on mental health that usually includes setting principles for strategies and establishing timelines and resource requirements.

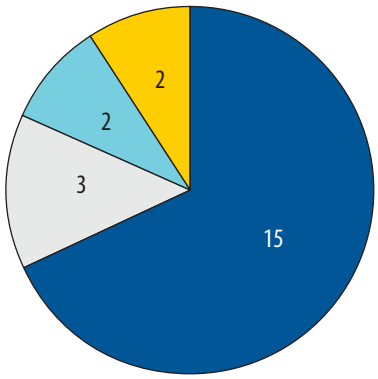
*Mental health atlas 2017* assessed whether countries have an approved mental health policy and/or plan and the level and quality of its implementation. In addition, and in line with the Action Plan, it asked countries to complete a checklist in order to assess the compliance of this mental health policy/plan with international human rights instruments. New indicators added in atlas 2017 asked countries to report on the existence of human or financial resources and specified indicators or targets needed to implement and monitor implementation of their policies and/or plans.

### Existence and revision of mental health policies and plans

Countries were asked about the presence of a stand-alone or integrated mental health policy or plan and the year of its latest revision. Of the 20 countries of the Region who reported, most (15 or 75%) have a stand-alone mental health policy or plan (see Fig. 5). Three countries (15%) have mental health integrated into other general health or disability policies or plans. The two countries (10%), Libya and Yemen, that do not have a mental health policy or plan are both fragile states. The percentage of countries with stand-alone policies and plans in the Region is 68% compared with 72% in the rest of the world, but when integrated policies and plans are added to these, the rates are similar (82 in both the Region and rest of the world).

Among countries in the Region with a mental health policy or plan, 15 (83%) were published in the

5a. Eastern Mediterranean Region




5b. Rest of the world

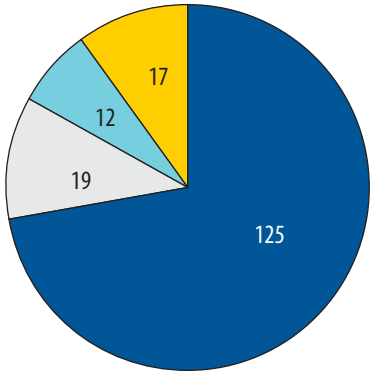




**Fig. 5. Number of countries with an approved or published mental health policy or plan in the Eastern Mediterranean Region and in the rest of the world**

previous five years, and all 18 (100%) were published since 2010 (see Fig. 6). This is an improvement on 2014, when two countries had mental health policies or plans that were published 10 or more years previously.

## Strategy for child and adolescent mental health

Ten countries (50% of those reporting) of the Region have a plan or strategy for child or adolescent mental health (CAMH). This is a similar proportion to the 46% of countries reporting this globally. The country plans or strategies in the Region for CAMH were all published since 2011.

While 80% of countries in group 1 (those with most resources) have a plan or strategy for CAMH, the corresponding rate is 50% of group 2 countries and only 20% of group 3 countries (see Fig. 7).

## Compliance of policies and plans with international human rights instruments

Countries were asked if their policies and plans are compliant with international human rights instruments. Of those reporting countries in the Region, 94% promote transition to community-based mental health services and pay explicit attention to respect for the human rights of people with mental disorders, 83% promote a full range of services and support to enable people to live independently and be included in the community, and 72% promote a recovery approach to mental health care. The area of compliance in which the Region has the lowest absolute rate of compliance (61%) is the promotion of participation of persons with mental disorders in decision-making processes.

Compared with the rest of the world, the rates are similar in the Region for compliance with human

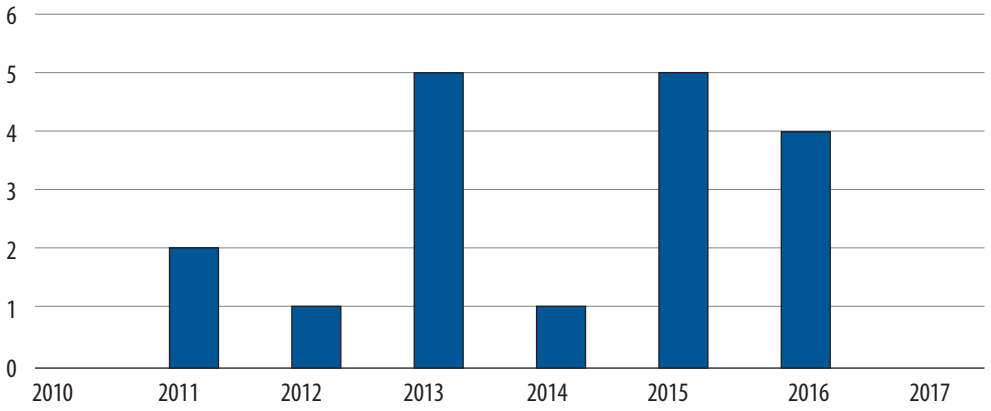



**Fig. 6.** Year of publication of mental health policies/plans in countries of the Region

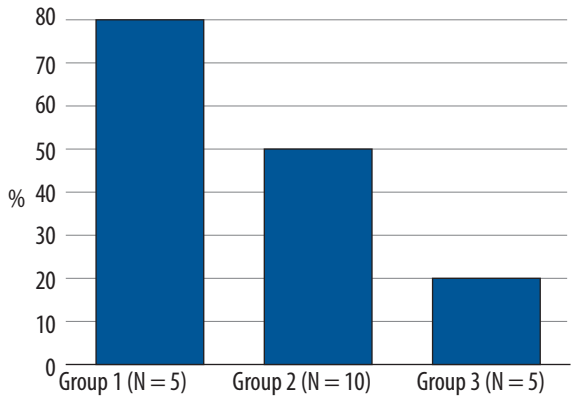



**Fig. 7.** Percentage of countries in the Region with a plan or strategy for child and adolescent mental health by country group

rights instruments in relation to community-based services, respect for human rights and supporting independence, but rates for promoting the recovery approach and promotion of participation fall below the rest of the world (see Fig. 8).

Between 2014 and 2017, there has been a substantial increase in the percentage of Eastern Mediterranean Region countries that are compliant with all five indicators – each has risen by 9–22% (see Fig. 9).

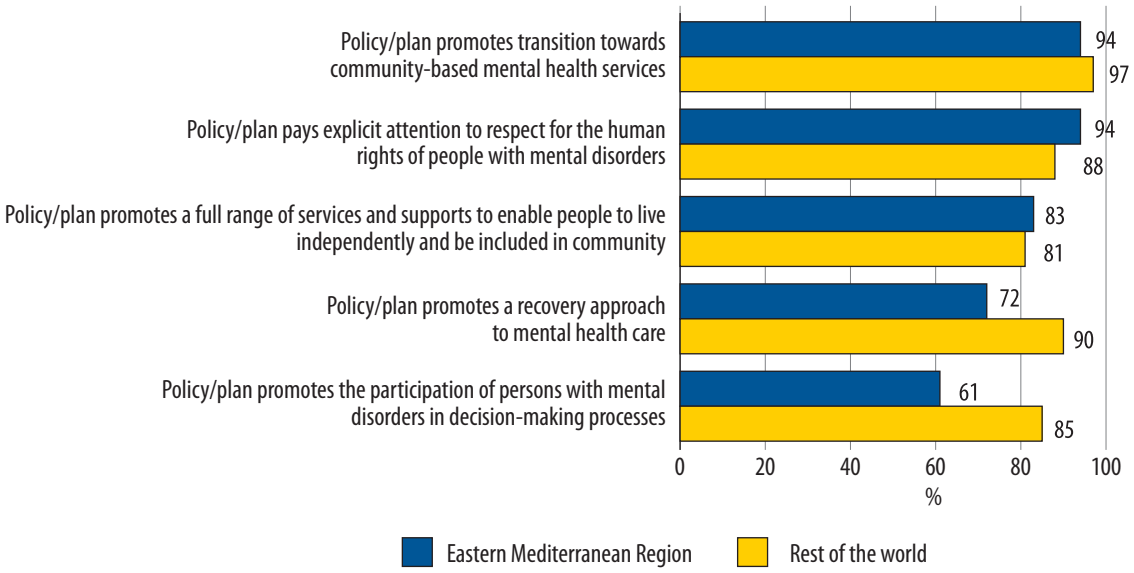



**Fig. 8.** **Percentage of countries with mental health policies or plans that are compliant with human rights instruments in the Eastern Mediterranean Region and the rest of the world**

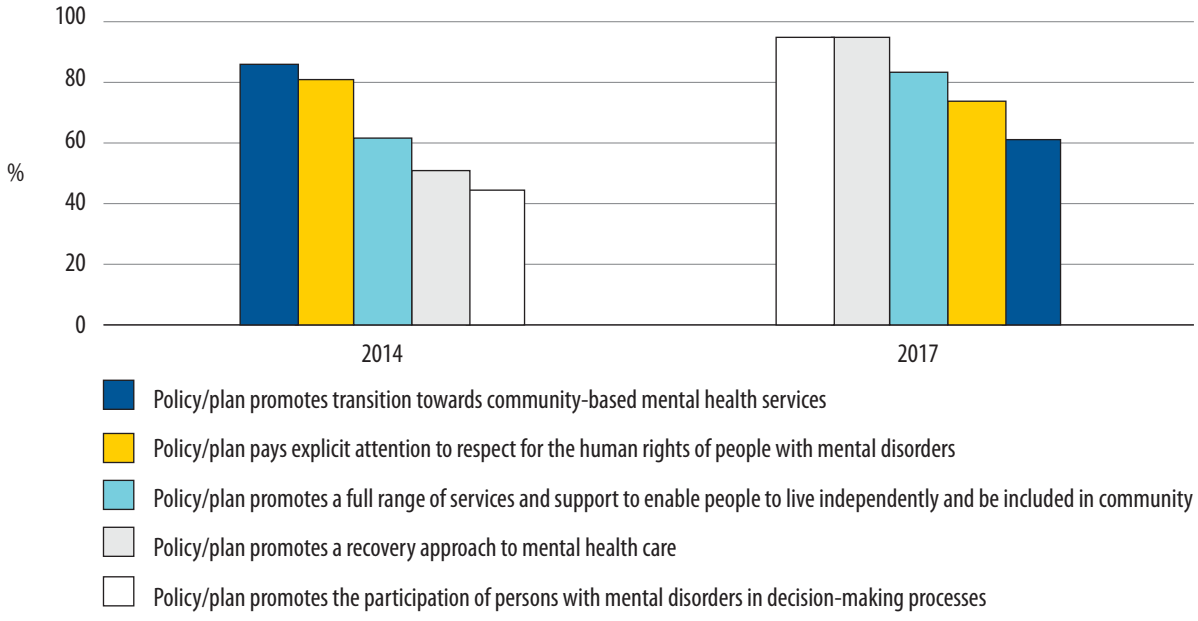



**Fig. 9.** **Percentage of countries in the Region with mental health policies or plans compliant with human rights instruments in 2014 and 2017**

## Provision of resources for mental health policies and plans

Eleven countries of the Region (58% of the 19 countries that reported this item), have a mental health policy or plan that contains estimates of the human or financial resources needed to implement it, or a separate assessment of resource needs has been undertaken. However, in only three countries (16%) have resources been allocated in line with the indicated resource needs to enable implementation of the policy or plan. The proportion of countries in which resource estimates have been included or carried out tends to be highest in group 3 countries (see Fig. 10). On the other hand, resources were actually allocated most frequently in group 1 countries, and were not allocated in any group 3 countries (see Fig. 10).

Six (31%) countries indicated that the mental health policy or plan contains estimates of the human or financial resources needed to implement it. This is lower than the corresponding global rate of a little over half of reporting countries indicating that estimates of required resources are included in their policy/plan. Three countries of the Region reported that resources have been allocated in line with indicated resource needs to enable implementation of the policy or plan (that is half of those with estimates; similar to the just more than half of countries with estimates globally).

## Indicators and targets to monitor implementation of mental health policies and plan

Fifteen (83%) of 18 countries of the Region with mental health policies or plans indicated that their plans contain specified indicators or targets against which implementation can be monitored. Eleven countries (61%) had used the indicators to monitor and evaluate implementation in the previous two years. However, only six countries (33%) had used them to monitor and evaluate most or all components of the current mental health policies/plans in the previous two years.

The overall rate of 83% of countries with policies/plans having indicators to monitor and evaluate their mental health policy/plan is slightly higher than the corresponding rate of 76% in the rest of the world.

Among group 1 and 2 countries, 80% and 77%, respectively, had used indicators to monitor and evaluate implementation of mental health policies and plans in the past two years, whereas no country in group 3 had actually used indicators in monitoring (see Fig. 11).

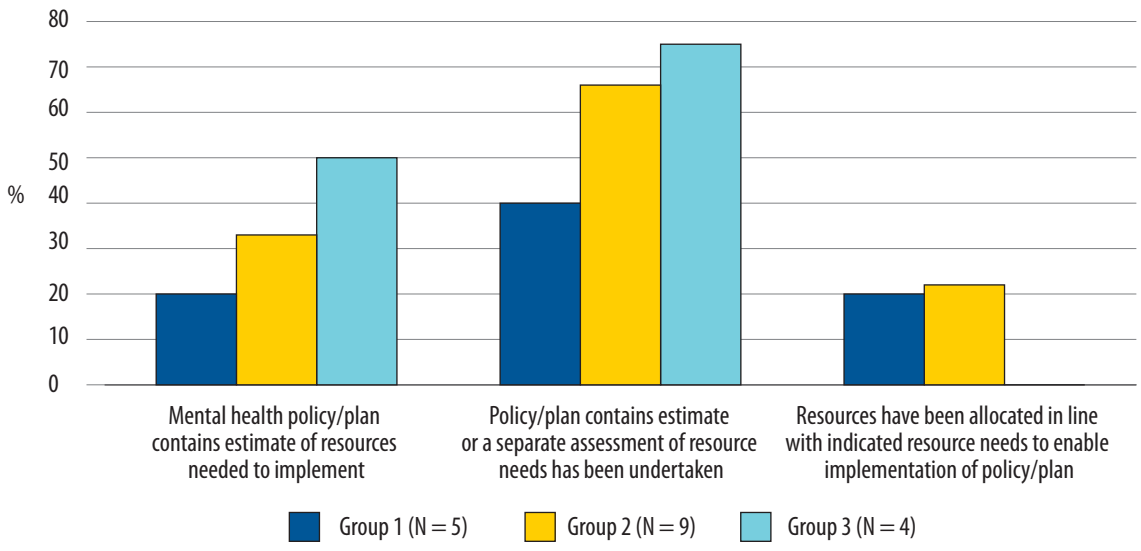



**Fig. 10.** **Percentage of countries with estimates and assessments of resources needed to implement mental health policies/plans by country group**

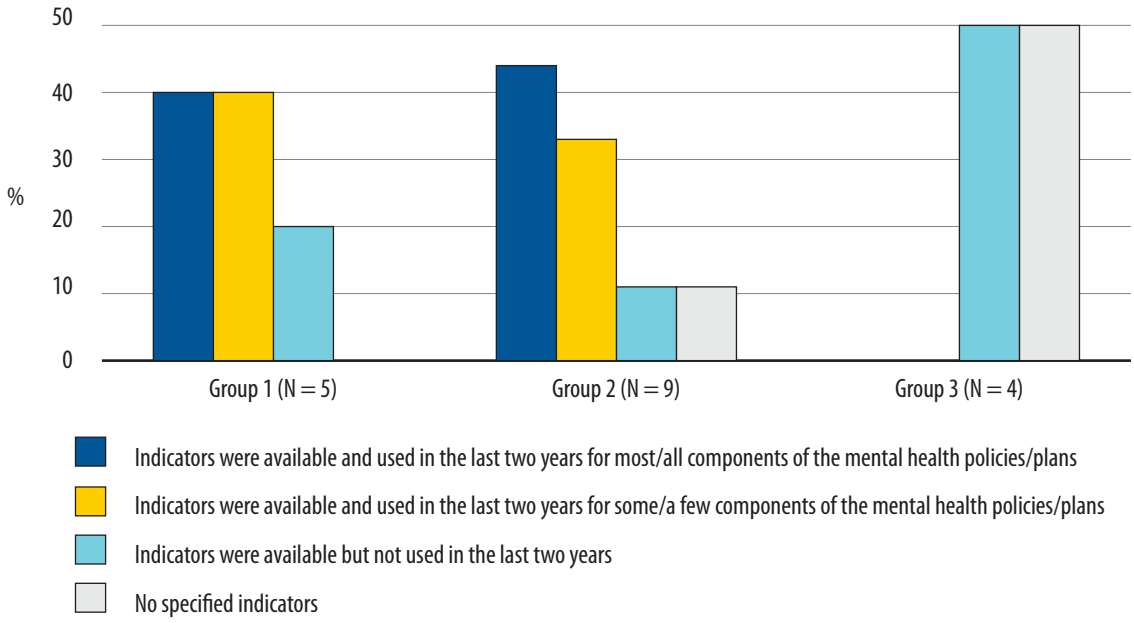



**Fig. 11. Percentage of countries that used indicators or targets to monitor implementation of mental health policies/plans in the past two years by country group**

## 2.2. Mental health legislation

Mental health legislation is another key component of good governance, and concerns the specific legal provisions that are primarily related to mental health, which typically focus on issues such as civil and human rights protection of people with mental disorders, involuntary admission and treatment, guardianship, and professional training and service structure. Global target 1.2 of the *Mental Health Action Plan 2013–2020*, states that 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.

*Mental health atlas 2017* assessed whether countries have a stand-alone mental health law, and the extent to which legislation is currently being used or implemented. As with mental health policy/plans, a checklist was developed and used to assess the degree to which laws fall in line with international human rights instruments.

### Existence and revision status of mental health legislation

Countries were asked about the presence of stand-alone or integrated mental health legislation and the year of its latest revision. Half of countries (11/22) in the Eastern Mediterranean Region reported that they have a stand-alone mental health law (see Fig. 12a). Three countries have mental health integrated into other general or public health, or disability laws. Six countries reported that they do not have a mental health law.

The percentages of countries reporting the presence of either stand-alone or integrated mental health legislation across country groups are: 80% in group 1 ($N = 5$ ), 70% in group 2 ($N = 10$), and 60% in group 3 ($N = 5$).

The proportion of countries with stand-alone and integrated mental health legislation in the rest of the world is larger than that reported in the Region (see Fig. 12b), leaving a larger proportion of countries in the Region (27%) having no mental health legislation compared with the rest of the world (16%). The proportion of countries in the Region with stand-alone mental health legislation in 2017 is similar to the corresponding proportion in 2014.

Among the 13 countries of the Region that provided data on year of enactment or updating of their mental health legislation, six were enacted/revised since 2010 (all within the past five years) (see Fig. 13). A further four were enacted between 2000 and 2010, while the remaining three were enacted more than 20 years ago, including one that dates back to 1959.

### Existence and functioning of a dedicated authority or independent body to assess compliance of mental health legislation

Eighteen countries of the Region reported on the existence and level of functioning of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights instruments. Overall, 17% have a dedicated authority or independent body providing regular inspections and reports, 22% have a body providing irregular inspections, and 17% have non-functional dedicated authorities or independent bodies. The remaining 44% of countries do not have a dedicated authority or independent body.

Half of group 1 and 2 countries have a body that provides some inspections, but no group 3 countries have a functioning dedicated authority or independent body (see Fig. 14). A larger proportion of countries in the rest of the world have functioning dedicated authorities or independent bodies: 50% in rest of the world compared with 39% in the Eastern Mediterranean Region (see Fig. 15).

### Compliance of mental health legislation with international human rights

Among the 12 countries of the Region that reported the compliance of their mental health legislation with human rights instruments, the majority indicated compliance in all five areas (see Fig. 16). The lowest rate of compliance (75%) was for promotion of transition towards community-based mental health services. All countries updated their mental health legislation in 2013 or later complied with all five aspects of human rights instruments.

Compliance rates are generally comparable with reported rates from the rest of the world, the exception being promoting the transition towards community-based mental health services, which is lower in the Region than the rest of the world. The percentage of countries with mental health legislation that is compliant with human rights instruments increased between 2014 and 2017 – rising for every criteria by between 18 and 33% (see Fig. 17).

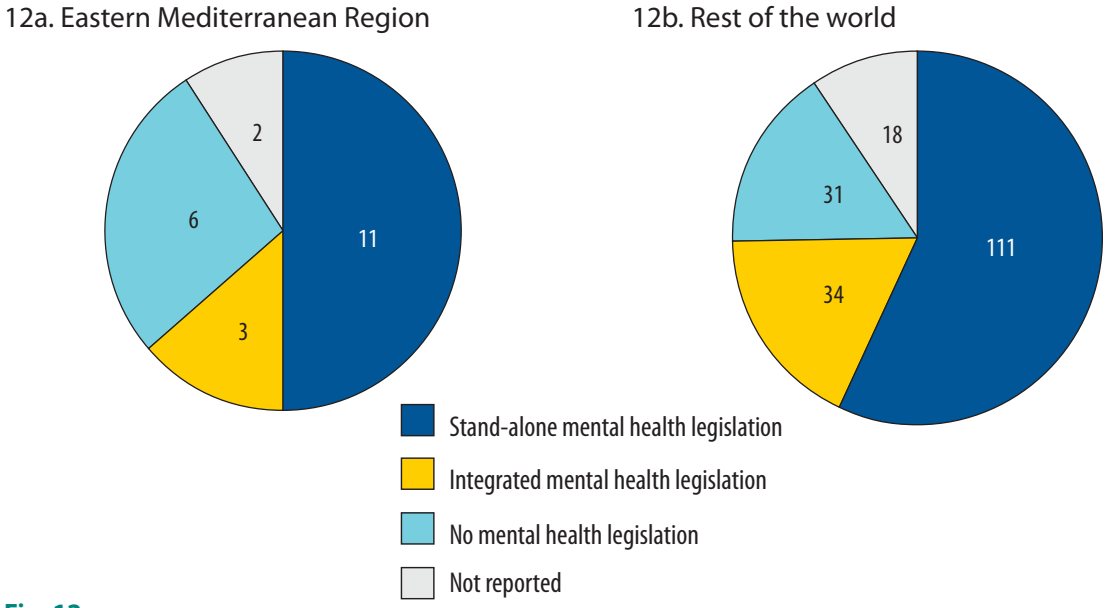



**Fig. 12**

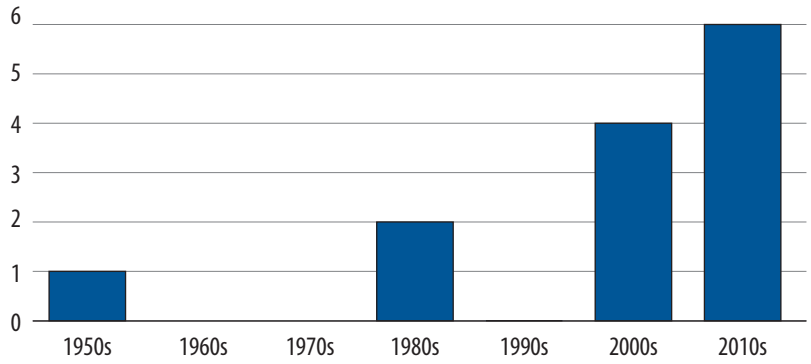



**Fig. 13.** Year that the mental health legislation was enacted

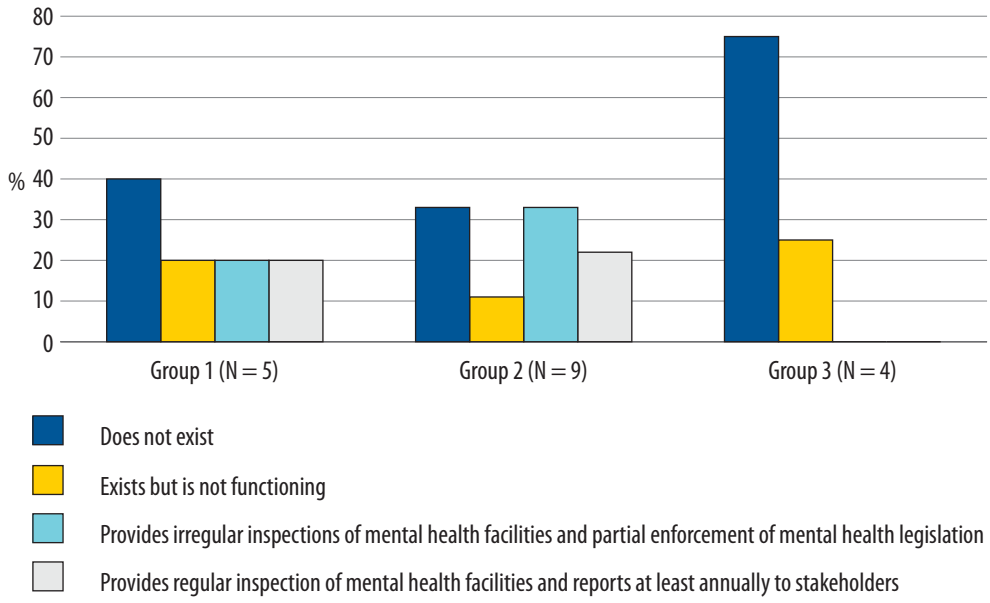



**Fig. 14.** Existence and functioning of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights instruments in countries of the Region by country group

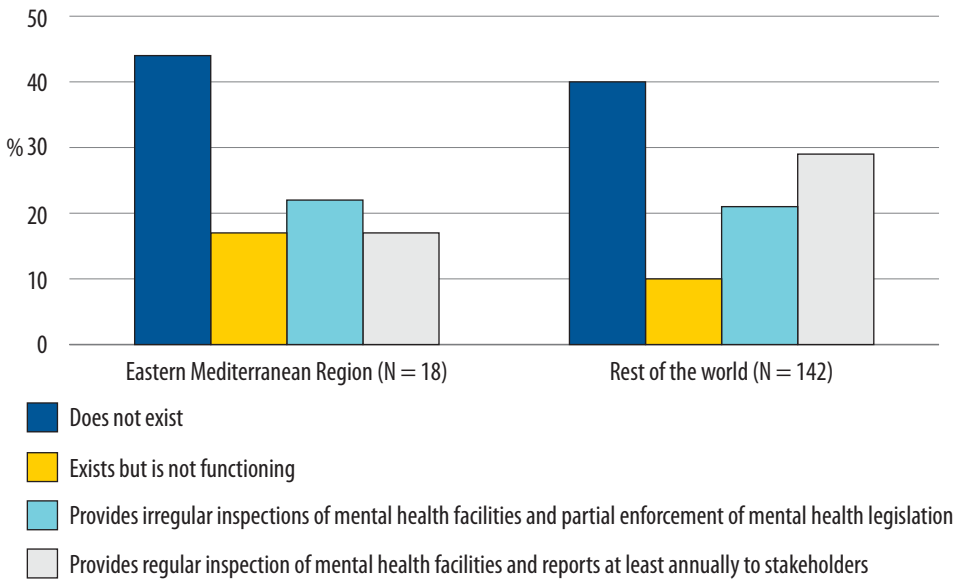



**Fig. 15. Existence and functioning of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights instruments in countries of the Region that have mental health legislation, and the rest of the world**

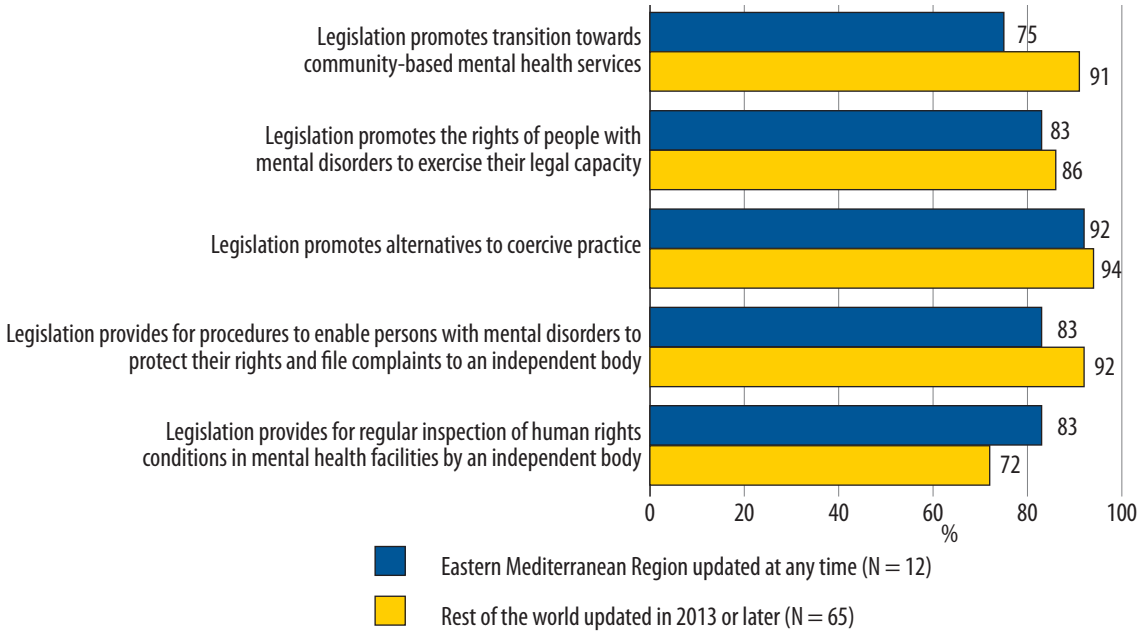



**Fig. 16. Compliance of mental health legislation with human rights instruments in the Eastern Mediterranean Region and the rest of the world**

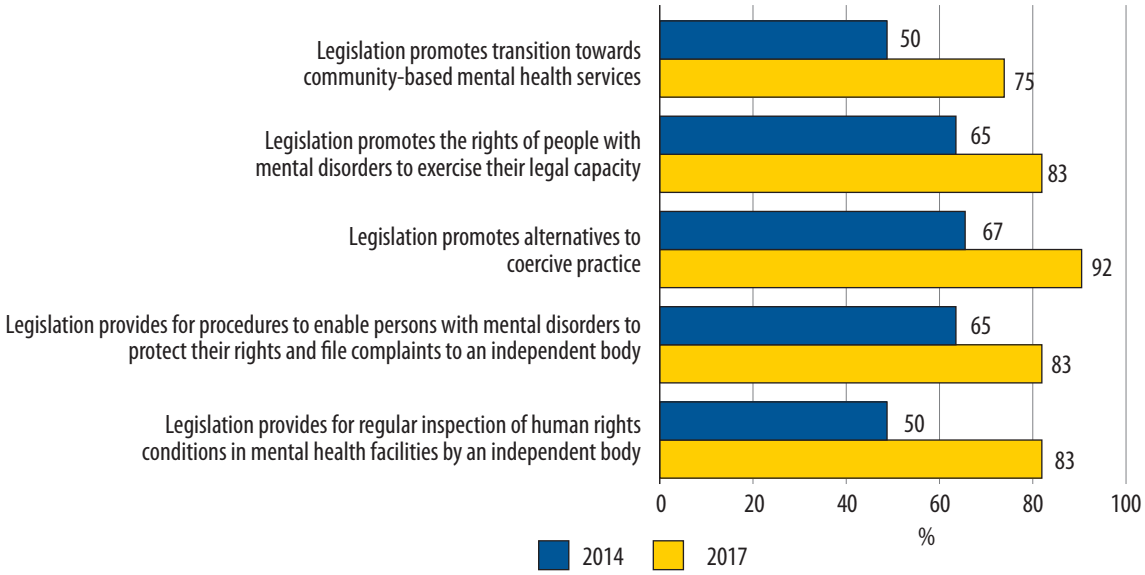



**Fig. 17. Compliance of mental health legislation with human rights instruments in the Eastern Mediterranean Region in 2014 and 2017**

## 2.3. Stakeholder collaboration

Successful coordination of mental health services involves many actors both within and beyond the health sector and enables strengthening of care pathways. It encompasses social affairs/social welfare, justice, education, housing and employment sectors (government or nongovernmental agencies), media sector, academia/institutions, local and international nongovernmental organizations who deliver or advocate for mental health services, private sector organizations, professional associations, faith-based organizations/institutions, traditional/indigenous healers, service users, and family or caregiver advocacy groups. It requires strong leadership to ensure stakeholder collaboration and intersectoral action.

*The Mental Health Action Plan 2013–2020* identifies the multisectoral approach as one of the six cross-cutting principles and approaches. The Action Plan outlines that a comprehensive and coordinated response for mental health requires partnership with multiple public sectors and other relevant sectors, as well as the private sector, as appropriate to the country situation. A proposed action for Member States is to motivate and engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.

In *Mental health atlas 2017*, countries were asked to identify if there is ongoing collaboration between government mental health services and other departments, services and sectors. They were also asked to identify the number and type of stakeholder groups that are currently collaborating with government mental health services in the planning or delivery of mental health promotion, prevention, treatment and rehabilitation services.

Stakeholder collaborations were considered as a 'formal' collaboration only when at least two out of three of the following checklist items applied: a) the existence of a formal agreement or joint plan with this partner; b) the availability of dedicated funding from or to this partner for service provision; and c) the holding of regular meetings with this partner (at least once per year).

### Collaboration between government mental health services and other departments, services and sectors

Nineteen countries of the Region completed at least part of this section of the atlas 2017 questionnaire. Eighteen (95%) of these countries reported ongoing collaboration between government mental health services and other departments, services and sectors, and 16 (84%) countries had formal collaboration. These overall regional rates are very similar to those reported by the rest of the world, where 81% of countries reported having at least one formal collaboration with stakeholder groups.

After applying the criteria for formal collaboration, more than half of the countries of the Region have formal collaboration with local (63%) and international (58%) nongovernmental organizations (see Fig. 18). The next most frequent formal collaboration is with other government sectors, such as social affairs (47%), education (47%), justice (26%) and interior/home affairs (32%), along with the academic sector/institutions (37%), the private sector (26%), professional associations (32%), and service users and family or caregiver groups (26%). Only a few countries have formal collaboration with the media sector (11%), faith-based organizations (10%), housing sector (5%), employment sector (5%), and traditional/indigenous healers (5%).

Compared with the rest of the world, a greater percentage of countries in the Region have formal collaboration with international and local nongovernmental organizations and with the Ministry of the Interior/Home Affairs, while a lower percentage of countries have collaborative links with the Ministry of Social Affairs/Social Welfare (see Fig. 18).

The number of formal collaborations reported by individual countries in the Region ranged from 0 to 12 with a median of 4 (see Fig. 19). Countries in group 3 have fewer formal collaborations (median = 0.5 per country) than countries in groups 1 and 2 (median = 5 per country).

### Collaborations with service users and family or caregiver advocacy groups

Nine (47%) countries of the Region reported ongoing collaboration with service users and family or caregiver advocacy groups, and all of these have regular meetings at least once per year. Five (26%) countries meet the criteria for formal collaboration. Collaboration with service users and family or caregiver advocacy groups appears to be better developed in group 1 and 2 countries, where 40% and 30% of countries, respectively, have formal collaboration, and least well developed in group 3 countries, where were reported no formal collaborations.

