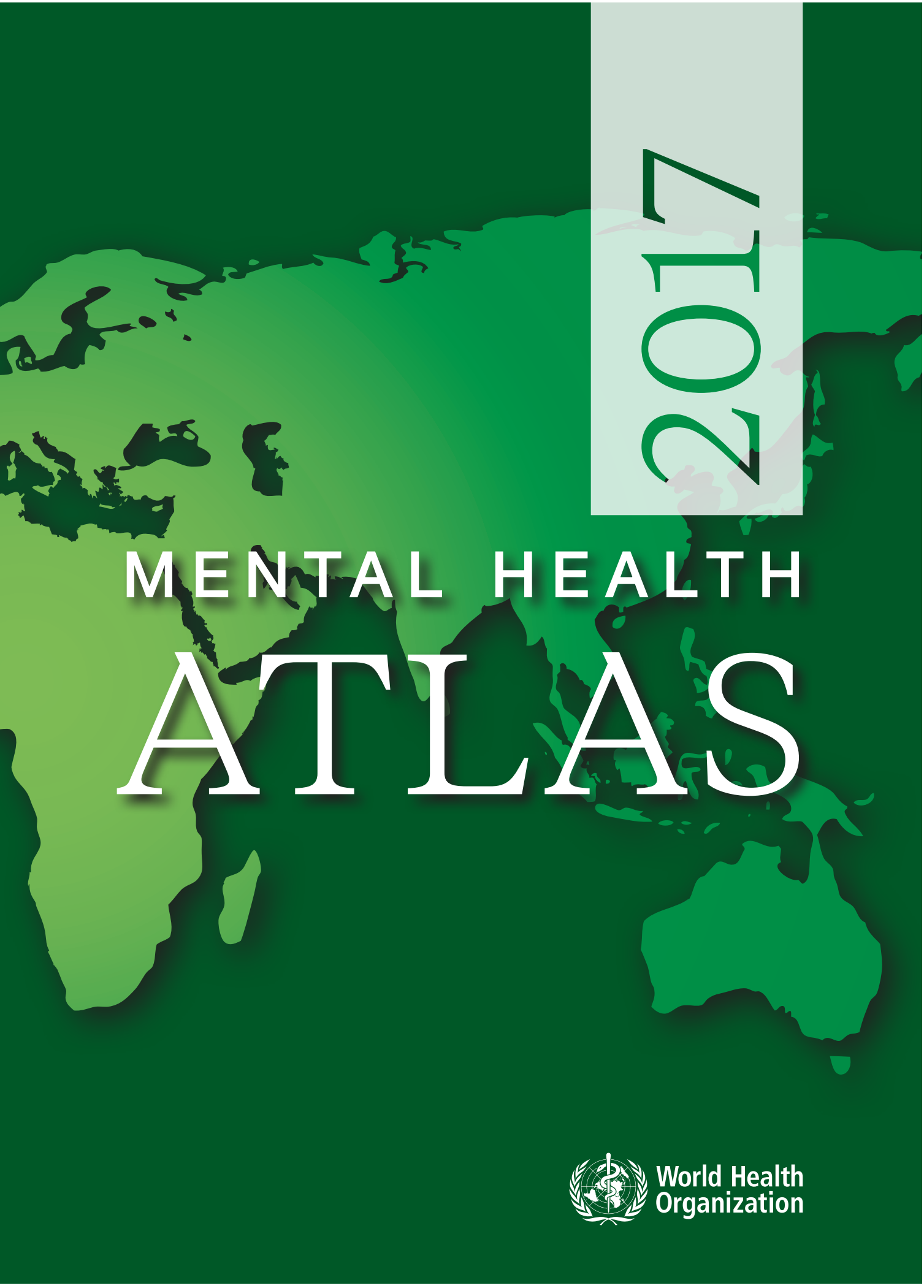
2017
MENTAL HEALTH
ATLAS
World Health Organization

2017

MENTAL HEALTH ATLAS

World Health Organization

Mental health atlas 2017

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PROJECT TEAM AND PARTNERS

Mental Health Atlas is a project of the World Health Organization. The overall vision and conceptualization of the project is provided by Shekhar Saxena. Mental health Atlas 2017 is the latest in a series of publications that first appeared in 2001, with subsequent updates published in 2005, 2011 and 2014. This edition of Mental Health Atlas is supervised and coordinated by Tarun Dua and Fahmy Hanna.

In WHO Member States, key project collaborators were the mental health focal points in Ministries of Health, who provided information and responses to the Atlas survey questionnaire and to follow-up queries for clarification. A full list of collaborators is provided as Appendix A of this report.

Mental Health Atlas team members from WHO Regional Offices, who contributed to the planning and collation of data and liaised with focal points in Member States, were: Sebastiana Da Gama Nkomo (WHO Regional Office for Africa); Dévora Kestel and Matías Irarrázaval (WHO Regional Office for the Americas); Khalid Saeed (WHO Regional Office for the Eastern Mediterranean); Dan Chisholm and Elena Shevkun (WHO Regional Office for Europe); Nazneen Anwar (WHO Regional Office for South East Asia); Martin Vandendyck (WHO Regional Office for the Western Pacific).

At WHO Headquarters, a team of staff and consultants comprising Corrado Barbui, Antonio Lora, Tarun Dua, Fahmy Hanna, Grazia Motturi, Dan Chisholm, Alexandra Fleishmann and Marieke van Regteren Altena provided the central technical and administrative support to the project, including development of the questionnaire and an associated completion guide, management of the online data collection system, validation of information and responses, liaison with Member States and WHO Regional Offices, as well as analysis of data and preparation of this report. They received inputs and advice from the following colleagues: Mark van Ommeren, Neerja Chowdhary, Chiara Servili, Nathalie Drew, Michelle Funk, Katrin Seeher and Meredith Fendt-Newlin. This edition of Atlas received valuable input and support from the following WHO Interns particularly; Brandon Gray, Joseph Heng, Maike Kristin Lieser and Peter Deli.

The development of the Atlas 2014 questionnaire and its update in 2017 was overseen and approved by an expert group, consisting of Florence Baingana, Harry Minas, Antonio Lora, Crick Lund, Pratap Sharan and Graham Thornicroft.

The contribution of each of these team members and partners, which has been crucial to the success of this project, is very warmly acknowledged. IT support and advice for the online data collection platform was provided by Marcel Minke. The graphic design of this publication was carried out by L'IV Com Sàrl.

PREFACE

The Mental Health Atlas 2017 is remarkably significant as it is providing information and data on the progress towards the achievement of objectives and targets of the Comprehensive Mental Health Action Plan 2013–2020 to be measured. This Action Plan contains four objectives:

(1) To strengthen effective leadership and governance for mental health;
(2) To provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
(3) To implement strategies for promotion and prevention in mental health;
(4) To strengthen information systems, evidence and research for mental health.

Global targets were established for each of these objectives to measure the collective action and achievements by Member States relating to the overall goal of the Action Plan. Mental Health Atlas is the mechanism through which indicators in relation to agreed global targets, as well as a set of other core mental health indicators, are being collected.

This edition of Mental Health Atlas also assumes new importance while WHO is embarking on a major transformation to increase its impact at country level and to be fit-for-purpose in the era of the Sustainable Development Goals (SDGs). The inclusion of mental health in the Sustainable Development Agenda, which was adopted at the United Nations General Assembly in September 2015, is likely to have a positive impact on communities and countries where millions of people will receive much needed help.

Data included in Mental Health Atlas 2017 demonstrates that progressive development is being made in relation to mental health policies, laws, programmes and services across WHO Member States. However extensive efforts, commitment and resources at global and country level are needed to meet the global targets.

Dr Shekhar Saxena
Director
Department of Mental Health and Substance Abuse

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EXECUTIVE SUMMARY

WHO's Mental Health Atlas project, dates back to 2000 when a first assessment of available mental health resources in WHO Member States was carried out (WHO, 2001). Subsequent updates have been published since then (WHO, 2005; WHO, 2011; WHO, 2014).

The 2017 version of Mental Health Atlas continues to provide up-to-date information on the availability of mental health services and resources across the world, including financial allocations, human resources and specialised facilities for mental health. This information was obtained via a questionnaire sent to designated focal points in each WHO Member State. Latest key findings are presented in the Box opposite.

KEY FINDINGS

GLOBAL REPORTING ON CORE MENTAL HEALTH INDICATORS

- 177 out of WHO's 194 Member States (91%) at least partially completed the Atlas questionnaire; the submission rate was above 85% in all WHO Regions;
- 37% of Member States regularly compile mental health specific data covering at least the public sector. In addition, 29% of WHO Member States compile mental health data as part of general health statistics only;
- 62% of Member States were able to report on a set of five selected indicators that covered mental health policy, mental health law, promotion and prevention programmes, service availability and mental health workforce.

MENTAL HEALTH SYSTEM GOVERNANCE

- 72% of Member States have a stand-alone policy or plan for mental health and 57% have a stand-alone mental health law;
- In the previous five years, 62% of WHO Member States have updated their policy and plan; and 40% their mental health law;
- 94 countries equivalent to 68% of those countries who responded, or 48% of all WHO Member States, have developed or updated their policies or plans for mental health in line with international and regional human rights instruments;
- 76 countries, equivalent to 75% of those countries who responded, or 39% of all WHO Member States, have developed or updated their law for mental health in line with international and regional human rights instruments;
- Human and financial resources allocated for implementation are limited; only 20% of Member States reported that indicators are available and used to monitor implementation of a majority of the components of their action plans.

FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

- Levels of public expenditure on mental health are very meagre in low and middle-income countries and more than 80% of these funds go to mental hospitals;
- Globally, the median number of mental health workers is 9 per 100 000 population, but there is extreme variation (from below 1 in low-income countries to 72 in high-income countries).

MENTAL HEALTH SERVICE AVAILABILITY AND UPTAKE

- The median number of mental health beds per 100 000 population ranges below 7 in low and lower middle-income countries to over 50 in high-income countries;
- Equally large disparities exist for outpatient services, child and adolescent services and social support; globally, the median number of child and adolescent beds is less than 1 per 100 000 population and ranges from below 0.2 in low and lower middle-income countries to over 1.5 in high-income countries.

MENTAL HEALTH PROMOTION AND PREVENTION

- 123 countries, equivalent to 69% of those countries who responded, or 63% of all WHO Member States, have at least two functioning national, multisectoral mental health promotion and prevention programmes;
- Out of almost 350 reported functioning programmes, 40% were aimed at improving mental health literacy or combating stigma and 12% were aimed at suicide prevention.

The Atlas is used to track progress in the implementation of WHO's *Mental Health Action Plan 2013-2020*. Mental Health Atlas 2014 provided baseline values for the Action Plan targets for 2013. This 2017 edition of Mental Health Atlas covers 2016 data and enables monitoring of progress towards meeting these targets by the year 2020.

Baseline values for the year 2013 and progress values for the year 2016 are given in the Table below for each of the six Action Plan targets. Progress values for 2016 indicate that the global targets can be reached, only if there is a collective global commitment that lead to substantial investment and expanded efforts at country level in relation to mental health policies, laws, programmes and services across WHO Member States.

Mental Health Action Plan 2013–2020: Baseline and progress values for global targets

Action Plan objective	Action Plan target	Baseline value for 2013 (Atlas 2014)	Progress value for 2016 (Atlas 2017)
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)	88 countries, 45% of all WHO Member States Value is based on a self-rating checklist (see Section 2.1 of report)	94 countries, 48% of all WHO Member States Value is based on a self-rating checklist (see Section 2.1 of report)
	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)	65 countries, 34% of all WHO Member States Value is based on a self-rating checklist (see Section 2.2 of report)	76 countries, 39% of all WHO Member States Value is based on a self-rating checklist (see Section 2.2 of report)
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)	Not computable from Mental Health Atlas 2014 data	Not computable from Mental Health Atlas 2017 data
Objective 3: **To implement strategies for promotion and prevention in mental health-based settings**	**Target 3.1:** 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020)	80 countries, 41% of all WHO Member States Value is based on a self-completed inventory of current programmes (see Section 5.1 of report)	123 countries, 63% of all WHO Member States Value is based on a self-completed inventory of current programmes. (see Section 5.1 of report)
	Target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020)	11.4 per 100 000 population Value is based on age-standardized global estimate Source: WHO report on suicide, 2014 (see Section 5.2 of report)	10.5 per 100 000 Value is based on age standardized global estimate Global age standardized suicide rate reduced by 8% Source: WHO Global Health Observatory, 2018 (see Section 5.2 of report)
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)	64 countries, 33% of all WHO Member States compile mental health specific data at least in public sector. Additionally, 62 Member States, equivalent to 32% of all WHO member states, compile mental health data as part of general health statistics only. Value is based on a self-rated ability to regularly compile mental health specific data that covers at least the public sector (see Section 1 of report)	71 member states, 37% of all WHO Member States, compile mental health specific data at least in public sector. Additionally, 57 member states, equivalent to 29% of all WHO member states, compile mental health data as part of general health statistics only. Value is based on a self-rated ability to regularly compile mental health specific data that covers at least the public sector (see Section 1 of report)

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INTRODUCTION

WHO first produced an Atlas of Mental Health Resources around the world in 2001, with updates produced in 2005, 2011 and 2014 (http://www.who.int/mental_health/evidence/atlasmnh/en/). The Mental Health 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.

This new edition of Mental Health Atlas, carried out in 2017, assumes new importance as a repository of mental health information in WHO Member States, because it is providing much of the data of progress towards the objectives and targets of the Comprehensive Mental Health Action Plan 2013–2020 to be measured. A total of six global targets were 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 1).

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, WHO Secretariat prepared and proposed a more complete set of indicators for Member States for data collection and reporting to WHO.

These fourteen indicators became the basis for the Mental Health Atlas questionnaire and it formed the baseline measurement for the Comprehensive Mental Health Action Plan 2013–2020 with the data published in 2014. This Mental Health Atlas survey carried out during 2017, which reflects countries in 2016, will also be followed by another survey in 2020, so that progress towards meeting the targets of the Action Plan can be measured over time.

TABLE 1. 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 **2b. Human resources:** Number of mental health workers **2c. Capacity building:** Number and proportion of general health care staff trained in mental health **2d. Stakeholder collaboration:** Number and type of formal collaborations with other departments, services and sectors, including service users and family or caregiver advocacy groups **2e. Service availability:** Number of mental health care facilities at different levels of service delivery **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 **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 **2h. Social support:** Number of persons with a severe mental disorder who receive disability payments or income support
	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	
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	
	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	
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	

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METHODOLOGY

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 was in line with that pursued in 2014, and is briefly outlined opposite.

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 based on response rate for variables, and feedback from Member States, WHO Regional and Country Offices e.g. questions on social care and continuity of care after discharge.

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 guide and glossary were integrated to 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, to provide additional guidance, and to assist focal points in completing the Atlas questionnaire. The questionnaire was also available on-line, 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 with each of the 177 Member States for their further reviews and inputs.

Upon receipt of the final questionnaires, data were aggregated by WHO Region and also by World Bank income group for 2016. Lists of countries by WHO Region and by World Bank income group are provided in Appendix A. As of 1 July 2016, low-income economies are defined as those with a GNI per capita, calculated using the World Bank Atlas method, of US$ 1,025 or less in 2015; lower middle-income economies are those with a GNI per capita between US$ 1,026 and US$ 4,035; upper middle-income economies are those with a GNI per capita between US$ 4,036 and US$ 12,475; high-income economies are those with a GNI per capita of US$ 12,476 or more.

Frequency distributions and measures of central tendency (e.g., means, medians) were calculated as appropriate for these country groupings. Rates per 100 000 population were calculated for a range of data points, using the official UN population estimates for 2015. Comparisons were made with 2014 data in relation to global targets and service development indicators.

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 Mental Health Atlas questionnaire. For example, some countries had difficulty in reporting data on involuntary admission at hospitals and data on capacity building 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, or the equivalent percent (out of a total of 194 WHO Member States).

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 two Atlas versions. Additionally, based on response rates for some of the variables, feedback from Member States' WHO regional and country offices, some questions were modified e.g. questions on social care and continuity of care after discharge. This has contributed to improvement of completion rates of these questions in 2017 compared to 2014, but these changes have limited 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.

Mental Health Atlas is an on-going activity of the WHO. As more accurate and comprehensive information covering all aspects of mental health resources become available and the concepts and definitions 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, countries' information systems are weak, the Mental Health Atlas may serve as a catalyst for further development by demonstrating the utility of such systems.

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RESULTS

1. GLOBAL REPORTING ON CORE MENTAL HEALTH INDICATORS
2. MENTAL HEALTH SYSTEM GOVERNANCE
3. FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH
4. MENTAL HEALTH SERVICE AVAILABILITY AND UPTAKE
5. MENTAL HEALTH PROMOTION AND PREVENTION

RESULTS
ATLAS 2017

1. GLOBAL REPORTING ON CORE MENTAL HEALTH INDICATORS

Considerable effort has been expended by 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 Mental Health Action Plan 2013-2020, against baseline values provided in the 2014 Mental Health Atlas.

In total, 177 out of WHO's 194 Member States were able to at least partially complete the questionnaire. As shown in Figure 1.1, the global and WHO Regional participation or Member States' submission rate for Mental Health Atlas 2017 is 85% or greater in all WHO Regions and is 91% overall. Responding countries account for 97.5% of the global population. This in itself is an important marker of countries' ability and willingness to collect, share and report their mental health situation and contribution to the Mental Health Action Plan 2013–2020. In addition to the 177 filled questionnaires from WHO Member States, filled questionnaires were also received from one WHO associate member and 16 from geographical territories, which were not included in the analysis for the purpose of this report but will be published as stand-alone profiles. In summary, WHO secretariat received as part of Atlas 2017 exercise a total of 194 Atlas questionnaires, from Member States, associate members and geographical territories.

While reporting and data completion levels for several mental health indicators or Atlas questions had remarkably improved from Atlas 2014 – including particularly those relating to mental health spending, workforce, continuity of care after discharge, social support for persons with mental disorders – the response rate for other indicators, in particular items relating to service coverage (treated prevalence), visits at outpatient facilities, general health care workers trained in mental health remains low compared to other indicators. The lower response rate for these indicators reflects the difficulty of obtaining these data especially at national level.

Mental Health Atlas 2017 requested Member States to rate the availability or status of mental health reporting; Figure 1.2 summarises the findings. 66% of all WHO Member States, or 83% of countries responding to this question report that mental health data is compiled in the last two years either as part of general health statistics report or a mental health specific data report. The Member States with a mental health specific data report compiled in the last two years for public sector or for both public and private sector represent only 37% of all WHO Member States and 46% of Member States responding to this question. However, 17% (26 Member States) of responding countries reported that mental health data has not been compiled into any report for policy, planning or management purposes in the last

FIG. 1.1 **Mental Health Atlas 2017: submission rate by Member States**

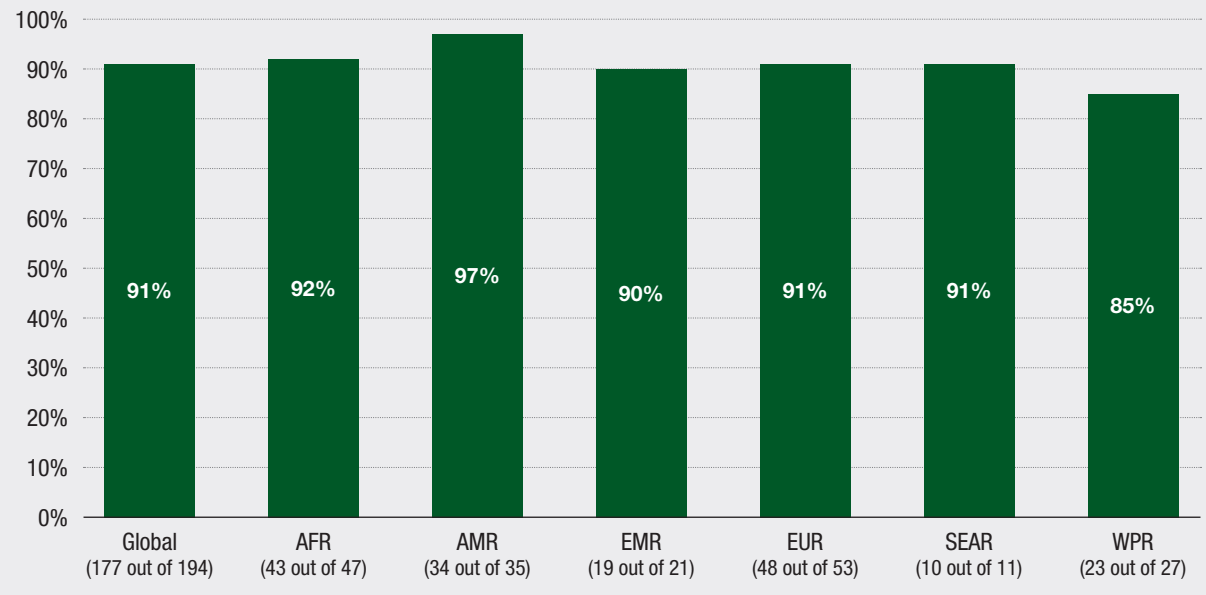
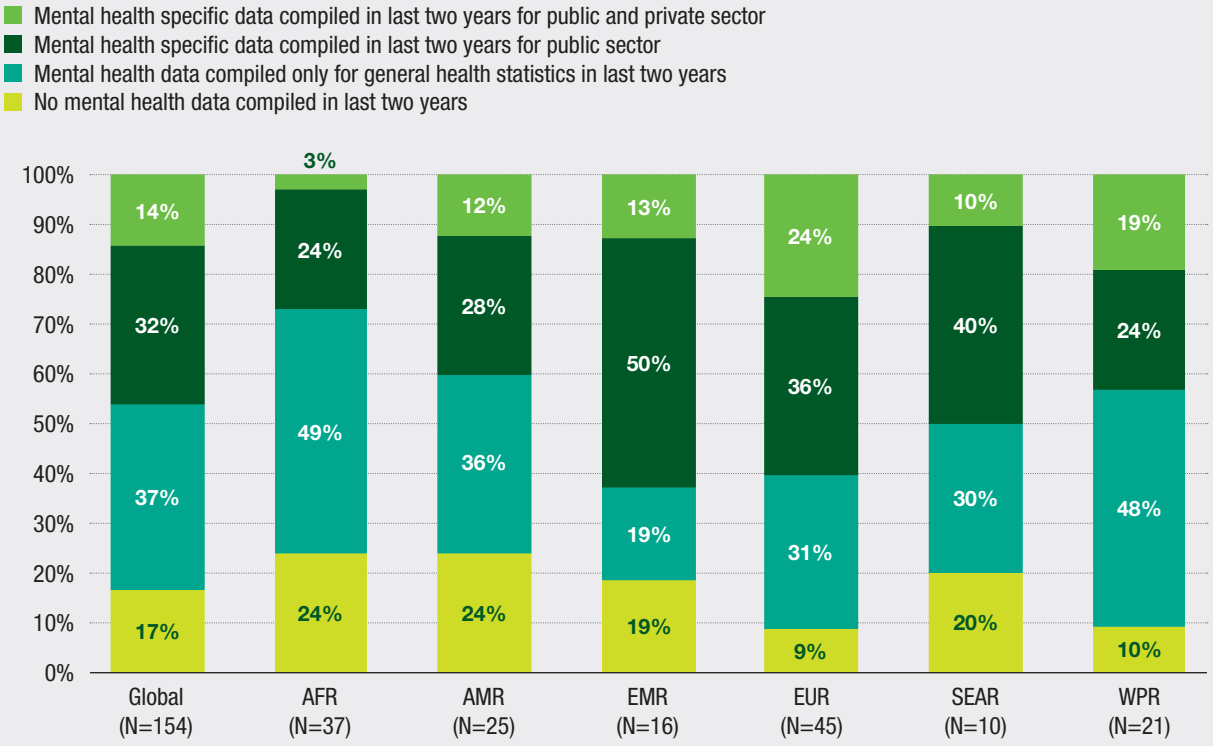


FIG. 1.2 **Mental health data availability and reporting, by WHO region**

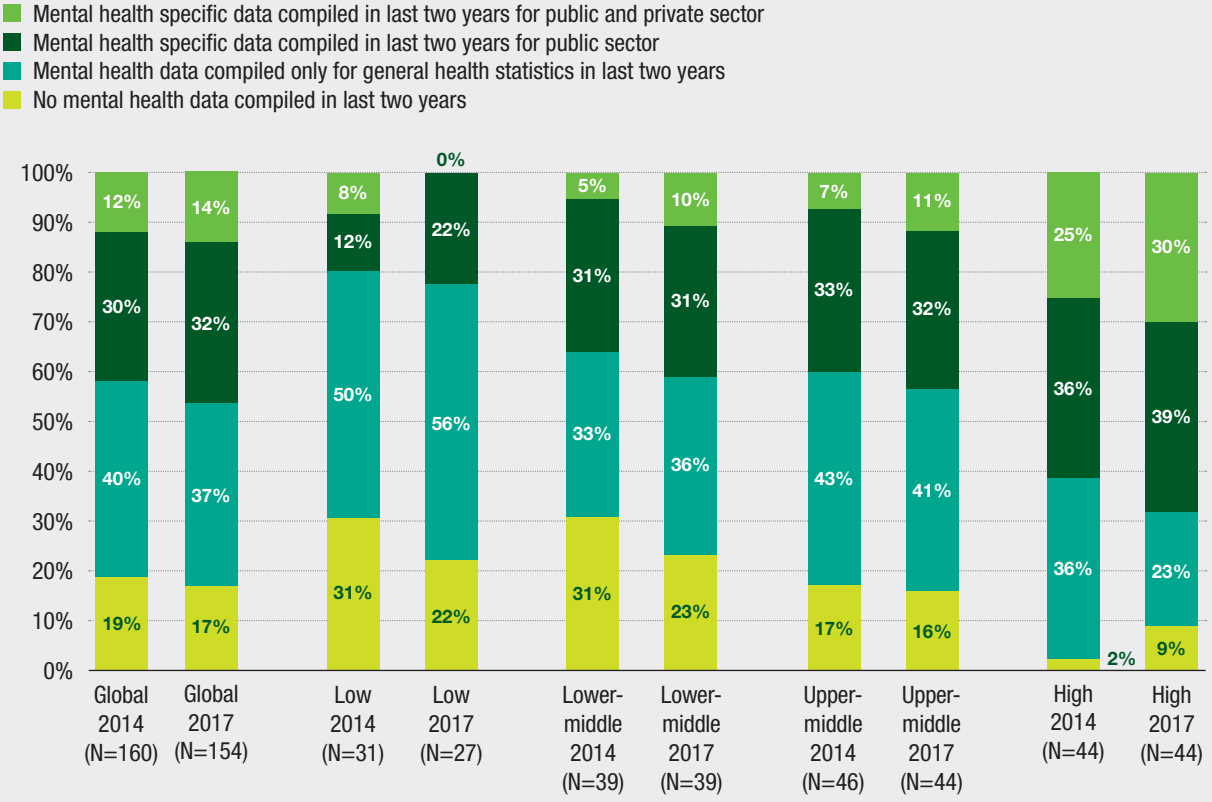


two years. When Member States responses are analysed based on World Bank income groups as shown in Figure 1.3, approximately 20% of responding countries belonging to both low and lower middle-income groups are reporting no data compilation for mental health indicators in the last two years compared to 9% of high-income countries which gave the same response.

In low-income countries, the majority of Member States reported that mental health data is compiled as part of general statistics, but not in a specific mental health report. Importantly, in none of the responding low-income countries 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. Reporting on mental health indicators that include both public and private sectors remains a challenge, and is below 25% in all WHO regions.

Based on actual data submitted through Mental Health Atlas 2017 to WHO, an assessment of countries' ability to report on a defined set of selected mental health indicators was also made. Included indicators were as follows: 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); 5) mental health promotion and prevention (completion of inventory, including if no programmes present). 121 countries (62% of all Member States) were able to report on all five of these items, similar to 2014 (117 countries, 60% of all Member States). Adding a further key indicator to the defined core set, e.g. service utilization for certain severe mental disorders – reduces substantially the number of countries able to report, to 82 or 46% of all Member States. This is a remarkable improvement in reporting compared to Mental Health Atlas 2014 where only

FIG. 1.3 **Mental health data availability and reporting, by World Bank income group (2014 and 2017)**



50 countries or 26% of all Member States were able to report on the above selected set of mental health indicators in addition to this data component. This latter, more stringent threshold gives a result quite similar to the total number of countries who self-reported their ability to regularly compile mental health specific data covering at least the public sector (71 countries, equivalent to 37% of all Member States).

Globally, the percentage of countries reporting that no mental health data is compiled in last two years, has slightly declined since Mental Health Atlas 2014 from 19% to 14%, while the percentage of countries reporting every two years data from public only or public and private increased from 42% in 2014 to 46% in 2017 as shown in Figure 1.3. Accordingly, much effort will be required to reach Target 4 of the Mental Health Action Plan, which states that 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).

In Mental Health Atlas 2017, countries were also asked in a specific question to report on the availability and completeness of specific mental health indicators to better understand the existing structures and limitations of mental health information systems. Approximately 60% of Member States responding to this question reported availability of data on mental health beds either at mental health hospitals or psychiatric wards in general hospitals. However only 33% of Member States responding to this question identified the data available on beds as complete, based on available data disaggregation by age, gender and diagnosis. This finding could possibly explain one of the factors that are contributing to the limited availability of information on service utilization for specific diagnoses by some Member States (Data not shown).

RESULTS
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2. MENTAL HEALTH SYSTEM GOVERNANCE

2.1 MENTAL HEALTH POLICIES/PLANS

Objective 1 of the Mental Health Action Plan 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 Mental Health 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.

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 Mental Health 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.

In aggregate terms, 139 countries state the existence of a stand-alone policy or plan for mental health, equivalent to 72% of all WHO Member States or 79% of responding countries (Table 2.1.1). There is little variation between WHO regions although a lower proportion of African and Eastern Mediterranean countries have policies/plans and fewer countries in the African and American regions have updated them. 120 (62% of all WHO Member States) have updated their policy/plan in the previous five years (since 2013) with 44 countries updated their policy/plan in last year (2016 or after). More than 55% of countries in any WHO region and more than 75% of Eastern Mediterranean, South East Asian, Western Pacific and European countries reported updating their policy/ plan in last five years.

Out of 36 countries stating that they do not have a stand-alone policy or plan, 22 confirmed that policies and plans for mental health are integrated into those for general health or disability. In Atlas 2017, countries were also asked about the existence of a plan or strategy for child and adolescent mental health. Out of 78 responding countries, 46% stated they had a plan or strategy for child and adolescent mental health.

TABLE 2.1.1 Existence and revision status of mental health policies/plans

	Countries stating they have a stand-alone mental health policy/plan (N=175)		Countries stating they have updated their policy/ plan in the last 5 years (since 2013) (N=167)	
	Number of countries	% of responding countries	Number of countries	% of responding countries
Global	139	79%	120	72%
WHO region				
AFR	31	72%	23	58%
AMR	27	82%	20	65%
EMR	14	78%	13	76%
EUR	39	81%	37	79%
SEAR	9	90%	8	80%
WPR	19	83%	19	86%

Concerning conformity with international (or regional) human rights instruments, Figure 2.1.1 shows the degree of compliance, self-rated, across five items of a constructed checklist both for 2014 and 2017 results. In Mental Health Atlas 2017, 97% of countries who responded to this question consider their policy/plan to promote the transition toward mental health services based in the community (including mental health integrated into general hospitals and primary care). 89% of responding countries consider their policy/plan to pay explicit attention to respect for the human rights of people with mental disorders and psychosocial disabilities and vulnerable and marginalized groups. A little over 80% consider their policy/plan promotes a full range of services and support to enable people to live independently and be included in the community, and the participation of persons with mental disorders and psychosocial disabilities in decision-making processes on issues affecting them (e.g. policy, law, service reform). The comparison with 2014 data shows an increase in positive responses across the five items of the checklist on compliance with human rights instruments (4% to 14%).

Using a total score across these five self-reporting checklist items to evaluate the compliance of the policy in terms of human rights, almost all responding countries (97%) scored at least 3, 83% scoring 4 out of 5 indicating a partial compliance, while 68% endorsed all five items of the checklist, indicating full compliance. This is equivalent to 48% of all Member States indicating full compliance. This represents only a limited progress from the baseline of 2014 where 45% of all Member states indicated full compliance. The global target to be achieved by 2020 is 80%. Figure 2.1.2 provides a breakdown by WHO Region. This target indicator is showing progress from the base line of 2014, where 56% endorsed all five items of checklist indicating full compliance and 72% of countries scored 4 indicating partial compliance.