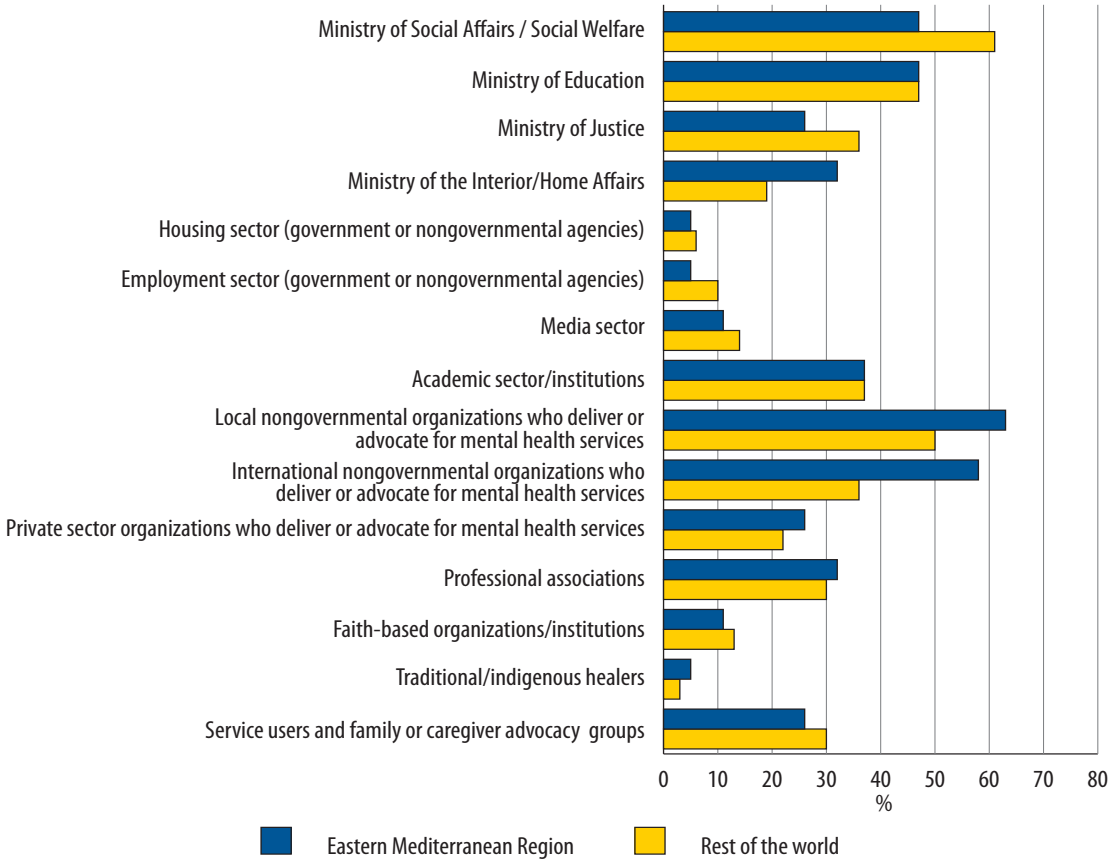



**Fig. 18.** **Percentages of all responding countries (N = 19) of the Region and rest of the world countries (N = 176) that identify formal collaboration with stakeholder groups (denominator includes all countries that responded to the mental health atlas questionnaire, including those that left parts or all of this section blank)[1]**

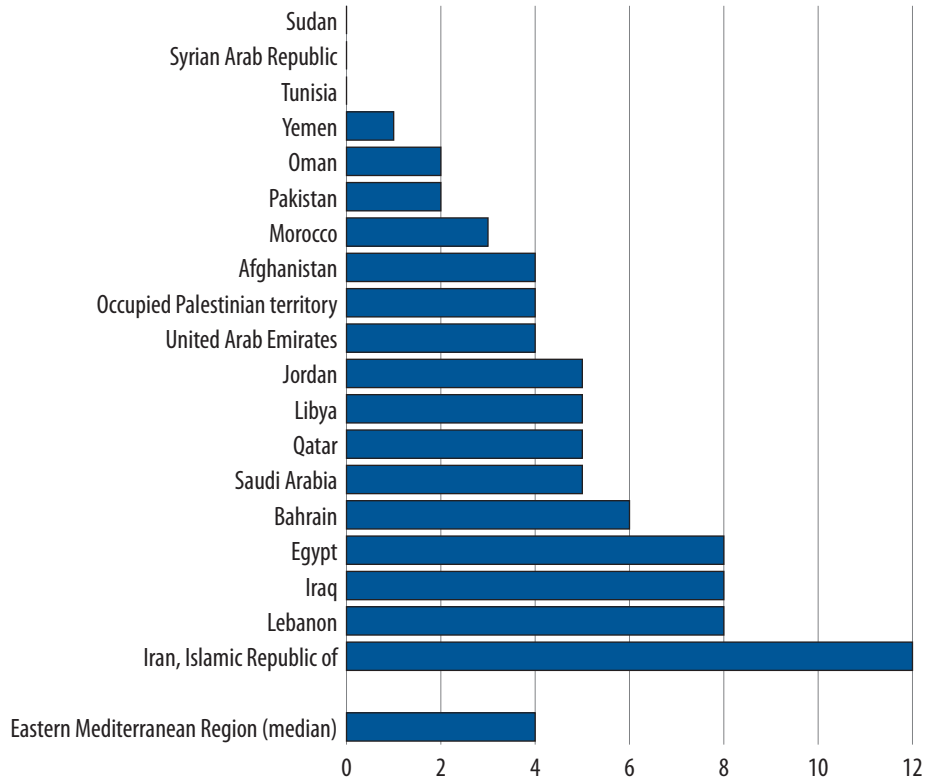



**Fig. 19.** **Numbers of formal collaborations by country**

1 The percentages for the rest of the world presented here appear very different from the global figures presented in *Mental health atlas 2017* (Fig 2.3.1) because they use different denominators.

# 3. Financial and human resources for mental health

## 3.1. Government mental health spending

Financial resources are an evident requirement for developing and maintaining mental health services and moving towards programme goals. Mental health spending can include activities delivered in social care and in primary or general care, as well as in specialist/secondary health care. Mental health spending may include programmatic costs such as administration/management, training and supervision, and mental health promotion activities. Estimation of mental health expenditure in a country, however, is complex, due to the range of funding sources (employers and households as well as governmental or nongovernmental agencies), the diverse set of service providers (specialist mental health services, general health services and social care services) and the diversity of services provided.

Twenty countries of the Region completed this section. Twelve (60%) countries indicated that the care of people with major mental disorders (psychosis, bipolar disorder, depression) is included in national insurance or reimbursement schemes (see Table 5). Nine (45%) countries explicitly list mental disorders as included conditions. One country (5%) explicitly lists major mental disorders as excluded conditions in its national health insurance or reimbursement schemes. This is a similar percentage to the 11 (7%) countries in the rest of the world that explicitly exclude mental disorders.

There is a tendency for fewer group 3 countries (40%) to include major mental disorders in their national insurance or reimbursement schemes than group 1 (60%) or group 2 (70%) countries (see Fig. 20). The total of 60% of countries in which care and treatment of mental disorders is included in national insurance or reimbursement schemes is lower than the corresponding figure of 74% in the rest of the world.

### How the majority of persons with mental disorders pay for care

In 80% (16 of 20) of countries of the Region, people pay nothing (are fully insured) or at least 20% towards the cost of mental health services at the point of service use (see Table 6). This percentage is similar to the corresponding rate of 83% in the rest of the world (see Fig. 21). There is a stepwise reduction in the percentage of countries in which mental health services are covered between group 1 (100%), group 2 (80%) and group 3 (60%) countries.

### Total government expenditure on mental health

Seven countries of the Region reported on components of mental health expenditure**.** All of these included mental hospitals and most included primary health care, hospital outpatient care, other hospital inpatient care, community mental health care, and training and management. Less than half included prevention and promotion, community residential care, and social care services.

Median total expenditure on mental health per capita was US$ 3.43/capita, based on seven countries: two from group 1, four from group 2 and one from group 3 (more countries of the Region than are reported on in the global mental health atlas report). This is higher than the global median mental health expenditure per capita of US$ 2.5 based on 80 countries. Median total expenditure on mental hospitals per capita was US$ 1.85/capita.

Each of the three country groups were represented among the countries that reported on expenditure, although in very small numbers (1–4). Nevertheless, per capita total expenditure on mental health and expenditure on mental hospitals in the Region follows the expected pattern, being highest in group 1 and lowest in group 3 (see Fig. 22).

The median expenditure on mental health as a percentage of total government health expenditure in this small number of countries is 0.61%. This percentage is higher in group 1 countries than in group 2 and 3 countries (see Fig. 23).

**Table 5.** Country responses to question on whether care and treatment of persons with major mental disorders is included in national health insurance or reimbursement schemes

| Is the care and treatment of persons with major mental disorders (psychosis, bipolar disorder, depression) included in national health insurance or reimbursement schemes in your country? | |
|---|---|
| **Yes** | **No** |
| ▪ Afghanistan* | ▪ Iraq |
| ▪ Bahrain* | ▪ Oman |
| ▪ Egypt* | ▪ Pakistan |
| ▪ Iran, Islamic Republic of* | ▪ Saudi Arabia |
| ▪ Jordan* | ▪ Somalia |
| ▪ Lebanon | ▪ Syrian Arab Republic† |
| ▪ Libya | ▪ Tunisia |
| ▪ Morocco* | ▪ Yemen |
| ▪ Occupied Palestinian territory | |
| ▪ Qatar* | |
| ▪ Sudan* | |
| ▪ United Arab Emirates* | |

* Explicitly lists major mental disorders as included conditions.
† Explicitly lists mental disorders as excluded conditions.

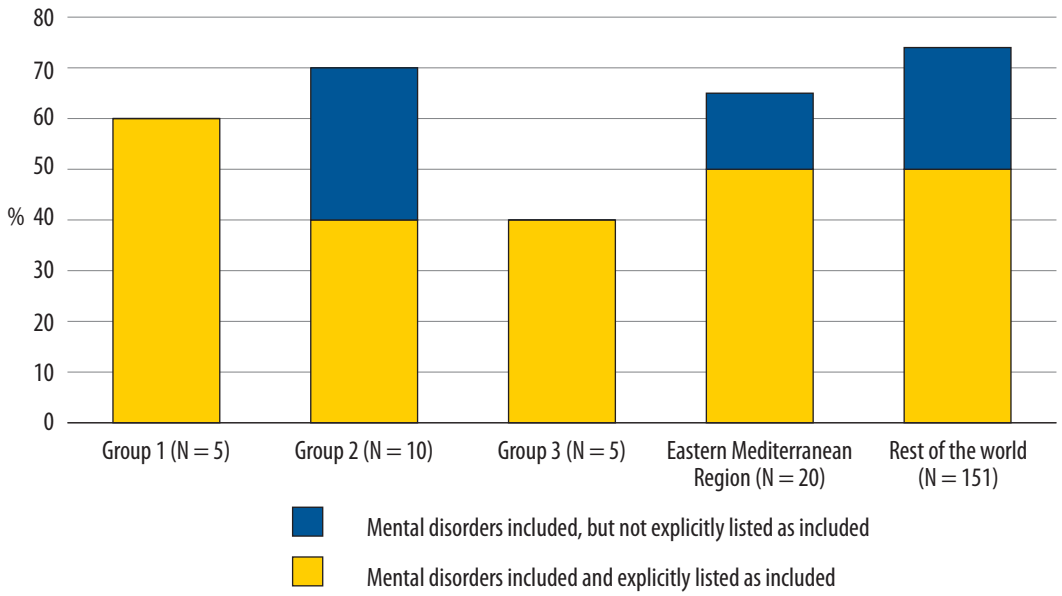



**Fig. 20.** Care and treatment of persons with major mental disorders (psychosis, bipolar disorder, depression) included in national health insurance or reimbursement schemes by country group

## Table 6. How the majority of people pay for mental health services in countries

| How the majority of persons with mental disorders pay for mental health services | | |
|---|---|---|
| Persons pay nothing at the point of service use (fully insured) | Persons pay at least 20% towards the cost of services and medicines | Persons pay mostly or entirely out of pocket for services and medicines |
| ▪ Afghanistan<br>▪ Bahrain<br>▪ Egypt<br>▪ Iran, Islamic Republic of<br>▪ Libya<br>▪ Occupied Palestinian territory<br>▪ Oman<br>▪ United Arab Emirates | ▪ Iraq<br>▪ Jordan<br>▪ Lebanon<br>▪ Morocco*<br>▪ Pakistan<br>▪ Qatar<br>▪ Saudi Arabia<br>▪ Sudan | ▪ Somalia<br>▪ Syrian Arab Republic<br>▪ Tunisia<br>▪ Yemen |

* In Morocco, persons pay at least 20% towards the cost of service at the point of service use, but nothing towards the cost of psychotropic medicines.

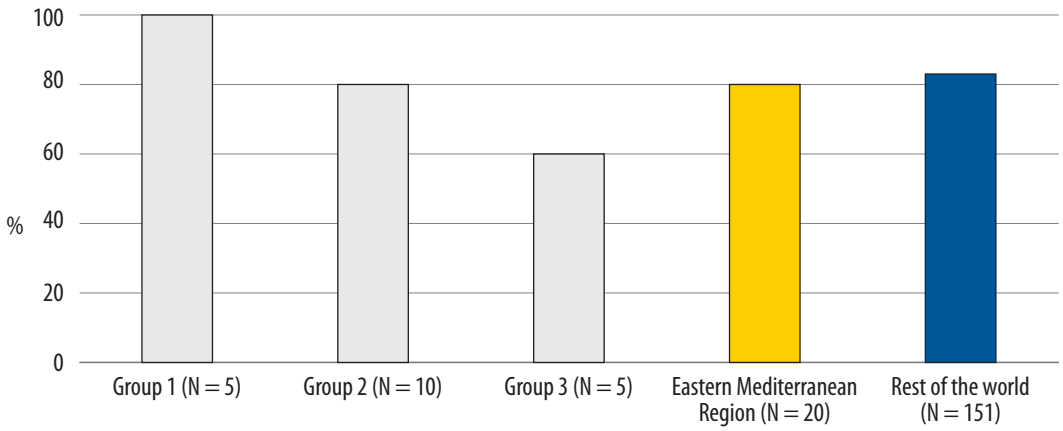



**Fig. 21. How people pay for mental health services: Percentage of countries where persons pay nothing (are fully insured) or at least 20% towards the cost of mental health services at the point of service use, by country group, for the Eastern Mediterranean Region and for the rest of the world**

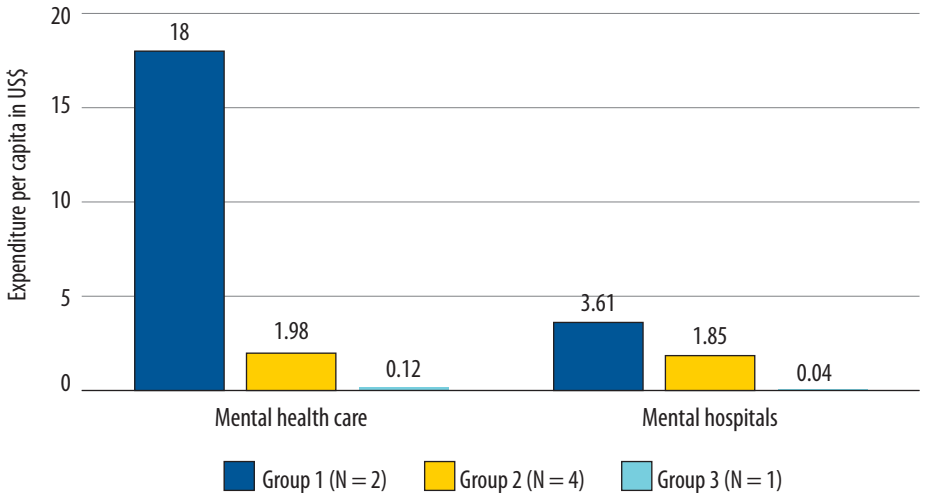



**Fig. 22. Total expenditure on mental health and on mental hospitals per capita, in US$, by country group**

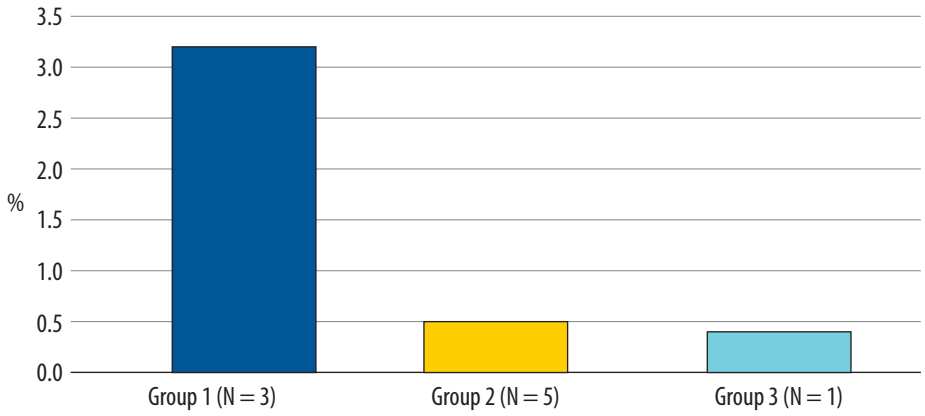



**Fig. 23. Expenditure on mental health as a percentage of total government health expenditure**

## 3.2. Mental health training in general health care

The training of primary care staff in mental health is a crucial issue for the capacity of this sector to recognize and to treat patients with severe and common mental disorders. A total of 3807 mental health training courses (lasting at least two days) for more than 75 000 health care workers in non-specialized/general health care settings were reported in the Eastern Mediterranean Region during the previous year. 3410 of these courses were in Islamic Republic of Iran (see Fig. 24). Syrian Arab Republic and Afghanistan both carried out more than 100 courses, while 20 or fewer courses were implemented in other reporting countries.

The total of 3807 is 27% of the total number of courses reported globally, but this indicator was under-reported or incompletely reported by many countries globally, particularly by high-income countries (perhaps because data on mental health training are not aggregated at national level at ministries of health).

In the Eastern Mediterranean Region, 17% (663) of the reported courses were for physicians/doctors, 7% (272) were for nurses, and 74% (2830) were for other health care workers (such as community health workers etc.). Only 1% (42) of the courses were for mixed groups (combining doctors, nurses or other health care workers in multidisciplinary learning).

Countries directed their mental health training at different types of trained health care workers in non-specialised/general health settings (see Fig. 25). Libya, Qatar and the Syrian Arabic Republic predominantly trained physicians/doctors. Somalia, Tunisia and Lebanon focused on training for nurses. Islamic Republic of Iran trained predominantly other healthcare workers.

Across the whole Region, mental health training reached a median of 0.32% of all physicians/doctors and similarly 0.32% of all nurses. However, Qatar, Islamic Republic of Iran, Syrian Arab Republic and Afghanistan implemented mental health training for more than 5% of their physicians/doctors, and Afghanistan, Islamic Republic of Iran and Somalia trained more than 2% of their nurses (see Fig. 26).

The percentage of physicians/doctors and nurses trained in mental health in the past two years in group 2 countries tends to be lower than the percentages trained in group 1 and group 3 countries (see Fig. 27). However, as with all the group comparisons, caution is needed because the numbers in the groups is very small and the differences are not statistically significant.

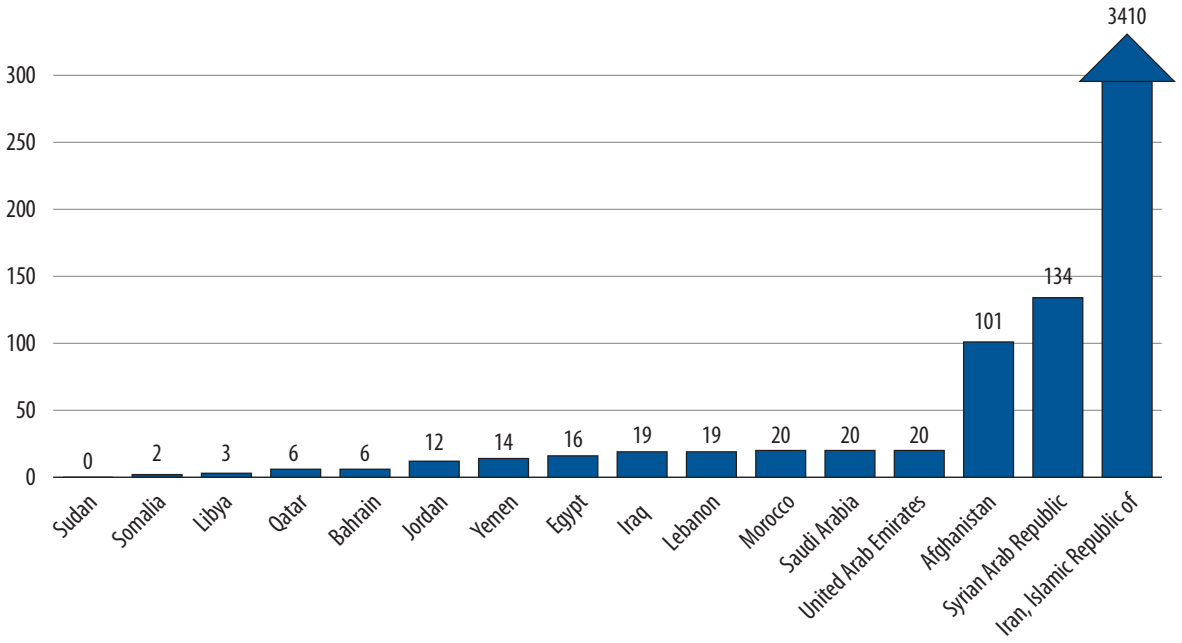



**Fig. 24.** Number of mental health training courses lasting at least two days in the last year by country

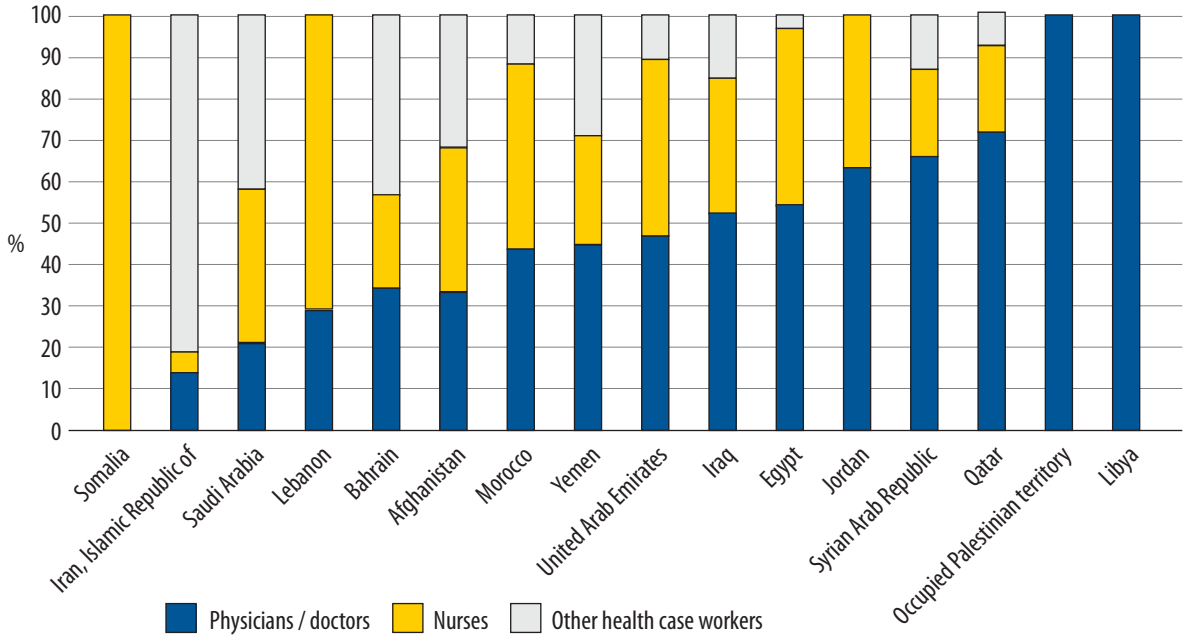



**Fig. 25.** General health care workers, by staff type, who attended mental health courses in the last year (numeric values are the numbers of staff trained)

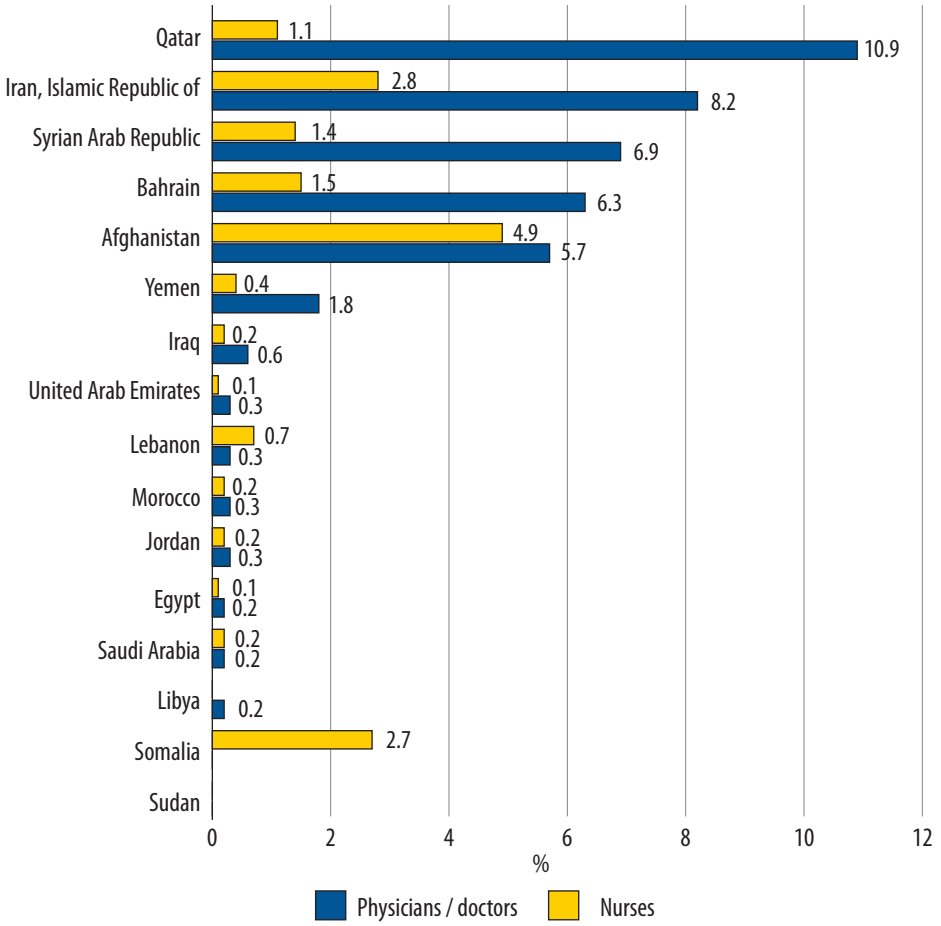



**Fig. 26.** **Median percentage of all physicians/doctors and nurses receiving mental health training lasting for at least two days in the past year in countries of the Region**

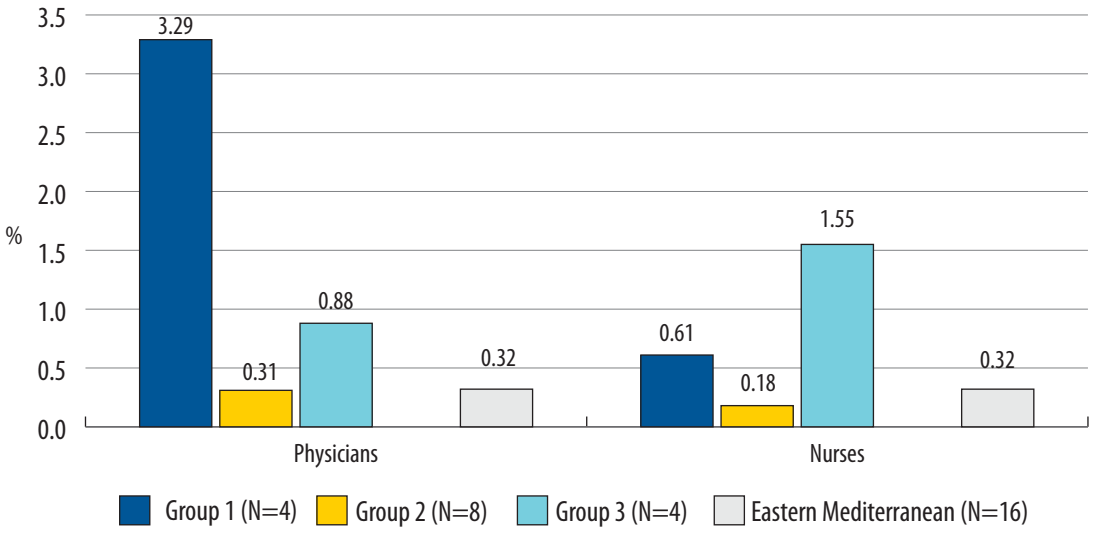



**Fig. 27.** **Median percentage of all physicians/doctors and nurses receiving mental health training lasting for at least two days in the past year by Eastern Mediterranean Region country group**

## 3.3. Mental health workforce

Countries were requested to provide estimates of the total number of mental health professionals working in the country, broken down by specific occupation, including psychiatrists, child psychiatrists, other medical doctors, nurses, psychologists, social workers, occupational therapists and other paid workers working in mental health.

Sixteen (80%) countries of the Region provided at least partial estimates of known mental health workers in their country (a similar percentage to that of global submissions). The total numbers of health workers varied between 0.6 per 100 000 population in Sudan and 38.5 per 100 000 in Bahrain (see Fig. 28).

Figs. 29 and 30 show the breakdown of the composition of the mental health workforce by country group. The highest workforce provision is found in group 1 countries (median of 18.6 per 100 000) and the lowest in group 3 countries (median of 0.7 per 100 000) (see Fig. 29). The provision in group 2 countries (5.7 per 100 000) is near that for the median total number of mental health workers across all countries of the Region (7.9 per 100 000), which is slightly lower than the 9.0 per 100 000 found globally.

Nurses make up half of the regional mental health workforce (see Fig. 30). Doctors (mainly psychiatrists) form a quarter of the workforce, followed by psychologists (14%) and social workers (9%). The percentage composition of the mental health workforce in countries of the Region as a whole is broadly similar to that found globally – the regional workforce has a slightly greater proportion of specialist doctors and social worker, and fewer other paid mental health workers.

More striking differences are seen between the three country groups. In addition to having the greatest absolute numbers per 100 000 population, group 1 countries have proportionately more nurses (53%), and fewer psychiatrists (9%). Group 2 countries have a pattern that is similar to the overall regional and global distributions. Group 3 countries have a smaller range of disciplines, proportionately fewer nurses (15%), and more psychiatrists (30%) and psychologists (45%).

The percentage of all psychiatrists, nurses, psychologists and social workers that work in government mental health services is shown in Fig. 31. These may overestimate the percentages in government services if there is underreporting of the mental health workforce in the private sector because of limited data availability at national level. Higher percentages (65–100%) of all four staff types work in government mental health services in group 1 countries than in group 2 and 3 countries.

Thirteen countries reported on staff working in government child and adolescent mental health services (CAMHS) (see Fig. 32). Seven countries reported that between 2.6% and 3.4% of government mental health staff work in CAMHS. No government mental health staff work in CAMHS in five countries (the remaining countries did not report these data). Lebanon directly employs 17.6% of its mental health staff in CAMHS. The percentage of staff working CAMHS in most countries of the Region is substantially lower than the global median of 9%.

It is difficult to confidently analyse changes in the size of the mental health workforce over time because some countries reported on different groups of staff in different atlas years, and some countries did not report in some years. Therefore, for each country, only the staff groups that they consistently reported in the mental health atlases for 2011, 2014 and 2017 were included in the analysis of trends over time (see Fig. 33). The data reported in atlas 2017 suggests that since 2014, the whole Eastern Mediterranean Region and each of the three country groups in the Region have increased their mental health workforces substantially.