In Mental Health Atlas 2017, countries were also asked whether estimates of required resources are included in their mental health policy/plan. Out of 162 responding countries, a little over half state that their mental health policy/plan contains estimates of financial or human

FIG. 2.1.1 Compliance of mental health policies/plans with human rights instruments (2014 and 2017)

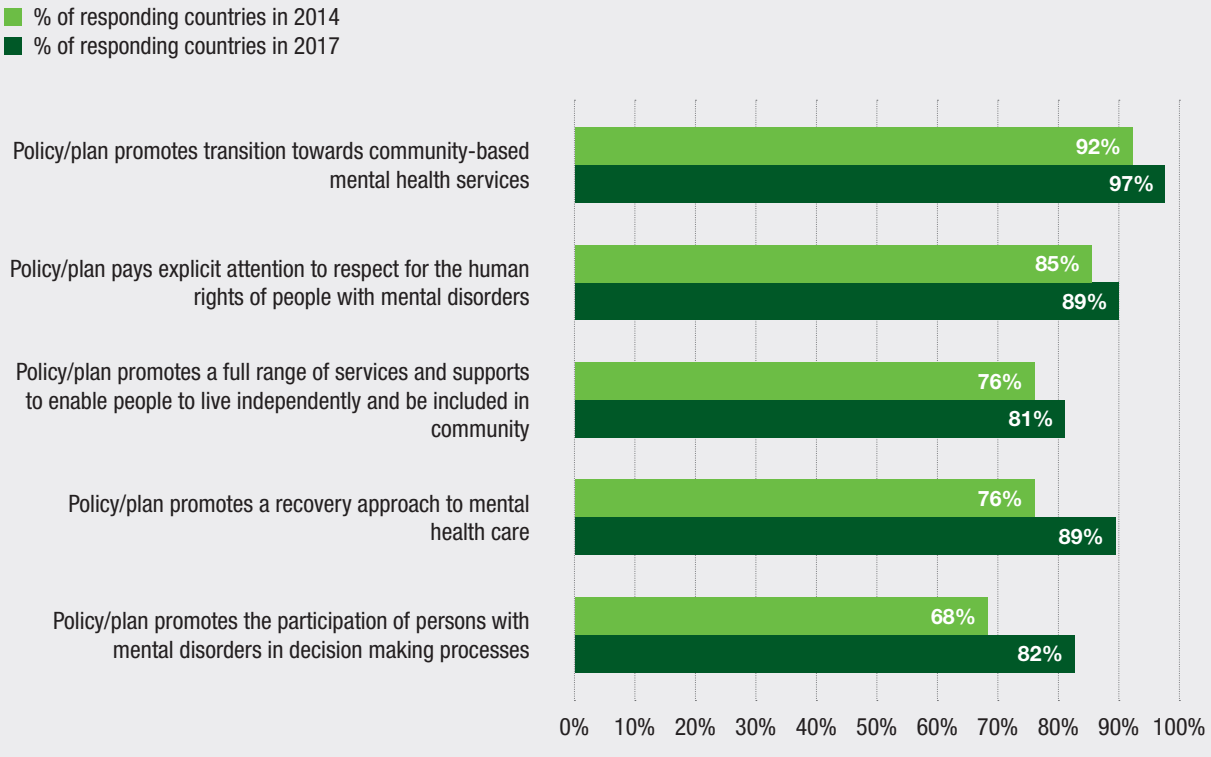
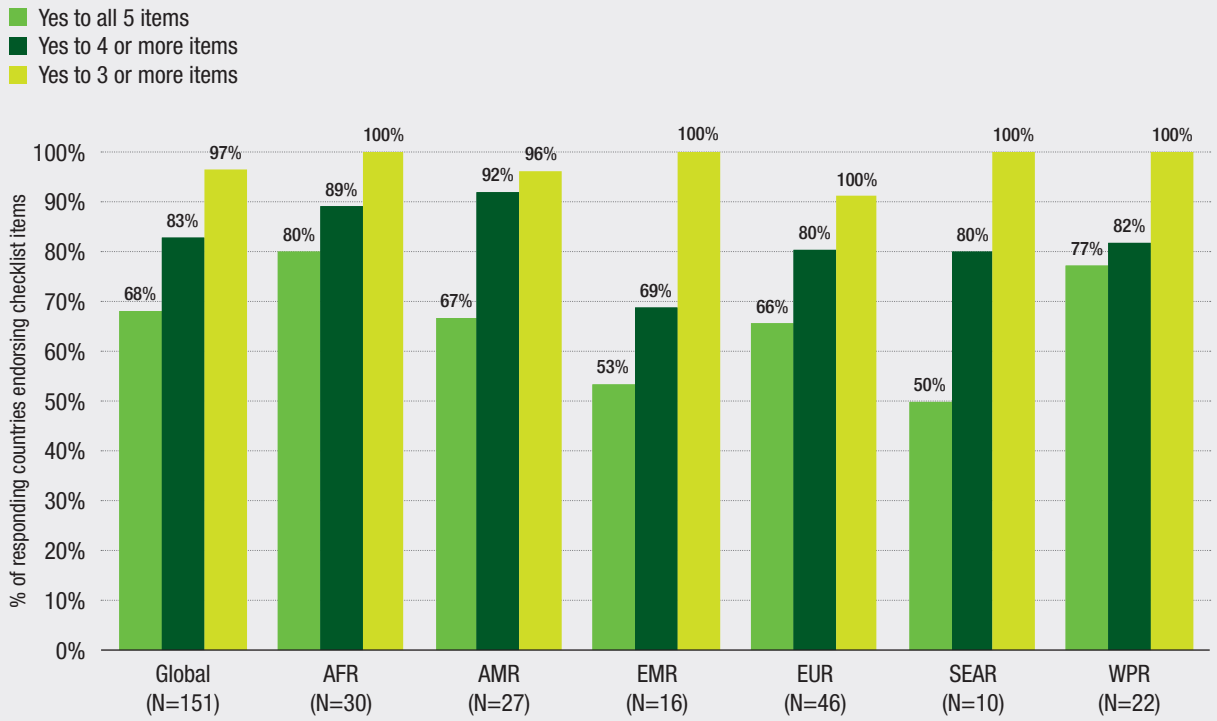


FIG. 2.1.2 **Mental health policies/plans and human rights: checklist score**



resources needed to implement it. Of those countries who state that estimates of financial or human resources are contained in their plan, just more than half of responding countries state that resources have been allocated in line with indicated resource needs to enable implementation of the policy / plan. There is a large variation across WHO regions, with 75% of EUR and WPR countries stating that resources have been allocated in line with indicated resource needs, compared with less than 30% of AFR countries. Table 2.1.2 provides a breakdown by WHO region and World Bank income group.

Countries were also asked about the availability and use of indicators or targets against which implementation of its policy/plan can be monitored. Of 123 countries who state the existence of specified indicators or targets, only 46 state that indicators were available and used in the last 2 years for some/a few components, while 33% state that indicators are available, but they are not used at all. Only 20% state that indicators are available and used for most or all components (Data not shown).

TABLE 2.1.2 Allocation of resources for mental health policies/plans

	Countries reporting that estimates of human and/or financial resources are contained in mental health policy/plan		Countries reporting that resources have been allocated for implementation in line with human and/or financial resources contained in mental health policy/plan
	Number of countries	% of countries	% of total
Global (N=169)	93	55%	53%
WHO region			
AFR (N=42)	26	62%	27%
AMR (N=31)	16	52%	50%
EMR (N=17)	5	29%	40%
EUR (N=47)	27	57%	75%
SEAR (N=10)	5	50%	50%
WPR (N=22)	14	64%	77%
World Bank income group			
Low (N=29)	19	66%	21%
Lower-middle (N=42)	21	50%	53%
Upper-middle (N=49)	28	57%	63%
High (N=49)	25	51%	70%

2.2 MENTAL HEALTH LEGISLATION

Mental health legislation is a further 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. The Global Target 1.2 of the Mental Health Action Plan, 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.

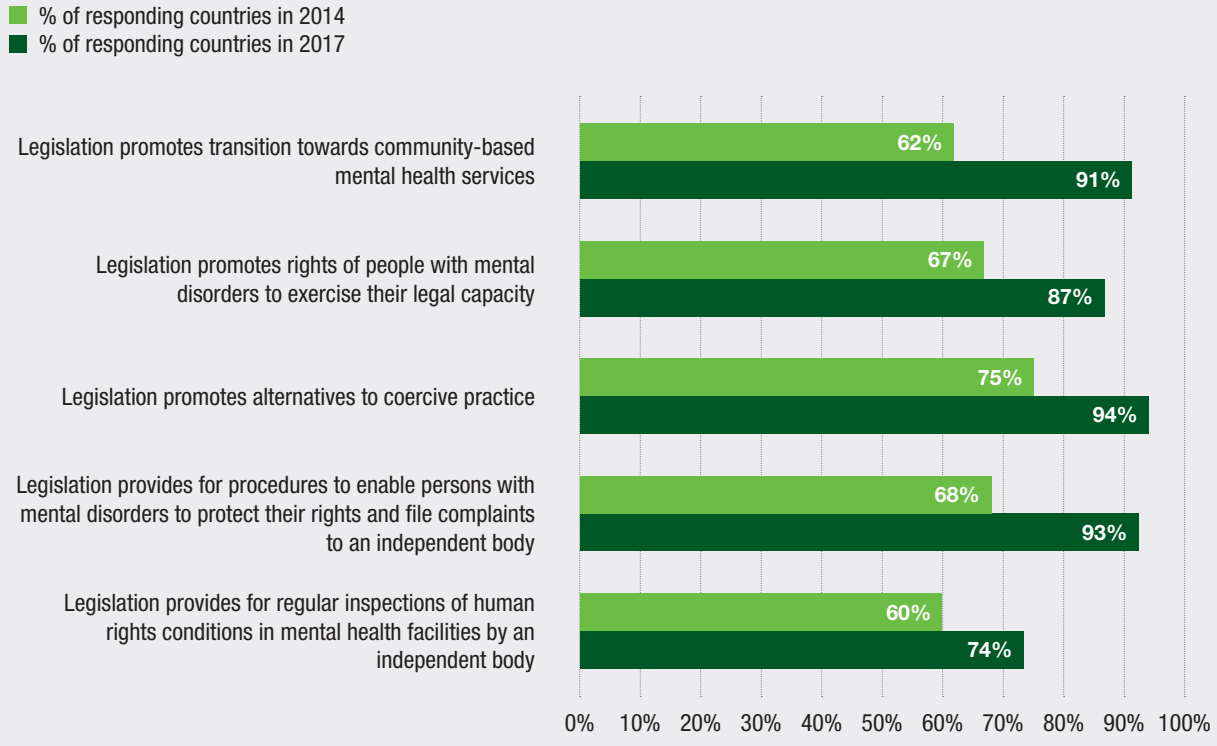
A total of 111 countries report having a stand-alone law for mental health, which represents 57% of WHO Member States and 63% of those who submitted a response (Table 2.2.1). The European and Western Pacific regions have the highest percentage (over 75%), which is an increase of 7% in European and 10% in Western Pacific regions from 2014. The African and South East Asia regions have the lowest percentage (44%-50%). 66 countries or 40% of responding countries have updated their mental health legislation in the previous 5 years (since 2013), most commonly in the European region however the proportion of countries that have updated their laws in the African region has more than doubled since 2014 to 21%. 20 countries have updated their stand-alone mental health law in 2016. Out of the 64 countries stating that they do not have a stand-alone mental health law for mental health, 34 have mental health legislation that is integrated into general health or disability law.

Regarding conformity with international (or regional) human rights instruments, Figure 2.2.1 shows positive responses to five items of a self-rated checklist constructed for this purpose. Between 85% and 95% of countries who responded consider their mental health law to: a) promote the transition toward mental health services based in the community (including mental health integrated into general hospitals and

TABLE 2.2.1 Existence and revision status of mental health legislation, by WHO region

	Countries stating they have a stand-alone mental health law (N=175)		Countries stating they have updated lesgislation in the last 5 years (since 2013) (N=164)	
	Number of countries	% of countries	Number of countries	% of countries
Global	111	63%	66	40%
WHO region				
AFR	19	44%	8	21%
AMR	20	61%	8	27%
EMR	11	61%	6	33%
EUR	37	77%	29	64%
SEAR	5	50%	5	50%
WPR	19	83%	10	45%

FIG. 2.2.1 Compliance of mental health legislation with human rights instruments (2014 and 2017)



primary care); b) promote the rights of persons with mental disorders and psychosocial disabilities to exercise their legal capacity; c) promote alternatives to coercive practice; d) provide for procedures to enable people with mental disorders and psychosocial disabilities to protect their rights and file appeals and complaints to an independent legal body. Just below 75% of responding countries consider their laws provide for regular inspections of human rights conditions in mental health facilities by an independent body. Global responses to the five checklist items are showing a positive increase compared to Member States responses in 2014 which may indicate a gradual progress towards alignment with international and regional human rights instruments.

Adding up these endorsed checklist items provides a measure of the extent to which countries' mental health laws are partially or fully in line with international human rights instruments, (Figure 2.2.2). Out of 118 responding countries, 95% endorsed at least 3 checklist items, and 75% endorsed all five items, indicating full compliance. This is equivalent to 39% of all Member States indicating full compliance. There was some variation between WHO regions with a lower proportion of European countries (65%) and countries in the Western Pacific region (67%) endorsing all 5 checklist items.

To further assess progress towards ensuring conformity of mental health legislation with international human rights instruments, countries were asked to self-rate the existence and level of functioning of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights. Figure 2.2.3 and Figure 2.2.4 show a dedicated authority or independent body either does not exist or exists but is not functioning in a little over half of responding countries. There was large variation across regions and income groups. Over 65% of countries in low and lower middle-income groups state that an authority or body does not exist or is not functioning, while over 70% of high-income countries state that they have a functioning authority or body. Less than 50% of responding countries reported that this body provides regular or irregular inspections in mental health facilities and reports at least annually to stakeholders, with lower percentages of countries reporting inspection and reporting in South East Asian and African regions.

FIG. 2.2.2 **Mental health legislation and human rights: checklist score**

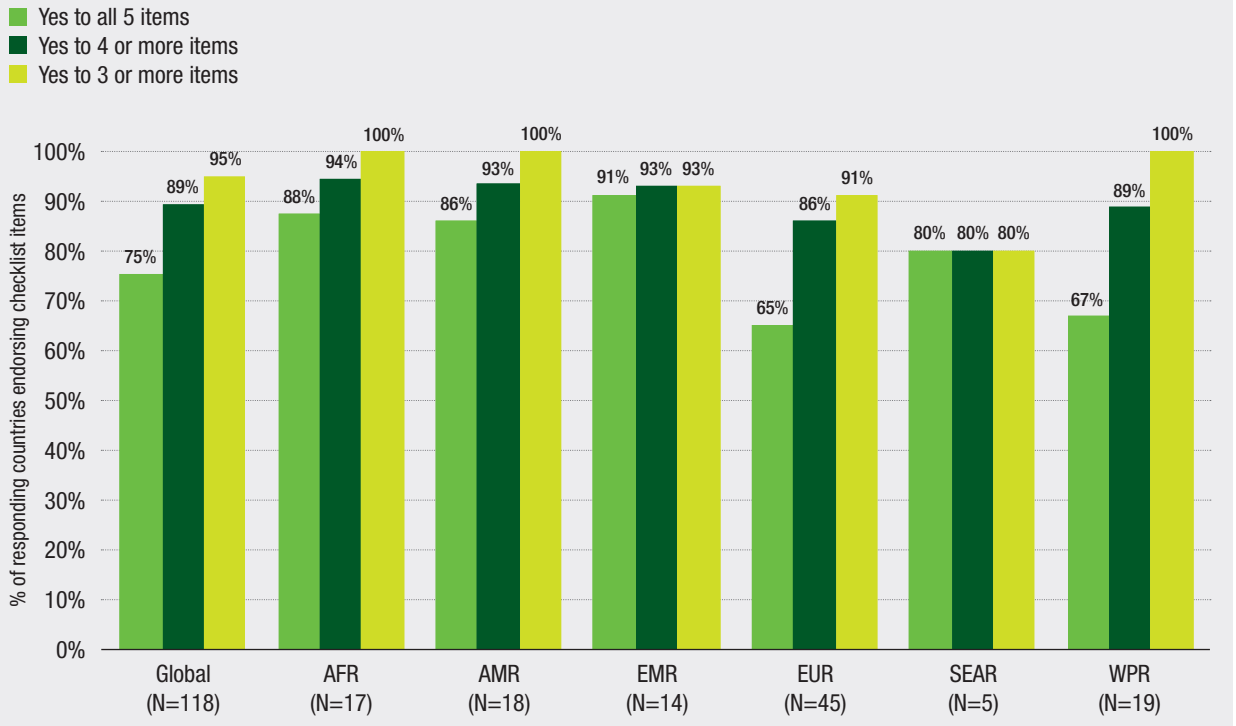


FIG. 2.2.3 Existence of a dedicated authority or independent body to assess compliance of mental health legislation with international human rights, by WHO region

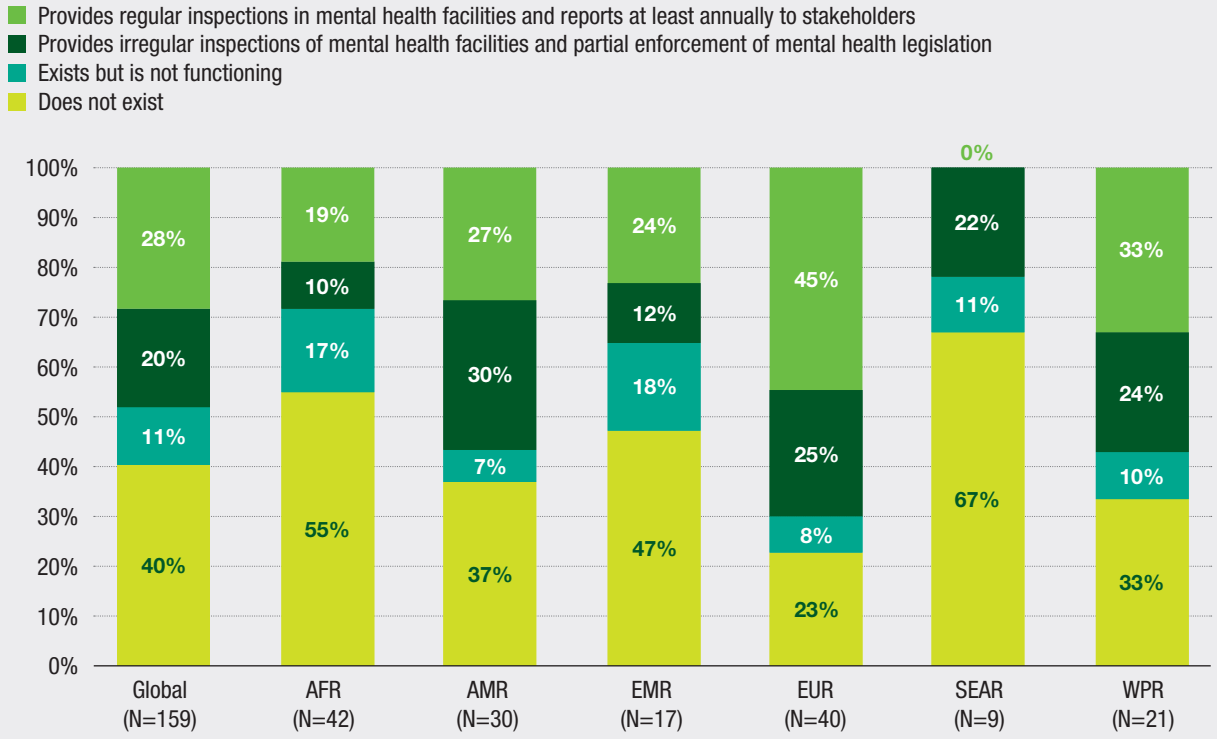
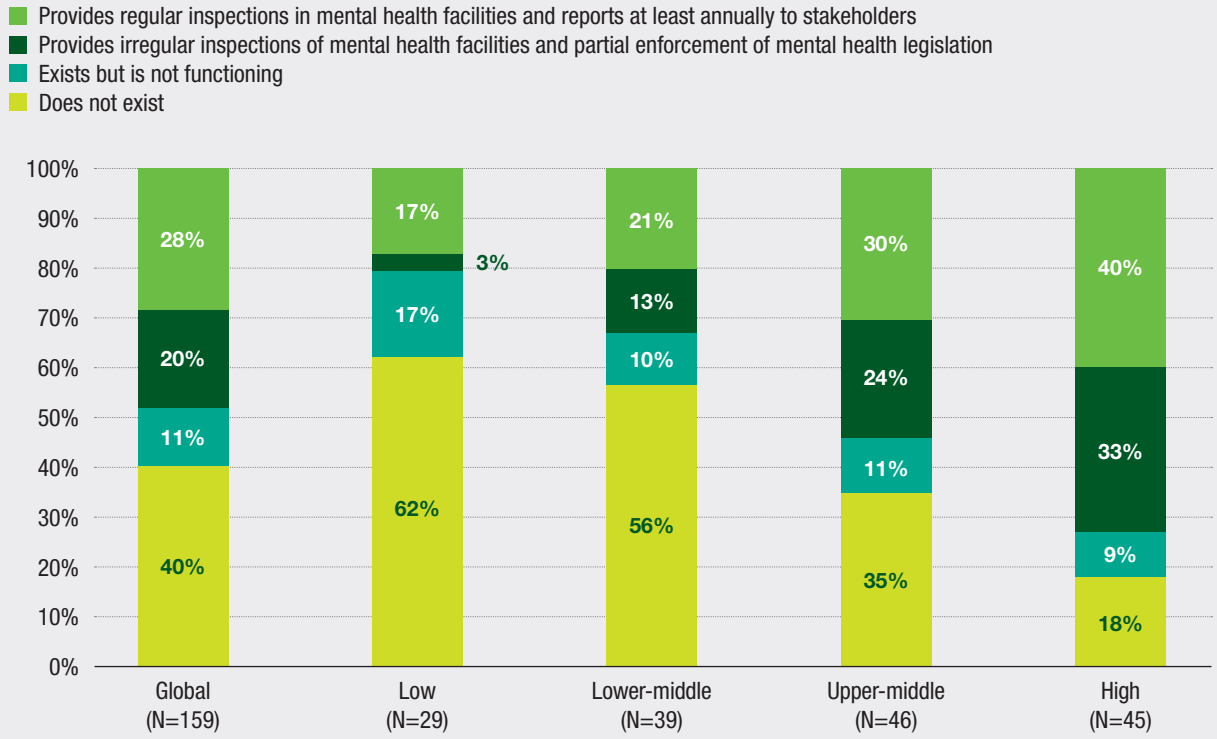


FIG. 2.2.4 Existence of a dedicated authority or independent body to assess compliance, by World Bank income group



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 non-governmental agencies), media, academia/institutions, local and international non-governmental organizations who deliver or advocate for mental health services, private sector, 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 2 out of 3 of the following checklist items apply; a) Existence of a formal agreement or joint plan with this partner, b) Availability of a dedicated funding from or to this partner for service provision, or c) Conduction of regular meetings with this partner (at least once per year).

Global findings relating to the number of countries reporting formal stakeholder collaborations are provided in Table 2.3.1. 126 countries reported having

TABLE 2.3.1 Proportion of ongoing collaboration with a formalised structure and/or mechanism, by WHO region and World Bank income group

	Number of countries stating formal collaborations with stakeholder groups	% countries stating formal collaborations with stakeholder groups
Global	126	81%
WHO region		
AFR	23	68%
AMR	23	74%
EMR	15	88%
EUR	39	89%
SEAR	8	89%
WPR	18	86%
World Bank income group		
Low	15	60%
Lower-middle	33	87%
Upper-middle	39	85%
High	39	83%

at least one 'formal' stakeholder collaboration. The proportion of formal collaboration, varied across stakeholder type, region and income group.

There were large variations in the type of formal stakeholder collaborations across income groups/ regions, ranging between 0% (SEAR) and 67% (AMR) for countries reporting formal collaborations with the employment sector, 11% (AFR) and 67% (AMR) reporting formal collaborations with the housing sector and 0% (EUR and SEAR) and 50% (WPR and AMR) reporting formal collaboration with traditional/ indigenous healers (Data not shown).Figure 2.3.1 shows global percentage of identified formal collaboration. The majority of responding countries reported having a formal collaboration with International Non-Governmental Organizations (67%), Local Non-Governmental Organizations (56%) and Ministry of Social Affairs (57%).

104 countries reported ongoing collaboration with service user and family/caregiver advocacy groups. The proportion of these countries that reported formal collaborations with this stakeholder group is provided in Figure 2.3.2.

FIG. 2.3.1 Global percentage of responding countries that identify formal collaboration with stakeholder group

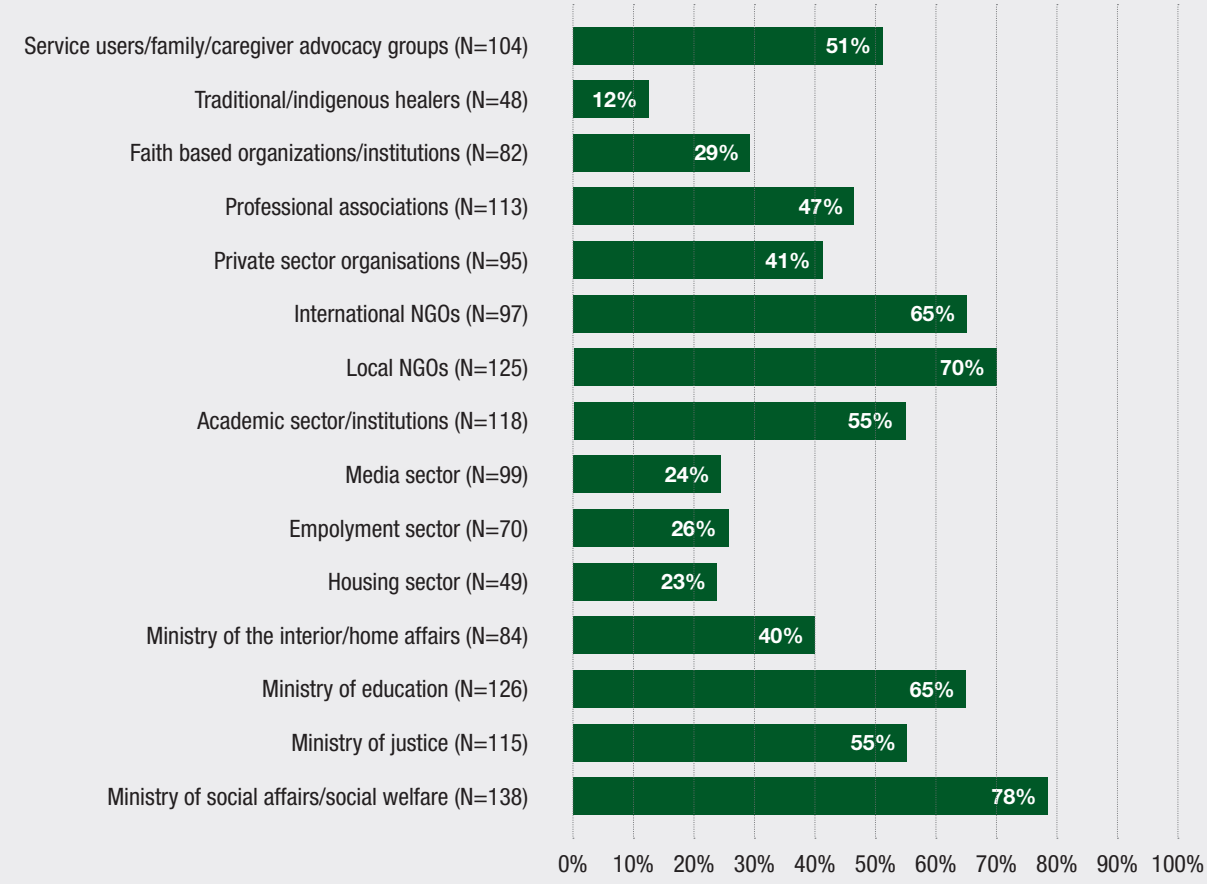
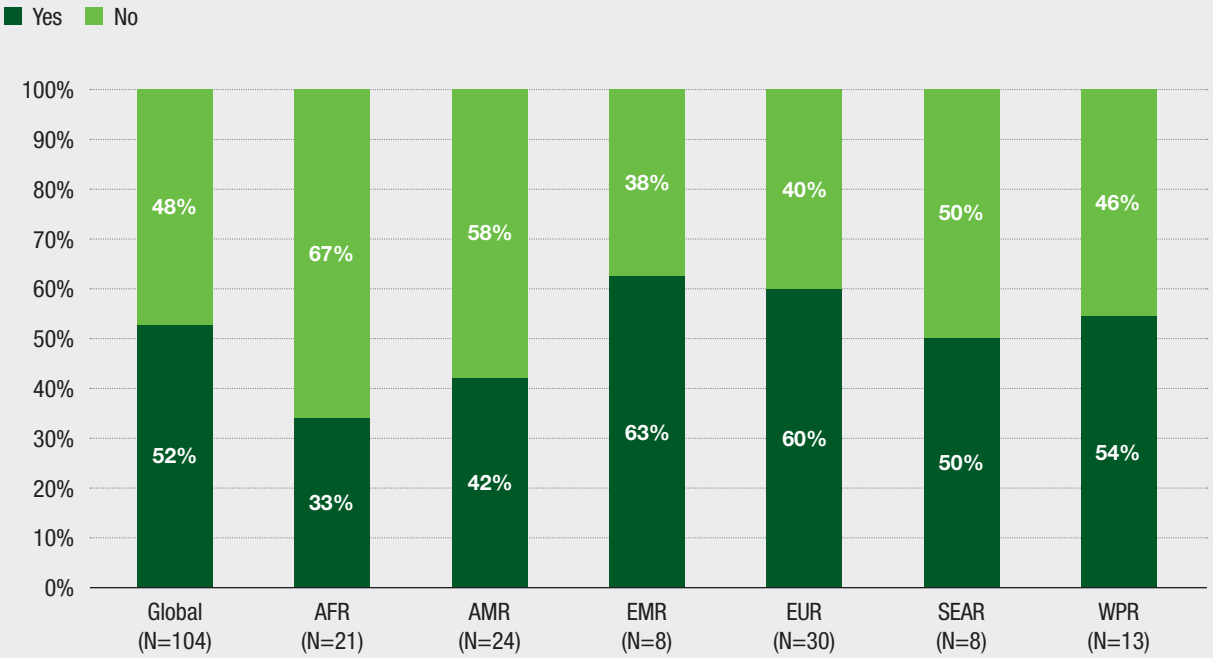


FIG. 2.3.2 Proportion of formal collaborations with service users/family/caregiver advocacy groups, by WHO region



RESULTS
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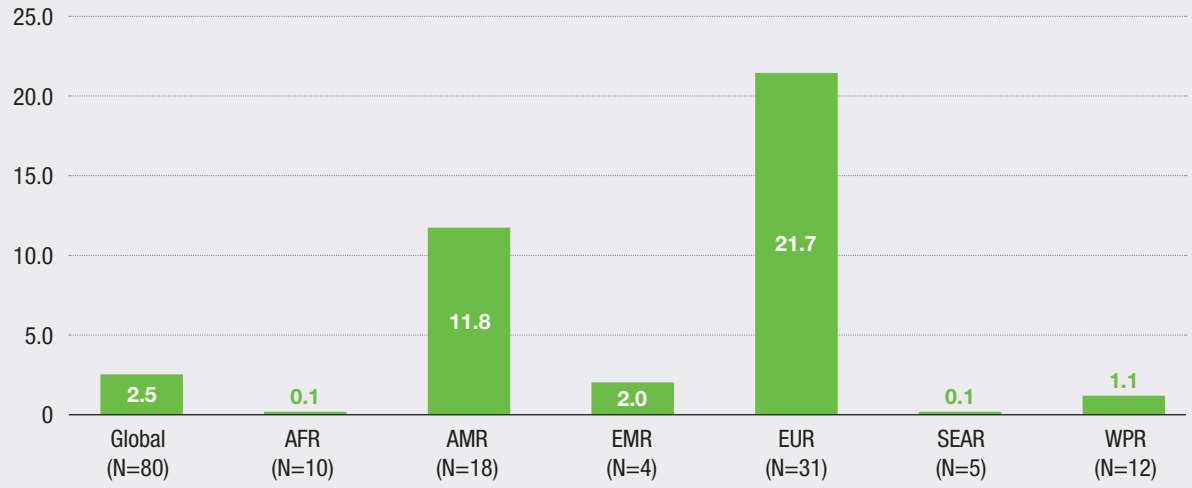
3. FINANCIAL AND HUMAN RESOURCES FOR MENTAL HEALTH

3.1 FINANCIAL RESOURCES

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 programme 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 non-governmental agencies), diverse set of service providers (specialist mental health services, general health services and social care services) and the diversity of services provided.

In Mental Health Atlas 2017, countries were requested to estimate government's total expenditure on mental health (combined national and sub-national government expenditure). Figure 3.1.1 depicts median government mental health spending per capita globally and by WHO regions. The global median mental health expenditure per capita is US$ 2.5. Based on the WHO Global Health Expenditure database, the global median of domestic general government health expenditure per capita in 2015 was US$ 141, thus making government mental health expenditure less than 2% of global median of government health expenditure. There is a large variation between regions. For example mental health expenditure per capita in European region is more than 20 times higher compared to African and South East Asian Region. The range between high-income

FIG. 3.1.1 Government mental health expenditure per capita (US$), by WHO region



and low-income countries on mental health expenditure per capita remains huge. As shown in Figure 3.1.2, most of the reported expenditure is allocated to mental hospitals in particular, except in high income countries where less than 43% of spending is on mental hospitals.

The reporting on this indicator has improved in 2017 as 80 countries are able to report data compared to 40 countries (including no low income countries) in 2014. However, still less than 50% of WHO Member States are able to report on this indicator which represents an important limitation for this data.

73% of responding countries (N=169) reported that care and treatment of persons with severe mental disorders (e.g. psychosis, bipolar disorder and moderate/severe depression) is included in national health insurance or reimbursement schemes and 68% of these countries reported that these disorders are explicitly listed as included conditions. On the other hand 27% of countries reported care and treatment is not included in national health insurance or reimbursement schemes and 19% of these countries stated that disorders are explicitly listed as excluded conditions from the national health insurance or reimbursement schemes.

In another question on how people pay for services (N=168), it was estimated by 17% and 18% of Member States that persons pay mostly or entirely out of their own pocket for mental health services and for psychotropic medicines respectively. The biggest rates for out of own pocket expenditures on mental health were noted in African and South East Asian regions. See Figures 3.1.3 and 3.1.4.