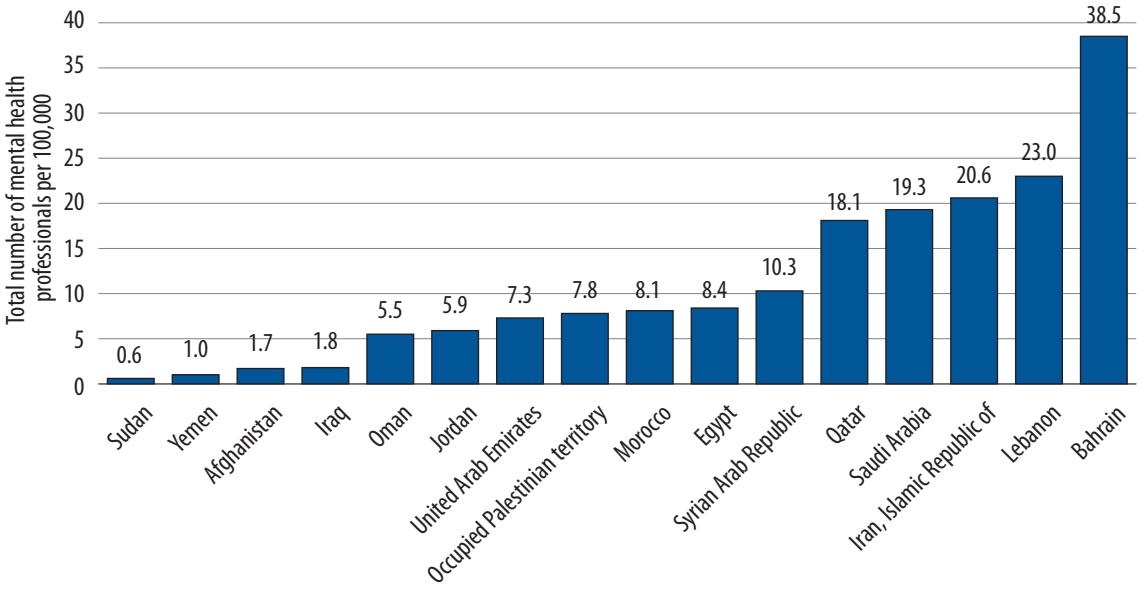
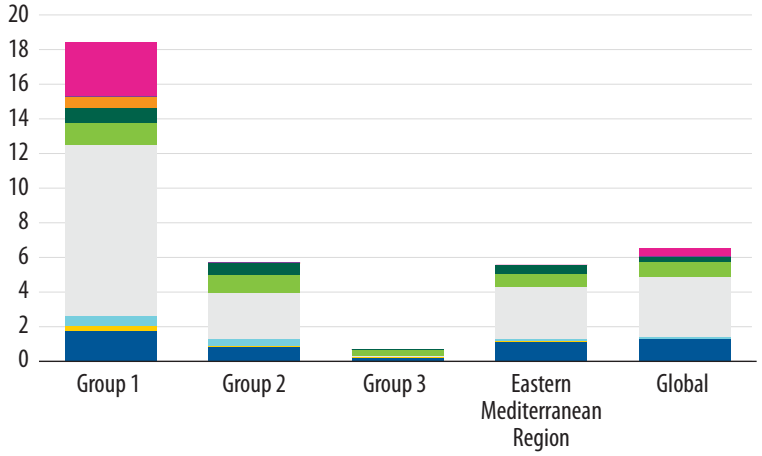
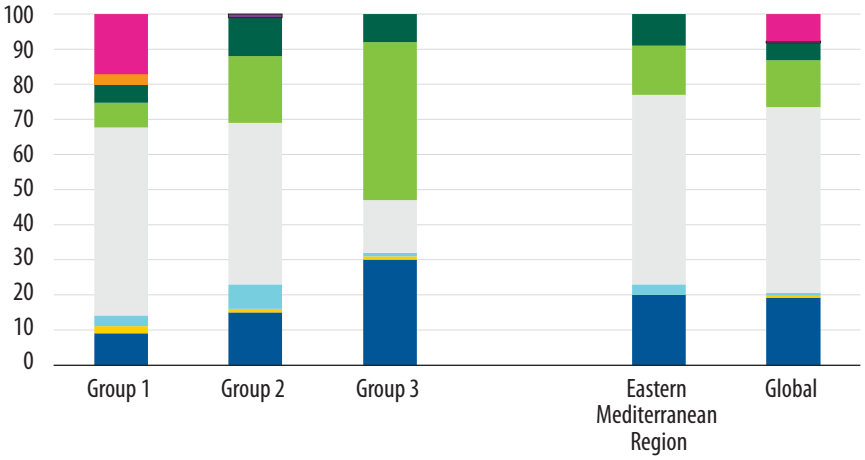



**Fig. 28.** **Total number of mental health professionals per 100 000 in countries of the Region (countries that did not report on numbers of psychiatrists, nurses or four other professional groups are not included)**




| | Group 1 (N = 1–5) | Group 2 (N = 7–9) | Group 3 (N = 3) | Eastern Mediterranean Region (N = 11–17) | Global (N = 115) |
|---|---|---|---|---|---|
| Psychiatrists | 1.74 | 0.84 | 0.2 | 1.12 | 1.27 |
| Child psychiatrists | 0.33 | 0.04 | 0.01 | 0.03 | 0.03 |
| Other specialist doctors | 0.58 | 0.41 | 0 | 0.15 | 0.06 |
| Nurses | 9.93 | 2.66 | 0.1 | 3 | 3.49 |
| Psychologists | 1.24 | 1.07 | 0.3 | 0.79 | 0.88 |
| Social workers | 0.91 | 0.65 | 0.06 | 0.5 | 0.33 |
| Occupational therapists | 0.61 | 0 | 0 | 0 | 0 |
| Speech therapists | 0.07 | 0.06 | 0 | 0.02 | 0.03 |
| Other paid mental health workers | 3.17 | 0 | 0 | 0 | 0.51 |

**Fig. 29.** **Mental health workforce breakdown, by country group, for the Eastern Mediterranean Region and globally (mental health workers per 100 000)**




| | Group 1 (N = 1–5) | Group 2 (N = 5–9) | Group 3 (N = 3–4) | Eastern Mediterranean Region (N = 9–18) | Global (N = 115) |
|---|---|---|---|---|---|
| Psychiatrists | 9% | 15% | 30% | 20% | 19% |
| Child psychiatrists | 2% | 1% | 1% | 0% | 0% |
| Other specialist doctors | 3% | 7% | 1% | 3% | 1% |
| Nurses | 53% | 46% | 15% | 54% | 53% |
| Psychologists | 7% | 19% | 45% | 14% | 13% |
| Social workers | 5% | 11% | 8% | 9% | 5% |
| Occupational therapists | 3% | 0% | 0% | 0% | 0% |
| Speech therapists | 0% | 1% | 0% | 0% | 0% |
| Other paid mental health workers | 17% | 0% | 0% | 0% | 8% |

**Fig. 30.** **Percentage composition of the mental health workforce, by Eastern Mediterranean Region country group, for the Eastern Mediterranean Region and globally**

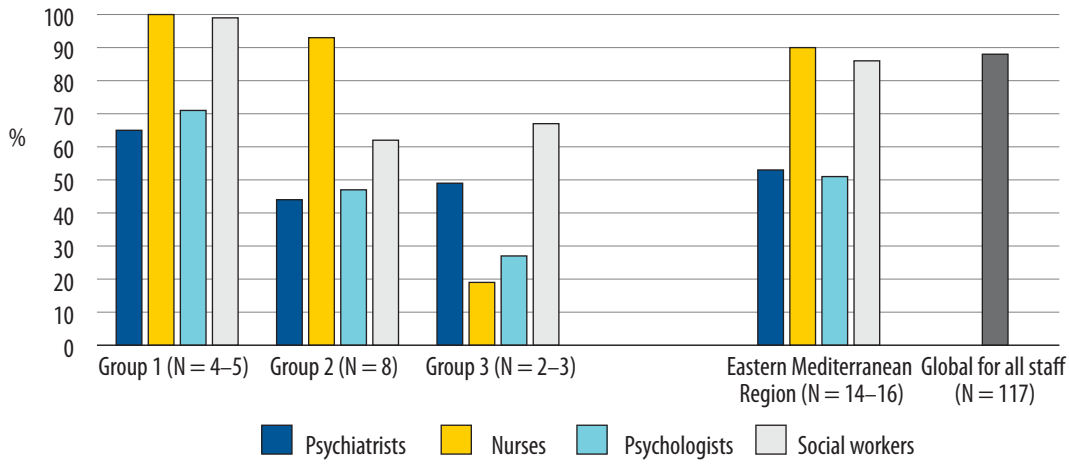



**Fig. 31.** **Percentages of all psychiatrists, nurses, psychologists and social workers that work in government mental health services**

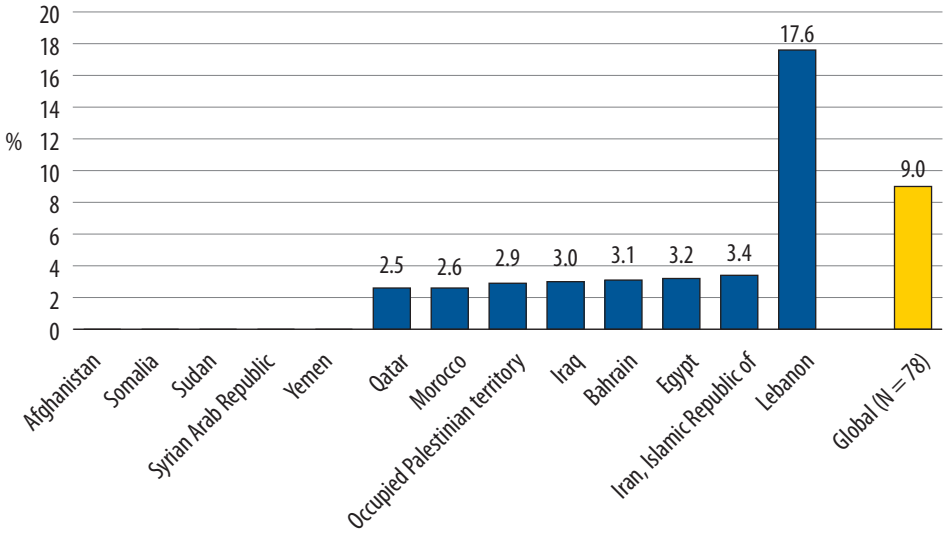



**Fig. 32.** Percentage of staff in government mental health service who work in government child and adolescent mental health services in countries of the Region

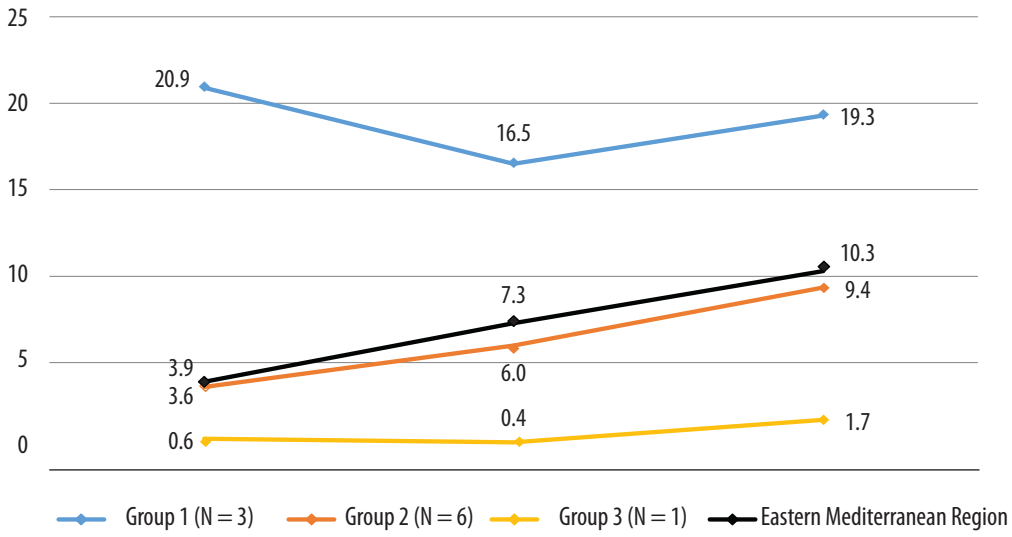



**Fig. 33.** Trends in mental health workforce (median numbers of staff per 100 000 population) over time (based on staff groups that were consistently reported for individual countries in all three mental health atlases 2011, 2014 and 2017)

# 4. Mental health service availability and utilization

## 4.1. Inpatient and residential care

Inpatient and residential care is composed of mental hospitals, psychiatric wards in general hospitals, community residential facilities and other residential facilities, forensic inpatient facilities (outside mental hospitals) and mental health inpatient facilities specifically for children and adolescents (both in mental hospitals and in general hospitals). Definitions of these facility types are provided in the Glossary of terms (see Annex 2).

Half of the countries in the Eastern Mediterranean Region have between three and nine hospital beds per 100 000 population (see Table 7). Four countries, Bahrain, Islamic Republic of Iran, Lebanon and Saudi Arabia have between 18 and 32 mental health beds per 100 000 population, while Afghanistan, Somalia and Sudan have less than one bed per 100 000. There is a progressive decrease in mental health beds and admissions per 100 000 between group 1, group 2 and group 3 countries (see Table 7 and Fig. 35).

Admission rates follow a similar pattern: almost twice as many admissions in group 2 than group 3 countries, and four times as many admissions in group 1 than group 3 countries (see Table 7).

Median adult inpatient mental health care provision is lower in countries of the Region than globally (5.6 beds per 100 000 compared with 16.4 beds per 100 000, respectively), and admission rates are lower (25.5 admissions per 100 000 compared with 99.1 admissions per 100 000, respectively). Even in group 1 countries, the median bed numbers and admissions are lower than the corresponding global medians.

### Mental hospitals

Mental hospitals are specialized hospital-based facilities that provide inpatient care and long-stay residential services for people with mental disorders. Usually these facilities are independent and stand alone, although they may have some links with the rest of the health care system. In many countries, they remain the main type of inpatient mental health care facility.

Most countries in the Region have the majority of their mental health beds in mental hospitals (see Table 8 and Fig. 34). Only Afghanistan, Islamic Republic of Iran, Pakistan and United Arab Emirates have half or fewer of their beds in mental hospitals. However, there is a substantial proportion of provision of mental health beds in psychiatric units in general hospitals in several countries, such as Afghanistan, Morocco, Pakistan and United Arab Emirates. The median numbers of beds and admissions to mental hospitals are lower in Eastern Mediterranean Region countries than globally.

### Psychiatric wards in general hospitals

Psychiatric wards in general hospitals are psychiatric units that provide inpatient care within a community-based hospital facility (such as a general hospital). These units provide care to users with acute psychiatric problems, and the period of stay is usually relatively short (weeks to months).

Most countries of the Region have fewer psychiatric beds in general hospitals than mental hospital beds. Islamic Republic of Iran, Morocco, Pakistan and United Arab Emirates have more than two psychiatric unit beds per 100 000. Bahrain, Libya, occupied Palestinian territory, Somalia and Sudan did not report any. The median numbers of beds and admissions to psychiatric units in general hospitals are lower in countries of the Region than globally. Only Islamic Republic of Iran, Morocco, Pakistan and United Arab Emirates have more beds in psychiatric units in general hospitals than globally, and only Islamic Republic of Iran has more admissions than the global median.

### Beds in community-based residential care facilities, forensic units and specialist child and adolescent mental health units

Community-based residential care facilities typically serve users with relatively stable and chronic mental disorders. Community-based residential care beds have been developed substantially only in Islamic Republic of Iran and Pakistan, and to a lesser extent in Bahrain, Lebanon, Qatar and Saudi Arabia (see Fig. 34). *Mental health atlas 2017* highlights that globally in high-income countries there are 23 residential care beds per 100 000 population, whereas these resources are almost non-existent in low- and middle-income countries. This contrasts with the situation in the Eastern Mediterranean Region, where most group 1 countries have very few or no community-based residential care facilities.

Forensic beds are reported in a minority of countries of the Region: Jordan, Lebanon, Saudi Arabia and Yemen. Child and adolescent beds are present in Bahrain, Egypt, Islamic Republic of Iran, Lebanon, Morocco and Pakistan.

## Duration of inpatient stay

Twelve countries of the Region reported on length of stay (see Fig. 36). Seven countries had relatively few (< 10%) inpatient stays of more than five years. Five countries (Bahrain, Iraq, Lebanon, occupied Palestinian territory and United Arab Emirates) reported a substantial percentage (20–65%) of patients staying over five years.

The distribution of length of stay for group 1 and 2 countries is remarkably similar – 83% staying less than one year, and the remainder dividing equally between stays of 2–5 years and more than five years. The one group 3 country to report this item, Afghanistan, had no admissions longer than one year.

## Involuntary admissions to inpatient mental health facilities

Globally, this indicator suffered from limited data availability and incomplete inputs, which put limits on analysis and reporting. Nine countries of the Region reported on involuntary admissions to mental hospitals. The percentage of involuntary admissions varies from 0% through to 100% (see Fig. 37). Six countries with psychiatric beds in general hospitals reported on involuntary admissions. In four countries (Afghanistan, Egypt, Iraq and Syrian Arab Republic) there were no involuntary admissions to psychiatric beds in general hospitals. In Lebanon and Islamic Republic of Iran there were 12% and 70%, respectively. Two countries with community-based residential facilities reported on involuntary admissions (Qatar and Saudi Arabia), and in both cases there were no involuntary admissions to community-based residential facilities.

## Continuity of care

In order to assess continuity of care – a marker for the quality of the mental health care system – *Mental health atlas 2017* enquired about the proportion of mental health inpatients discharged from hospitals who had been followed-up within one month. For countries of the Region, 65% (11 of 17) reported that more than 50% of discharged inpatients received a follow-up outpatient visit within one month of discharge from hospital (see Table 9), while 29% (5 of 17) reported that 25% or less were followed-up within one month of being discharged from hospital.

In group 1 and group 2 countries, 75% and 78%, respectively, reported more than 50% of patients were followed up within one month (see Fig. 38). While 75% of group 1 countries report that they achieve the standard of more than 75% of patients being followed up within one month, only 11% of group 2 countries achieve this level of continuity. Follow-up within one month is achieved less frequently in group 3 countries, with 75% reporting that 50% or less of discharged patients are followed up within one month.

The overall Eastern Mediterranean Region rate of 65% of countries following up more than 50% of discharged patients within one month is similar to the global rate (62%). However, fewer countries of the Region report achieving more than 75% follow-up, and more report 25% or less follow-up, compared with countries globally.

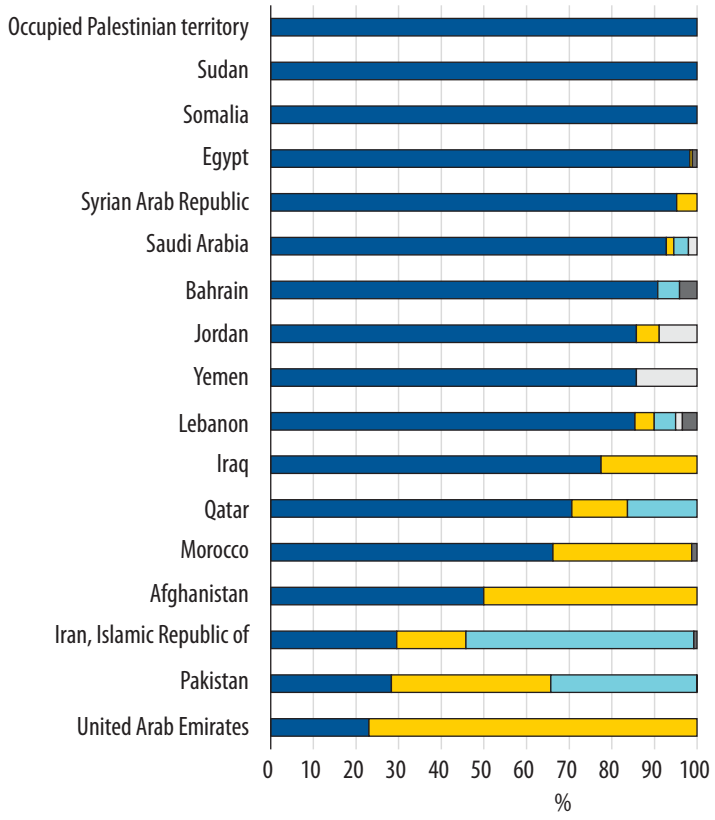
**Table 7.** Adult inpatient care indicators per 100 000 (mental hospital, forensic, psychiatric wards, community residential facilities) for countries of the Region, and medians for country groups, the Eastern Mediterranean Region and globally

| | Facilities per 100 000 population | Beds per 100 000 population | Admissions per 100 000 population |
|---|---|---|---|
| Afghanistan | 0.01 | 0.59 | 27.12 |
| Bahrain | 0.29 | 20.41 | 145.28 |
| Egypt | 0.02 | 7.08 | 14.76 |
| Iran, Islamic Republic of | 0.47 | 28.50 | 204.94 |
| Iraq | 0.07 | 4.51 | 9.29 |
| Jordan | 0.10 | 7.75 | |
| Lebanon | 0.36 | 31.10 | 96.01 |
| Libya | 0.03 | | |
| Morocco | 0.18 | 6.23 | 67.82 |
| Occupied Palestinian territory | 0.04 | 4.07 | 23.96 |
| Pakistan | 0.73 | 8.73 | |
| Qatar | 0.15 | 3.51 | 42.25 |
| Saudi Arabia | 0.11 | 18.45 | 79.30 |
| Somalia | 0.01 | 0.50 | 2.24 |
| Sudan | | 0.81 | |
| Syrian Arab Republic | 0.03 | 5.60 | 16.87 |
| United Arab Emirates | 0.12 | 3.89 | 12.06 |
| Yemen | 0.06 | 4.43 | |
| | | | |
| Group 1 countries | 0.14 (N = 4) | 11.17 (N = 4) | 60.78 (N = 4) |
| Group 2 countries | 0.07 (N = 9) | 6.65 (N = 8) | 23.96 (N = 7) |
| Group 3 countries | 0.04 (N =4) | 0.81 (N=5) | 14.68 (N=2) |
| | | | |
| Eastern Mediterranean Region | 0.10 (N = 17) | 5.60 (N = 17) | 27.12 (N = 13) |
| Global | 0.22 (N = 159) | 16.43 (N = 156) | 99.08 (N = 134) |

**Table 8. Summary of indicators for mental hospitals and psychiatric wards in general hospitals for countries of the Region, country groups, the Eastern Mediterranean Region and globally**

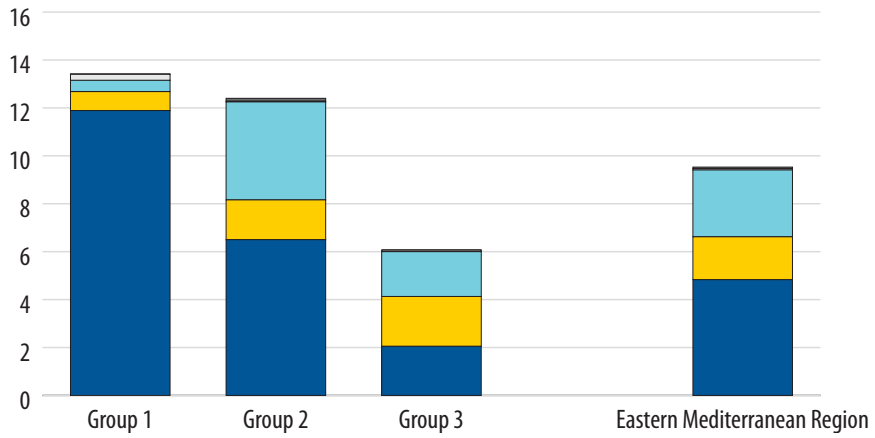
| | Mental hospital facilities per 100 000 | Mental hospital beds per 100 000 | Mental hospital admissions per 100 000 | Psychiatric wards in general hospitals Facilities per 100 000 | Psychiatric wards in general hospitals Beds per 100 000 | Psychiatric wards in general hospitals Admissions per 100 000 |
|---|---|---|---|---|---|---|
| Afghanistan | 0.003 | 0.30 | 7.25 | 0.01 | 0.30 | 19.87 |
| Bahrain | 0.15 | 19.32 | 145.3 | 0 | 0 | 0 |
| Egypt | 0.02 | 7.04 | 14.5 | 0.002 | 0.04 | 0.31 |
| Iran, Islamic Republic of | 0.05 | 8.49 | 123.9 | 0.20 | 4.66 | 81.04 |
| Iraq | 0.01 | 3.49 | 2.23 | 0.06 | 1.01 | 7.06 |
| Jordan | 0.05 | 6.65 | | 0.03 | 0.41 | |
| Lebanon | 0.09 | 27.51 | 54.28 | 0.14 | 1.45 | 40.43 |
| Libya | 0.03 | | 21.24 | 0 | 0 | 0 |
| Morocco | 0.03 | 4.17 | 32.24 | 0.08 | 2.05 | 35.59 |
| Occupied Palestinian territory | 0.04 | 4.07 | 23.96 | 0 | 0 | 0 |
| Pakistan | 0.006 | 2.47 | | 0.42 | 3.27 | |
| Qatar | 0.04 | 2.48 | 42.0 | 0.04 | 0.46 | |
| Saudi Arabia | 0.08 | 17.11 | 78.67 | 0.01 | 0.32 | |
| Somalia | 0.01 | 0.50 | 2.24 | 0 | 0 | 0 |
| Sudan | | 0.81 | | | | |
| Syrian Arab Republic | 0.02 | 5.34 | 11.53 | 0.02 | 0.27 | 5.34 |
| United Arab Emirates | 0.01 | 0.90 | 6.98 | 0.05 | 2.99 | 5.08 |
| Yemen | 0.03 | 3.80 | | 0.03 | | |
| | | | | | | |
| Group 1 | 0.06 (N = 4) | 9.80 (N = 4) | 60.33 (N = 4) | 0.03 (N = 4) | 0.39 (N = 4) | 2.54* (N = 2) |
| Group 2 | 0.03 (N = 9) | 5.99 (N = 8) | 22.60 (N = 8) | 0.03 (N = 9) | 0.41 (N = 9) | 6.20 (N = 8) |
| Group 3 | 0.01 (N = 4) | 0.81 (N = 5) | 4.75* (N = 2) | 0.02 (N = 4) | 0.30 (N = 3) | 9.93* (N = 2) |
| | | | | | | |
| Eastern Mediterranean Region | 0.03 (N = 17) | 4.07 (N = 17) | 22.6 (N = 14) | 0.03 (N = 17) | 0.37 (N = 16) | 5.21 (N = 12) |
| Global | 0.06 (N = 129) | 11.29 (N = 128) | 56.28 (N = 113) | 0.13 (N = 139) | 1.95 (N = 128) | 44.43 (N = 100) |

* Note that only two countries from group 3 reported data on admissions to mental hospitals, and only two countries from groups 1 and 3 reported data on admissions to psychiatric units in general hospitals – therefore these medians have very wide ranges of confidence.




| | United Arab Emirates | Pakistan | Iran, Islamic Republic of | Afghanistan | Morocco | Qatar | Iraq | Lebanon | Yemen | Jordan | Bahrain | Saudi Arabia | Syrian Arab Republic | Egypt | Somalia | Sudan | Occupied Palestinian territory |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mental hospital beds | 0.9 | 2.5 | 8.5 | 0.3 | 4.2 | 2.5 | 3.5 | 27.5 | 3.8 | 6.6 | 19.3 | 17.1 | 5.3 | 7 | 0.5 | 0.8 | 4.1 |
| Psychiatric unit beds | 3 | 3.3 | 4.7 | 0.3 | 2.1 | 0.5 | 1 | 1.5 | | 0.4 | | 0.3 | 0.3 | 0.04 | | | |
| Residential care beds | | 3 | 15.3 | | | 0.6 | | 1.6 | | | 1.1 | 0.6 | | | | | |
| Forensic beds | | | | | | | | 0.5 | 0.6 | 0.7 | | 0.4 | | | | | |
| Child and adolescent beds | | 0.01 | 0.2 | | 0.1 | | | 1.1 | | | 0.9 | | | 0.1 | | | |

**Fig. 34. Distribution of mental health beds in countries of the Region (number of mental health beds per 100 000 population)**




| | Group 1 | Group 2 | Group 3 | Eastern Mediterranean Region |
|---|---|---|---|---|
| Child and adolescent beds | 0.02 | 0.12 | 0.01 | 0.06 |
| Forensic beds | 0.25 | 0.03 | 0.06 | 0.06 |
| Residential care beds | 0.47 | 4.09 | 1.87 | 2.79 |
| Psychiatric unit beds | 0.79 | 1.66 | 2.08 | 1.79 |
| Mental hospital beds | 11.89 | 6.5 | 2.05 | 4.83 |

**Fig. 35.** **Total mental health beds per 100 000 population by country group (calculated as sum of reported beds in all countries divided by the total population at risk – hence different from the medians quoted elsewhere)**

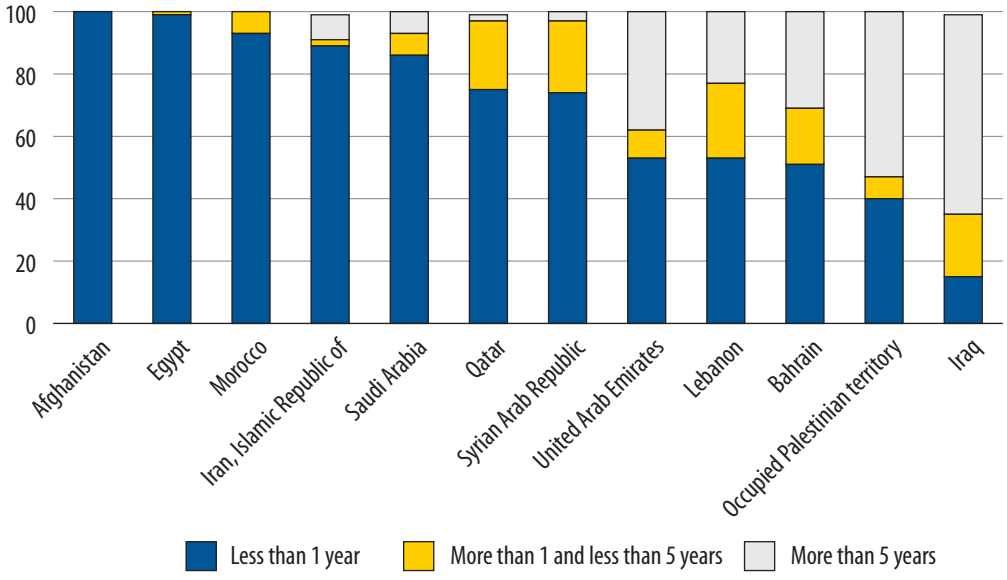



**Fig. 36.** **Duration of stay for countries of the Region**

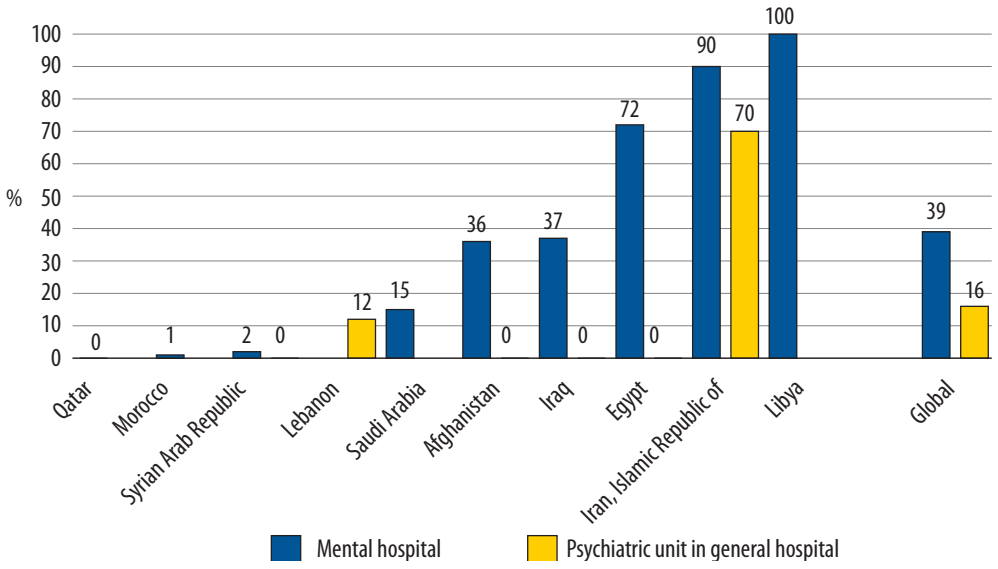



**Fig. 37. Percentage of mental hospital admissions that were involuntary in countries of the Region**

**Table 9. Follow-up of people with mental disorder discharged from hospital in the last year**

| Percentage of discharged inpatients received a follow-up outpatient visit within one month | Country |
|---|---|
| 25% or less | ▪ Lebanon<br>▪ Qatar<br>▪ Sudan<br>▪ Syrian Arabic Republic<br>▪ Yemen |
| 26–50% | ▪ Afghanistan |
| 51–75% | ▪ Egypt<br>▪ Iran, Islamic Republic<br>▪ Iraq<br>▪ Libya<br>▪ Morocco<br>▪ Occupied Palestinian territory<br>▪ Pakistan |
| More than 75% | ▪ Bahrain<br>▪ Jordan<br>▪ Saudi Arabia<br>▪ United Arab Emirates |

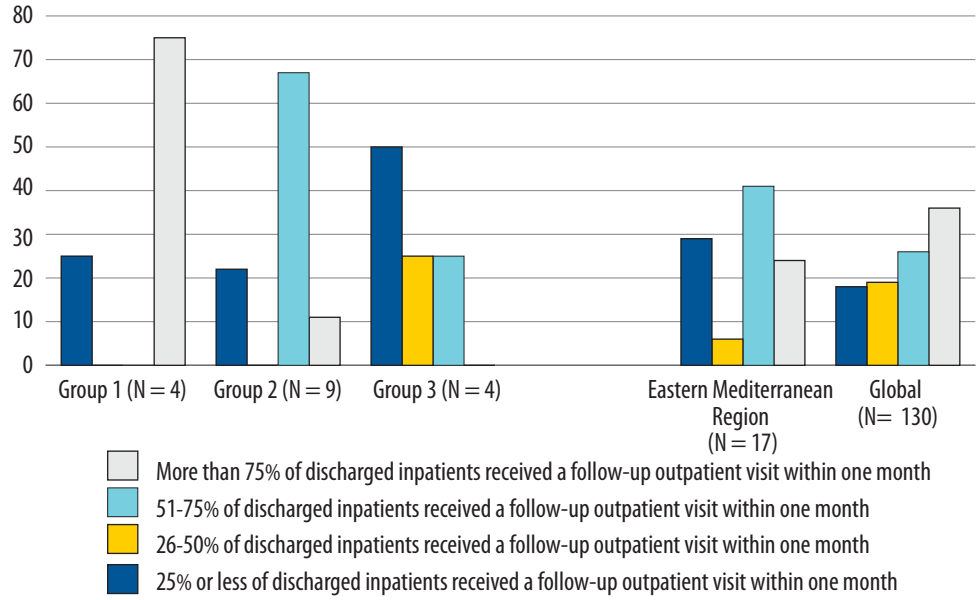



**Fig. 38. Continuity of care: proportion of discharged patients seen within a month in the Region by country group**

## 4.2. Outpatient care

Outpatient care is composed of hospital outpatient departments, mental health outpatient clinics, community mental health centres, and community-based mental health care facilities, including day-care centres. Definitions for these types of facility are provided in Annex 2.

The total reported outpatient visits in countries of the Region varies between 0 and 5114 per 100 000 population (see Table 10). Median numbers of visits are greatest in group 1 countries (877 per 100 000) and lowest in group 3 countries (4 per 100 000) (see Fig. 39). The median number of various types of outpatient facility and outpatient visits per 100 000 population in countries of the Region are half or less than half of those reported globally; this difference is most marked for community-based outpatient facilities and visits. Even group 1 countries reported median numbers of outpatient visits per 100 000 population that are smaller than the global median.

*Mental health atlas 2017* points out that hospital-based outpatient visits are remarkably higher than community-based outpatient visits in the Eastern Mediterranean Region. This does appear to be the case for Afghanistan, Bahrain, Egypt, Qatar, Somalia and United Arab Emirates, but some countries, such as Islamic Republic of Iran, occupied Palestinian territory and Syrian Arab Republic have more community- than hospital-based outpatient visits (see Fig. 40).

Twelve countries of the Region reported that they have mental health outpatient services specifically for children and adolescents (see Table 11). In countries of the Region with CAMHS, the number of child and adolescent mental health outpatient visits varies between 10 and 360 per 100 000. The median number of CAMHS visits is highest in the relatively well-resourced group 1 countries (284 per 100 000), followed by group 2 countries (49 per 100 000), with no visits reported to services specifically for children and adolescents in the poorly resourced group 3 countries. The median of reported CAMHS outpatient visits across all Eastern Mediterranean Region countries of the Region (81 per 100 000) is half of that reported globally (164 per 100 000).

Fourteen countries reported on the number of outpatient facilities in 2014 and 2017. Eleven reported increased numbers of outpatient facilities per 100 000 population, 10 of which were increases of more than 20%. Median percentage increases in outpatient facilities were greatest in group 1 countries (368%, N = 4), followed by group 2 countries (124%, N = 8). There was a reported reduction in outpatient facilities in group 3 countries (-51%, N = 2).