FIG. 3.1.2 Government mental health expenditure and government expenditure on mental hospitals per capita (US$), by World Bank income groups

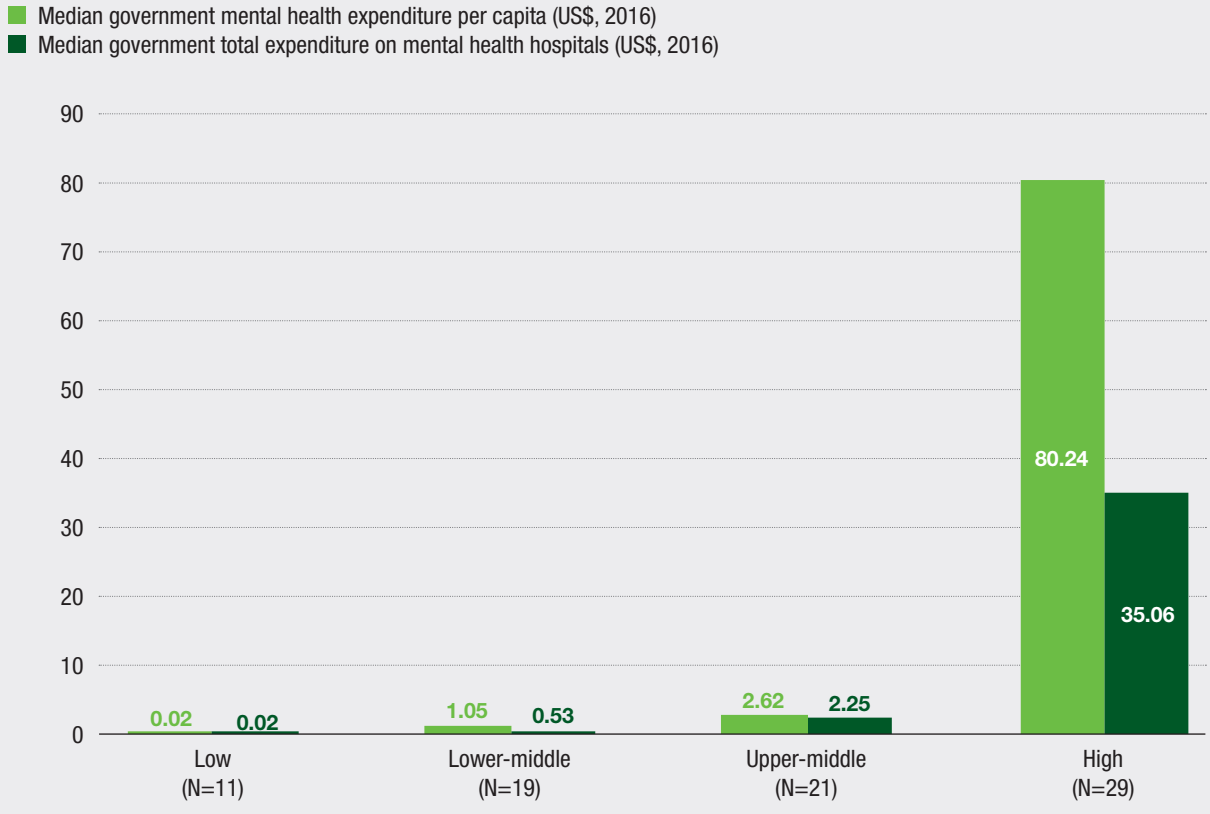


FIG. 3.1.3 Source of payment for mental health services, by WHO region

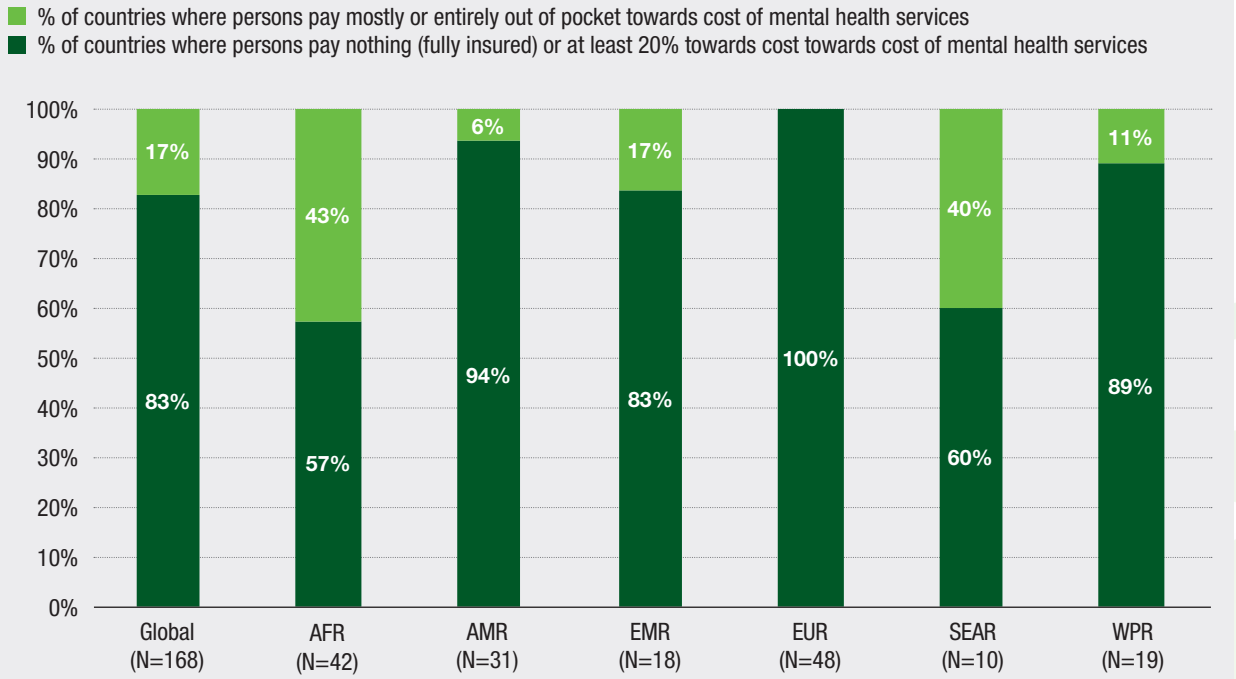
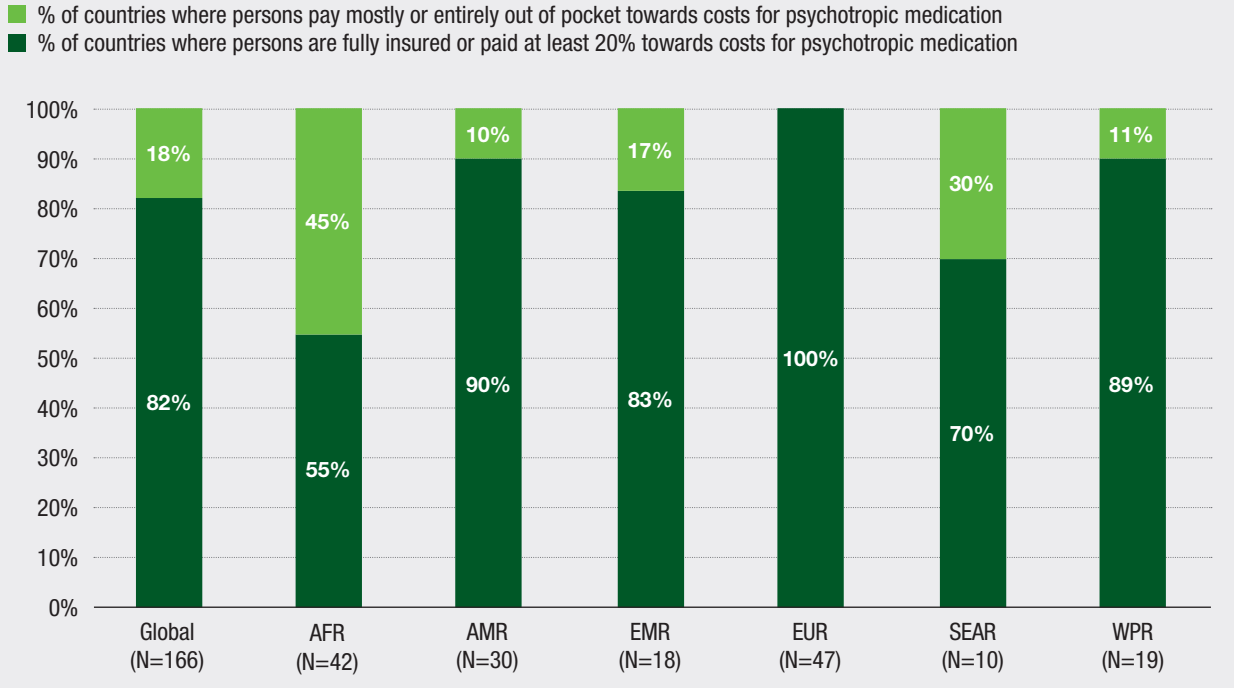


FIG. 3.1.4 Source of payment for psychotropic medications, by WHO region



As shown in Figure 3.1.5 and 3.1.6, there is a strong association between total government mental health spending per capita and gross national income (GNI) per capita. More than 75% of the observed variance is explained by this association. Expressed as a proportion of total health expenditure, however, the association is much weaker (less than 25% of the variance explained); this reflects the fact that a number of countries at lower levels of national income are allocating an appreciable proportion of total health spending to mental health (even if not a large amount in absolute dollar terms), and vice versa for some higher-income countries (which devote only a small proportion of their relatively large health budget to mental health).

FIG. 3.1.5 **Association between per capita mental health expenditure and gross national income (N = 75)**

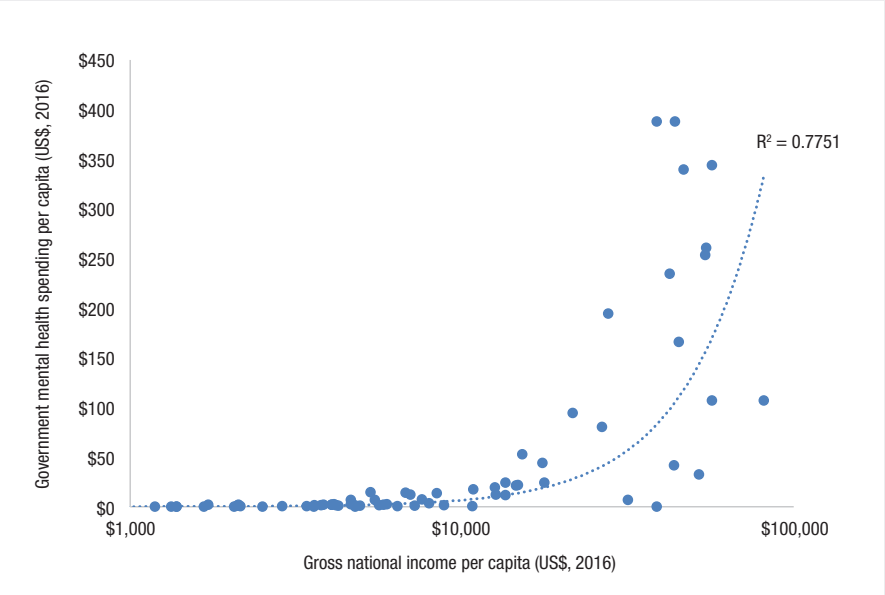
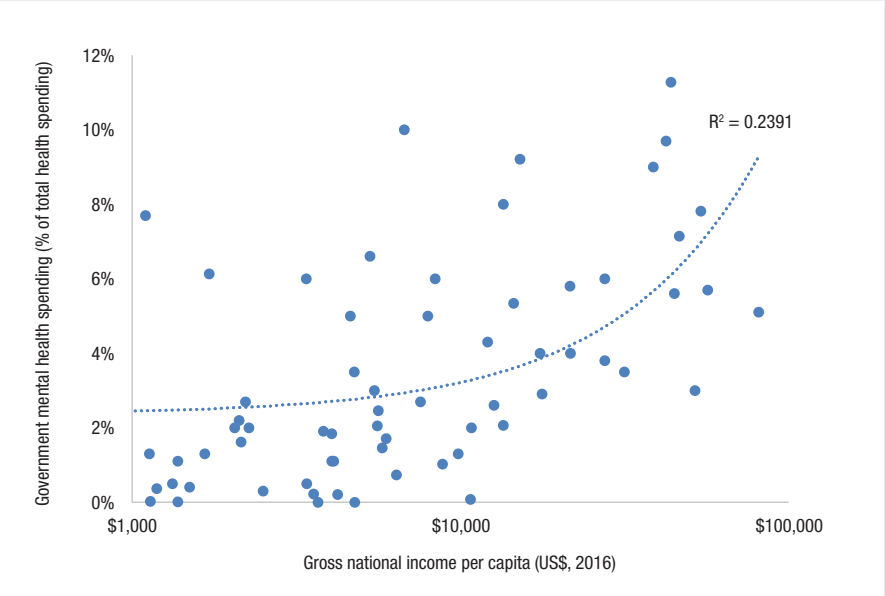


FIG. 3.1.6 **Association between mental health expenditure (as a percentage of total health expenditure) and gross national income (N = 69)**



3.2 MENTAL HEALTH WORKFORCE

Member States 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).

A total of 149 countries, representing a little over 75% of all WHO Member States, were able to provide at least partial estimates of known mental health workers in their country. This reflects an improved completion rate for this important indicator compared to 130 countries in 2014, but also adds some limitations to comparing the two complete datasets.

Median numbers of mental health workers per 100 000 population are shown for different WHO regions and for countries at different income levels in Figures 3.2.1 and 3.2.2, respectively. Based on these reported data, rates are estimated to vary from below 2 per 100 000 population in low-income countries to over 70 in high-income countries. The global median remains at 9 per 100 000 population, or less than one mental health worker per 10 000 population.

FIG. 3.2.1 **Mental health workforce per 100 000 population, by WHO region**

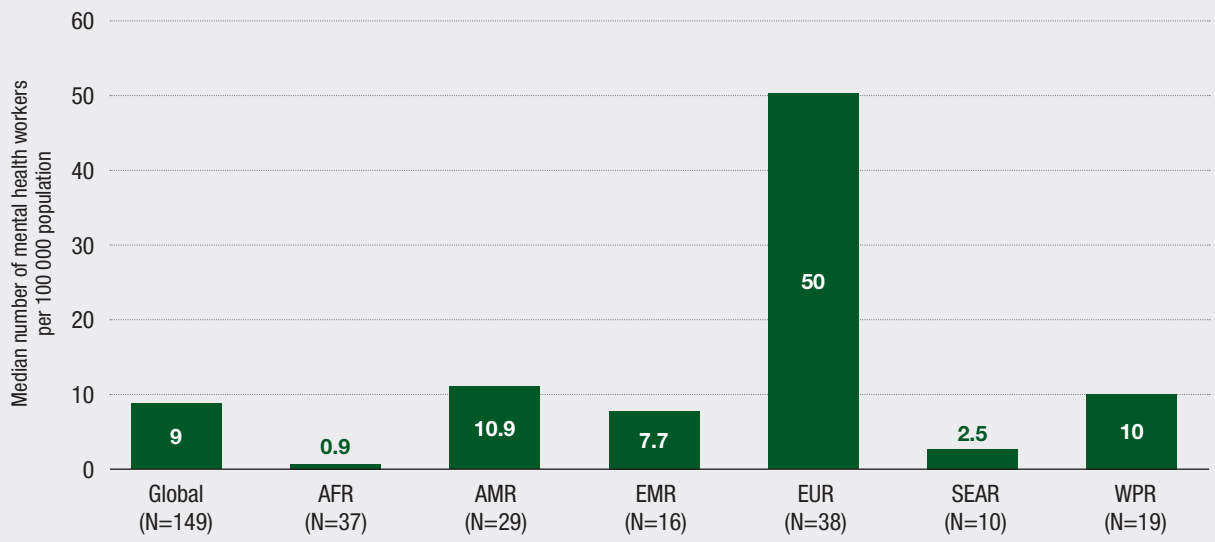
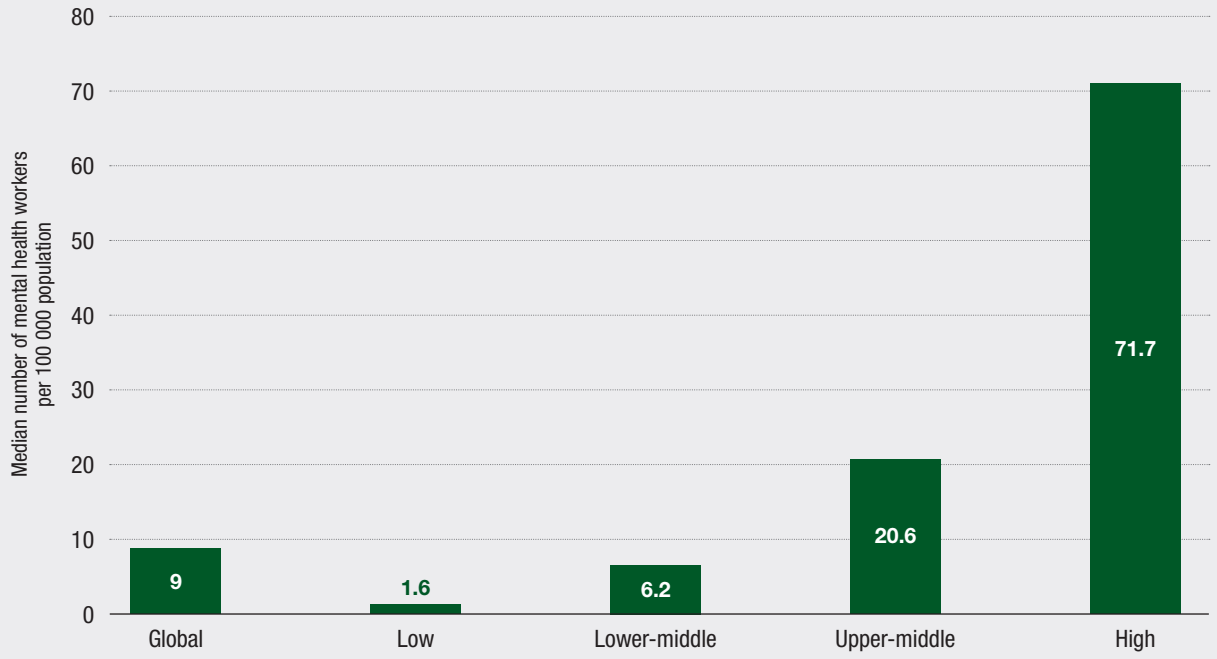


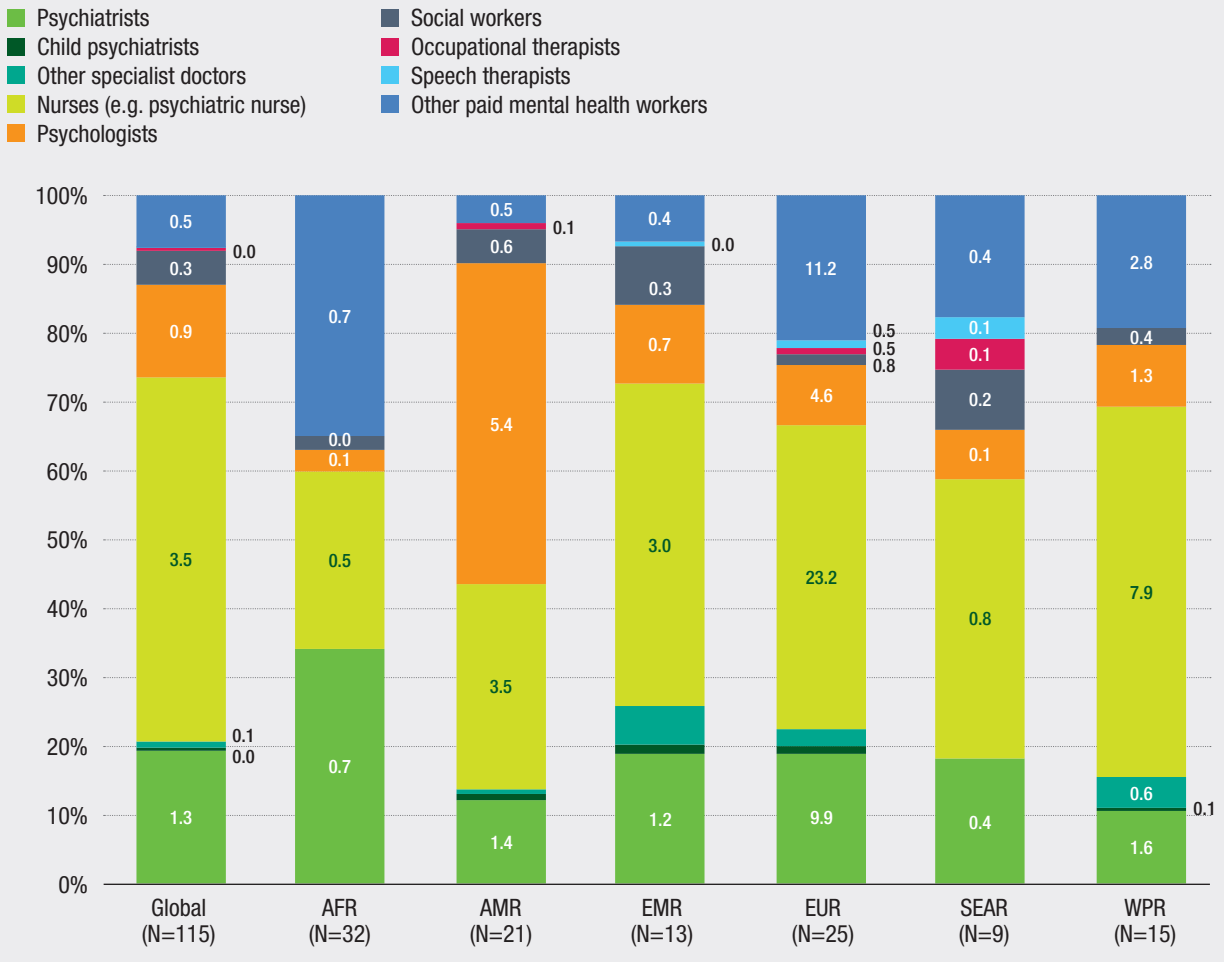
FIG. 3.2.2 Mental health workforce per 100 000 population, by World Bank income group



Figures 3.2.3 and 3.2.4 provide a breakdown of the composition of this workforce, again by WHO region and income group. Results indicate that the proportion of different staff categories is mostly stable across countries at different income levels, with nurses comprising the single largest group of workers (30–50%). Exceptionally in the American and African regions the proportion of psychologists and psychiatrists/other doctors, respectively, is reported to be higher than nurses.

As reported in 2014, the absolute number of workers per 100 000 population varies enormously; for example there are 11.9 psychiatrists per 100 000 population in high-income countries compared to less than 0.1 in low income countries. Similarly, there are 23.5 nurses working in mental health per 100 000 in high-income countries compared to 0.3 in low-income countries, 1.4 in lower middle-income countries and 6.8 in upper middle-income countries.

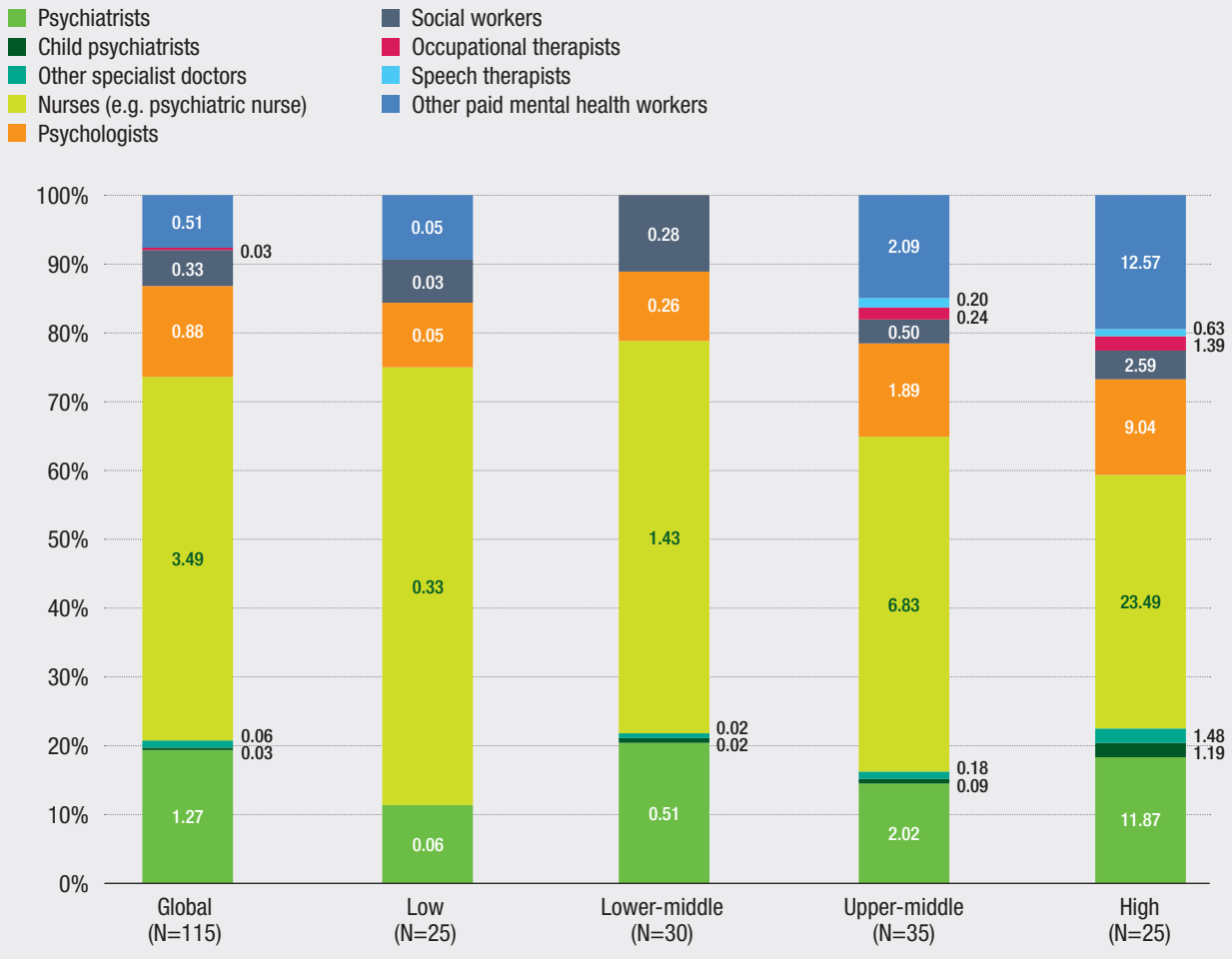
FIG. 3.2.3 **Mental health workforce breakdown per 100 000 population, by WHO region**



The number of occupational therapists and speech therapists working in mental health is very low, with less than 0.25 per 100 000 in all income groups except the high-income group where there are 1.39 occupational therapists and 0.68 speech therapists per 100 000. There are even fewer child psychiatrists, with less than 0.1 per 100 000 population in all income levels except the high-income group where the number of child psychiatrists is 1.19 per 100 000.

The proportion of mental health workforce in government mental health services providing government inpatient and outpatient mental health services, shows that globally 88% of the reported mental health workforce are working in the government health sector. This may also reflect the underreporting of the mental health workforce in the private sector because of limited data availability at national level. Only 78 Member States reported on the percentage of government mental health workers providing child and adolescent mental health services. The median rate is below 9% globally and below 20% in all WHO regions (Data not shown).

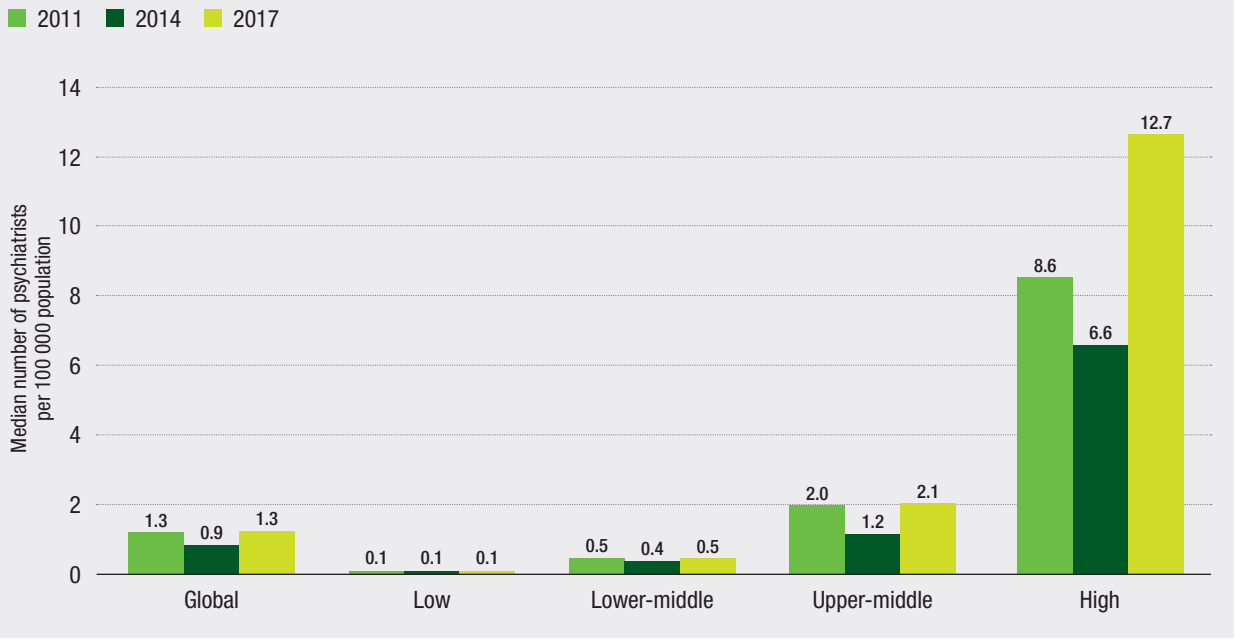
FIG. 3.2.4 **Mental health workforce breakdown per 100 000 population, by World Bank income group**



Countries were requested to report the total number of primary care staff – broken down by profession – who were trained in mental health for at least two days in the last two years. These reported numbers were then divided by official WHO estimates of the total workforce of doctors, nurses and community health workers in each country (that is, not just those working in primary care) and the resulting data show that globally less than 2% of physicians and nurses in all WHO regions received training courses to recognize and to treat patients with severe and common mental disorders during the last year. However it is important to note that this indicator suffered from major underreporting and incomplete responses in all regions and across all income groups. A possibility for underreporting is that data on mental health training for primary care staff are not aggregated at national level at Ministries of Health (Data not shown).

Utilisation of Atlas datasets at successive time points can provide important information and insights into emerging trends. Using data set of all countries reporting data on psychiatrists in Atlas 2011, 2014 and 2017, Figure 3.2.5 was generated. Globally, psychiatrists still remain a rare human resource, with global median number of psychiatrists remaining at approximately only one psychiatrist for every 100 000 population. High income countries have approximately 120 times more psychiatrists than low income countries.

FIG. 3.2.5 **Psychiatrists per 100 000 population 2011, 2014 and 2017, by World Bank income group**



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4. MENTAL HEALTH SERVICE AVAILABILITY AND UPTAKE

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 (Appendix B).

Table 4.1.1 provides a summary of adult inpatient care indicators (including mental hospitals, psychiatric units in general hospitals, residential facilities and forensic inpatient facilities) by WHO region and World Bank income group. Based on reported data there are 16.4 mental health inpatient beds per 100 000 population. High-income countries continue to have a much higher number of hospital beds (52.60 beds per 100 000 population) compared to low-income groups 1.9 beds per 100 000 population. High-income countries report to have 14 times more forensic beds and 8 times more child and adolescent beds per 100 000 population than low-income groups.

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. Table 4.1.2 provides a summary of indicators for mental hospital and psychiatric wards in general hospitals by WHO region and World Bank country income group.

Based on reported data, there are 11.3 mental hospital beds per 100 000 population globally. Despite the transition in a number of high-income countries towards psychiatric wards in general hospitals and the provision of community-based residential care, high-income countries still have a far higher number of mental hospital beds (31.1 per 100 000 population) and admission rates (163.2 per 100 000 population) than lower-income countries; this is true especially for countries in the European region. Analysed by

TABLE 4.1.1 Total adult inpatient care indicators (mental hospital, forensic inpatient units, psychiatric wards, community residential facilities) by WHO region and World Bank income group

	Facilities (median rate per 100 000 population) (N=159)	Beds (median rate per 100 000 population) (N=156)	Admissions (median rate per 100 000 population) (N=134)
Global	0.22	16.4	99.1
WHO region			
AFR	0.1	2.5	20.2
AMR	0.5	20.8	83.9
EMR	0.1	5.1	42.3
EUR	0.7	59.7	453.4
SEAR	0.1	3.2	35.7
WPR	0.7	18.4	114.3
World Bank income group			
Low	0.1	1.9	17.0
Lower-middle	0.1	6.3	43.8
Upper-middle	0.5	24.3	117.2
High	1.2	52.6	334.1

TABLE 4.1.2 Summary of indicators for mental hospitals and psychiatric wards in general hospitals by WHO region and World Bank income group

	Mental hospitals (median rate per 100 000 population)			Psychiatric wards in general hospitals (median rate per 100 000 population)		
	Facilities (N=129)	Beds (N=128)	Admissions (N=113)	Facilities (N=139)	Beds (N=128)	Admissions (N=100)
Global	0.06	11.3	56.3	0.13	2.0	44.4
WHO region						
AFR	0.02	2.0	10.3	0.05	0.6	9.7
AMR	0.07	16.7	33.6	0.17	1.7	48.0
EMR	0.03	4.0	21.2	0.03	0.4	21.3
EUR	0.15	34.2	89.6	0.31	12.3	160.5
SEAR	0.01	2.1	35.7	0.07	0.8	27.2
WPR	0.07	14.8	89.6	0.45	4.2	24.3
World Bank income group						
Low	0.01	1.6	8.6	0.03	0.4	6.9
Lower-middle	0.03	5.1	32.2	0.07	0.9	10.0
Upper-middle	0.07	16.7	56.3	0.15	3.4	55.0
High	0.17	31.1	163.2	0.40	13.1	156.9

WHO region, there are 34.2 mental hospitals beds per 100 000 population in the European region compared to under 20 beds per 100 000 in the American and Western Pacific regions and under or equal to 4 beds per 100 000 in all other regions.