Outpatient visits were reported in 2014 and 2017 by seven countries, all in groups 1 and 2. All seven countries reported increased outpatient visits per 100 000 in 2017, and six countries had increases of more than 20%.[1]

**Table 10. Summary of outpatient care (OP) facility indicators by country, country group, Eastern Mediterranean Region and globally**

| | Adult outpatient facilities per 100 000 | Total adult OP visits per 100 000 | Hospital based OP facilities per 100 000 | Hospital based OP visits per 100 000 | Community OP facilities per 100 000 | Community OP visits per 100 000 |
|---|---|---|---|---|---|---|
| Afghanistan | 0.01 | 124 | 0.003 | 87 | 0.003 | 37 |
| Bahrain | 0.66 | 426 | 0.66 | 426 | 0 | 0 |
| Egypt | 0.02 | 571 | 0.02 | 556 | 0.001 | 6 |
| Iran, Islamic Republic of | 5.24 | 5114 | 0.33 | 1197 | 4.73 | 3906 |
| Iraq | 1.69 | 659 | 0.09 | 307 | 1.59 | 351 |
| Jordan | 0.51 | | 0.27 | | 0.24 | |
| Lebanon | 0.56 | 40 | 0.21 | 19 | 0.34 | 21 |

[1] The countries that reported outpatient visits per 100 000 in 2017 that were more than 20% greater than those reported in 2014 were Egypt, Iran (Islamic Republic of), Iraq, Morocco, occupied Palestinian territory and Qatar. Jordan also reported rates of visits that were 5% greater in 2017 than 2014. Other countries did not report in both 2014 and 2017.

**Table 10. Summary of outpatient care (OP) facility indicators by country, country group, Eastern Mediterranean Region and globally** *(continued)*

| | Adult outpatient facilities per 100 000 | Total adult OP visits per 100 000 | Hospital based OP facilities per 100 000 | Hospital based OP visits per 100 000 | Community OP facilities per 100 000 | Community OP visits per 100 000 |
|---|---|---|---|---|---|---|
| Morocco | 0.34 | 661 | 0.09 | | 0.24 | 661 |
| Occupied Palestinian territory | 0.49 | 3281 | 0.04 | 69 | 0.41 | 3121 |
| Pakistan | 2.30 | | 1.97 | | 0.33 | |
| Qatar | 0.34 | 1299 | 0.27 | 1084 | 0 | 0 |
| Saudi Arabia | 0.45 | 1571 | 0.08 | 1571 | 0.37 | |
| Somalia | 0.01 | 4 | 0.01 | 4 | 0 | 0 |
| Sudan | 0 | 0 | 0 | 0 | 0 | 0 |
| Syrian Arab Republic | 2.18 | 606 | 0.05 | 152 | 2.14 | 454 |
| United Arab Emirates | 0.45 | 454 | 0.11 | 448 | 0.34 | 7 |
| Yemen | 0.06 | | 0.06 | | 0 | 0 |
| | | | | | | |
| Group 1 | 0.45 (N = 4) | 877 (N = 4) | 0.19 (N = 4) | 766 (N = 4) | 0.17 (N = 4) | 0 (N = 3) |
| Group 2 | 0.54 (N = 8) | 659 (N = 7) | 0.09 (N = 8) | 230 (N = 6) | 0.37 (N = 8) | 454 (N = 7) |
| Group 3 | 0.01 (N = 5) | 4 (N = 3) | 0.01 (N = 5) | 4 (N = 3) | 0.00 (N =5) | 0 (N = 4) |
| | | | | | | |
| Eastern Mediterranean Region | 0.45 (N = 17) | 588 (N = 14) | 0.09 (N = 17) | 230 (N = 13) | 0.24 (N = 17) | 21 (N = 14) |
| Global | 0.90 (N = 140) | 1601 (N = 113) | 0.26 (N = 121) | 961 (N = 95) | 0.81 (N = 80) | 1071 (N = 63) |

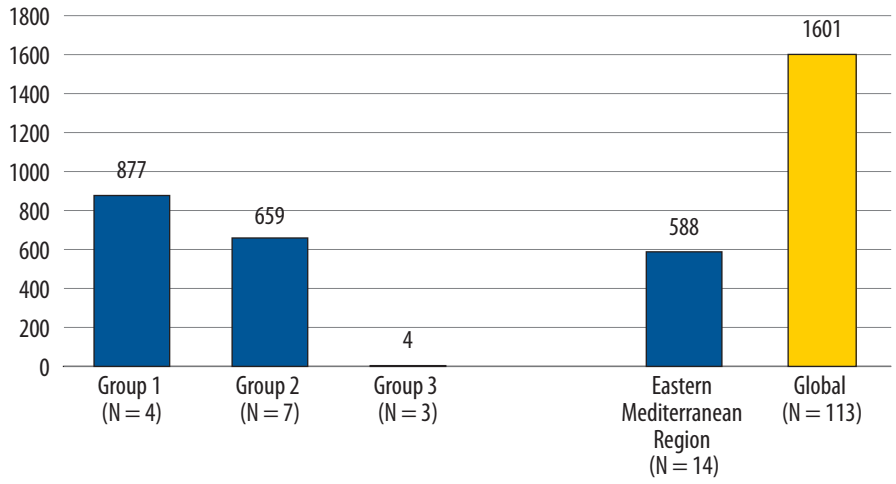



**Fig. 39. Total outpatient visits per 100 000 population by country group, Eastern Mediterranean Region and globally**

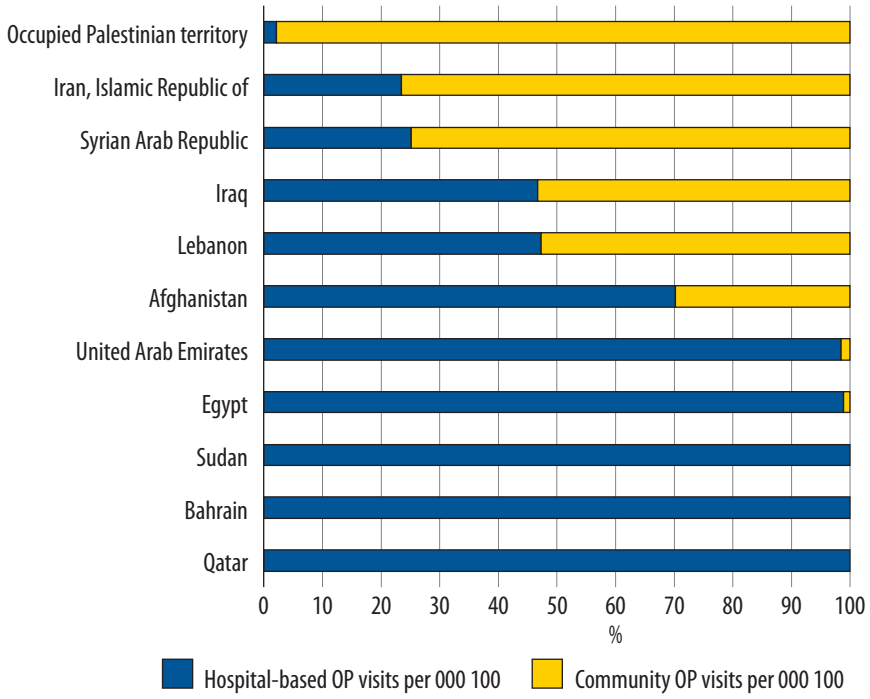



**Fig. 40. Balance of hospital- and community-based outpatient visits for countries of the Region that reported the relevant data (numeric values are outpatient visits per 100 000)**

**Table 11. Summary of child and adolescent mental health outpatient care facilities indicators by country, and medians for country group, Eastern Mediterranean Region and globally**

| | Total child and adolescent mental health outpatient facilities per 100 000 | Total child and adolescent mental health outpatient visits per 100 000 |
|---|---|---|
| Afghanistan | 0 | 0 |
| Bahrain | 1.31 | 360 |
| Egypt | 0.02 | 84 |
| Iran, Islamic Republic of | 0.13 | 79 |
| Iraq | 0.02 | 10 |
| Jordan | 0 | 0 |
| Lebanon | 0.24 | |
| Libya | 0 | 0 |
| Morocco | 0.13 | 20 |
| Occupied Palestinian territory | 0.02 | 241 |
| Pakistan | 0.002 | |
| Qatar | 0.11 | 207 |
| Saudi Arabia | 0.06 | |
| Somalia | 0 | 0 |

**Table 11. Summary of child and adolescent mental health outpatient care facilities indicators by country, and medians for country group, Eastern Mediterranean Region and globally** *(continued)*

| | Total child and adolescent mental health outpatient facilities per 100 000 | Total child and adolescent mental health outpatient visits per 100 000 |
|---|---|---|
| Sudan | 0 | 0 |
| Syrian Arab Republic | 0.08 | 13 |
| United Arab Emirates | 0.08 | |
| Yemen | 0 | 0 |
| | | |
| Group 1 | 0.10 (N = 4 with facilities) | 284 (N = 2 with visits) |
| Group 2 | 0.08 (N = 7 with facilities) | 49 (N = 6 with visits) |
| Group 3 | 0.02 (N = 1 with facilities) | No visits |
| | | |
| Eastern Mediterranean Region | 0.08 (N = 12 with facilities) | 81 (N = 8 with visits) |
| Global | | 164 |

## 4.3. Treated prevalence

Treated prevalence refers to the proportion of people with mental disorders served by mental health systems. The number of people per 100 000 population who received care for mental disorders in the various types of mental health facility (outpatient facilities, day care facilities, psychiatric wards in general hospitals and mental hospitals) over the previous year can serve as a proxy for treated prevalence in specialist mental health care services.

To achieve a better completion rate of this important indicator, the questionnaire was modified in 2017 to ask about depression instead of moderate to severe depression. The two other mental disorders included in the questionnaire were psychosis and bipolar disorder.

Twelve countries of the Region responded to this section of the atlas 2017 questionnaire: 50% of these used national data, while 25% used regional data, and the remaining 25% used data from specific sites/localities. To report on service utilization for these three mental disorders, 92% of reporting countries used routine health information systems and 8% used periodic survey data. Eight countries provided comprehensive data on all three disorders covering inpatient, outpatient and total treated prevalence, three countries provided inpatient data, and one country provided comprehensive data on non-affective psychosis and depression only.

Reported rates of treated prevalence of severe mental disorders (non-affective psychosis, bipolar disorder and depression) vary greatly between individual countries of the Region (see Table 12). To some extent this is accounted for by differences in resources as shown by the higher rates in group 1 than group 2, and lowest rates in group 3 countries (see Fig. 41).

The median treated prevalence of non-affective psychosis in the Region is 74.8 per 100 000. This is less than half of the global median treated prevalence. Within the Region, treated prevalence of non-affective psychosis is highest in better-resourced group 1 countries (235.6 per 100 000) than in group 2 countries (74.8 per 100 000). No group 3 countries were able to provide data on total treated prevalence. Median treated prevalence in group 1 countries in the Region is greater than the global median.

The median treated prevalence of bipolar disorder in the Region is the lowest of the three disorders at 17.4 per 100 000. This is also less than half of the global median treated prevalence. Within the Region, treated prevalence of bipolar disorder is highest in better-resourced group 1 countries (164 per 100 000). Median treated prevalence in group 1 countries in the Region is considerably more than that found globally.

The median treated prevalence of depression in the Region is 91.0 per 100 000. This is similar to the global treated prevalence. Unlike other mental disorders,

the treated prevalence of depression is not highest in the better-resourced countries, but is similar in group 1 and 2 countries.

Table 12 also shows that the vast majority of patients with severe mental disorders in countries are treated as outpatients: 84% of people with non-affective psychosis and bipolar disorder are treated as outpatients, and 97% of people with depression are treated as outpatients.

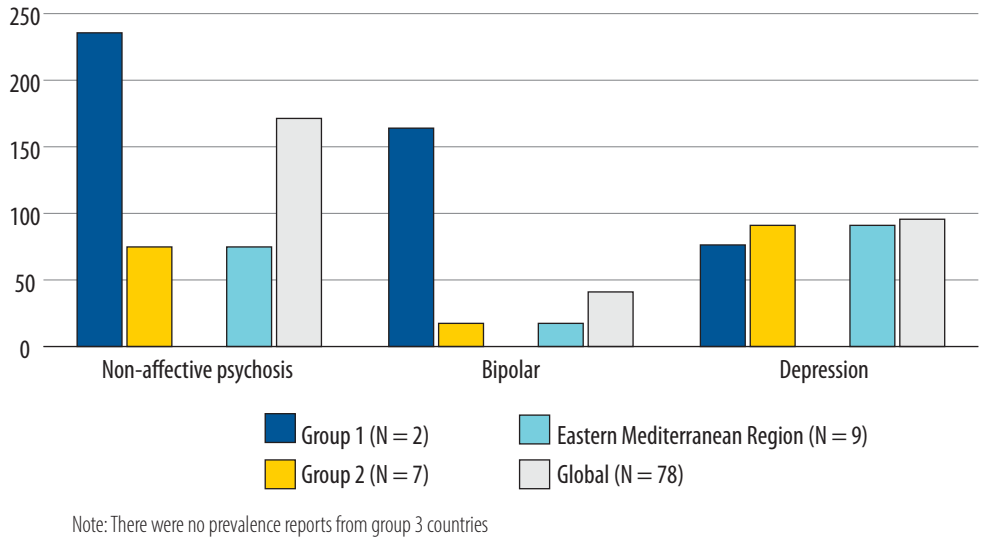
**Table 12. Treated prevalence of severe mental disorders in specialized mental health services per 100 000 population for countries of the Region by country group (median), and for the Eastern Mediterranean Region (median) and globally (median)**

| | Non-affective psychosis | | | Bipolar disorder | | | Depression | | |
|---|---|---|---|---|---|---|---|---|---|
| | Inpatient mental health services | Outpatient mental health services | Total | Inpatient mental health services | Outpatient mental health services | Total | Inpatient mental health services | Outpatient mental health services | Total |
| Afghanistan[3] | 2.0 | | | 0.5 | | | 1.0 | | |
| Bahrain[1] | 6.6 | | | 10.5 | | | 0.9 | | |
| Egypt[1] | 7.3 | 10.4 | 17.6 | 2.9 | 7.1 | 10.0 | 2.2 | 14.2 | 16.4 |
| Iran, Islamic Republic of[1] | 50.6 | 88.6 | 139.2 | 120.3 | 12.7 | 132.9 | 6.3 | 208.9 | 215.2 |
| Iraq[2] | 1.6 | 55.9 | 57.5 | 0.7 | 16.6 | 17.3 | 2.0 | 54.9 | 56.9 |
| Lebanon[3] | 9.5 | 27.2 | 36.7 | 0.2 | 0.8 | 1.0 | 17.8 | 26.6 | 44.5 |
| Morocco[1] | 70.7 | 128.4 | 199.2 | 5.0 | 96.4 | 101.4 | 1.5 | 167.5 | 169.0 |
| Occupied Palestinian territory[2] | 47.8 | 1506.6 | 1554.4 | | | | 37.0 | 539.1 | 576.1 |
| Qatar[1] | 4.2 | 0.0 | 4.2 | 8.6 | 0.0 | 8.6 | 6.1 | 11.6 | 17.7 |
| Saudi Arabia[1] | 26.7 | 440.2 | 466.9 | 6.2 | 313.2 | 319.4 | 3.1 | 131.8 | 134.9 |
| Syrian Arab Republic[2] | 12.0 | 62.8 | 74.8 | 0.7 | 16.7 | 17.4 | 3.0 | 88.0 | 91.0 |
| United Arab Emirates[3] | 21.6 | | | 3.9 | | | 3.0 | | |
| | | | | | | | | | |
| **Group 1 (N = 2–4)** | 14.1 | 220.1 | 235.6 | 6.2 | 156.6 | 164.0 | 3.1 | 71.7 | 76.3 |
| **Group 2 (N = 6–7)** | 12.0 | 62.8 | 74.8 | 1.8 | 14.6 | 17.4 | 3.0 | 88.0 | 91.0 |
| **Group 3 (N = 1)** | 2.0 | - | - | 0.5 | - | - | 1.0 | - | - |
| | | | | | | | | | |
| Eastern Mediterranean Region (9–12) | 10.8 | 62.8 | 74.8 | 3.9 | 14.6 | 17.4 | 3.0 | 88.0 | 91.0 |
| Global | | | 171.3 | | | 41.0 | | | 95.6 |

[1] National level (the total population of the country)

[2] Regional/provincial level (the total population of one or more regions/provinces)

[3] Specific sites/localities (local areas where the data are available or have been collected)




Note: There were no prevalence reports from group 3 countries

**Fig. 41. Total treated prevalence of severe mental disorders in specialised mental health services, median per 100 000 population by Eastern Mediterranean Region country group**

## 4.4 Social support

Social support refers to monetary/non-monetary welfare benefits from public funds that may be provided as part of a legal right to people with health conditions that reduce a person's capacity to function. In atlas 2017, Member States were requested to report on the availability of government social support for persons with mental disorders and to include specifically persons with a mental disorder who are officially recorded/recognized as being in receipt of government support (such as disability payments or income support). Member States were requested to exclude from this reporting persons with a mental disorder who are in receipt of monetary/non-monetary support from family members, local charities and other nongovernmental organizations.

Eastern Mediterranean Region countries reported the whole range of levels of provision of support, from the majority of persons with severe and non-severe mental disorders receiving social support through to none receiving any social support (see Table 13). Most group 1 countries (with the highest levels of resources) provide support to the majority of persons with both severe and at least some persons with non-severe mental disorders, while group 3 countries (those with the least resources) provide social support to no or few persons with severe mental disorders (see Fig. 42). Most group 2 countries lie between these two extremes, and government social support is provided to at least some and usually the majority of people with severe mental disorders. The availability of government social support for persons with severe and non-severe mental disorders in the Region as a whole is distributed in a broadly similar pattern to the rest of the world, although there are somewhat higher percentages of countries where no or few persons with mental disorders who receive government support than in the rest of the world.

In terms of the specific types of government support provided, fewer countries in the Region provide all types of support, except housing support, than countries in the rest of the world (see Fig. 43). The percentage of countries providing social care support is 29% lower among countries of the Region than in the rest of the world. The percentages of countries of the Region providing income support, employment support, legal support, family support and other support are all at least 10% lower than the rest of the world.

**Table 13. Provision of social support for persons with mental disorders by country of the Region**

| Provision of support for persons with mental disorders | Country |
|---|---|
| No persons with mental disorders receive social support from the government | Pakistan<br>Sudan<br>Yemen |
| Few or some persons with severe mental disorders receive social support from the government | Afghanistan<br>Egypt<br>Lebanon<br>Morocco<br>Qatar<br>Syrian Arab Republic |
| The majority of persons with severe mental disorders receive social support from the government | Iraq<br>Occupied Palestinian territory |
| The majority of persons with severe mental disorders, and also some with non-severe mental disorders, receive social support from the government | Bahrain<br>Iran, Islamic Republic of<br>Libya |
| The majority of patients with severe and non-severe mental disorders receive social support from the government | Jordan<br>Saudi Arabia<br>United Arab Emirates |

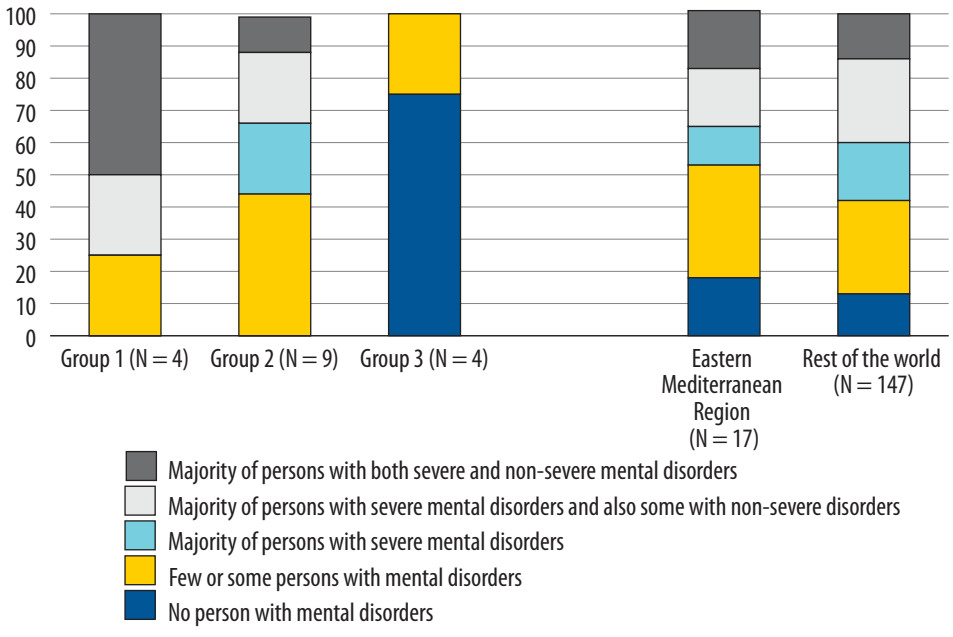



**Fig. 42. Availability of government social support for persons with severe and non-severe mental disorders by country group, in the Eastern Mediterranean Region, and in the rest of the world**

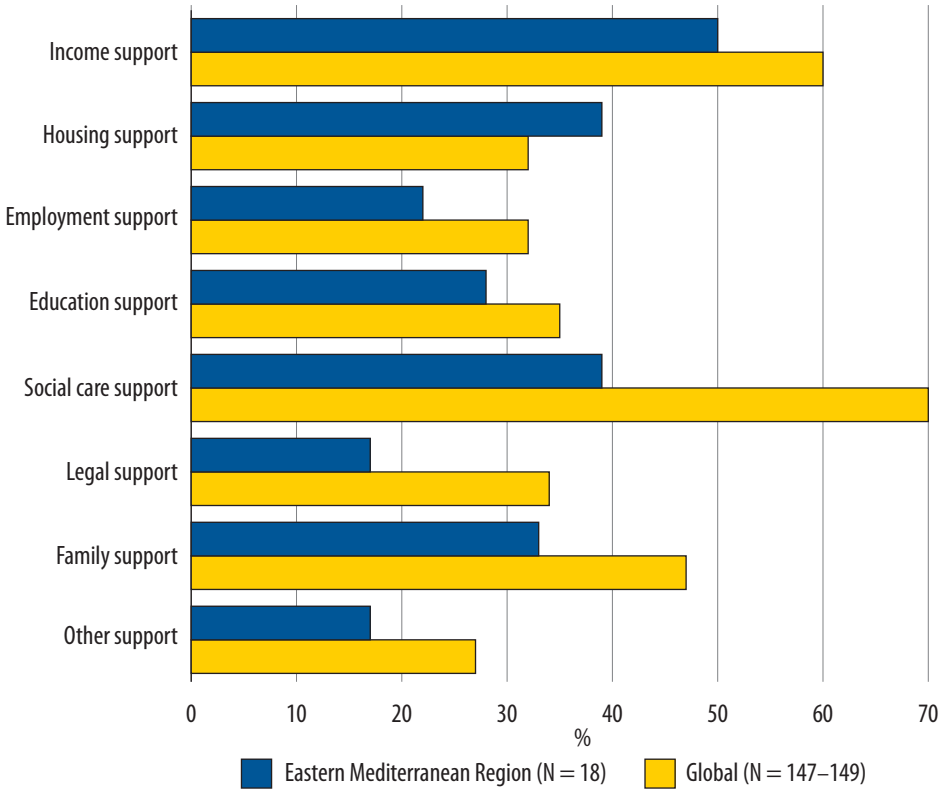



**Fig. 43.** **Main types of government and social support provided for persons with severe mental disorders in the Eastern Mediterranean Region and the rest of the world**

# 5. Mental health promotion and prevention

## 5.1. Mental health promotion and prevention programmes

In *Mental Health Action Plan 2013–2020*, WHO recommends that Member States lead and coordinate a multisectoral strategy that combines universal and targeted interventions for: promoting mental health and preventing mental disorders; reducing stigmatization, discrimination and human rights violations; and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.

The inclusion of mental health in the Sustainable Development Agenda, which was adopted at the United Nations General Assembly in September 2015, added greater importance to Objective 3 of the Action Plan. Goal 3 of the Sustainable Development Goals (SDGs) is to ensure healthy lives and promote well-being for all, at all ages. Among the targets of Goal 3, Target 3.4 is to reduce by one third premature mortality from noncommunicable diseases by 2030, through prevention and treatment, and promote mental health and well-being. Within Target 3.4, the suicide rate is an indicator (3.4.2). Objective 3 of the *Mental Health Action Plan 2013–2020* concerns the implementation of strategies for promotion and prevention in mental health, including prevention of suicide and self-harm. The Global Target 3.1 is for 80% of countries to have at a least two functioning national, multisectoral promotion and prevention programmes in mental health (by the year 2020).

In *Mental health atlas 2017*, to be considered "functional", a programme needed to have at least two of the following three characteristics: a) dedicated financial and human resources; b) a defined plan of implementation; and c) evidence of progress and/or impact. Programmes which did not meet this threshold, or which were evidently related to treatment or care, were excluded from the analysis.

A total of 46 functioning programmes were reported in the Eastern Mediterranean Region (the atlas questionnaire allowed countries to report a maximum of five programmes) (see Fig. 44). Overall, 16 countries of the Region reported at least one mental health promotion and prevention programme, and 13 (59% of all) countries reported at least two functioning mental health promotion and prevention programmes. Eight (36% of all) countries have two or more programmes functioning with a national scope. The percentage of all countries reporting two or more functional programmes of any scope from each country group was: group 1 = 66% (N = 6), group 2 = 70% (N = 10), and group 3 = 33% (N = 6).

Promotion and prevention programmes were categorized according to their geographical scope (national, regional, district, and community) and their ownership/management (government, nongovernmental organization, private, or jointly managed). As in the rest of the world, the majority (67%) of programmes in countries of the Region were national programmes. The remainder were regional (7%), district (11%) and community (15%) in scope. Governments manage 46% of prevention and promotion programmes in countries of the Region, compared with 69% in the rest of the world, while 33% of programmes are jointly managed and 22% are managed by nongovernmental organizations, both higher proportions than in the rest of the world.

The highest proportion of programmes (35%) were mental health awareness/anti-stigma/human rights protection programmes (see Fig. 45). These were followed by similar proportions of programmes aimed at violence prevention, early childhood development/stimulation, parental/maternal mental health promotion, and school-based mental health promotion (11–15%). The least frequent types of programme were suicide prevention (7%), workplace mental health promotion (4%), and others, such as for refugees (2%). These percentages are all within the 8% of those found in the rest of the world, although it is worth noting that there are higher percentages of violence prevention, early childhood development/stimulation, paternal/maternal health promotion, and school-based mental health promotion, and fewer mental health awareness/anti-stigma/human rights, suicide prevention, workplace and other programmes in the Region compared with the rest of the world.

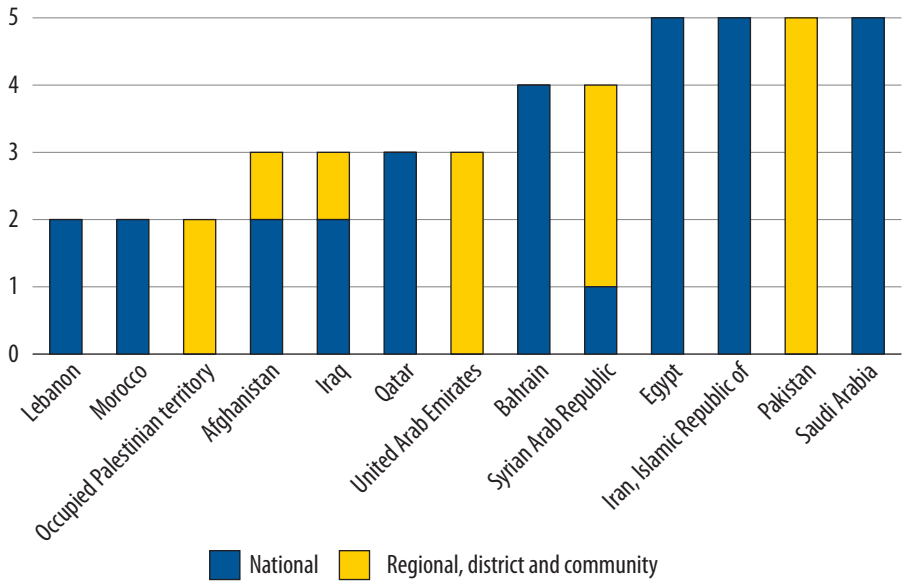



**Fig. 44. Number and scope of functioning promotion and prevention programmes in countries of the Region**

* Jordan, Libya and Oman reported promotion and prevention programmes but are not included because they do not meet the criteria for functioning programmes.

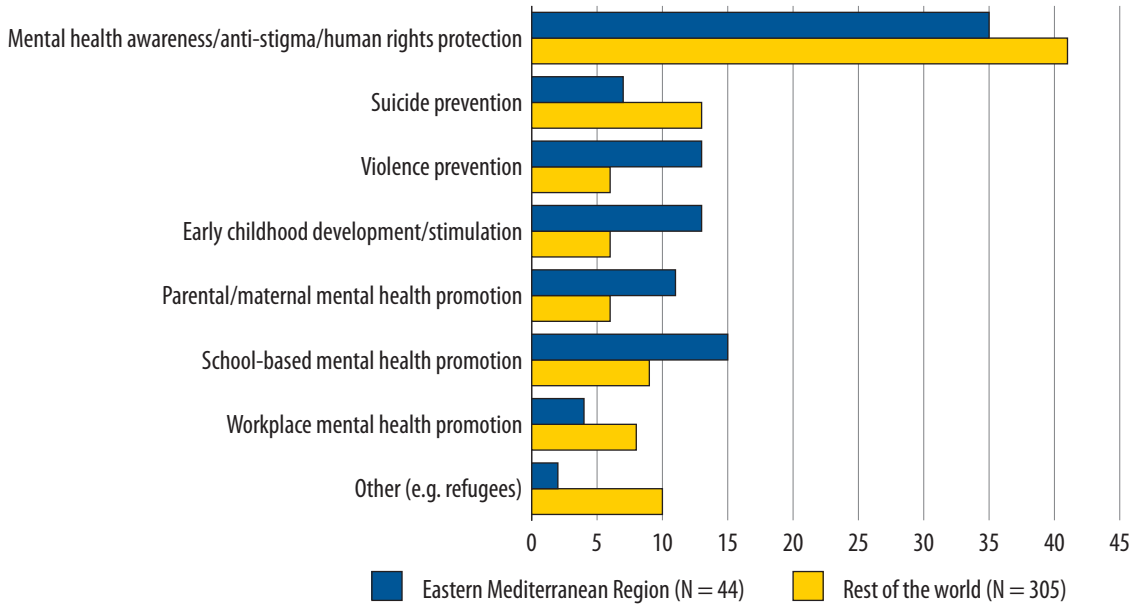



**Fig. 45. Type/main focus of promotion and prevention programmes in the Eastern Mediterranean Region and the rest of the world**

# 5.2. Suicide prevention

## Suicide prevention strategy

A particular prevention priority in the area of mental health concerns suicide, which accounted for an estimated 793 000 deaths in 2016 *(9)*. Target 3.2 of the *Mental Health Action Plan 2013–2020* calls for a 10% reduction in the rate of suicide by 2020. The United Nations SDGs include Target 3.4 to address noncommunicable diseases and mental health, with an indicator to reduce suicide mortality by a third by 2030.

Two (11%) of 19 reporting countries in the Eastern Mediterranean Region have a national suicide prevention strategy (as a stand-alone document or as an integrated element of the national policy/plan adopted by government). Afghanistan and Islamic Republic of Iran have both published their suicide prevention strategies since 2015. This rate of 11% is considerably lower than that the rest of the world, where 41% (63 of 154) of reporting countries have national suicide prevention strategies, most of which had been updated in the previous five years (since 2013).

## Suicide rate

Given weak vital registration systems in many countries, and the known problem of the underreporting of suicide as a cause of death, the most consistent and reliable estimates for baseline rates of suicide in different regions of the world come from the WHO global report on suicide *(7)*. The global age-standardized rate of suicide in 2012 was estimated to be 11.4 per 100 000 population; this provided the best available baseline value against which to measure progress towards reducing the suicide rate over the period of the Mental Health Action Plan.

Fig. 46 shows age-standardized suicide rates in the Eastern Mediterranean Region in 2016, available from the WHO Global Health Estimates *(9)*. There is a wide range of estimated suicide rates across countries of the Region, from the lowest rate of 1.9 per 100 000 in the Syrian Arab Republic through to the highest of 8.5 per 100 000 in Yemen. There is a trend for suicide rates to be higher in group 3 (median of 4.7 per 100 000) than in group 1 and 2 countries (medians of 3.9 and 3.3 per 100 000, respectively) (see Fig. 47). The overall median estimated age-standardized suicide rate in the Eastern Mediterranean Region (3.9 per 100 000) is less than half the global rate (10.5 per 100 000).

Previous estimated age-standardized suicide rates reported in the Global Health Observatory suggest that there has been a reduction in the median suicide rate from 5.4 to 3.9 per 100 000 in the Eastern Mediterranean Region since 2010 (see Fig. 48). Reductions in estimated suicide rate of more than 10% between 2011 and 2017 have been estimated for Afghanistan, Bahrain, Iraq, Islamic Republic of Iran, Jordan, Libya, Morocco, Oman, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

Member States were also requested to report on the source and availability of suicide data as part of their information systems. As noted earlier (see Fig. 3), more than half of countries in the Region self-reported at least periodic/regular reporting of the suicide mortality rate in the last year.

The responsible body for ascertainment of suicide is summarized in Fig. 49. As in the rest of the world, this was most commonly the medico-legal authorities (56%). In the Eastern Mediterranean Region, the remainder divided between coroner (19%) and police (25%).