A further question requested countries to report median percentage of duration of stay in mental hospitals, results for which are shown in Figures 4.1.3 and 4.1.4 (for the 87 countries providing data). This shows that in all regions of the world, the great majority of inpatients are discharged within one year (global median 82% and above; 70% in all regions except Western Pacific). However, in certain regions including the American, African and Western Pacific Regions, there are still a significant proportion (20% or more) of mental hospital residents who have had a length of stay of more than one year or even five

FIG. 4.1.3 Duration of stay in mental hospitals, by WHO region (median percentage values)

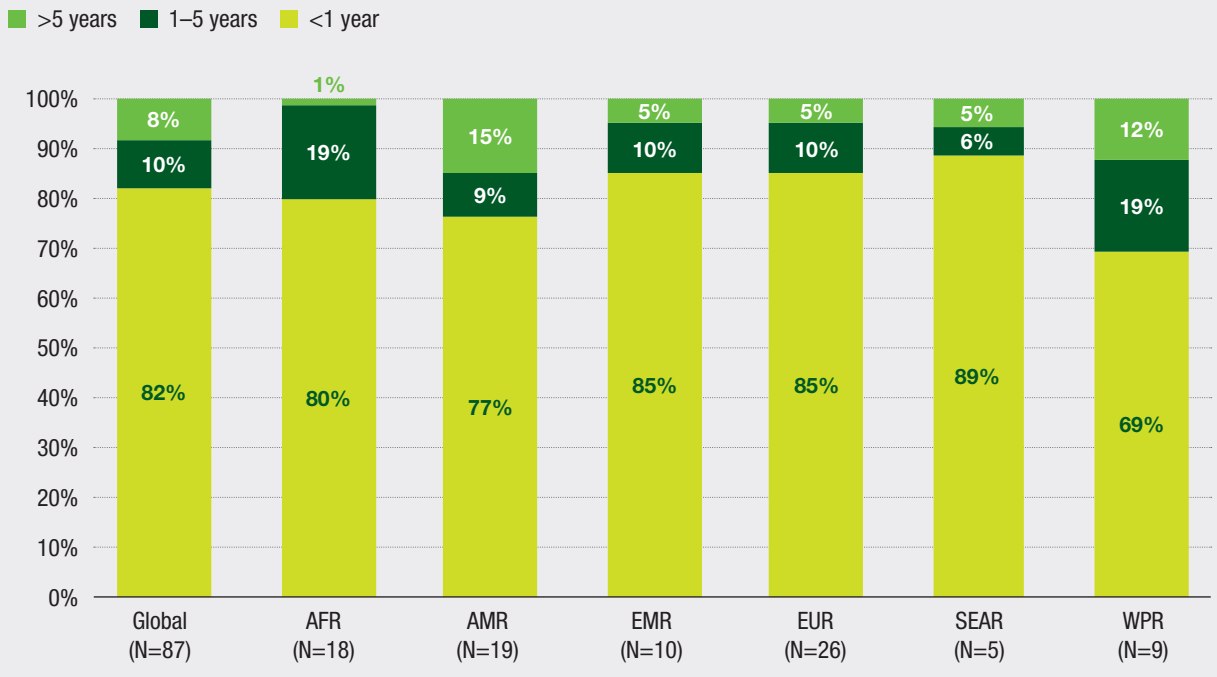
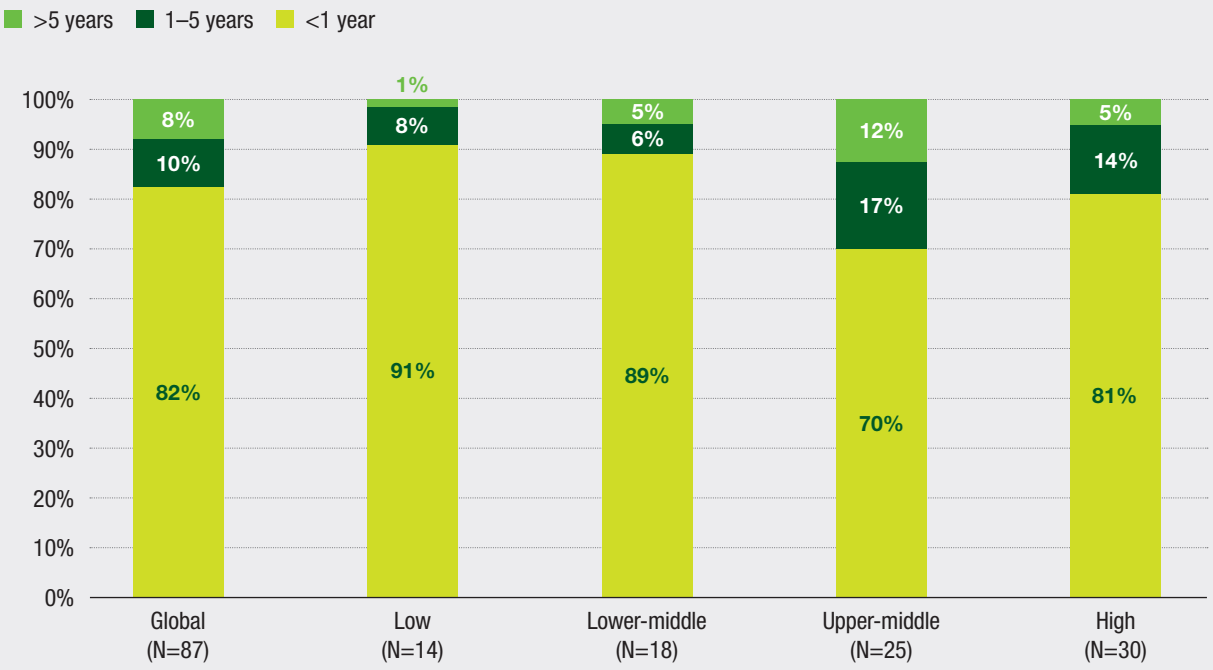


FIG. 4.1.4 Duration of stay in mental hospitals, by World Bank income group (median percentage values)



years. A key finding, when data regarding length of stay is aggregated by income groups, is that in low income countries more than 90% of inpatient service users are staying less than one year, which may reflect an effective utilization of the available limited resources.

PSYCHIATRIC WARDS IN GENERAL HOSPITALS

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

In Atlas 2017, the global rate of mental hospital beds (11.29 per 100 000 population) was reported to be six times more (11.29 per 100 000 population) than the rate of psychiatric ward beds. As shown in Table 4.1.2, globally, there are 2.0 beds per 100 000 population in psychiatric wards in general hospitals, although this masks substantial differences between regions and country income groups; for example, there are over 13 beds per 100 000 population in high-income countries compared to less than 1 in low-income and lower middle-income countries. Similar differences are seen for the rate of admissions and the number of facilities.

Globally, the involuntary admission median percentage is 39.2% at mental hospitals and 16% at psychiatric wards in general hospitals. This indicator suffered from limited data availability and incomplete inputs which put limitations on reporting at regional and income group levels (Data not shown).

Figure 4.1.5 comparing general hospital beds using Mental Health Atlas data sets of 2011, 2014 and 2017, shows slight increase or almost same rates globally and across in high income groups also, there is no increase compared to 2011. Figure 4.1.6 is showing increase in upper-middle and lower-middle income countries utilization of psychiatric ward beds in general hospital, in 2017 compared to 2011.

FIG. 4.1.5 Psychiatric ward beds at general hospital per 100 000 population 2011, 2014, 2017, by World Bank income group

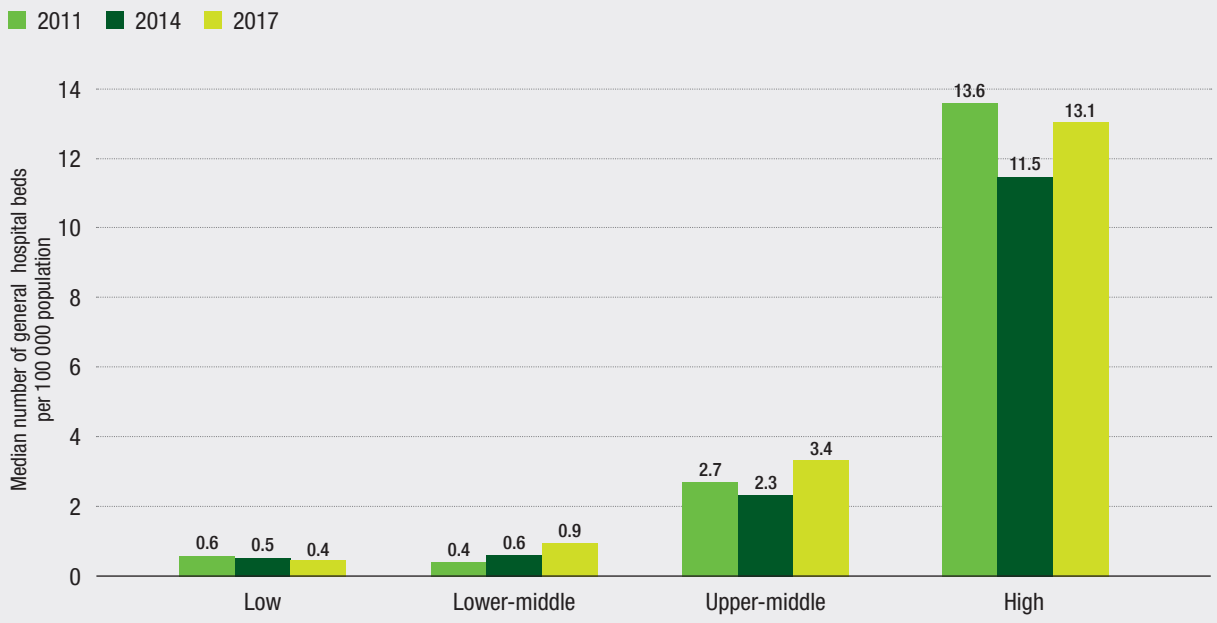
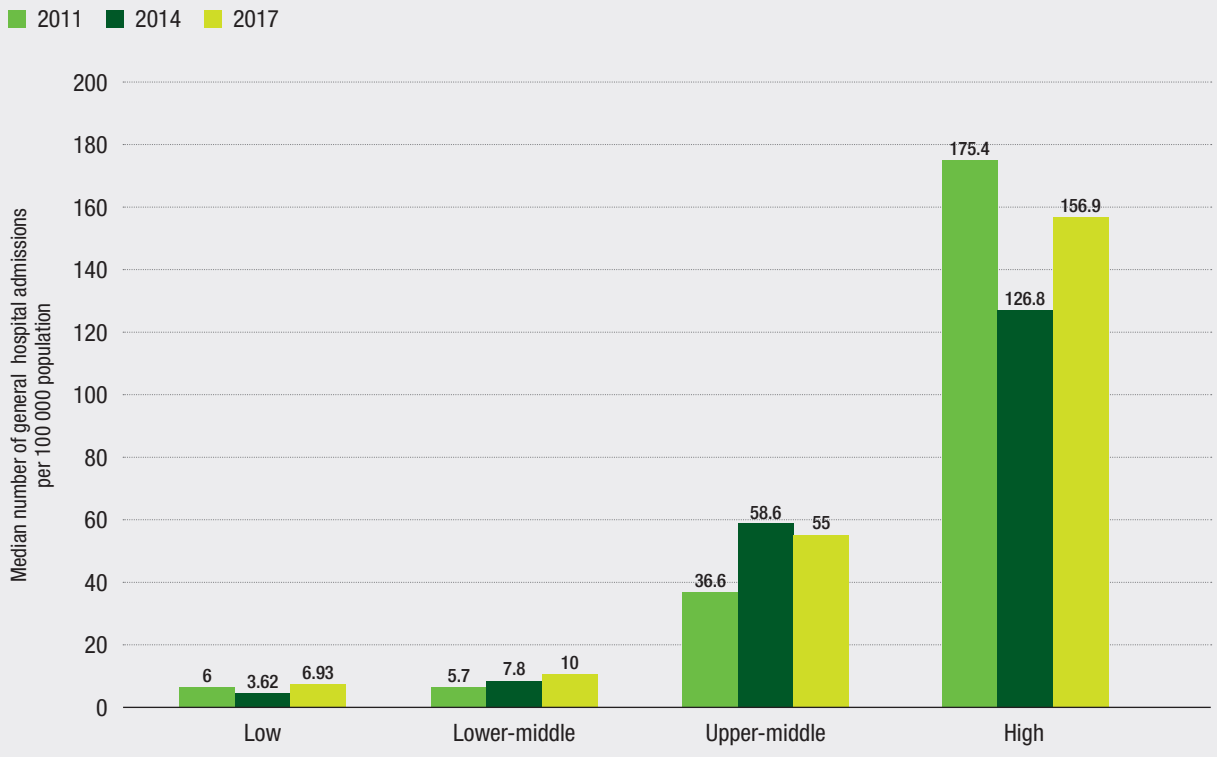


FIG. 4.1.6 Psychiatric ward admissions at general hospital per 100 000 population 2011, 2014, 2017, by World Bank income group



COMMUNITY-BASED RESIDENTIAL CARE FACILITIES

Community-based residential care facilities, which typically serve users with relatively stable and chronic mental disorders, are an almost non-existent resource in low and middle-income countries (according to submitted Mental Health Atlas data from 64 countries). In high-income countries, by comparison, there are 23 residential care beds per 100 000 population, thereby marking them out as an important resource in the overall provision of mental health care services. Again, the European region has a far higher number of facilities, beds and admissions than other regions, with 42 residential care beds per 100 000 population.

Based on the data presented in Tables 4.1.1 and 4.1.2, Figures 4.1.7 and 4.1.8 show the overall number of beds per 100 000 population, by WHO region and World Bank income group respectively. This includes: children and adolescent, forensic, residential care, psychiatric unit and mental hospital beds. Children and adolescent and forensic beds are very rare type of beds particularly in low and lower-middle income countries.

FIG. 4.1.7 Total median number of mental health beds per 100 000 population, by WHO region