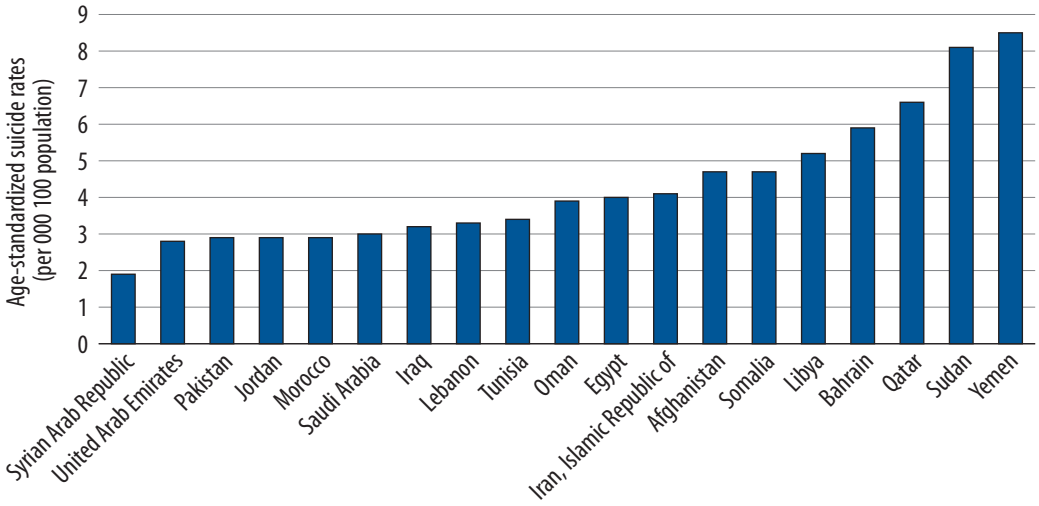



**Fig. 46.** Age-standardized suicide rates (per 100 000 population) for countries of the Eastern Mediterranean Region

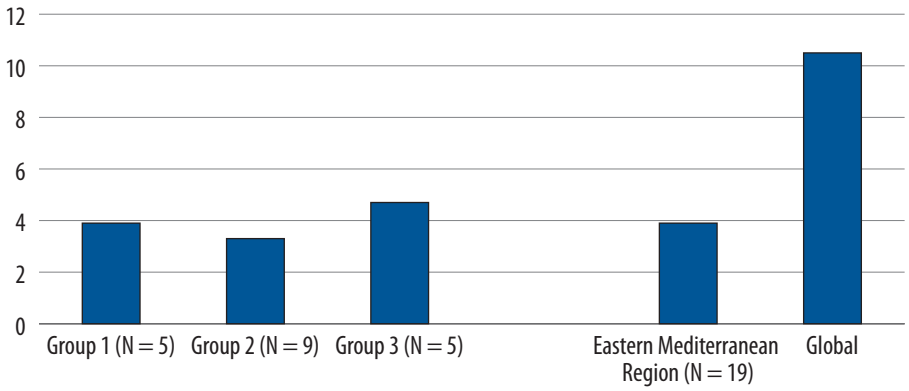



**Fig. 47.** Median age-standardized suicide rates per 100 000 population for country groups, the Eastern Mediterranean Region and globally

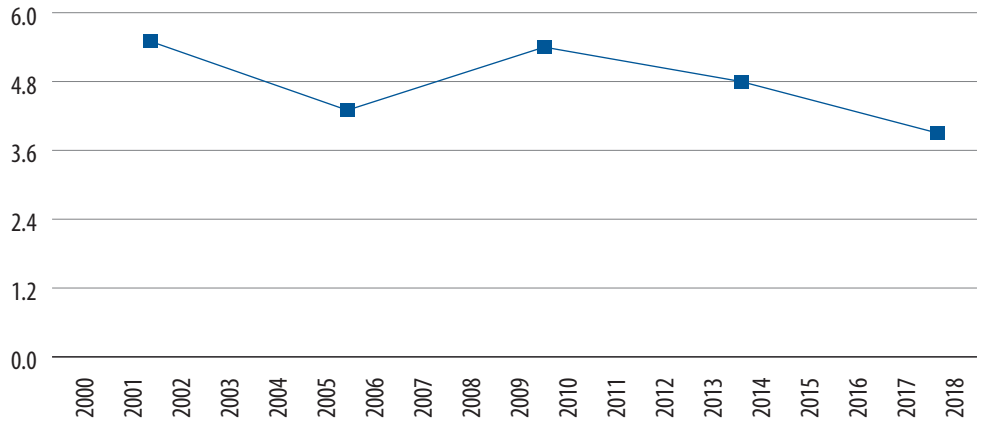



**Fig. 48.** Median age-standardized suicide rate in the Eastern Mediterranean Region per 100 000 since 2000, as reported on the Global Health Observatory

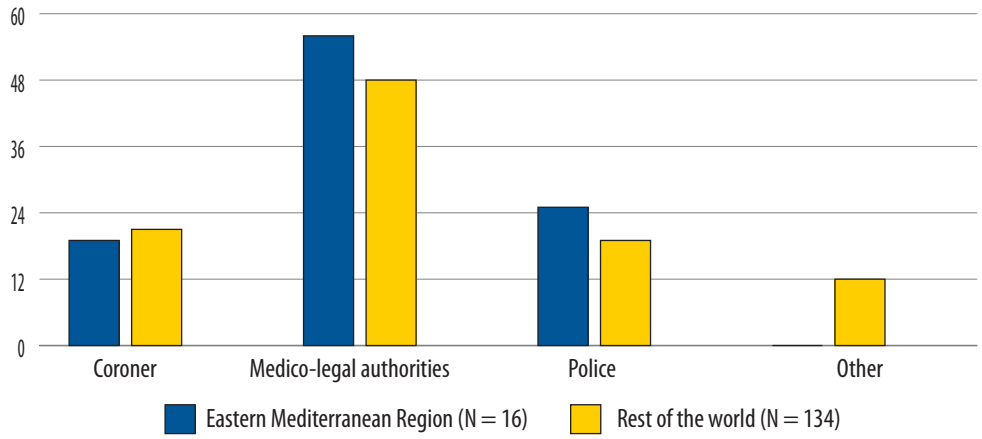



**Fig. 49.** **Responsible body for ascertainment of suicide in the Eastern Mediterranean Region and the rest of the world**

# Discussion

Nineteen countries in the Eastern Mediterranean Region submitted data for *Mental health atlas 2017*. These countries all submitted basic data on plans and legislation, but there were gaps for more detailed information (such as meeting the criteria for international human rights), and for other more demanding indicators, such as finances, service use and suicide. Some items were only answered by a minority of countries. This limits the confidence and scope of analysis, and poses particular problems for comparisons over time when different countries have provided data in 2017 to those that provided the same data in 2014. It also means that examination of the extent to which progress has been made towards the targets of the *Mental Health Action Plan 2013–2020* may underestimate the real state of achievement, because if it has not been reported on, it has been assumed that the target has not been met.

Many countries in the Eastern Mediterranean Region have been active in revising their mental health policies and plans since 2013, and these new policies and plans have been more compliant with international human rights. However, there remain concerns about the ability of some countries to implement their mental health plans, since less than half have an allocated budget. Most plans have indicators or targets against which to monitor their implementation, although not all of these are always used to monitor progress. Successful implementation of mental health plans is usually also a collaborative process. It is noteworthy that countries with more formal collaboration in place have met more Action Plan targets.[1] Among the six countries with two or fewer formal collaborative partnerships, five (83%) have met fewer than three targets, while among the 13 countries with three or more collaborative partnerships only one (8%) has met fewer than three targets. Collaboration with service user and family caregiver advocacy groups is particularly infrequent, compared with the rest of the world.

As in 2014, the majority of countries in the Region could not provide specific data on mental health spending, which raises a concern that there may not be specific budgets for mental health. Together, these suggest that there is scope for some countries to strengthen governance to provide a clear framework, formal collaboration (including with service user and family caregiver advocacy groups), and funding for implementation of their mental health policies and plans.

The majority of countries have reoriented their general health policies towards universal health coverage, and therefore need to address which services are covered and issues of financial protection. This is particularly relevant for the eight countries that do not include persons with major mental disorder in their national health insurance or reimbursement schemes, including four countries with mainly out-of-pocket payment for services and medicines. Full coverage with no out-of-pocket expenses is not a realistic prospect, particularly for group 3 countries, but covering the full population with a defined set of packages of care with at least 80% of direct costs covered may be manageable, and would significantly reduce the risk of catastrophic health care expenditure.

The Eastern Mediterranean Region accounts for a disproportionately large proportion of the global total number of reported mental health training courses for general health staff. However, this is almost entirely due to the remarkable investment in training made by Islamic Republic of Iran, combined with underreporting from other countries globally. Islamic Republic of Iran is a beacon not just for the Region, but for the rest of the world, in its commitment to, and organization of, training. Like Afghanistan, Bahrain, Qatar and Syrian Arab Republic, Islamic Republic of Iran has trained more than 5% of its nurses and more than 1% of its doctors, but the majority of its training courses have been for other health care workers. A substantial number of courses have also been delivered in Afghanistan and Syrian Arab Republic, the former demonstrating what can be achieved in countries with limited resources. The vast majority (99%) of training courses were for single discipline groups, and countries could consider whether there are additional benefits from multidisciplinary training.

It is difficult to track mental health workforce numbers with confidence because of different reporting in the different versions of the mental health atlas and small group sizes. Nevertheless, the data suggest that the workforce is growing in the Region and in countries of all three country groups. This is encouraging, although the overall figures conceal reductions in the mental health workforce in individual countries caused by socio-political or economic factors (for instance, the insurgency in Iraq has resulted in a reduced mental health workforce).

Median rates of mental health facilities and beds per 100 000 population are generally lower in the

[1] Mental Health Action Plan 2013–2020 targets are discussed in more detail in the following section.

Eastern Mediterranean Region than in the rest of the world. Even group 1 countries have median rates for most inpatient and outpatient facilities that are lower than the median for the rest of the world. Even more striking is the gradation in service provision, treated prevalence and provision of social support between well-resourced and poorly-resourced countries within the Region. There are large variations in mental health facilities: group 3 countries have the lowest median rates of inpatient and outpatient facilities and beds, while group 1 countries have the highest. Child and adolescent mental health provision is also lower than globally, and particularly so in group 3 countries.

As expected, because of the fewer facilities, the Region has lower overall treated prevalence rates for severe mental disorders than global medians, and group 3 countries have lower treated prevalence rates than group 1 countries. The median treated prevalence rates reported from group 1 countries for non-affective psychosis, bipolar disorder and depression, are of a similar order to the global medians. The median treated prevalence for depression in group 2 and 3 countries is between half and three quarters of that reported globally. Only one group 3 country was able to report on inpatient treated prevalence rates, and the rates reported were extremely low in comparison to group 1 and 2 countries. Social support for persons with mental disorders is provided to people with severe and non-severe disorders in most group 1 countries, while no person with mental disorder receives social support in most group 3 countries. There are some examples of countries with limited resources achieving more substantial provision, such as Pakistan's hospital and community-based outpatient facilities and its follow-up of discharged inpatients, along with its balance between mental hospital, psychiatric unit in general hospital and community residential facility beds. However, these are exceptions rather than the rule.

Just over half of countries of the Region, including countries from all three country groups, have developed functioning mental health prevention or promotion programmes. However, only one group 3 country has functioning programmes at the national level. Countries with successful prevention or promotion programmes at district or regional level could consider extending their scope to cover more of the population at national level. For the 40% of countries of the Region that did not report having prevention and promotion programmes, this remains an important opportunity for mental health improvement.

Suicide prevention programmes have been adopted by only two countries of the Region; a much lower proportion of countries than in other parts of the world. Estimated age-standardized suicide rates per 100 000 population are lower in the Region than elsewhere, although it is difficult to achieve accurate estimates where suicide is criminalized and underreported. This remains an area for development in the Region using strategies that respect the social, religious and cultural aspects of suicide and suicide reporting.

# Progress against the targets of the *Mental Health Action Plan 2013–2020*

The mental health atlas is being used to monitor progress on the targets and indicators identified in the *Mental Health Action Plan 2013–2020*. In the final section of this review, the extent to which the Eastern Mediterranean Region measures up in 2017 against the six global targets for 2020 is examined (also see Table 1).

## *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 2020)*

Fifteen (68% of all) Eastern Mediterranean Region countries have updated their mental health policies/plans in the past five years. Between 2014 and 2017, there has been a substantial increase in the percentage of countries in the Region that are compliant with all five indicators of compliance with international human rights instruments. For each indicator, the percentage of compliant countries has risen by 9–22%. Nevertheless, only 10 countries reported that their mental health policies/plans are in line with all five international human rights standards.[1] This is 53% of those reporting, or 45% of all countries in the Region. Since 2014, the number of countries meeting all five standards has increased by three (it was seven in 2014). If the target of 80% is to be achieved in the Region, policies/plans need to be updated in line with human rights instruments in at least eight more countries by 2020. Ongoing leadership is required to ensure that these policies/plans are properly resourced and implemented.

## *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 2020)*

While 14 countries of the Region have mental health legislation (either stand-alone or integrated into other legislation), as with policy this is often not compliant with some or all international human rights instruments. In 2017, eight[2] countries of the Region, which is 42% of those reporting or 36% of all the countries in the Eastern Mediterranean Region, reported compliance with all five measured components of human rights instruments. If the target of 50% is to be achieved in the Region, mental health legislation in line with human rights instruments needs to be updated and enacted in at least three more countries of the Region, along with the appropriate governance to ensure that mental health laws are implemented.

## *Global Target 2. Service coverage for severe mental disorders will have increased by 20% (by 2020)*

In 2014, it was recognized that it was difficult to establish a baseline for service coverage. First, because the denominator for calculating coverage was the total population at risk, rather than the total population in need. Second, data on the number of treated persons with severe mental disorders were not available for many countries. In 2017, 12 countries of the Region were able to provide some data on service coverage and nine provided data on outpatient coverage. Three countries provided data on the number of persons with severe mental disorders who received mental health care in both 2014 and 2017, and only one country provided both inpatient and outpatient coverage data in both 2014 and 2017. Since increasing service coverage is most likely to be achieved mainly by increasing outpatient coverage, there is only one country (Iraq) that provided data that would allow a comparison between rates of coverage in 2014 and 2017. However, the rate of service utilization reported from Iraq actually fell between 2014 and 2017, due to disruption of mental health services during the insurgency crisis.

In the absence of coverage data to compare between 2014 and 2017, it is informative to look for a proxy measure. Outpatient facilities and visits can give an indication of changes in coverage – in particular, more outpatient visits suggests greater coverage. Outpatient facilities were reported in 2014 and 2017 by 14 countries and visits by six countries of the Region. Outpatient facilities increased by more than

[1] The 10 countries that reported compliance of mental health policy/plans with all five international human rights instruments were Bahrain, Islamic Republic of Iran, Jordan, Lebanon, Pakistan, occupied Palestinian territory, Qatar, Syrian Arab Republic, Tunisia, and United Arab Emirates.

[2] The eight countries that reported compliance of mental health legislation with all five international human rights instruments were Afghanistan, Bahrain, Islamic Republic of Iran, Lebanon, Morocco, Pakistan, Qatar and United Arab Emirates.

20% in 10 (45% of all) countries. Outpatient visits per 100 000 increased by more than 20% in five (23% of all) countries.

### *Global Target 3.1. 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by 2020)*

Based on the responses for *Mental health atlas 2017*, 13 countries of the Region have two or more functioning mental health promotion or preventions programmes. However, some of these are regional or district level programmes. When only national level programmes are counted, nine countries have two or more national mental health promotion and prevention programmes. To meet the target by 2020, the existing nine countries with two or more programmes must continue to have eligible programmes, and a further nine countries of the Region 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 2020)*

This target requires a baseline against which to measure progress towards a 10% reduction by 2020. This is problematic given the weak vital registration systems in many countries of the world. In *Mental health atlas 2014*, only five Eastern Mediterranean Region countries reported rates of suicide, with a median of 1.6 suicides per 100 000 per year. However, those reported rates may have underestimated the true suicide rate due to possible underreporting for social, religious and cultural reasons. The most reliable and consistent estimates of the baseline rate of suicide in different regions of the world comes from the Global Health Observatory and the 2014 WHO global report on suicide *(7)*. These indicate a reduction in median suicide rate for the Eastern Mediterranean Region from 5.4 to 3.9 per 100 000 between 2010 and 2015, which is a 28% reduction. Fifteen countries in the Region, which is 79% of those with estimated suicide rates in 2010 and 2017 had reductions of more than 10%.

### *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 2020)*

A total of 14 countries (64% of all) of the Eastern Mediterranean Region self-reported that mental health data have been compiled and reported, either separately or as part of the general health statistics in the last two years. An assessment of countries' ability to report on a defined set of five core mental health indicators made by examining data submitted for *Mental health atlas 2017*, found that 14 countries (64% of all) of the Region reported on all five of these items – the same number as self-reported. The addition of a sixth key indicator to the defined core set, service utilization for certain severe mental disorders, reduces the number of countries able to report to 12 (or 55% of all) countries of the Region. Group 1 countries self-reported automatic/continuous/periodic/regular reporting of most indicators, while countries with lower levels of resources are less able to achieve comprehensive reporting. If the target of 80% of all countries of the Region reporting every two years is to be met, then at least four more countries need to report a core set of mental health indicators every two years.

## Individual countries

The extent to which individual countries have met the targets set out in the *Mental Health Action Plan 2013–2020* is shown in Table 14. The ticks indicate countries that have reported information indicating that they have fully met the target or its proxy. Some countries that did not fully complete the whole *Mental health atlas 2017* questionnaire may have met more targets in reality, but did not submit the relevant information.

The summary score of the total number of targets met by each country are shown arranged according to country group in Table 15. All countries that reported in Mental Health Atlas 2017 have met at least one target. Islamic Republic of Iran, a group 2 country, has met all six targets, demonstrating that they are realistic targets for most countries. Morocco (group 2), Bahrain and Qatar (group 1) have met all but one target. Country groups 1 and 2 have met at least one target, and 80% of them have met three or more targets. In contrast, 80% of group 3 countries have reported data meeting fewer than three targets.

## Summary

In summary, there has been progress across the Eastern Mediterranean Region towards the global targets and goals of the *Mental Health Action Plan 2013–2020,* particularly in the areas of planning and legislation. Group 1 and 2 countries have also moved forward in the areas of coverage, promotion and prevention, and information systems. Only a few countries of the Region have established suicide prevention strategies or achieved a reduction in

suicide rates. Further success will depend on strong collaborative governance for mental health in each country to ensure that the plans are actually implemented.

WHO will continue to provide technical advice and support to countries as they work towards implementation of the regional framework (see Annex 2) in support of the *Mental Health Action Plan 2013–2020* goal to "promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders" *(6)*.

## Table 14. Targets set out in the *Mental Health Action Plan 2013–2020* as met by countries of the Eastern Mediterranean Region

| Country | Targets set out in the *Mental Health Action Plan 2013–2020* | | | | | | Total |
|---|---|---|---|---|---|---|---|
| | Plan | Legislation | Coverage† | Prevention | Suicide◆ | Information | |
| Afghanistan | | ✓ | | ✓ | ✓ | ✓ | 4 |
| Bahrain | ✓ | ✓ | | ✓ | ✓ | ✓ | 5 |
| Djibouti* | | | | | | | DNR▲ |
| Egypt | | | ✓ | ✓ | | ✓ | 3 |
| Iran, Islamic Republic of | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 |
| Iraq | | | ✓ | ✓ | ✓ | ✓ | 4 |
| Jordan | ✓ | | | | ✓ | ✓ | 3 |
| Kuwait* | | | | | | | DNR▲ |
| Lebanon | ✓ | ✓ | | ✓ | | ✓ | 4 |
| Libya | | | | | ✓ | | 1 |
| Morocco | | ✓ | ✓ | ✓ | ✓ | ✓ | 5 |
| Occupied Palestinian territory | ✓ | | ✓ | | - | ✓ | 3 |
| Oman | | | | | ✓ | ✓ | 2 |
| Pakistan | ✓ | ✓ | | | | | 2 |
| Qatar | ✓ | ✓ | ✓ | ✓ | | ✓ | 5 |
| Saudi Arabia | | | | ✓ | ✓ | ✓ | 3 |
| Somalia | | | | | ✓ | | 1 |
| Sudan | | | | | ✓ | | 1 |
| Syrian Arab Republic | ✓ | | | | ✓ | ✓ | 3 |
| Tunisia | ✓ | | | | ✓ | | 2 |
| United Arab Emirates | ✓ | ✓ | | | ✓ | ✓ | 4 |
| Yemen | | | | | ✓ | | 1 |
| **Total** | **10** | **8** | **6** | **9** | **15** | **14** | |

* Did not report in *Mental health atlas 2017*.
† Insufficient data to report directly on change in coverage – therefore 20% increase in outpatient visits used as proxy.
◆ Based on change in estimated age-standardized suicide rates between 2010 and 2017 reported in the Global Health Observatory.
▲ DNR = Did not return questionnaire for *Mental health atlas 2017*.

**Table 15. Number of *Mental Health Action Plan 2013–2020* targets met by countries of the Eastern Mediterranean Region organized by country group**

| Number of targets met | Group 1 | Group 2 | Group 3 |
|---|---|---|---|
| | | Islamic Republic of Iran | |
| **5** | Qatar | Morocco | |
| **4** | Bahrain | Lebanon | Afghanistan |
| **3** | Saudi Arabia<br>United Arab Emirates | Egypt<br>Iraq<br>Jordan<br>Occupied Palestinian territory<br>Syrian Arab Republic | |
| **2** | | Tunisia | Pakistan |
| **1** | Oman | Libya | Somalia<br>Sudan |
| **0** | | | Yemen |
| **Did not report in 2017** | Kuwait | | Djibouti |

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8. Global Health Expenditure Database [online database]. Table of regional averages for key indicators. Geneva: World Health Organization; 2018 (http://apps.who.int/nha/database/Regional_Averages/Index/en, accessed 25 July 2019).
9. Global Health Observatory (GHO) data [online database]. Geneva: World Health Organization; 2018 (http://www.who.int/gho/en/, accessed 25 July 2019).

# Annex 1. Participating countries and contributors

| Country | Country group | Contributors to *Mental health atlas 2017* |
|---|---|---|
| Afghanistan | 3 | Bashir Ahmad Sarwari |
| Bahrain | 1 | Eman Ahmad Haji |
| Egypt | 2 | Hisham Ahmed Ramy |
| Iran (Islamic Republic of) | 2 | Ahmad Hajebi |
| Iraq | 2 | Emad Abdulrazaq |
| Jordan | 2 | Fateen Janim |
| Lebanon | 2 | Rabih El Chammay |
| Libya | 2 | Amjad Shagrouni |
| Morocco | 2 | Maaroufi Abderahman |
| Occupied Palestinian territory | 2 | Samah Jabr |
| Oman | 1 | Amira Al Raidan |
| Pakistan | 3 | Fareed Aslam Minhas |
| Qatar | 1 | Susan Clelland |
| Saudi Arabia | 1 | Abdulhameed A. Al-Habeeb |
| Somalia | 3 | Zeynab Ahmed Noor |
| Sudan | 3 | Hoyam Ibrahim |
| Syrian Arab Republic | 2 | Ramadan Mahfouri |
| Tunisia | 2 | Wahid Melki |
| United Arab Emirates | 1 | Muna Al Kuwari |
| Yemen | 3 | Mohammed Yahya Alashwal |

# Annex 2. *Glossary of terms*

## Type of facility

**Forensic inpatient unit:** An inpatient unit that is exclusively maintained for the evaluation or treatment of people with mental disorders who are involved with the criminal justice system. These units can be located in mental hospitals, general hospitals, or elsewhere.

**Mental hospital:** A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders. Includes**:** Public and private non-profit and for-profit facilities; mental hospitals for children and adolescents and other specific groups (e.g. the elderly)**.** Excludes**:** Community-based psychiatric inpatient units; forensic inpatient units/hospitals; facilities that treat only people with alcohol and substance abuse disorders or intellectual disability.

**Psychiatric ward in a general hospital:** A psychiatric unit that provides inpatient care within a community-based hospital facility (e.g. a general hospital); period of stay is usually short (weeks to months). Includes: Public and private non-profit and for-profit facilities; psychiatric ward or unit in a general hospital, including those for children and adolescents or other specific groups (e.g. the elderly). Excludes: Mental hospitals; community residential facilities; facilities for alcohol and substance abuse disorders or intellectual disability only.

**Mental health community residential facility:** A non-hospital, community-based mental health facility providing overnight residence for people with mental disorders. Both public and private nonprofit and for-profit facilities are included. Includes**:** Staffed or un-staffed group homes or hostels for people with mental disorders; halfway houses; therapeutic communities. Excludes**:** Mental hospitals; facilities for alcohol and substance abuse disorder or intellectual disability only; residential facilities for elderly people; institutions treating neurological disorders, or physical disability problems.

**Mental health day treatment facility:** A facility providing care and activities for groups of users during the day that lasts half or one full day, including those for children and adolescents only or other specifics groups (e.g. the elderly). Includes**:** Day or day care centres; sheltered workshops; club houses; drop-in centres. Both public and private non-profit and for-profit facilities are included. Excludes**:** Day treatment facilities for inpatients; facilities for alcohol and substance abuse disorders or intellectual disability only.

**Mental health outpatient facility:** An outpatient facility that manages mental disorders and related clinical and social problems. Includes**:** Community mental health centres; mental health outpatient clinics or departments in general or mental hospitals, including those for specific mental disorders, treatments or user group (e.g. the elderly). Both public and private non-profit and for-profit facilities are included. Excludes**:** Private practice; facilities for alcohol and substance abuse disorders or intellectual disability only.

**Other residential facility:** A residential facility that houses people with mental disorders but does not meet the definition for community residential facility or any other defined mental health facility. Includes**:** Residential facilities specifically for people with intellectual disability, people with substance abuse problems, or people with dementia; residential facilities that formally are not mental health facilities but where the majority of residents have diagnosable mental disorders.

**Primary health care clinic:** A clinic that often offers the first point of entry into the health care system. Primary health care clinics usually provide the initial assessment and treatment for common health conditions and refer those requiring more specialized diagnosis and treatment to facilities with staff with a higher level of training.

## Type of worker

**Nurse:** A health professional having completed formal training in nursing at a recognized, university-level school for a diploma or degree in nursing.

**Occupational therapist:** A health professional having completed formal training in occupational therapy at a recognized, university-level school for a diploma or degree in occupational therapy.

**Other health or mental health worker:** A health or mental health worker that possesses some training in health care or mental health care but does not fit into any of the defined professional categories (e.g. medical doctors, nurses, psychologists, social workers, occupational therapists). Includes**:** Non-doctor/non-nurse primary care workers, psychosocial counsellors, auxiliary staff. Excludes**:** General staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

**Primary health care doctor:** A general practitioner, family doctor, or other non-specialized medical doctor working in a primary health care clinic.

**Primary health care nurse:** A nurse working in a primary health care clinic.

**Psychiatrist:** A medical doctor who has had at least two years of post-graduate training in psychiatry at a recognized teaching institution. This period may include training in any sub-specialty of psychiatry.

**Psychologist**: A professional having completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology. The *Mental health atlas 2017* applied the same condition as WHO Assessment Instrument for Mental Health Systems (WHO-AIMS) and asked for information only on psychologists working in mental health care.

**Social worker:** A professional having completed formal training in social work at a recognized, university-level school for a diploma or degree in social work. The *Mental health atlas 2017* applied the same condition as WHO-AIMS and asked for information only on social workers working in mental health care.

## Other terms used

**Legal capacity:** The United Nations Convention on the Rights of Persons with Disabilities recognizes that people with disabilities, including mental disabilities, have the right to exercise their legal capacity and make decisions and choices on all aspects of their lives, on an equal basis with others. The Convention promotes a supported decision-making model, which enables people with mental disabilities to nominate a trusted person or a network of people with whom they can consult and discuss issues affecting them.

**Recovery approach:** From the perspective of the individual with mental illness, recovery means gaining and retaining hope, understanding one's abilities and disabilities, engaging in an active life, and having personal autonomy, social identity, meaning and purpose in life, and a positive sense of self. Recovery is not synonymous with cure.

**Seclusion and restraints**: 'Seclusion' means the voluntary placement of an individual alone in a locked room or secured area from which he or she is physically prevented from leaving. 'Restraint' means the use of a mechanical device or medication to prevent a person from moving his or her body. 'Alternatives to seclusion' include prompt assessment and rapid intervention in potential crises; using problem-solving methods and/or stress management techniques such as breathing exercises.

**Vulnerable and marginalized groups:** Certain groups have an elevated risk of developing mental disorders. This vulnerability is brought about by societal factors and the environments in which they live. Vulnerable groups in society will differ across countries, but in general they share common challenges related to their social and economic status, social supports, and living conditions, including: stigma and discrimination; violence and abuse; restrictions in exercising civil and political rights; exclusion from participating fully in society; reduced access to health and social services; reduced access to emergency relief services; lack of educational opportunities; exclusion from income generation and employment opportunities; and increased disability and premature death.

# Annex 3. Regional framework to scale up action on Mental health in the Eastern Mediterranean Region

## Regional framework to scale up action on mental health in the Eastern Mediterranean Region

World Health Organization
Regional Office for the Eastern Mediterranean

| Domain | Strategic interventions | Proposed indicators |
|---|---|---|
| **Governance** | Establish/update a multisectoral national policy/strategic action plan for mental health | Country has an operational multisectoral national mental health policy/plan in line with international/regional human rights instruments |
| | Embed mental health and psychosocial support in national emergency preparedness and recovery plans | Mental health and psychosocial support provision is integrated in the national emergency preparedness plans |
| | Review legislation related to mental health in line with international human rights covenants/ instruments | Country has updated mental health legislation in line with international/regional human rights instruments |
| | Integrate priority mental conditions in the basic health delivery package of the government and social/private insurance reimbursement schemes | Inclusion of specified priority mental health conditions in basic packages of health care of public and private insurance/reimbursement schemes |
| | | Enhanced budgetary allocations are in place for addressing the agreed upon national mental health service delivery targets |
| **Health care** | Establish mental health services in general hospitals for outpatient and short-stay inpatient care | Proportion of general hospitals which have mental health units, including inpatient and outpatient units |
| | Integrate delivery of cost-effective, feasible and affordable evidence-based interventions for mental conditions in primary health care and other priority health programmes | Proportion of persons with mental health conditions utilizing health services (disaggregated by age, sex, diagnosis and setting) |
| | Provide people with mental health conditions and their families with access to self-help and community-based interventions. | Proportion of primary health care facilities with regular availability of essential psychotropic medicines |
| | Downsize the existing long-stay mental hospitals | Proportion of primary health care facilities with at least one staff trained to deliver non-pharmacological interventions |
| | | Proportion of mental health facilities monitored annually to ensure protection of human rights of persons with mental conditions using quality and rights standards |
| | Implement best practices for mental health and psychosocial support in emergencies | Proportion of health care workers trained in recognition and management of priority mental conditions during emergencies |
| **Promotion and prevention** | Provide cost-effective, feasible and affordable preventive interventions through community and population-based platforms | Proportion of schools implementing the whole-school approach to promote life skills |
| | | Proportion of mother and child health care personnel trained in providing early childhood care and development and parenting skills to mothers and families |
| | Train emergency responders to provide psychological first aid | Proportion of mother and child health care personnel trained in early recognition and management of maternal depression |
| | | Availability of operational national suicide prevention action plan |
| | | Regular national campaigns to improve mental health literacy and reduce stigma using multiple delivery channels |
| | | Psychological first aid (PFA) training is incorporated in all emergency responder trainings at national level |
| **Surveillance, monitoring and research** | Integrate the core indicators within the national health information systems | Routine data and reports at national level available on the core set of mental health indicators |
| | Enhance the national capacity to undertake prioritized research | Annual reporting of national data on numbers of deaths by suicide |

# Annex 4. *Country profiles*

# Afghanistan

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 33 736 494 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Low income | Disability-adjusted life years (per 100 000 population):[c] | **5457.15** |
| Country group: | 3 | Suicide (age-standardized per 100 000 population):[d] | **4.7** |
| Total mental health expenditure per person (reported currency): | US$ 0.12 | | |
| Availability/status of mental health reporting: | Mental health data (either in the public system, private system or both) have been compiled for general health statistics in the last two years, but not in a specific mental health report | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2016. ✓
- Resources estimated, but not allocated in line with estimates.
- Specified indicators available but not used to monitor implementation.
- Plan or strategy for CAMH published in 2016. ✓

### Mental health legislation

- Stand-alone mental health legislation enacted in 1987.
- A dedicated authority or independent body to provide regular inspections in mental health facilities exists, but is not functioning.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

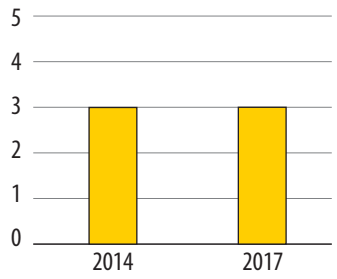
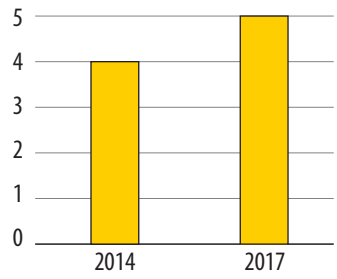



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Four formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders are explicitly listed as included. ✓
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 38 | 553 | 5.8% |
| Nurses | 29 | 557 | 4.9% |
| Other health care workers | 29 | 513 | – |
| Mixed groups | 5 | – | – |
| **Total** | **101** | **1 623** | – |

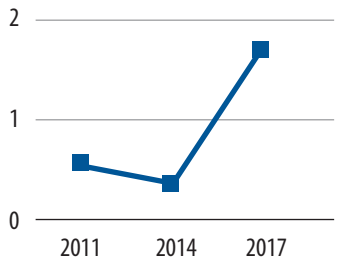
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.01 | 0.01 | 0.23 |
| Child psychiatrists | - | - | 0.00 |
| Other specialist doctors | 0.34 | 0.09 | 0.15 |
| Nurses (e.g. psychiatric nurse) | 0.14 | 0.11 | 0.10 |
| Psychologists | 0.01 | 0.04 | 0.30 |
| Social workers | 0.00 | 0.01 | 0.00 |
| Occupational therapists | 0.01 | 0.01 | 0.00 |
| Speech therapists | - | - | 0.00 |
| Other paid mental health workers | 0.04 | 0.04 | 0.89 |

72% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

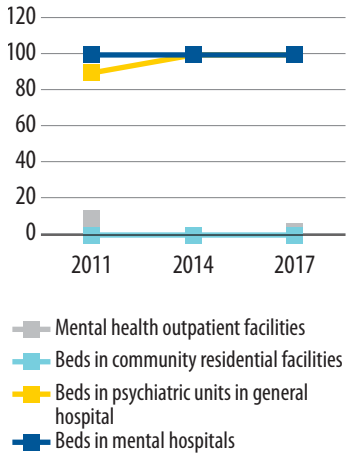
**Table 4. Availability and use of inpatient mental health services**

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 1 | 0.003 | 100 | 0.30 | 2447 | 7.25 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 4 | 0.012 | 100 | 0.30 | 6703* | 19.9 |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5. Availability and use of outpatient mental health services**

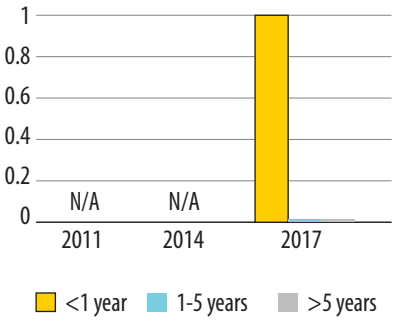
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 1 | 0.003 | 29 321 | 86.9 |
| Community-based outpatient facility | 1 | 0.003 | 12 467 | 37.0 |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 0 | 0 | 0 | 0 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4. Changes in bed numbers and outpatient provision**



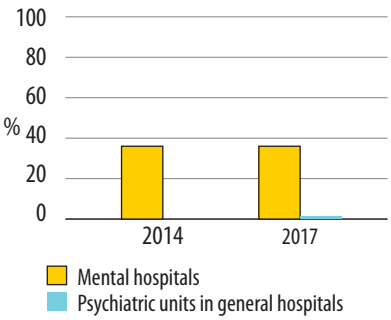

### Duration of stay

**Fig. 5. Length of stay for mental hospital inpatients**




### Involuntary admissions

**Fig. 6. Percentage of involuntary admissions to psychiatric beds**




### Treated prevalence

**Table 6. Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population**

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 2.0 | 0.5 | 1.0 |
| Outpatient | - | - | - |
| **Total** | **-** | **-** | **-** |

### Follow-up and social support

- 26–50% of discharged inpatients received a follow-up outpatient visit within one month.
- Few or some persons with severe mental disorders receive social support from government.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy published/revised in 2017 ✓ Three functioning prevention/promotion programmes ✓

**Table 7. Functioning mental health promotion and prevention programmes**

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| Mental health awareness | Mental health awareness/anti-stigma | National | Jointly managed |
| Life skills in school base and school health including mental health | School-based mental health promotion | Regional | Jointly managed |
| Psychological first aid for community volunteers and emergency counselling through mid-level within health facility | Other | National | Nongovernmental organization |

- Health status and outcome indicators. Automatic and/or continuous reporting of: prevalence of mental disorders; and suicide mortality rate. Occasional reporting of mental health status or outcomes for persons using mental health services.
- Health system indicators. Automatic and/or continuous reporting of: beds in mental hospitals; beds in psychiatric units of general hospitals; admissions to mental hospitals; admissions to psychiatric units of general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services. Periodic/regular reporting of: primary/general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Bahrain

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 1 371 855 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | High income | Disability-adjusted life years (per 100 000 population):[c] | **4 100.25** |
| Country group: | 1 | Suicide (age-standardized per 100 000 population):[d] | **5.9** |
| Total mental health expenditure per person (reported currency): | 9.36 Bahraini dinars | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only published by the Health Department or other government unit in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2015 ✓
- Does not contain estimates of resource needs, and a separate assessment of resource needs has not been carried out.
- Indicators specified and used to monitor implementation of most or all components in last two years. ✓
- Plan or strategy for CAMH published in 2015 ✓

### Mental health legislation

- Mental health legislation integrated into general health or disability law, enacted in 2009.
- A dedicated authority or independent body provides irregular inspections of mental health facilities and partial enforcement of mental health legislation.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

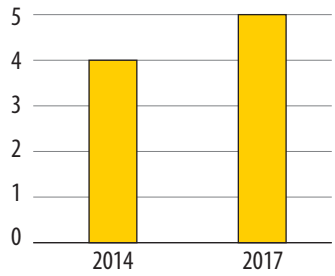
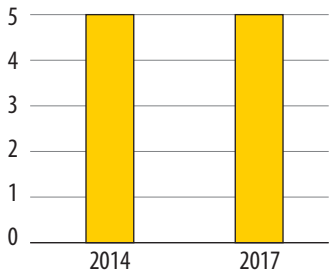



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Six formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | × |
| Ministry of the interior | ✓ |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | ✓ |
| Local NGOs | × |
| International NGOs | × |
| Private sector | ✓ |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | ✓ |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 3.16%.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders are explicitly listed as included. ✓
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 2 | 80 | 6.25% |
| Nurses | 1 | 50 | 1.50% |
| Other health care workers | 2 | 100 | – |
| Mixed groups | 1 | – | – |
| **Total** | **6** | **230** | – |

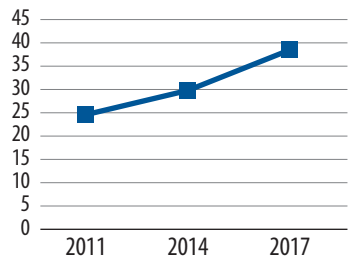
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 4.99 | 4.84 | 5.47 |
| Child psychiatrists | - | - | 0.51 |
| Other specialist doctors | - | 0.07 | 0.58 |
| Nurses (e.g. psychiatric nurse) | 17.7 | 22.69 | 27.92 |
| Psychologists | 0.31 | 0.74 | 1.24 |
| Social workers | 0.53 | 0.74 | 1.46 |
| Occupational therapists | 1.06 | 0.67 | 0.80 |
| Speech therapists | - | - | 0.51 |
| Other paid mental health workers | (10.94) | (4.02) | 0.00 |

9% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




3.1% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 2 | 0.146 | 265 | 19.32 | 1 993 | 145.28 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 0 | 0 | 0 | 0 | 0 | 0 |
| Community residential unit | 2 | 0.146 | 15 | 1.09 | - | - |
| Inpatient for children and adolescents | 1 | 0.073 | 12 | 0.87 | 80 | 5.83 |

**Fig. 4.** Changes in bed numbers and outpatient provision

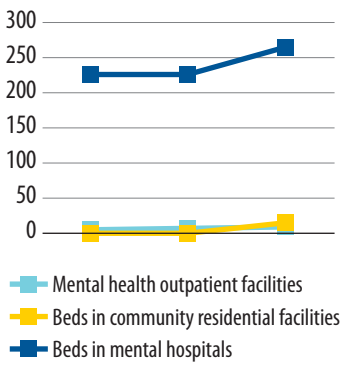
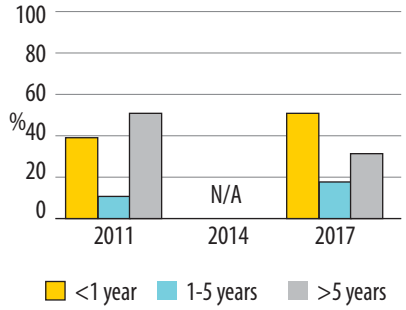



**Table 5.** Availability and use of outpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 9 | 0.656 | 5 848 | 426.3 |
| Community-based outpatient facility | - | - | - | - |
| Other outpatient facility (e.g. day care) | - | - | - | - |
| Outpatient service for children and adolescents | 8 | 0.583 | 4 940 | 360.1 |
| Other outpatient for children and adolescents | 10 | 0.729 | - | - |

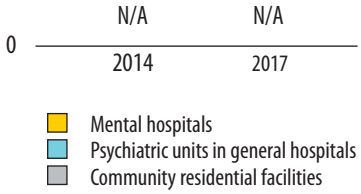
### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 6.6 | 10.5 | 0.9 |
| Outpatient | - | - | - |
| **Total** | - | - | - |

### Follow-up and social support

- More than 75% of discharged inpatients received a follow-up outpatient visit within one month. ✓
- The majority of patients with severe and non-severe mental disorders receive social support from government. This includes income, housing, employment, education, social care, and family support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist.

Four functioning prevention/promotion programmes ✓

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| Mental health awareness anti-stigma | Mental health awareness/prevention/anti-stigma | National | Government |
| Violence prevention | Violence prevention (incl. child abuse) | National | Government |
| Early childhood development | Early childhood development/stimulation | National | Government |
| Parental/maternal mental health programme | Early childhood development/stimulation | National | Jointly managed |

- Health status and outcome indicators. Automatic and/or continuous reporting of: prevalence of mental disorders; and suicide mortality rate. Mental health status or outcomes for persons using mental health services not reported.
- Health system indicators. Automatic and/or continuous reporting of: beds in mental hospitals; admissions to mental hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; and primary/general health workers receiving in-service training. Number of beds and admissions in psychiatric units of general hospitals: not reported.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Egypt

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 93 778 172 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 566.81** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **4.0** |
| Total mental health expenditure per person (reported currency): | 3.73 Egyptian pounds | | |
| Availability/status of mental health reporting: | A specific report focusing mental health activities in both the public and private sector has been published by the Health Department or any other responsible government unit in the last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2015. ✓
- Does not contain estimate of resources needed, but has been a separate assessment of resources.
- Specified indicators used to monitor implementation of some/a few components. ✓
- Plan or strategy for CAMH published in 2015. ✓

### Mental health legislation

- Stand-alone mental health legislation enacted in 2009.
- A dedicated authority or independent body provides regular inspections in mental health facilities and reports at least annually to stakeholders. ✓

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

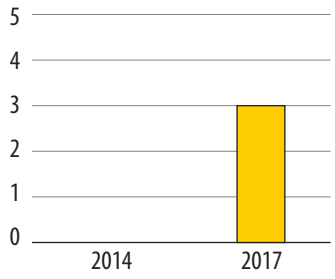
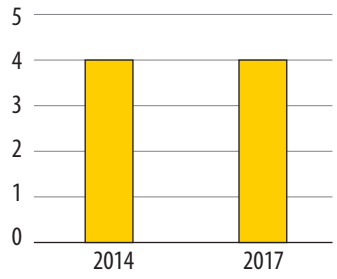



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Eight formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | ✓ |
| Ministry of the interior | ✓ |
| Housing sector | × |
| Employment sector | × |
| Media sector | ✓ |
| Academic sector | ✓ |
| Local NGOs | × |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | ✓ |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 0.5%.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders are explicitly listed as included. ✓
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 8 | 177 | 0.24% |
| Nurses | 6 | 140 | 0.11% |
| Other health care workers | 2 | 8 | – |
| Mixed groups | 0 | – | – |
| **Total** | **16** | **325** | – |

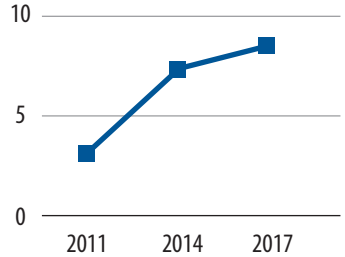
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.54 | 0.68 | 1.60 |
| Child psychiatrists | - | - | 0.21 |
| Other specialist doctors | 0.31 | 0.56 | 0.64 |
| Nurses (e.g. psychiatric nurse) | 2.08 | 3.10 | 4.8 |
| Psychologists | 0.13 | 0.12 | 0.26 |
| Social workers | 0.23 | 0.29 | 0.45 |
| Occupational therapists | 0 | - | 0.00 |
| Speech therapists | - | - | 0.01 |
| Other paid mental health workers | - | 2.56 | 0.44 |

70% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




2.2% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

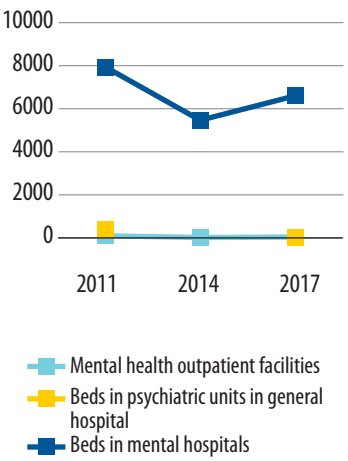
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 18 | 0.02 | 6 600 | 7.04 | 13 552 | 14.45 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 2 | 0.002 | 36 | 0.04 | 294 | 0.31 |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 3 | 0.003 | 75 | 0.08 | 156 | 0.17 |

**Table 5.** Availability and use of outpatient mental health services

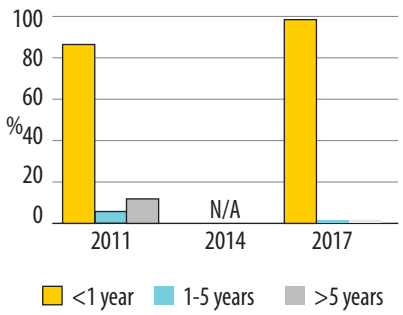
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 18 | 0.02 | 521 314 | 555.9 |
| Community-based outpatient facility | 1 | 0.001 | 5 760 | 6.14 |
| Other outpatient facility (e.g. day care) | 4 | 0.004 | 8 389 | 8.95 |
| Outpatient service for children and adolescents | 10 | 0.011 | 73 580 | 78.46 |
| Other outpatient for children and adolescents | 6 | 0.006 | 4 980 | 5.31 |

**Fig. 4.** Changes in bed numbers and outpatient provision



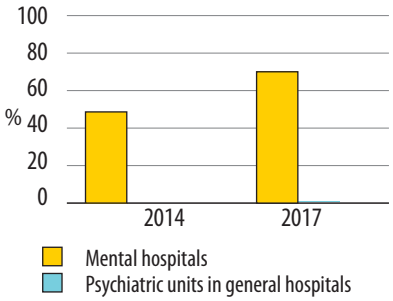

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 7.3 | 2.9 | 2.2 |
| Outpatient | 10.4 | 7.1 | 14.2 |
| **Total** | **17.6** | **10.0** | **16.4** |

### Follow-up and social support

- 51–75% of discharged inpatients received a follow-up outpatient visit within one month.
- Few or some persons with severe mental disorders receive social support from government. This includes income, housing, social care and family support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist

Five or more functioning prevention/promotion programmes ✓

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| It's time to know about mental disorder | Mental health awareness/anti-stigma | National | Government |
| You can without it | Mental health awareness/anti-stigma | National | Jointly managed |
| Attention-deficit/hyperactivity disorder | Mental health awareness/anti-stigma | National | Government |
| Autism | Mental health awareness/anti-stigma | National | Jointly managed |
| Hotline for psychiatric help | Mental health awareness/anti-stigma | National | Government |

- Health status and outcome indicators. Automatic and/or continuous reporting of mental health status or outcomes for persons using mental health services. Occasional reporting of prevalence of mental disorders. No reporting of suicide mortality rate.
- Health system indicators. Automatic and/or continuous reporting of: beds in mental hospitals; admissions to mental hospitals; involuntary hospital admissions; and persons with mental disorders using mental health outpatient services. Occasional reporting of beds and admissions to psychiatric units in general hospital, and primary/general health workers receiving in-service training. No reporting of persons with mental disorders using primary health care services.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Islamic Republic of Iran

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 79 360 487 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Upper-middle | Disability-adjusted life years (per 100 000 population):[c] | **3527.06** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **4.1** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only has been published by the Health Department or other government unit in last 2 years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2015 ✓
- Resources allocated in line with estimates
- Specified indicators used to monitor implementation of most/all components ✓
- Plan or strategy for CAHM published in 2015 ✓

### Mental health legislation

- Stand-alone mental health legislation enacted in 2017 ✓
- A dedicated authority or independent body provides regular inspections in mental health facilities and reports at least annually to stakeholders ✓

### Multisectoral collaboration

**Table 1.** Twelve formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | ✓ |
| Ministry of the interior | ✓ |
| Housing sector | ✓ |
| Employment sector | ✓ |
| Media sector | ✓ |
| Academic sector | ✓ |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | ✓ |
| Professional associations | ✓ |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

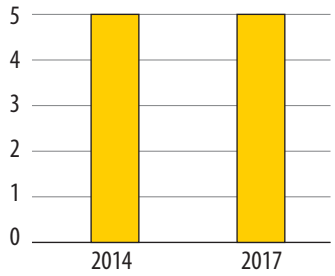
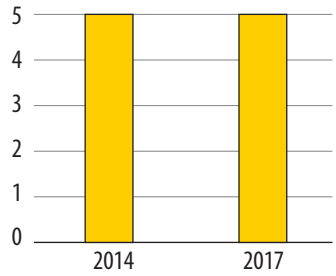



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders are explicitly listed as included. ✓
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 480 | 9 600 | 8.2% |
| Nurses | 170 | 3 400 | 2.8% |
| Other health care workers | 2 760 | 55 200 | – |
| Mixed groups | – | – | – |
| **Total** | **3 410** | **68 200** | – |

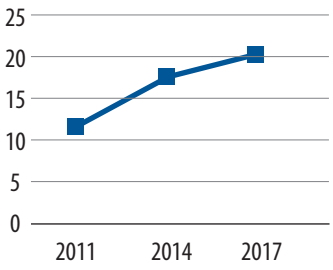
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 1.49 | 1.79 | 2.02 |
| Child psychiatrists | - | - | 0.15 |
| Other specialist doctors | (11.43) | 0.49 | 0.63 |
| Nurses (e.g. psychiatric nurse) | 7.46 | 8.86 | 9.45 |
| Psychologists | 2.19 | 5.07 | 5.17 |
| Social workers | 0.67 | 0.72 | 1.51 |
| Occupational therapists | 0.59 | 0.67 | 1.01 |
| Speech therapists | - | - | 0.63 |
| Other paid mental health workers | (40.9) | 0 | 0.00 |

72% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




2.4% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

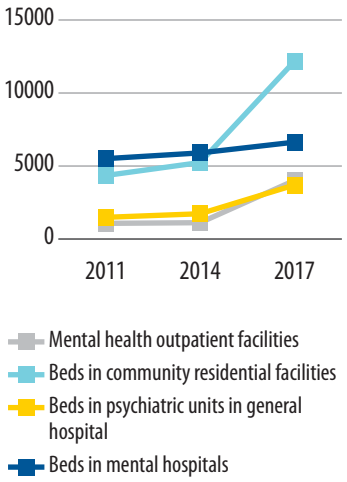
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 39 | 0.05 | 6 635 | 8.49 | 98 331 | 123.90 |
| Forensic inpatient unit | - | - | - | - | - | - |
| Psychiatric unit in general hospital | 159 | 0.20 | 3 700 | 4.66 | 64 310 | 81.04 |
| Community residential unit | 178 | 0.22 | 12 180 | 15.35 | - | - |
| Inpatient for children and adolescents | 11 | 0.01 | 181 | 0.23 | 2 642 | 3.33 |

**Table 5.** Availability and use of outpatient mental health services

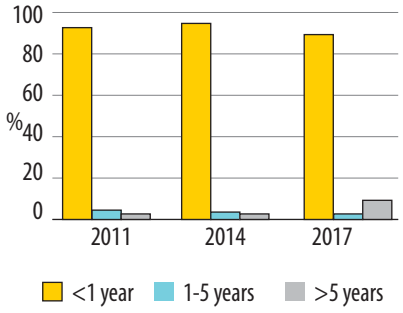
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 260 | 0.33 | 950 000 | 1 197.07 |
| Community-based outpatient facility | 3 755 | 4.73 | 3 100 000 | 3 906.23 |
| Other outpatient facility (e.g. day care) | 142 | 0.18 | 8 500 | 10.71 |
| Outpatient service for children and adolescents | 24 | 0.03 | 62 400 | 78.63 |
| Other outpatient for children and adolescents | 81 | 0.10 | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



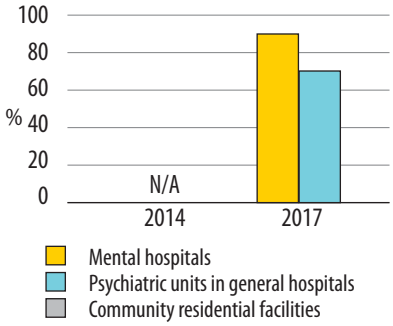

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 50.6 | 120.3 | 6.3 |
| Outpatient | 88.6 | 12.7 | 208.9 |
| **Total** | **139.2** | **132.9** | **215.2** |

### Follow-up and social support

- 51–75% of discharged inpatients received a follow-up outpatient visit within one month.
- The majority of persons with severe mental disorders, and also some with non-severe mental disorders, receive social support from the government. This includes housing, education, social care, legal, family and other support. ✓

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy published/revised 2015 ✓ Five or more functioning prevention/promotion programmes ✓

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| National Life Skills Training Programme | Mental health awareness/anti-stigma | National | Government |
| National Parenting Skills Education Programme | Parental mental health promotion | National | Government |
| Domestic Violence Prevention Programme | Violence prevention | National | Government |
| National Suicide Prevention Programme | Suicide prevention | National | Government |
| Substance Use Prevention Education Programme | Mental health awareness/anti-stigma | National | Government |

- Automatic and/or continuous reporting of the following health status and outcome indicators: prevalence of mental disorders; suicide mortality rate; mental health status or outcomes for persons using mental health services. ✓
- Automatic and/or continuous reporting of the following health system indicators: beds in mental hospitals; beds in psychiatric units of general hospitals; admissions to mental hospitals; admissions to psychiatric units of general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary/general health workers receiving in-service training. ✓

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Iraq

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 36 115 649 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Upper-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 101.88** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **3.0** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only has been published by the Health Department or other government unit in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2014 ✓
- Separate assessment of resource needs has been carried out
- Specified indicators used to monitor implementation of some/a few components
- Plan or strategy for CAMH does not exist

### Mental health legislation

- Stand-alone Mental Health Legislation enacted in 2005
- A dedicated authority or independent body provides irregular inspections of mental health facilities and partial enforcement of mental health legislation

### Multisectoral collaboration

**Table 1.** Eight formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | × |
| Ministry of the interior | ✓ |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | ✓ |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | ✓ |
| Professional associations | ✓ |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

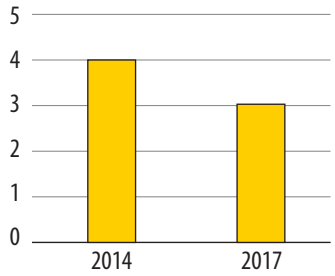
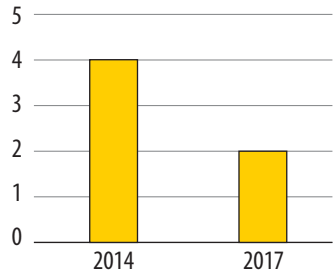



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes.
- Persons pay at least 20% towards the cost of mental health services psychotropic medicines

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 8 | 172 | 0.57% |
| Nurses | 4 | 106 | 0.17% |
| Other health care workers | 3 | 49 | – |
| Mixed groups | 4 | – | – |
| **Total** | **19** | **327** | – |

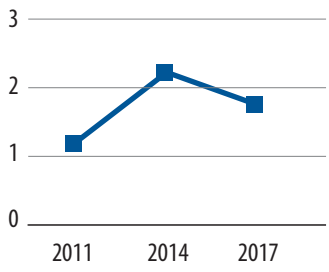
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.27 | 0.37 | 0.34 |
| Child psychiatrists | | | 0.01 |
| Other specialist doctors | | 0.07 | 0.00 |
| Nurses (e.g. psychiatric nurse) | 0.89 | 1.46 | 1.22 |
| Psychologists | | 0.09 | 0.11 |
| Social workers | | 0.22 | 0.09 |
| Occupational therapists | | 0.01 | 0.00 |
| Speech therapists | | | 0.00 |
| Other paid mental health workers | | 0.01 | 0.00 |

94% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




2.8% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

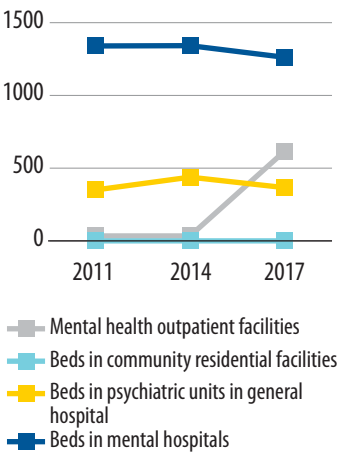
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 2 | 0.006 | 1,262 | 3.49 | 807 | 2.23 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 22 | 0.061 | 366 | 1.01 | 2 548 | 7.06 |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

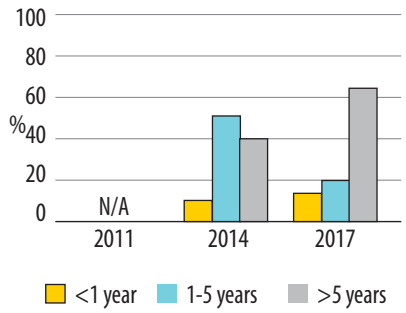
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 34 | 0.094 | 111 028 | 307.42 |
| Community-based outpatient facility | 575 | 1.592 | 126 894 | 351.35 |
| Other outpatient facility (e.g. day care) | 1 | 0.003 | 29 | 0.08 |
| Outpatient service for children and adolescents | 7 | 0.019 | 3 446 | 9.54 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



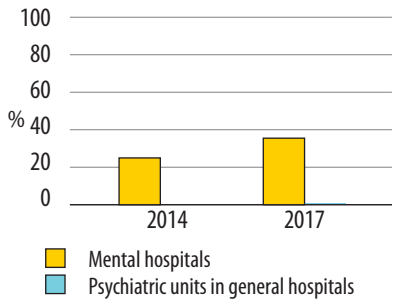

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 1.4 | 0.6 | 1.8 |
| Outpatient | 49.2 | 14..6 | 48.3 |
| **Total** | **50.6** | **15.2** | **50.1** |

### Follow-up and social support

- 51–75% of discharged inpatients received a follow-up outpatient visit within one month.
- The majority of persons with severe mental disorders receive social support from government. This includes income support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist — Three functioning prevention/promotion programmes ✓

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| Mental health promotion | Mental health awareness/anti-stigma | National | Jointly managed |
| Suicide prevention programme | Suicide prevention | National | Jointly managed |
| Psycho-social support for the displaced population | Violence prevention | District | NGO |

- Health status and outcome indicators. Automatic and/or continuous reporting of: prevalence of mental disorders and suicide mortality rate. No reporting of mental health status or outcomes for persons using mental health services.
- Health system indicators. Automatic and/or continuous reporting of: admissions to mental hospitals; admissions to psychiatric units in general hospital; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services. Periodic/regular reporting of involuntary hospital admissions. Occasional reporting of: beds in mental hospitals and psychiatric units of general hospitals; primary/general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Jordan

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 9 159 302 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Upper-middle | Disability-adjusted life years (per 100 000 population):[c] | **3 030.18** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **2.9** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | A specific report focusing mental health activities in both public and private sector has been published by the Health Department or any other responsible government unit in the last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2011
- Resource allocation in line with estimates: not reported
- Specified indicators available and used to monitor implementation of most/all components.
- Plan or strategy for CAMH published in 2011

### Mental health legislation

- Mental health legislation is integrated within the Public Health Law
- A dedicated authority or independent body to provide inspections of mental health facilities exists but is not functioning

### Multisectoral collaboration

**Table 1.** Five formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | ✓ |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | ✓ |
| Traditional healers | × |
| Service users and family/carer advocacy groups | ✓ |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

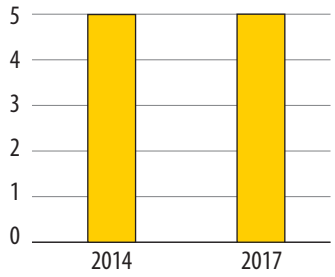
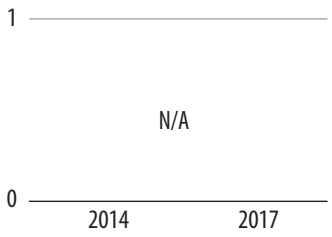



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders are explicitly listed as included. ✓
- Persons pay at least 20% to the cost of mental health services/psychotropic medicines

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 3 | 61 | 0.31% |
| Nurses | 2 | 35 | 0.17% |
| Other health care workers | – | – | – |
| Mixed groups | 7 | 150 | – |
| **Total** | **12** | **246** | – |

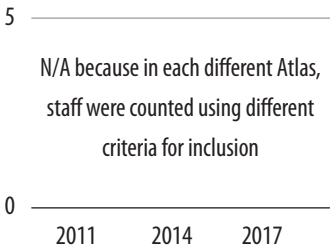
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 10.8 | 0.51 | 1.12 |
| Child psychiatrists | - | - | - |
| Other specialist doctors | 0.03 | 0.57 | - |
| Nurses (e.g. psychiatric nurse) | 4.03 | 4.72 | 3.3* |
| Psychologists | 0.17 | 0.27 | 1.27 |
| Social workers | 0.25 | 0.16 | 0.22* |
| Occupational therapists | 0.03 | - | - |
| Speech therapists | - | - | - |
| Other paid mental health workers | - | - | - |

* 2017 nurses and social workers are given for public sector only
19.3% of psychiatrists work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




Mental health staff working in CAMH: not reported

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

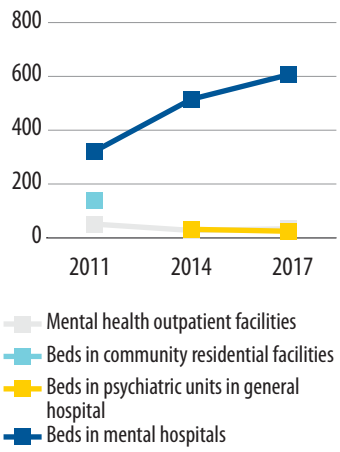
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 5 | 0.06 | 609 | 6.65 | 4 450 | 48.58 |
| Forensic inpatient unit | 1 | 0.01 | 63 | 0.69 | | |
| Psychiatric unit in general hospital | 3 | 0.03 | 38 | 0.41 | | |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

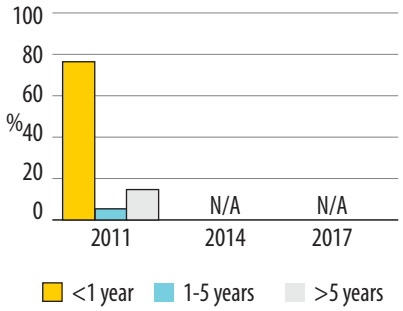
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 25 | 0.27 | 75 833 | 827.9 |
| Community-based outpatient facility | 22 | 0.24 | | |
| Other outpatient facility (e.g. day care) | - | - | | |
| Outpatient service for children and adolescents | 0 | 0 | 0 | 0 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



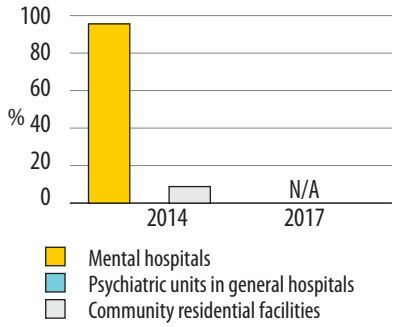

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | - | - | - |

### Follow-up and social support

- More than 75% of discharged inpatients received a follow-up outpatient visit within one month. ✓
- The majority of patients with severe and non-severe mental disorders receive social support from government. This includes income support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist

No functioning prevention/promotion programmes

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

- Health status and outcome indicators. Occasional reporting of mental health status or outcomes for persons using mental health services.
- Health system indicators. Automatic and/or continuous reporting of: admissions to mental hospitals and psychiatric units in general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services. Periodic / regular reporting of beds in mental hospitals and psychiatric units of general hospitals.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Lebanon

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 5 851 479 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Upper-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 740.07** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **3.3** |
| Total mental health expenditure per person (reported currency): | 5 171.24 Lebanese pounds | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector has been published by the Health Department or other government unit in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2015. ✓
- Does not contain resources needed, and a separate assessment of resources needed has not been carried out.
- Specified indicators used to monitor implementation of most/all components. ✓
- Plan or strategy for CAMH do not exist.

### Mental health legislation

- Stand-alone Mental Health Legislation enacted in 1983.
- A dedicated authority or independent body to provide inspections in mental health facilities does not exist.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

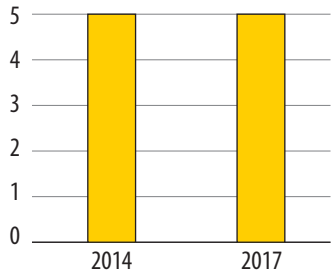
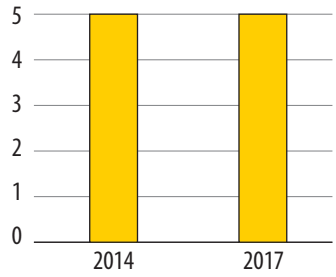



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Eight formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | ✓ |
| Ministry of the interior | ✓ |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | ✓ |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | ✓ |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 5%
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, but mental disorders are not explicitly listed as included.
- Persons pay at least 20% to the cost of mental health services/psychotropic medicines

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 4 | 41 | 0.31% |
| Nurses | 4 | 102 | 0.71% |
| Other health care workers | 0 | 0 | – |
| Mixed groups | 11 | – | – |
| **Total** | **19** | **143** | – |

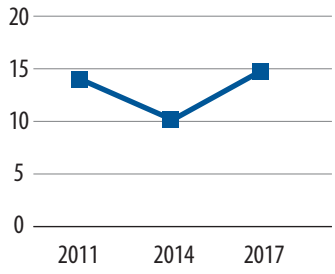
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 1.41 | 0.87 | 1.21 |
| Child psychiatrists | - | - | 0.09 |
| Other specialist doctors | 0.24 | 0.12 | 0.48 |
| Nurses (e.g. psychiatric nurse) | 0.72 | 0.77 | 3.14 |
| Psychologists | 2.12 | 1.65 | 3.30 |
| Social workers | 0.47 | 2.32 | 1.33 |
| Occupational therapists | 1.18 | 0.91 | 1.03 |
| Speech therapists | - | - | 8.54 |
| Other paid mental health workers | 7.05 | 3.83 | 3.88 |

1% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




2017 does not include speech therapists

0.2% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

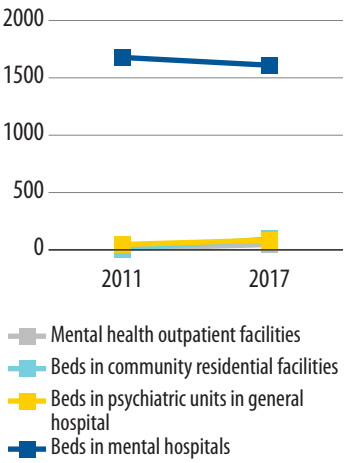
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 5 | 0.09 | 1,610 | 27.51 | 3 176 | 54.28 |
| Forensic inpatient unit | 1 | 0.02 | 30 | 0.45 | 76 | 1.30 |
| Psychiatric unit in general hospital | 8 | 0.14 | 85 | 1.51 | 2 366 | 40.43 |
| Community residential unit | 7 | 0.12 | 95 | 1.62 | - | - |
| Inpatient for children and adolescents | 3 | 0.05 | 65 | 1.11 | - | - |

**Table 5.** Availability and use of outpatient mental health services

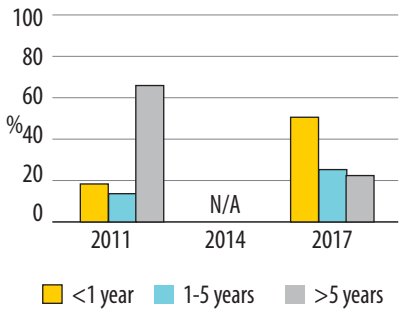
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 12 | 0.21 | 1,118 | 19.11 |
| Community-based outpatient facility | 20 | 0.34 | 1,248 | 21.33 |
| Other outpatient facility (e.g. day care) | 1 | 0.02 | - | - |
| Outpatient service for children and adolescents | 10 | 0.17 | - | - |
| Other outpatient for children and adolescents | 4 | 0.07 | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



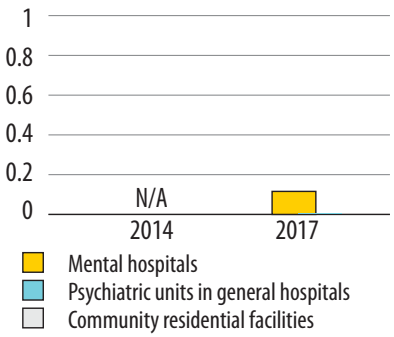

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 9.2 | 0.2 | 17.2 |
| Outpatient | 26.2 | 0.8 | 25.7 |
| **Total** | **35.4** | **1.0** | **42.9** |

### Follow-up and social support

- 25% or less of discharged inpatients received a follow-up outpatient visit within one month.
- Few or some persons with severe mental disorders receive social support from government. This includes income, housing, employment, and education support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist.

Two functioning prevention/promotion programmes.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| National mental health campaign | Mental health awareness/anti-stigma | National | Government |
| Suicide hotline pilot | Suicide prevention | National | NGO |

- Health status and outcome indicators. Occasional reporting of: prevalence of mental disorders; suicide mortality rate. Mental health status or outcomes for persons using mental health services: not reported.
- Health system indicators. Automatic and/or continuous reporting of: persons with mental disorders using primary health care services; primary/general health workers receiving in-service training. Periodic/regular reporting of: beds in mental hospitals; beds in psychiatric units of general hospitals. Occasional reporting of: admissions to mental hospitals; admissions to psychiatric units of general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Libya

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 6 234 955 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Upper-middle | Disability-adjusted life years (per 100 000 population):[c] | **3 684.72** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **5.2** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | Not reported | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Published mental health policy not reported or does not exist.
- Plan or strategy for CAMH published in 2015. ✓

### Mental health legislation

- Mental health legislation not reported or does not exist

### Multisectoral collaboration

**Table 1.** Five formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | ✓ |
| Professional associations | ✓ |
| Faith-based organizations | ✓ |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

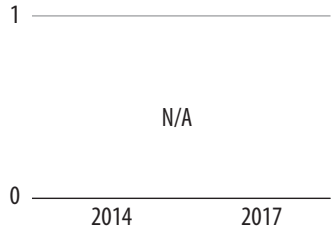
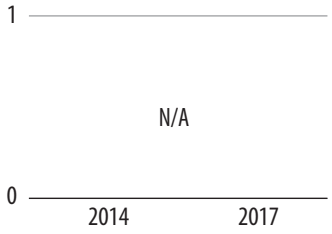



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, but mental disorders not explicitly listed as included.
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 1 | 20 | 0.15 |
| Nurses | 1 | – | – |
| Other health care workers | 1 | – | – |
| Mixed groups | – | – | – |
| **Total** | **3** | **–** | **–** |

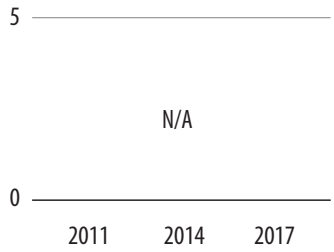
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | - | - | - |
| Child psychiatrists | - | - | - |
| Other specialist doctors | - | - | - |
| Nurses (e.g. psychiatric nurse) | - | 5.18 | - |
| Psychologists | - | 1.04 | - |
| Social workers | - | 0.58 | - |
| Occupational therapists | - | - | - |
| Speech therapists | - | - | - |
| Other paid mental health workers | - | 0.06 | - |

Percentage of mental health staff work in government mental health services: not reported

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




Percentage of mental health staff work in CAMH: not reported

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

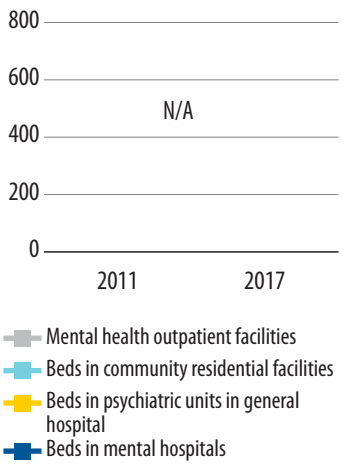
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 2 | 0.03 | - | - | 1 324 | 21.24 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 0 | 0 | 0 | 0 | 0 | 0 |
| Community residential unit | - | - | - | - | - | - |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

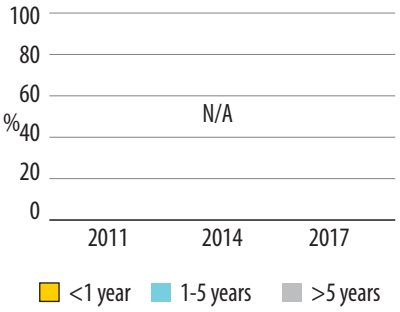
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | - | - | - | - |
| Community-based outpatient facility | - | - | - | - |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 0 | 0 | 0 | 0 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



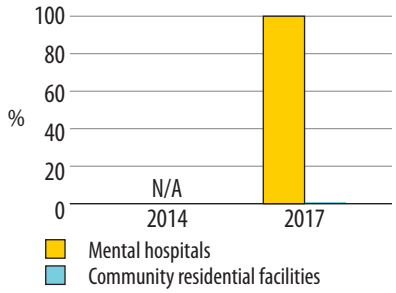

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | **-** | **-** | **-** |

### Follow-up and social support

- 51-75% of discharged inpatients received a follow-up outpatient visit within one month.
- The majority of persons with severe mental disorders, and also some with non-severe mental disorders, receive social support from government. This includes income support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist.

No functioning prevention/promotion programmes.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| - | - | - | - |
| - | - | - | - |

- Health status and outcome indicators. Not reported
- Health system indicators. Not reported

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Morocco

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 34 803 322 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **3 417.64** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **2.9** |
| Total mental health expenditure per person (reported currency): | 5.23 MAD | | |
| Availability/status of mental health reporting: | Mental health data (either public or private system or both) compiled for general health statistics in the last two years, but not in a specific mental health report | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone Mental Health Policy published/revised in 2013 ✓
- Resource needs estimated, but not allocated in line with estimates
- Specified indicators used to monitor implementation of most/all components ✓
- Plan or strategy for CAHM does not exist.

### Mental health legislation

- Stand-alone Mental Health Legislation enacted in 1959.
- A dedicated authority or independent body provides regular inspections in mental health facilities and reports at least annually to stakeholders ✓

### Multisectoral collaboration

**Table 1.** Three formal collaborations between government mental health services & other departments, services & sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | ✓ |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | × |
| Private sector | × |
| Professional associations | ✓ |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

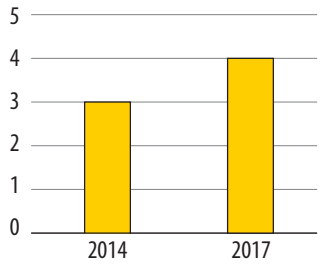
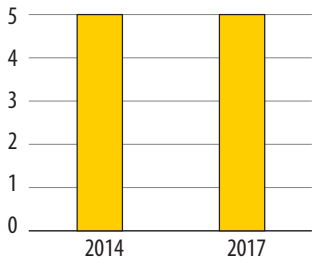



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care & treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders are explicitly listed as included. ✓
- Persons pay at least 20% to costs of mental health services, and nothing for psychotropic medicines, at point of use. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 10 | 60 | 0.29% |
| Nurses | 8 | 60 | 0.20% |
| Other health care workers | 2 | 16 | – |
| Mixed groups | – | – | – |
| **Total** | **20** | **136** | **–** |

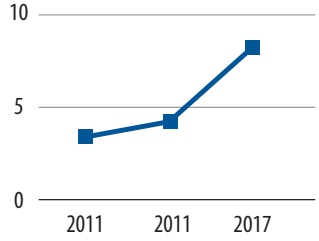
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.9 | 0.44 | 0.84 |
| Child psychiatrists | | | 0.14 |
| Other specialist doctors | 0.01 | 0.04 | 0.00 |
| Nurses (e.g. psychiatric nurse) | 2.33 | 4.10 | 2.45 |
| Psychologists | 0.04 | 0.05 | 0.57 |
| Social workers | 0.01 | 0.03 | 0.65 |
| Occupational therapists | | | 0.00 |
| Speech therapists | | | 0.53 |
| Other paid mental health workers | 0.61 | | 2.87 |

35% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




2.1% of mental health staff work in CAMHS

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

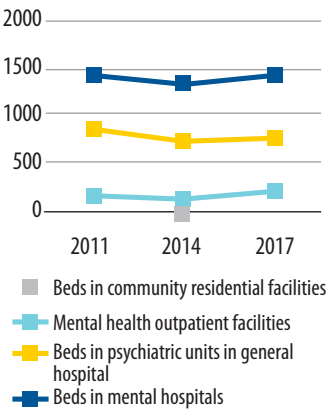
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 11 | 0.03 | 1,453 | 4.17 | 11,240 | 32.24 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 28 | 0.08 | 715 | 2.05 | 12,385 | 35.59 |
| Community residential unit | 24 | 0.07 | - | - | - | - |
| Inpatient for children and adolescents | 2 | 0.006 | 28 | 0.08 | - | - |

**Table 5.** Availability and use of outpatient mental health services

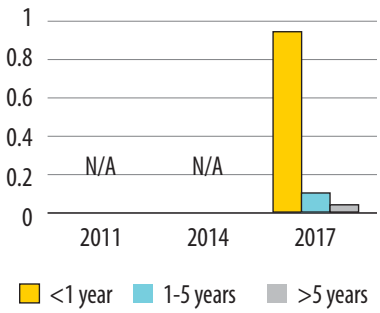
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 32 | 0.09 | - | - |
| Community-based outpatient facility | 83 | 0.24 | 230,000 | 660.86 |
| Other outpatient facility (e.g. day care) | 3 | 0.01 | - | - |
| Outpatient service for children and adolescents | 14 | 0.04 | 6,984 | 20.07 |
| Other outpatient for children and adolescents | 32 | 0.09 | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



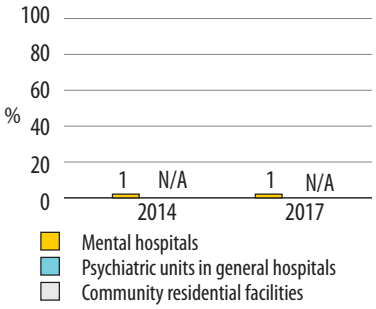

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 67.6 | 5.0 | 1.5 |
| Outpatient | 128.4 | 96.4 | 167.5 |
| **Total** | **199.0** | **101.4** | **169.0** |

### Follow-up and social support

- 51%-75% of discharged inpatients received a follow-up outpatient visit within one month.
- Few or some persons with severe mental disorders receive social support from government. This includes social care, and family support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Two functioning prevention/promotion programmes

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| Live Life Programme | Mental health awareness/anti-stigma | Regional | Jointly managed |
| Mental Health Awareness for RTA Drivers | Workplace mental health promotion | District | Jointly managed |
| Sehhat Ajyal (ADHD) | School-based mental health promotion | Community | Jointly managed |

- Health status and outcome indicators. Periodic / regular reporting of: prevalence of mental disorders. Occasional reporting of suicide mortality rate. Mental health status or outcomes for persons using mental health services: not reported.
- Health service indicators. Periodic / regular reporting of: beds in mental hospitals; admissions to mental hospitals; beds in psychiatric units of general hospitals; admissions to psychiatric units of general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary / general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Occupied Palestinian territory

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 4 662 884 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | | Disability-adjusted life years (per 100 000 population):[c] | – |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | – |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | Mental health data (public system, private system or both) have been compiled for general health statistics in last two years, but not in a specific mental health report | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2015 ✓
- Resources allocated in line with estimates
- Specified indicators available, but not used to monitor implementation of mental health policies/plans.
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Mental health legislation does not exist. Draft legislation is awaiting approval.
- A dedicated authority or independent body provides irregular inspections in mental health facilities.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

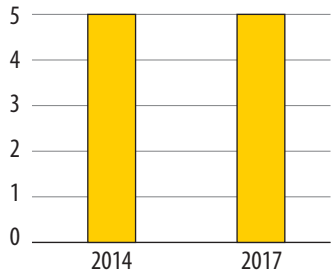
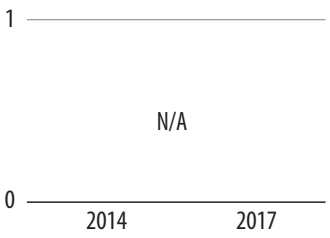



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Four formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | ✓ |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | ✓ |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 2.3%.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, but mental disorders are not explicitly listed as included.
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 5 | 20 | – |
| Nurses | – | – | – |
| Other health care workers | – | – | – |
| Mixed groups | – | – | – |
| **Total** | – | – | – |

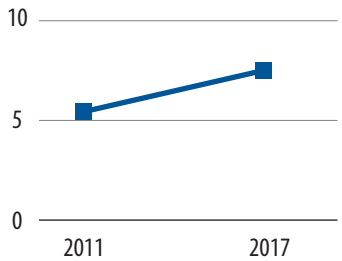
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.82 | - | 0.39 |
| Child psychiatrists | - | - | 0.04 |
| Other specialist doctors | 0.25 | - | 0.41 |
| Nurses (e.g. psychiatric nurse) | 3.31 | - | 2.66 |
| Psychologists | 0.34 | - | 1.99 |
| Social workers | 0.5 | - | 2.10 |
| Occupational therapists | 0.2 | - | 0.11 |
| Speech therapists | - | - | 0.11 |
| Other paid mental health workers | - | - | 0.00 |

75% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




2.2% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

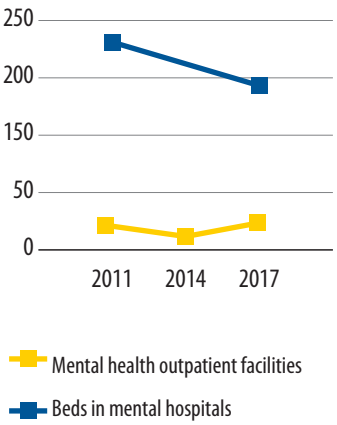
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 2 | 0.043 | 190 | 4.07 | 1 117 | 23.96 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 0 | 0 | 0 | 0 | 0 | 0 |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

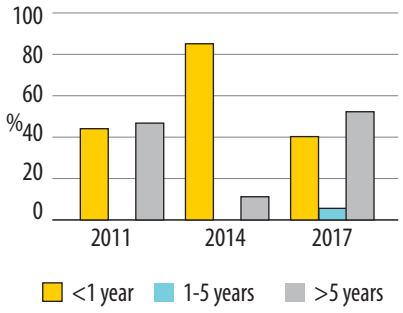
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 2 | 0.043 | 3 224 | 69.14 |
| Community-based outpatient facility | 19 | 0.407 | 145,549 | 3 121.44 |
| Other outpatient facility (e.g. day care) | 2 | 0.043 | 4 233 | 90.78 |
| Outpatient service for children and adolescents | 1 | 0.021 | 11 258 | 241.44 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



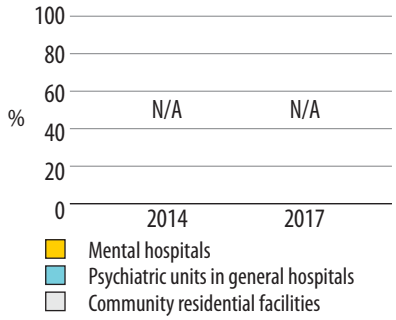

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 47.8 | - | 37.0 |
| Outpatient | 1 506.6 | - | 539.1 |
| **Total** | **1 554.4** | **-** | **576.1** |

### Follow-up and social support

- 51–75% of discharged inpatients received a follow-up outpatient visit within one month. ✓
- The majority of persons with severe mental disorders receive social support from government. This includes income support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Two functioning prevention/promotion programmes.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| School-Based programme | School-based mental health promotion | District | Jointly managed |
| Child protection programme | Violence prevention (including child abuse) | District | Jointly managed |

- Health status and outcome indicators. Periodic/regular reporting of: prevalence of mental disorders, and suicide mortality rate. No reporting of: mental health status or outcomes for persons using mental health services.
- Health system indicators. Periodic/regular reporting of: beds in mental hospitals; admissions to mental hospitals; persons with mental disorders using mental health outpatient services; primary/general health workers receiving in-service training. Occasional reporting of: involuntary hospital admissions; persons with mental disorders using primary health care services.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Oman

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 4 199 810 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | High income | Disability-adjusted life years (per 100 000 population):[c] | **2 827.66** |
| Country group: | 1 | Suicide (age-standardized per 100 000 population):[d] | **3.9** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | Mental health data (in the public or private system or both) compiled for general health statistics in the last two years, but not in a specific mental health report. | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone Mental Health Policy published/revised in 2016. ✓
- Resources needed to implement: not estimated.
- Specified indicators used to monitor implementation of some / a few components. ✓
- Plan or strategy for CAMH published in 2016. ✓

### Mental health legislation

- Mental Health Legislation does not exist.
- A dedicated authority or independent body to provide regular inspections in mental health facilities does not exist.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

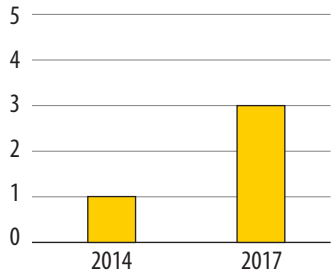
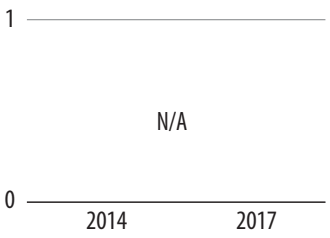



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Two formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | × |
| International NGOs | × |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, but mental disorders not explicitly listed as excluded.
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | – | – | – |
| Nurses | – | – | – |
| Other health care workers | – | – | – |
| Mixed groups | – | – | – |
| **Total** | – | – | – |

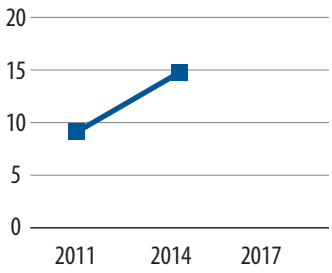
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 2.31 | 2.32 | 1.74 |
| Child psychiatrists | - | - | 0.00 |
| Other specialist doctors | 0.41 | - | 0.00 |
| Nurses (e.g. psychiatric nurse) | 6.57 | 12.71 | 3.00 |
| Psychologists | 0.17 | 0.38 | 0.79 |
| Social workers | 0.07 | 0.25 | 0.00 |
| Occupational therapists | 0.1 | 0.25 | 0.00 |
| Speech therapists | - | - | 0.00 |
| Other paid mental health workers | - | 0.18 | 0.00 |

100% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

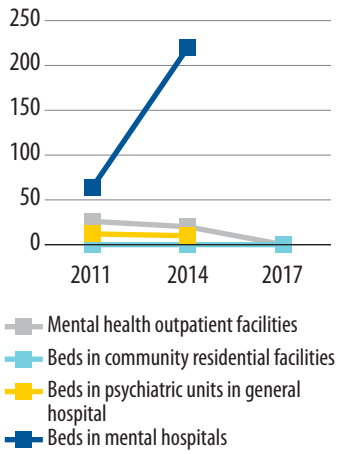
**Table 4.** Availability and use of inpatient mental health services

| *If appears as "0", it was reported as not existing. If appears as "-", it was not reported.* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | - | - | - | - | - | - |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | - | - | - | - | - | - |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | - | - | - | - | - | - |

**Table 5.** Availability and use of outpatient mental health services

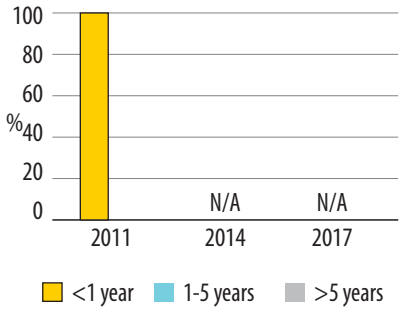
| *If appears as "0", it was reported as not existing. If appears as "-", it was not reported.* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 0 | 0 | 0 | 0 |
| Community-based outpatient facility | - | - | - | - |
| Other outpatient facility (e.g. day care) | - | - | - | - |
| Outpatient service for children and adolescents | - | - | - | - |
| Other outpatient for children and adolescents | - | - | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



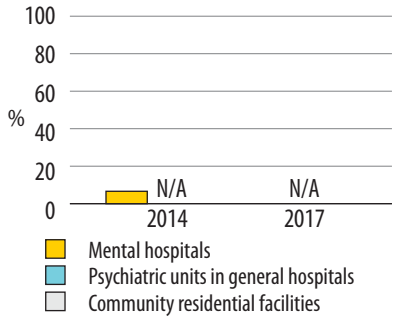

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | - | - | - |

### Follow-up and social support

- Percentage of discharged inpatients who received a follow-up outpatient visit within one month: not reported.
- Government social support provided to persons with mental disorders does not include: income, housing, employment, education, social care, legal, family and other support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist.

Functioning prevention/promotion programmes: not reported.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| - | - | - | - |
| - | - | - | - |

- Health status and outcome indicators. Periodic/regular reporting of: prevalence of mental disorders; mental health status or outcomes for persons using mental health services. No reporting of: suicide mortality rate.
- Health system indicators. Periodic/regular reporting of: beds in mental hospitals; beds in psychiatric units of general hospitals; admissions to mental hospitals; admissions to psychiatric units of general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary/general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Pakistan

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 189 380 513 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 430.27** |
| Country group: | 3 | Suicide (age-standardized per 100 000 population):[d] | **2.9** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | No mental health data have been compiled in a report for policy, planning or management purposes in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Mental health policy integrated into the plan for general health or disability published/revised in 2016.
- Separate assessment of resources needed has been undertaken.
- Does not contain specified indicators to monitor implementation.
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Stand-alone mental health legislation enacted in 2001.
- A dedicated authority or independent body to provide regular inspections in mental health facilities does not exist.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

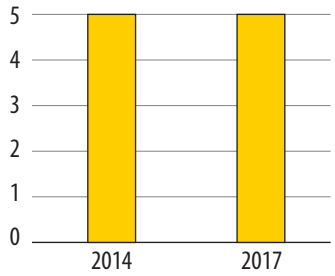
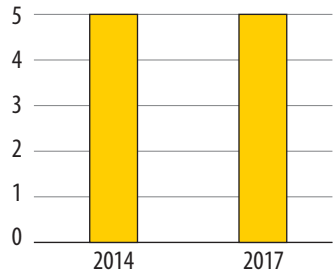



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Two formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 0.4%.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, but mental disorders not explicitly listed as excluded conditions.
- Persons pay at least 20% to the cost of mental health services/psychotropic medicines

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | – | – | – |
| Nurses | – | – | – |
| Other health care workers | – | – | – |
| Mixed groups | – | – | – |
| **Total** | – | – | – |

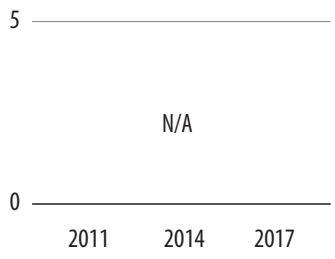
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported for 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.185 | 0.31 | - |
| Child psychiatrists | - | - | - |
| Other specialist doctors | 13.96 | 49.40 | - |
| Nurses (e.g. psychiatric nurse) | 7.38 | 15.43 | - |
| Psychologists | 0.26 | 1.09 | - |
| Social workers | 1.70 | 2.32 | - |
| Occupational therapists | 0.01 | 0.03 | - |
| Speech therapists | - | - | - |
| Other paid mental health workers | 55.5 | 116.84 | - |

Percentage of mental health staff work in government mental health services: not reported

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




Percentage of mental health staff work in CAMH: not reported

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

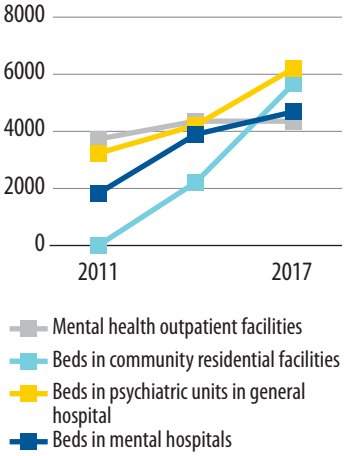
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 11 | 0.006 | 4 682 | 2.47 | - | - |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 800 | 0.422 | 6 200 | 3.27 | - | - |
| Community residential unit | 578 | 0.305 | 5 660 | 2.99 | - | - |
| Inpatient for children and adolescents | 2 | 0.001 | 15 | 0.01 | - | - |

**Table 5.** Availability and use of outpatient mental health services

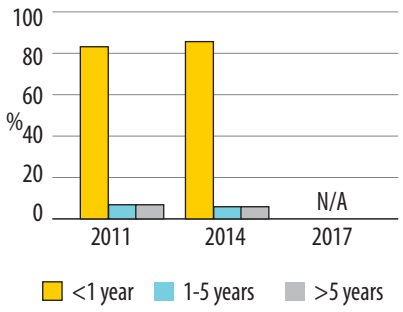
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 3 729 | 1 969 | - | - |
| Community-based outpatient facility | 624 | 0.329 | - | - |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 3 | 0.002 | - | - |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



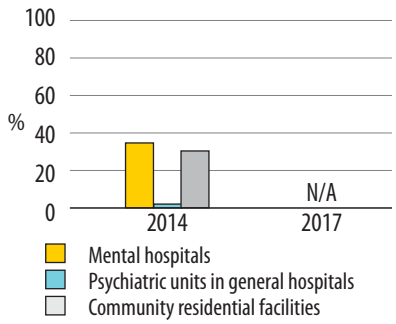

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | - | - | - |

### Follow-up and social support

- 51–75% of discharged inpatients received a follow-up outpatient visit within one month.
- No persons with mental disorders receive social support from government.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Five or more functioning prevention/promotion programmes.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| School Mental Health Programme | School-based mental health promotion | District | NGO |
| Family Networks to improve outcomes in children with developmental disorders (FaNs for Kids Project) | Early childhood development/stimulation | Community | NGO |
| Thinking health programme | Mental health awareness/anti-stigma | Community | NGO |
| Sustainable Programme Incorporating Nutrition and Games (SPRING) | Early childhood development/stimulation | Community | NGO |
| South Asian Hub for Advocacy Research and Education in Mental Health (SHARE) | Parental/maternal mental health promotion | Regional | Jointly managed |

- Health status and outcome indicators. No reporting of: prevalence of mental disorders; suicide mortality rate; mental health status or outcomes for persons using mental health services.
- Health system indicators: not reported.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Qatar

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 2 617 634 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | High income | Disability-adjusted life years (per 100 000 population):[c] | **4 214.00** |
| Country group: | 1 | Suicide (age-standardized per 100 000 population):[d] | **6.6** |
| Total mental health expenditure per person (reported currency): | 40.42 riyals | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only has been published by the Health Department or other government unit last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2013. ✓
- Resources allocated in line with estimates.
- Specified indicators used to monitor implementation of most/all components. ✓
- Plan or strategy for CAMH published in 2013. ✓

### Mental health legislation

- Stand-alone mental health legislation enacted in 2016. ✓
- A dedicated authority or independent body to provide regular inspections in mental health facilities exists but it is not functioning.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

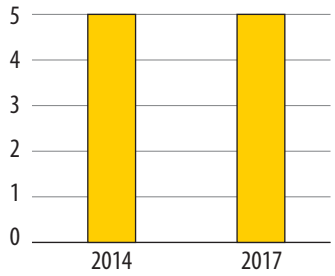
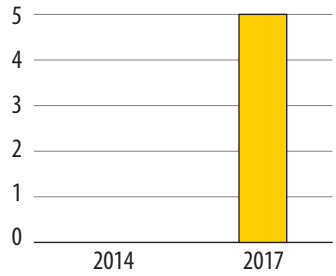



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** Five formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | ✓ |
| Local NGOs | ✓ |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | ✓ |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | ✓ |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 0.61%.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders explicitly listed as included. ✓
- Persons pay at least 20% to the cost of mental health services/psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 1 | 463 | 10.9% |
| Nurses | 1 | 132 | 1.1% |
| Other health care workers | 2 | 48 | – |
| Mixed groups | 2 | – | – |
| **Total** | **6** | **643** | – |

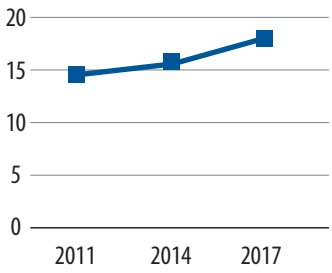
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 1.66 | 2.95 | 2.71 |
| Child psychiatrists | - | - | 0.15 |
| Other specialist doctors | 0.2 | - | 0.00 |
| Nurses (e.g. psychiatric nurse) | 10.94 | 8.82 | 9.93 |
| Psychologists | 1.26 | 1.28 | 1.41 |
| Social workers | 0.46 | 0.13 | 0.11 |
| Occupational therapists | 0.4 | 0.26 | 0.61 |
| Speech therapists | - | - | 0.00 |
| Other paid mental health workers | - | 2.82 | 3.17 |

74% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




1.9% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

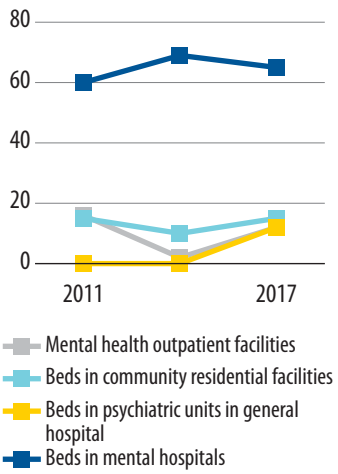
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 1 | 0.04 | 65 | 2.48 | 1,099 | 41.98 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 1 | 0.04 | 12 | 0.46 | - | - |
| Community residential unit | 2 | 0.08 | 15 | 0.57 | 7 | 0.27 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

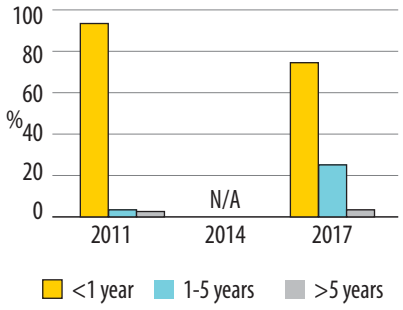
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 7 | 0.27 | 28 368 | 1 083.73 |
| Community-based outpatient facility | 0 | 0 | 0 | 0 |
| Other outpatient facility (e.g. day care) | 2 | 0.08 | 5 648 | 215.77 |
| Outpatient service for children and adolescents | 2 | 0.08 | 5 423 | 207.17 |
| Other outpatient for children and adolescents | 1 | 0.04 | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



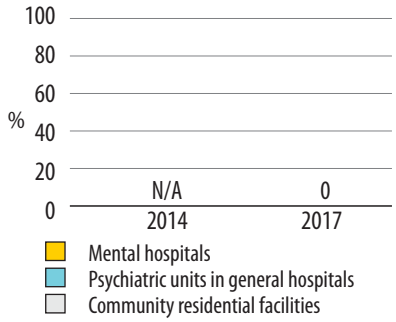

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 4.2 | 8.6 | 6.1 |
| Outpatient | 0 | 0 | 11.6 |
| **Total** | **4.2** | **8.6** | **17.7** |

### Follow-up and social support

- 25% or less of discharged inpatients received a follow-up outpatient visit within one month.
- Few or some persons with severe mental disorders receive social support from government. This includes social care and family support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Three functioning prevention/promotion programmes. ✓

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| Mental Health Awareness | Mental health awareness/anti-stigma | National | Government |
| Mental Health and Wellbeing Champions | Workplace mental health promotion | National | Government |
| Mental Health in Schools | School-based mental health promotion | National | Jointly managed |

- Health status and outcome indicators. Periodic or regular reporting of: prevalence of mental disorders; mental health status or outcomes for persons using mental health services. No reporting of: suicide mortality rate.
- Health system indicators. Automatic and/or continuous reporting of: beds in mental hospitals; admissions to mental hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services. Periodic/regular reporting of: primary/general health workers receiving in-service training. No reporting of: beds in psychiatric units of general hospitals; admissions to psychiatric units of general hospitals.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Saudi Arabia

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 31 557 144 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | High income | Disability-adjusted life years (per 100 000 population):[c] | **2 916.55** |
| Country group: | 1 | Suicide (age-standardized per 100 000 population):[d] | **3.2** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only has been published by the Health Department or other government unit in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2011.
- Separate assessment of resources needed to implement. ✓
- Specified indicators used to monitor implementation of most/all components ✓
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Stand-alone mental health legislation enacted in 2016.
- A dedicated authority or independent body provides regular inspections in mental health facilities and reports at least annually to stakeholders. ✓

### Multisectoral collaboration

**Table 1.** Five formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | ✓ |
| Ministry of justice | ✓ |
| Ministry of the interior | ✓ |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | × |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

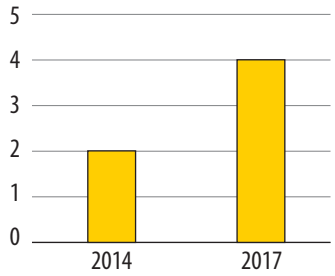
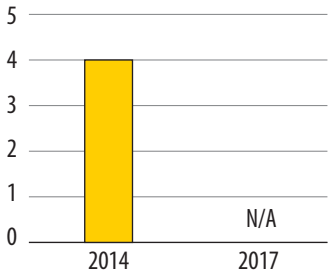



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 4%.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, but mental disorders not explicitly listed as excluded.
- Persons pay at least 20% to the cost of mental health services and psychotropic medicines.

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 5 | 150 | 0.19% |
| Nurses | 8 | 260 | 0.16% |
| Other health care workers | 7 | 290 | – |
| Mixed groups | – | – | – |
| **Total** | **20** | **700** | – |

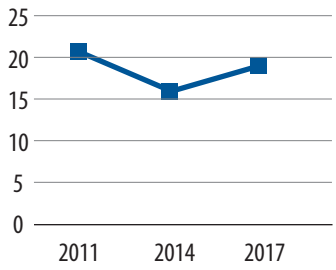
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *If 0.00, it has either not been reported or is zero* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 2.9 | 2.1 | 1.32 |
| Child psychiatrists | - | - | 0.00 |
| Other specialist doctors | - | - | 1.36 |
| Nurses (e.g. psychiatric nurse) | 13.4 | 10.5 | 10.66 |
| Psychologists | 1.7 | 1.4 | 2.03 |
| Social workers | 2.9 | 2.5 | 3.95 |
| Occupational therapists | - | - | 0.00 |
| Speech therapists | - | - | 0.00 |
| Other paid mental health workers | - | - | 0.00 |

100% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

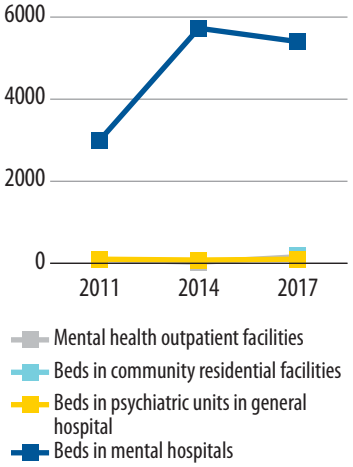
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 25 | 0.08 | 5 401 | 17.11 | 24 825 | 78.7 |
| Forensic inpatient unit | 3 | 0.01 | 120 | 0.38 | 200 | 0.63 |
| Psychiatric unit in general hospital | 4 | 0.01 | 100 | 0.32 | - | - |
| Community residential unit | 4 | 0.01 | 200 | 0.63 | - | - |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

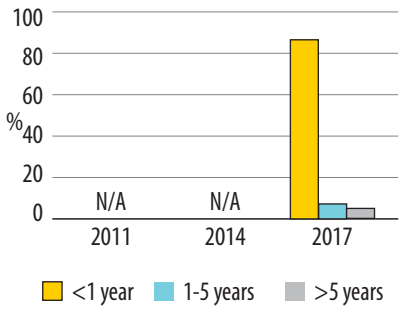
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 25 | 0.08 | 495 692 | 1 570.78 |
| Community-based outpatient facility | 116 | 0.37 | - | - |
| Other outpatient facility (e.g. day care) | 0 | 0 | - | - |
| Outpatient service for children and adolescents | 19 | 0.06 | - | - |
| Other outpatient for children and adolescents | - | - | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



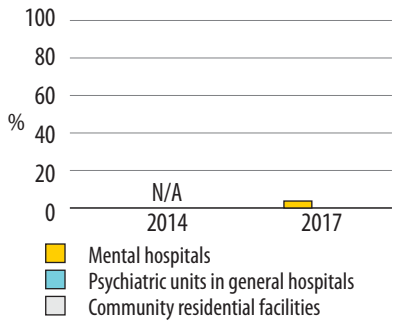

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 27.6 | 6.4 | 3.6 |
| Outpatient | 455.8 | 324.3 | 136.5 |
| **Total** | 483.4 | 330.7 | 139.7 |

### Follow-up and social support

- More than 75% of discharged inpatients received a follow-up outpatient visit within one month. ✓
- The majority of patients with severe and non-severe mental disorders receive social support from government. This includes income, housing, employment, education, social care, legal and family support. ✓

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist.

Five or more functioning prevention/promotion programmes ✓

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| School Mental Health Programme | School-based mental health promotion | National | Government |
| Early Childhood Programme | Early childhood development / stimulation | National | Government |
| Family Safety Programme | Parental / maternal mental health promotion | National | Government |
| High Risk Group Program | Violence prevention (including child abuse) | National | Government |
| Women Mental Health Programme | Parental/maternal mental health promotion | National | Government |

- Health status and outcome indicators. Periodic/regular reporting of: prevalence of mental disorders, suicide mortality rate, and mental health status or outcomes for persons using mental health services.
- Health system indicators. Periodic/regular reporting of: beds in mental hospitals; beds in psychiatric units in general hospitals; admissions to mental hospitals; admissions to psychiatric units in general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary/general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Somalia

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 13 908 129 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Low income | Disability-adjusted life years (per 100 000 population):[c] | **2 656.55** |
| Country group: | 3 | Suicide (age-standardized per 100 000 population):[d] | **4.7** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | No mental health data have been compiled in a report for policy, planning or management purposes in the last two years. | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Mental health policy integrated into those for general health or disability published/ revised in 2013.
- No estimate or assessment of resources needed to implement.
- Does not contain specified indicators to monitor implementation.
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Mental health legislation does not exist.
- A dedicated authority or independent body does not exist.

### Multisectoral collaboration

**Table 1.** No formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | × |
| International NGOs | × |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

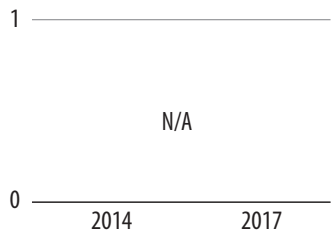
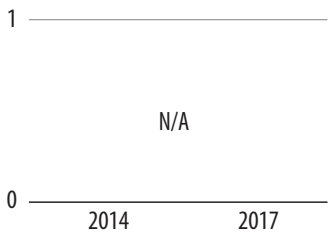



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, but mental disorders not explicitly listed as excluded.
- Persons pay mostly or entirely out of pocket for services and medicines.

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | – | – | – |
| Nurses | – | – | – |
| Other health care workers | – | – | – |
| Mixed groups | – | – | – |
| **Total** | **–** | **–** | **–** |

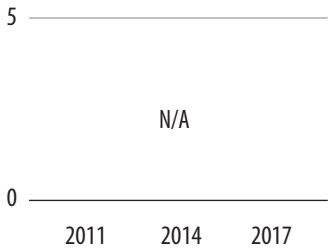
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported in 2014 and 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.04 | - | - |
| Child psychiatrists | - | - | - |
| Other specialist doctors | 0.02 | - | - |
| Nurses (e.g. psychiatric nurse) | 0.45 | - | - |
| Psychologists | 0 | - | - |
| Social workers | 0.96 | - | - |
| Occupational therapists | 0 | - | - |
| Speech therapists | - | - | - |
| Other paid mental health workers | 1.66 | - | - |

100% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

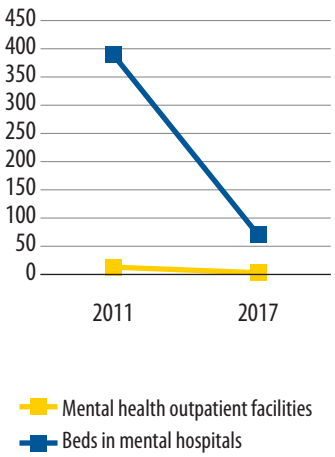
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 1 | 0.007 | 70 | 0.50 | 312 | 2.24 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 0 | 0 | 0 | 0 | 0 | 0 |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

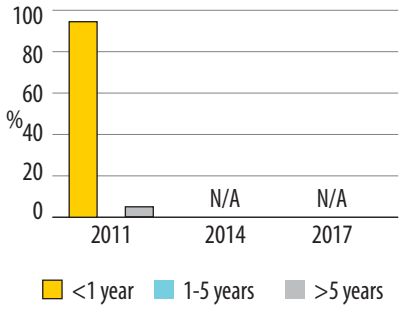
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 1 | 0.007 | 613 | 4.41 |
| Community-based outpatient facility | 0 | 0 | 0 | 0 |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 0 | 0 | 0 | 0 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



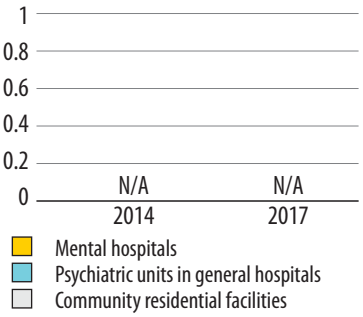

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | **-** | **-** | **-** |

### Follow-up and social support

- Percentage of discharged inpatients, who received a follow-up outpatient visit within one month: not reported.
- Social support from government for persons with mental disorders: not reported.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. No functioning prevention/promotion programmes reported.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| | | | |

- Health status and outcome indicators. Not reported
- Health system indicators. Not reported

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Sudan

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 38 647 803 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 855.54** |
| Country group: | 3 | Suicide (age-standardized per 100 000 population):[d] | **8.1** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | No mental health data have been compiled in a report for policy, planning or management purposes in last two years. | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2012.
- Contains an estimate of resources needed, but resources have not been allocated in line with estimates.
- Contains specified indicators to monitor implementation, but these have not been used in last two years.
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Stand-alone mental health legislation enacted in 2016. ✓
- A dedicated authority or independent body to provide regular inspections in mental health facilities does not exist.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

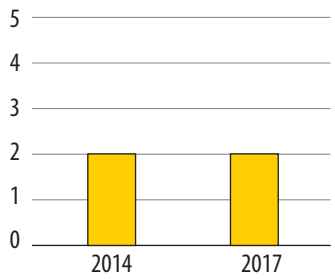
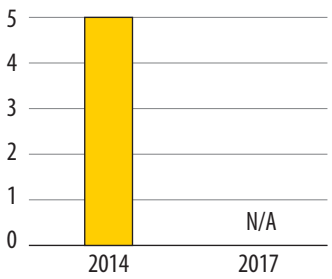



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




### Multisectoral collaboration

**Table 1.** No formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | × |
| International NGOs | × |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders explicitly listed as included. ✓
- Persons pay at least 20% to the cost of mental health services/psychotropic medicines.

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 0 | 0 | 0% |
| Nurses | 0 | 0 | 0% |
| Other health care workers | 0 | 0 | – |
| Mixed groups | 0 | – | – |
| **Total** | **0** | **0** | – |

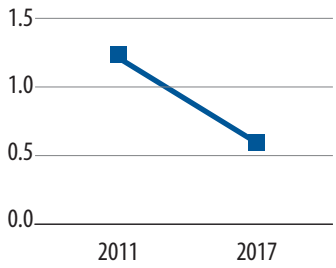
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported in 2014 and 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.06 | - | 0.08 |
| Child psychiatrists | - | - | 0.01 |
| Other specialist doctors | (8.17) | - | 0.0 |
| Nurses (e.g. psychiatric nurse) | 0.1 | - | 0.0 |
| Psychologists | 0.48 | - | 0.0 |
| Social workers | 0.6 | - | 0.55 |
| Occupational therapists | 0 | - | 0.0 |
| Speech therapists | - | - | 0.0 |
| Other paid mental health workers | (21.03) | - | 0.0 |

99% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

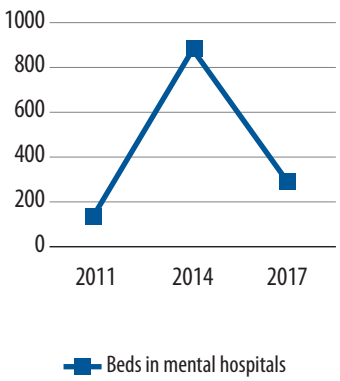
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | - | - | 314 | 0.81 | 3,358 | 8.69 |
| Forensic inpatient unit | - | - | - | - | - | - |
| Psychiatric unit in general hospital | - | - | - | - | - | - |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

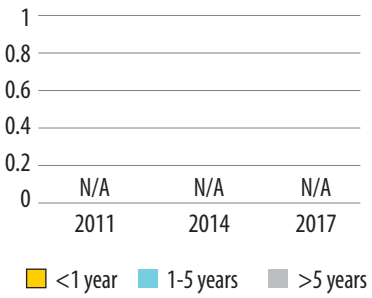
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 0 | 0 | 0 | 0 |
| Community-based outpatient facility | 0 | 0 | 0 | 0 |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 0 | 0 | 0 | 0 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



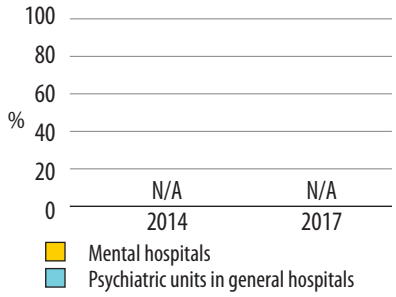

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | **-** | **-** | **-** |

### Follow-up and social support

- 25% or less of discharged inpatients received a follow-up outpatient visit within one month.
- No persons with mental disorders receive social support from government.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist.

No functioning prevention/promotion programmes reported.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|

- Health status and outcome indicators. No reporting of: prevalence of mental disorders. Suicide mortality rate, and mental health status or outcomes for persons using mental health services: not reported.
- Health system indicators. No reporting of: beds in mental hospitals; beds in psychiatric units of general hospitals; admissions to mental hospitals; admissions to psychiatric units of general hospitals. Involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary/general health workers receiving in-service training: not reported.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Syrian Arab Republic

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 18 734 987 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 784.60** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **1.9** |
| Total mental health expenditure per person (reported currency): | 133.44 Syrian pounds | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only has been published by the Health Department or other government unit in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2013.
- A separate assessment of resource needs has been carried out.
- Specified indicators used to monitor implementation of most/all components. ✓
- Plan or strategy for CAMH published in 2017. ✓

### Mental health legislation

- Mental health legislation is integrated into general health or disability law enacted in 2013.
- A dedicated authority or independent body to provide regular inspections in mental health facilities does not exists.

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

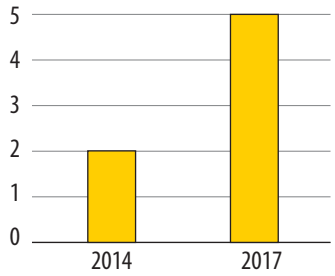



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)


### Multisectoral collaboration

**Table 1.** No formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | × |
| International NGOs | × |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: 0.2%.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, and mental disorders explicitly listed as excluded.
- Persons pay mostly or entirely out of pocket for mental health services and medicines.

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 86 | 2 000 | 6.9% |
| Nurses | 25 | 600 | 1.4% |
| Other health care workers | 17 | 400 | – |
| Mixed groups | 6 | – | – |
| **Total** | 134 | 3 000 | – |

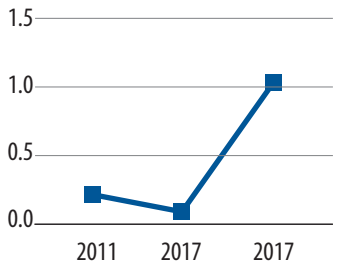
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported in 2014 and 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.31 | - | 0.37 |
| Child psychiatrists | - | - | 0.00 |
| Other specialist doctors | 0.38 | 0.15 | 6.94 |
| Nurses (e.g. psychiatric nurse) | 1.21 | 0.83 | 1.07 |
| Psychologists | 0.1 | 0.12 | 1.07 |
| Social workers | 0.12 | 0.05 | 0.80 |
| Occupational therapists | 0 | 0.05 | 0.00 |
| Speech therapists | - | - | 0.06 |
| Other paid mental health workers | 0.2 | - | 0.00 |

5% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

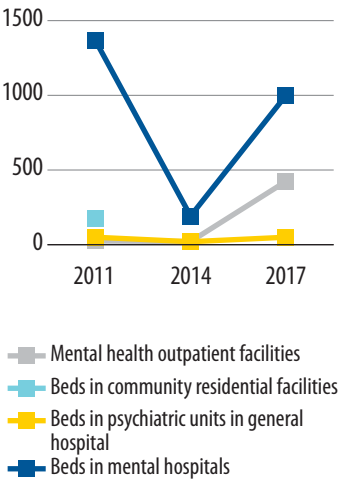
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 3 | 0.016 | 1000 | 5.34 | 2160 | 11.53 |
| Forensic inpatient unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Psychiatric unit in general hospital | 3 | 0.016 | 50 | 0.27 | 1000 | 5.34 |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

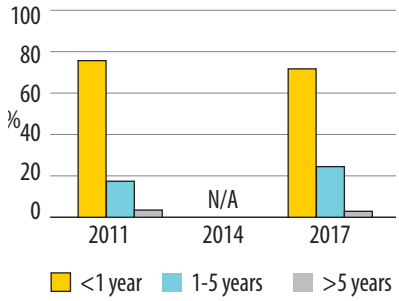
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 9 | 0.048 | 28500 | 152.12 |
| Community-based outpatient facility | 400 | 2.135 | 85000 | 453.70 |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 15 | 0.080 | 2500 | 13.34 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



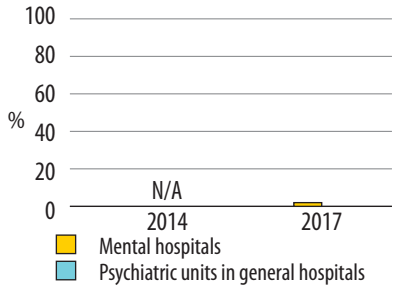

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 10.7 | 0.7 | 2.7 |
| Outpatient | 56.0 | 14.9 | 78.5 |
| **Total** | **66.6** | **15.5** | **81.1** |

### Follow-up and social support

- 25% or less of discharged inpatients received a follow-up outpatient visit within one month.
- Few or some persons with severe mental disorders receive social support from government. This does not include income, housing, employment, education, social care, legal or family support. It does include other support.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Four functioning prevention/promotion programmes.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| The importance of mental health during crisis | Mental health awareness/anti-stigma | National | Government |
| Raising awareness about mental health | Violence prevention (including child abuse) | Community | NGO |
| Raising awareness about mental health | Early childhood development / stimulation | Community | NGO |
| Raising awareness about mental health | Parental / maternal mental health promotion | Community | NGO |

- Health status and outcome indicators. Periodic/regular reporting of: prevalence of mental disorders; suicide mortality rate. No reporting of: mental health status or outcomes for persons using mental health services.
- Health system indicators. Periodic regular reporting of: beds in mental hospitals; beds in psychiatric units in general hospitals; admissions to mental hospitals; admissions to psychiatric units in general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary/general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Tunisia

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 11 273 661 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **3 116.06** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **3.4** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | Not reported or not available | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy/plan published in 1990 and revised in 2014.
- Estimate of resources needed is not contained in policy/plan, and no separate assessment of resources.
- No specified indicators to monitor implementation.
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Stand-alone mental health legislation enacted in 1992.
- A dedicated authority or independent body to assess compliance of mental health legislation does not exist.

### Multisectoral collaboration

**Table 1.** No formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | × |
| International NGOs | × |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

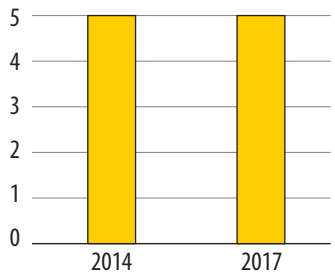
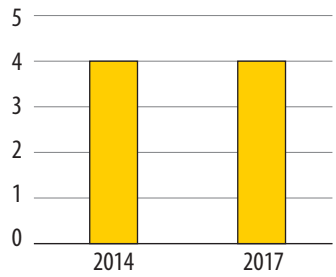



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, but mental disorders not explicitly listed as excluded.
- Persons pay mostly or entirely out of pocket for mental health services and medicines.

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | – | – | – |
| Nurses | 2 | 22 | 0.06% |
| Other health care workers | – | – | – |
| Mixed groups | – | – | – |
| **Total** | – | – | – |

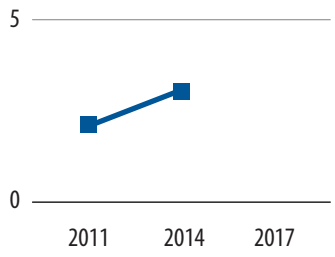
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported in 2014 and 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 1.98 | 2.58 | - |
| Child psychiatrists | - | - | - |
| Other specialist doctors | 0.92 | - | - |
| Nurses (e.g. psychiatric nurse) | 4.08 | - | - |
| Psychologists | 1.12 | 1.06 | 0.20 |
| Social workers | 0.31 | 0.35 | 0.01 |
| Occupational therapists | 0.04 | - | - |
| Speech therapists | - | - | - |
| Other paid mental health workers | - | - | - |

Percentage of mental health staff working in government mental health services: not reported.

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




Percentage of psychiatrists in government CAMH: not reported.

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

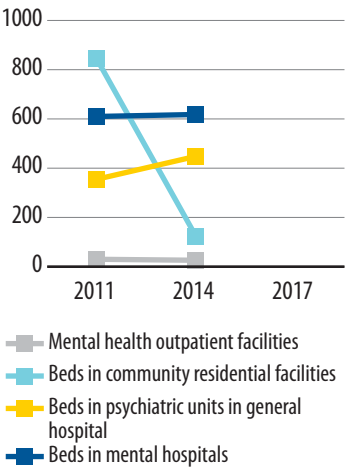
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 1 | 0.009 | 30 | 0.27 | - | - |
| Forensic inpatient unit | - | - | - | - | - | - |
| Psychiatric unit in general hospital | - | - | - | - | - | - |
| Community residential unit | - | - | - | - | - | - |
| Inpatient for children and adolescents | - | - | - | - | - | - |

**Table 5.** Availability and use of outpatient mental health services

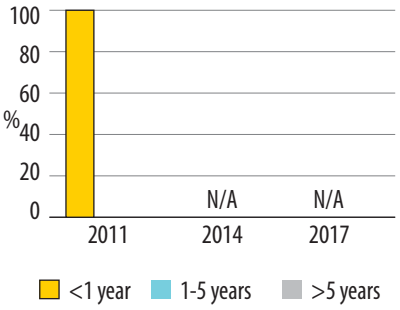
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | - | - | - | - |
| Community-based outpatient facility | - | - | - | - |
| Other outpatient facility (e.g. day care) | - | - | - | - |
| Outpatient service for children and adolescents | - | - | - | - |
| Other outpatient for children and adolescents | - | - | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



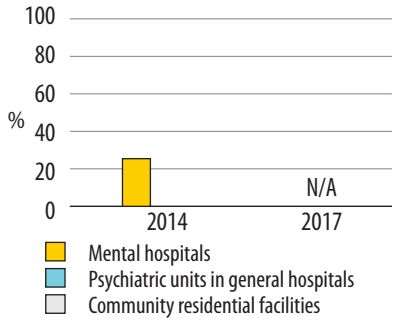

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | **-** | **-** | **-** |

### Follow-up and social support

- Percentage of discharged inpatients received a follow-up outpatient visit within one month: not reported.
- Availability of government social support: not reported

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy is in development. Functioning prevention/promotion programmes: not reported.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| | | | |

- Health status and outcome indicators. Not reported.
- Health system indicators. Not reported.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# United Arab Emirates

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 9 154 302 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | High income | Disability-adjusted life years (per 100 000 population):[c] | **4 240.82** |
| Country group: | 1 | Suicide (age-standardized per 100 000 population):[d] | **2.8** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | A specific report focusing on mental health activities in the public sector only published by the Health Department or other government unit in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Stand-alone mental health policy published/revised in 2016. ✓
- Does not contain estimate of resources needed, and no separate assessment of resources needed has been carried out.
- Specified indicators used to monitor implementation of some/a few components.
- Plan or strategy for CAMH published in 2016. ✓

### Mental health legislation

- Stand-alone mental health legislation enacted in 2016 ✓
- A dedicated authority or independent body to provide regular inspections in mental health facilities does not exist.

### Multisectoral collaboration

**Table 1.** Four formal collaborations between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | ✓ |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | ✓ |
| International NGOs | × |
| Private sector | × |
| Professional associations | ✓ |
| Faith-based organizations | × |
| Traditional healers | ✓ |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

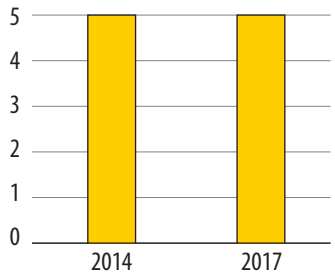
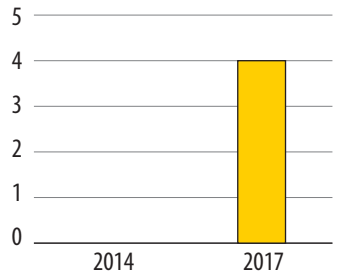



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders included in national health insurance or reimbursement schemes, and disorders explicitly listed as included. ✓
- Persons pay nothing at point of use for mental health services and psychotropic medicines. ✓

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 8 | 46 | 0.32% |
| Nurses | 8 | 40 | 0.14% |
| Other health care workers | 3 | 10 | – |
| Mixed groups | 1 | – | – |
| **Total** | **20** | **96** | – |

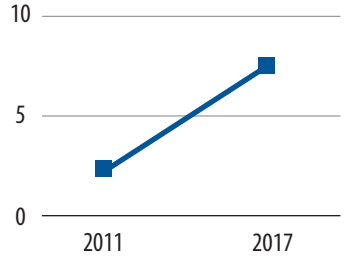
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported in 2014 and 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.18 | - | 1.65 |
| Child psychiatrists | - | - | - |
| Other specialist doctors | 0.07 | - | - |
| Nurses (e.g. psychiatric nurse) | 1.26 | - | 4.37 |
| Psychologists | 0.3 | - | 0.76 |
| Social workers | 0.15 | - | 0.36 |
| Occupational therapists | 0.02 | - | 0.04 |
| Speech therapists | - | - | 0.07 |
| Other paid mental health workers | 0.02 | - | - |

89% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

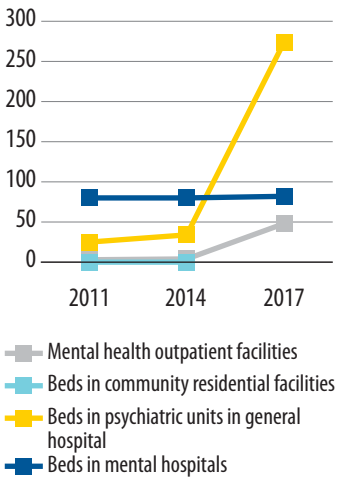
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 1 | 0.011 | 82 | 0.90 | 639 | 6.98 |
| Forensic inpatient unit | 2 | 0.022 | - | - | - | - |
| Psychiatric unit in general hospital | 5 | 0.055 | 274 | 2.99 | 465 | 5.08 |
| Community residential unit | 3 | 0.033 | - | - | - | - |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

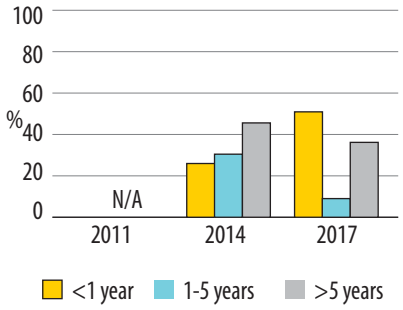
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 10 | 0.109 | 40,972 | 447.57 |
| Community-based outpatient facility | 31 | 0.339 | 633 | 6.91 |
| Other outpatient facility (e.g. day care) | - | - | - | - |
| Outpatient service for children and adolescents | 7 | 0.076 | - | - |
| Other outpatient for children and adolescents | - | - | - | - |

**Fig. 4.** Changes in bed numbers and outpatient provision



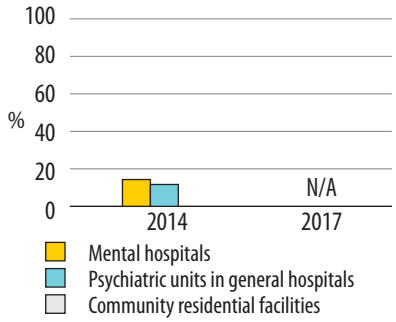

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | 21.6 | 3.9 | 3.0 |
| Outpatient | - | - | - |
| **Total** | - | - | - |

### Follow-up and social support

- More than 75% of discharged inpatients received a follow-up outpatient visit within one month. ✓
- The majority of patients with severe and non-severe mental disorders receive social support from government. This includes income, housing, employment, education, social care, legal, and other support. ✓

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Three functioning prevention/promotion programmes

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|
| Live Life Programme | Mental health awareness/anti-stigma | Regional | Jointly managed |
| Mental Health Awareness for RTA Drivers | Workplace mental health promotion | District | Jointly managed |
| Sehhat Ajyal (ADHD) | School-based mental health promotion | Community | Jointly managed |

- Health status and outcome indicators. Automatic and/or continuous reporting of mental health status or outcomes for persons using mental health services. Periodic/regular reporting of: prevalence of mental disorders. No reporting of: suicide mortality rate.
- Health system indicators. Periodic/regular reporting of: beds in mental hospitals; beds in psychiatric units in general hospitals; admissions to mental hospitals; admissions to psychiatric units in general hospitals; involuntary hospital admissions; persons with mental disorders using mental health outpatient services; persons with mental disorders using primary health care services; primary/general health workers receiving in-service training.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

# Yemen

| | | | |
|---|---|---|---|
| Total population (UN estimate):[a] | 26 916 207 | **Burden of mental disorders (WHO official estimates)** | |
| Income group:[b] | Lower-middle | Disability-adjusted life years (per 100 000 population):[c] | **2 864.48** |
| Country group: | 2 | Suicide (age-standardized per 100 000 population):[d] | **8.5** |
| Total mental health expenditure per person (reported currency): | Not reported | | |
| Availability/status of mental health reporting: | No mental health data have been compiled in a report for policy, planning or management purposes in last two years | | |

## MENTAL HEALTH SYSTEM GOVERNANCE

### Mental health policy/plan

- Mental health policy/plan 2011–2015.
- Plan does not include estimates of human or financial resources required to implement it.
- Plan does not include specified indicators against which its implementation can be measured.
- Plan or strategy for CAMH does not exist.

### Mental health legislation

- Mental health legislation does not exist.
- A dedicated authority or independent body to provides regular inspections in mental health facilities does not exist

### Multisectoral collaboration

**Table 1.** One formal collaboration between government mental health services and other departments, services and sectors

| | |
|---|---|
| Ministry of social affairs | × |
| Ministry of education | × |
| Ministry of justice | × |
| Ministry of the interior | × |
| Housing sector | × |
| Employment sector | × |
| Media sector | × |
| Academic sector | × |
| Local NGOs | × |
| International NGOs | ✓ |
| Private sector | × |
| Professional associations | × |
| Faith-based organizations | × |
| Traditional healers | × |
| Service users and family/carer advocacy groups | × |

**Fig 1.** Compliance of policy/plan with international human rights instruments (5 criteria)

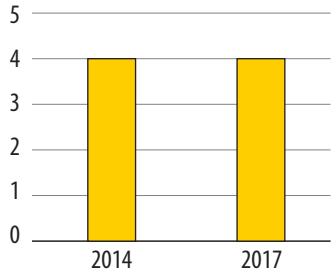
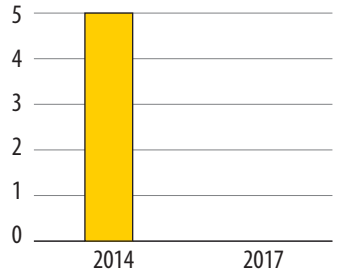



**Fig 2.** Compliance of legislation with international human rights instruments (5 criteria)




## FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

### Government mental health spending

- Government total expenditure on mental health as percentage of total health expenditure: not reported.
- Care and treatment for major mental disorders not included in national health insurance or reimbursement schemes, but mental disorders not explicitly excluded.
- Persons pay mostly or entirely out of pocket for services and medicines.

### Mental health training in general health care

**Table 2.** Training for staff working in general health care in the last year

| | Number of courses | Number trained | % of total workforce |
|---|---|---|---|
| Doctors | 4 | 143 | 1.76% |
| Nurses | 3 | 86 | 0.43% |
| Other health care workers | 2 | 92 | – |
| Mixed groups | 5 | – | – |
| **Total** | **14** | **321** | – |

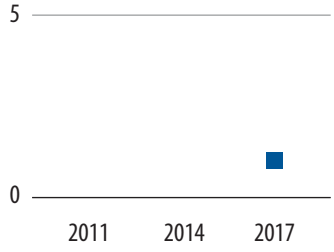
### Mental health workforce

**Table 3.** Numbers of mental health staff per 100 000 population

| *Not reported in 2014 and 2017* | 2011 | 2014 | 2017 |
|---|---|---|---|
| Psychiatrists | 0.21 | - | 0.20 |
| Child psychiatrists | - | - | 0.01 |
| Other specialist doctors | 0.08 | - | 0.004 |
| Nurses (e.g. psychiatric nurse) | - | - | 0.32 |
| Psychologists | - | - | 0.41 |
| Social workers | - | - | 0.06 |
| Occupational therapists | - | - | 0.0 |
| Speech therapists | - | - | 0.02 |
| Other paid mental health workers | - | - | 0.0 |

35% of mental health staff work in government mental health services

**Fig 3.** Total mental health workforce per 100 000 population in 2011, 2014 and 2017




0% of mental health staff work in CAMH

## MENTAL HEALTH SERVICE AVAILABILITY AND UTILIZATION

### Service availability

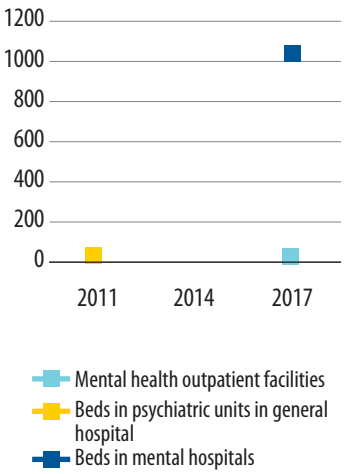
**Table 4.** Availability and use of inpatient mental health services

| *If 0, it has either not been reported or is zero* | Facilities | | Beds | | Admissions | |
|---|---|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Mental hospital | 9 | 0.033 | 1 023 | 3.80 | - | - |
| Forensic inpatient unit | 1 | 0.004 | 170 | 0.63 | - | - |
| Psychiatric unit in general hospital | 7 | 0.026 | - | - | - | - |
| Community residential unit | 0 | 0 | 0 | 0 | 0 | 0 |
| Inpatient for children and adolescents | 0 | 0 | 0 | 0 | 0 | 0 |

**Table 5.** Availability and use of outpatient mental health services

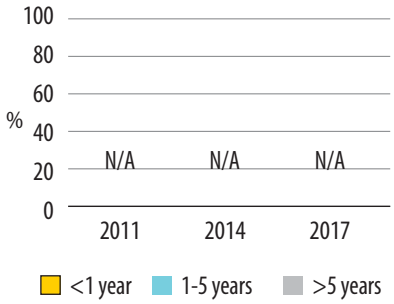
| *If 0, it has either not been reported or is zero* | Facilities | | Visits | |
|---|---|---|---|---|
| | Number | Rate per 100 000 | Number | Rate per 100 000 |
| Hospital-based outpatient facility | 17 | 0.063 | - | - |
| Community-based outpatient facility | 0 | 0 | 0 | 0 |
| Other outpatient facility (e.g. day care) | 0 | 0 | 0 | 0 |
| Outpatient service for children and adolescents | 0 | 0 | 0 | 0 |
| Other outpatient for children and adolescents | 0 | 0 | 0 | 0 |

**Fig. 4.** Changes in bed numbers and outpatient provision



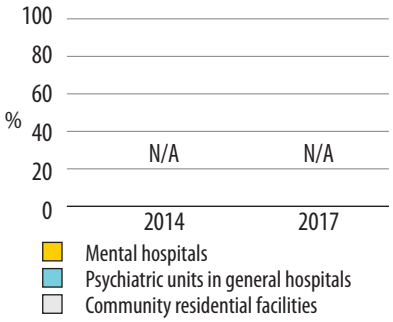

### Duration of stay

**Fig. 5.** Length of stay for mental hospital inpatients




### Involuntary admissions

**Fig. 6.** Percentage of involuntary admissions to psychiatric beds




### Treated prevalence

**Table 6.** Persons with severe mental disorders who received mental health care from mental health services in the last year per 100 000 population

| | Non-affective psychosis | Bipolar disorder | Depression |
|---|---|---|---|
| Inpatient | - | - | - |
| Outpatient | - | - | - |
| **Total** | - | - | - |

### Follow-up and social support

- 25% or less of discharged inpatients received a follow-up outpatient visit within one month.
- No persons with mental disorders receive social support from the government.

## MENTAL HEALTH PREVENTION AND PROMOTION

National suicide prevention strategy does not exist. Functioning prevention/promotion programmes: none reported.

**Table 7.** Functioning mental health promotion and prevention programmes

| Name of programme | Category of programme | Scope | Management |
|---|---|---|---|

- Health status and outcome indicators. Not reported.
- Health system indicators. Not reported.

[a] UN World Population Prospects, 2015 (http://esa.un.org/unpd/wpp/)
[b] World Bank Income Groups, 2016 (http://databank.worldbank.org)
[c] WHO Global Health Estimates (http://www.who.int/healthinfo/global_burden_disease/en/)
[d] WHO, 2018: World Health Statistics data visualisation dashboard (http://apps.who.int/gho/data/)
Note: Age-standardized suicide rates, computed using standard categories, definitions and methods, are reported to facilitate comparisons over time and between countries, and may not be the same as official national estimates.

Mental disorders have a profound effect on individuals, their families and society. *The Mental health atlas 2017* provides up-to-date information on the availability of mental health services and resources across the WHO Eastern Mediterranean Region. All the countries of the Region have participated and contributed to this exercise. The results provide an invaluable resource that will assist stakeholders to identify gaps in current provision and inform decisions around increasing resources to scale up services for mental health, and support the monitoring of progress towards global and regional targets.