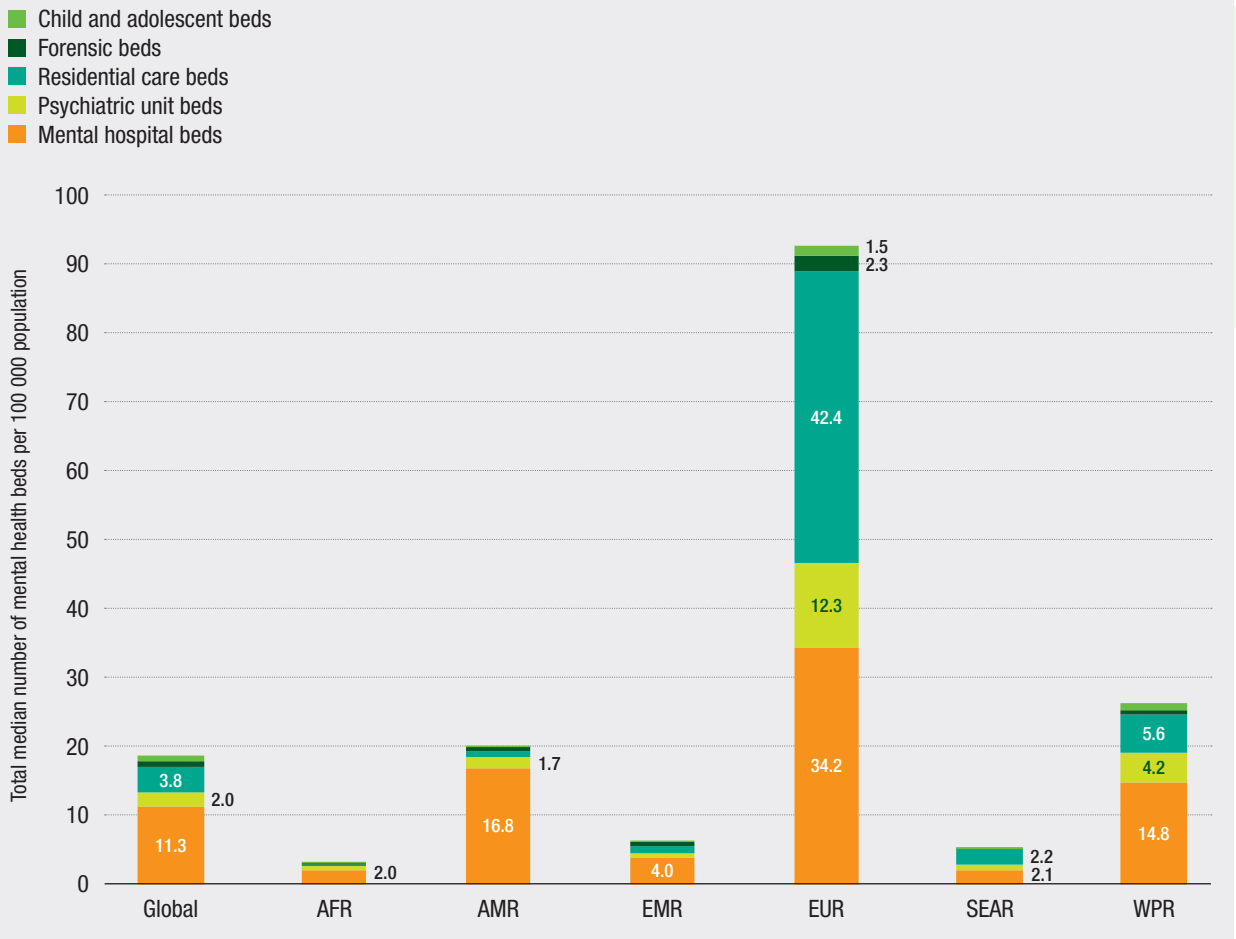
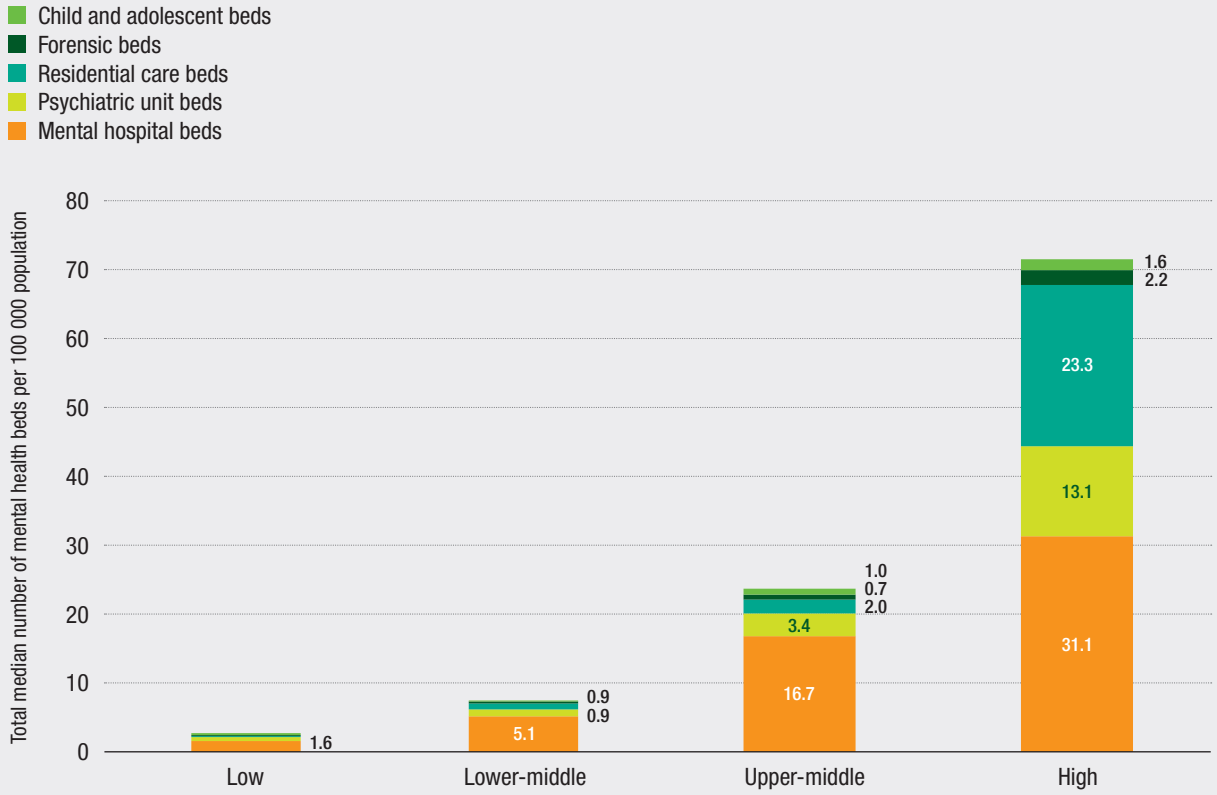


FIG. 4.1.8 Total median number of mental health beds per 100 000 population, by World Bank income group



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 facilities are provided in Appendix B.

Mental health outpatient facilities manage mental disorders and related clinical and social problems on an outpatient basis. Table 4.2.1 shows a summary of adult outpatient care facilities indicators including the total number of facilities and visits relates to hospital-based facilities, community-based/non-hospital facilities and other outpatient facilities indicators. The global median number of visits to adult outpatient facilities is 1601 visits per 100 000 population.

The availability and utilization of outpatient facilities is dramatically different for countries of different regions and income levels for both outpatient adult and outpatient child and adolescent facilities. The availability of outpatient facilities in high-income countries is 30 times more than low-income countries. The total number of adult outpatient visits per 100 000 population in high-income countries (7,966) is 36 times higher than in low-income countries (220).

Similar discrepancies exist across regions and income levels in relation to child and adolescent outpatient visits. The global median number of visits to child and adolescent mental health outpatient facilities is just 164 per 100 000 population with a far higher number of visits in high-income countries (1609 visits per 100 000 population) than low-income countries (11 visits per 100 000 population) (Data not shown).

There are 3 times more hospital-based outpatient clinic visits (144 per 100 000) in low-income countries compared to community-based non-hospital visits (48 per 100 000), while in high-income countries there are a greater number of community-based outpatient visits than hospital-based outpatient visits. In South East Asian, Eastern Mediterranean and Western Pacific regions the hospital based outpatients visits are remarkably higher than community based outpatient visits, which may reflect the centralization of care at hospital-based settings.

TABLE 4.2.1 **Summary of adult outpatient care facilities indicators by WHO region and World Bank country income group (median rate per 100 000)**

	Total		Hospital-based outpatient		Community-based/ non-hospital	
	Facilities (N=140)	Visits (N=113)	Facilities (N=121)	Visits (N=95)	Facilities (N=80)	Visits (N=63)
Global	0.90	1601	0.26	961	0.81	1071
WHO region						
AFR	0.07	508	0.07	250	0.65	566
AMR	1.38	3071	0.29	1350	1.15	1645
EMR	0.45	632	0.10	448	0.33	194
EUR	1.63	8073	0.42	2571	1.21	3952
SEAR	1.21	437	0.48	437	0.93	30
WPR	2.08	693	0.95	705	0.89	167
World Bank income group						
Low	0.07	220	0.08	144	0.04	48
Lower-middle	0.50	588	0.08	204	0.48	470
Upper-middle	1.68	1993	0.31	1165	0.70	663
High	2.08	7966	0.48	3853	1.82	4323

CONTINUITY OF CARE

In order to assess continuity of care – a marker for the quality of the mental health care system – Atlas 2017 also enquired about the proportion of mental health inpatients discharged from hospitals, who had been followed-up within one month. As shown in Figures 4.2.1 and 4.2.2 reported rates on this indicator (from 130 countries) were generally high, with over 60% of responding countries stating that discharged patients are seen within a month in more than 50% of cases. There was variation between WHO regions and income groups with almost 60% of countries in the Western Pacific region reporting that discharged patients received a follow-up outpatient visit within one month more than 75% of the time, compared with 25% in Eastern Mediterranean countries.

FIG. 4.2.1 Continuity of care: proportion of discharged patients seen within a month, by World Bank group

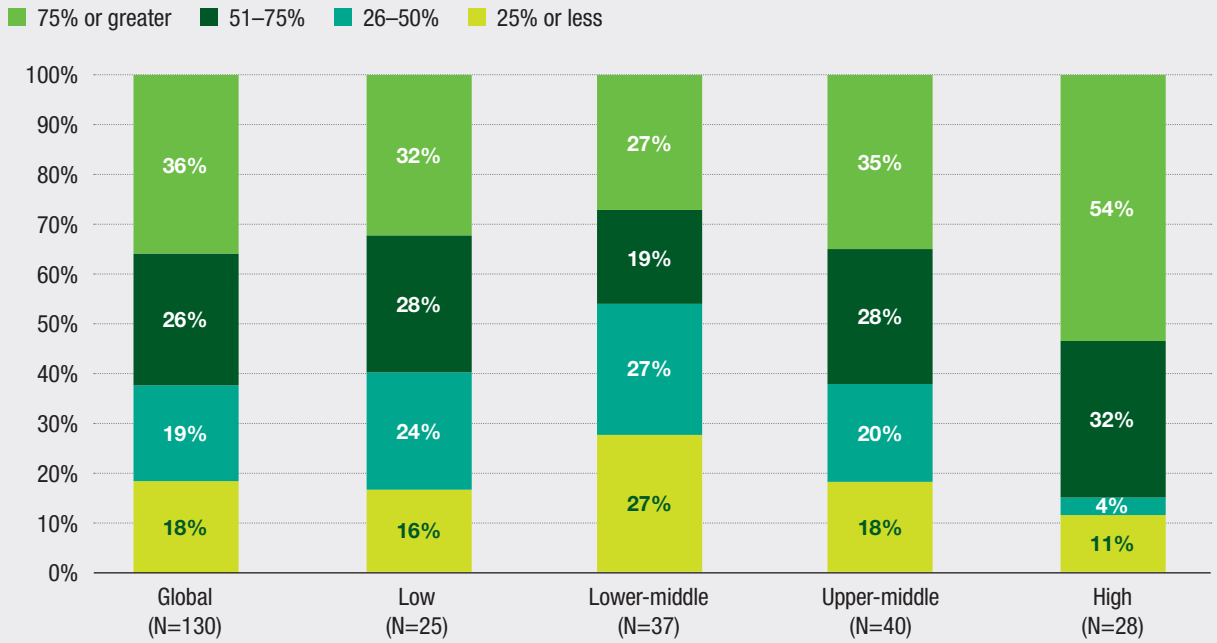
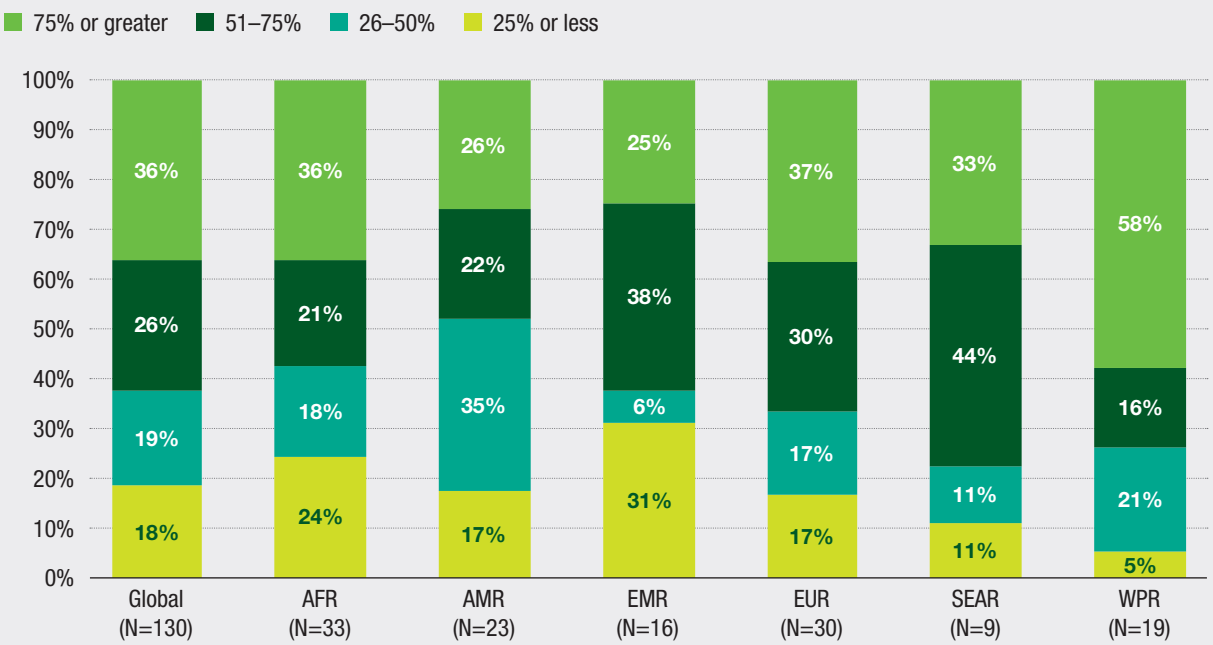


FIG. 4.2.2 Continuity of care: proportion of discharged patients seen within a month, by WHO region

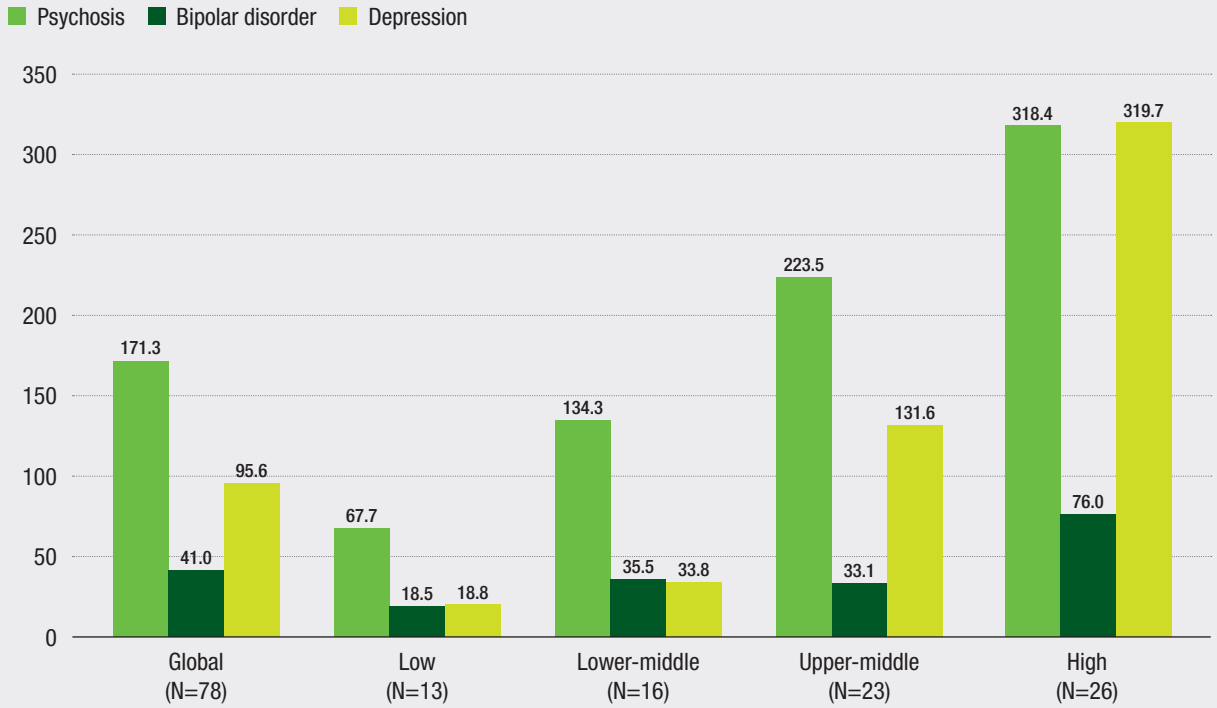


4.3 TREATED PREVALENCE

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 facilities (outpatient and inpatient facilities) over the previous year can serve as a proxy for treated prevalence in specialist mental health care services. Aiming 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.

79% of Member States responding to this section of the Atlas 2017 questionnaire reported using national level data, while 16% used data from specific sites/localities and 6% only used regional data to report on service utilization for psychosis, bipolar disorder and depression. 84% of reporting countries used routine health information systems and 16% used periodic survey to report the data on service utilization for these three mental disorders. There is a wide gap between treated prevalence of the three disorders in high and low-income countries as shown in Figure 4.3.1. Psychosis is showing the highest treated prevalence among the three conditions in low-income, lower-middle and upper-middle countries, while depression treated prevalence in high-income group is almost similar as psychosis. Treated prevalence for bipolar disorder is exceptionally low across all income groups.

FIG. 4.3.1 Total treated prevalence of psychosis, bipolar disorder and depression per 100 000 in mental health services, by World Bank income 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 Mental Health 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 (e.g. 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 non-governmental organizations.

As shown in Figure 4.4.1, the availability of government social support for persons with mental disorders is strongly influenced by income level. A far higher proportion of high-income countries report that persons with mental disorders receive social support (96%) compared with low-income countries, where 86% of countries state that no persons or only few or some persons with mental disorder receive social support.

In Mental Health Atlas 2017, countries were also asked about the main types of government social support provided to persons with severe mental disorders. As shown in Figure 4.4.2, globally, the main types of government social support provided to persons with severe mental disorders are social care support and income support. However responses vary significantly across income groups with 85% of high-income countries reporting that income support is provided compared to only 11% of low-income countries. Other discrepancies exist across income groups, most notably that high-income countries report that significantly more employment (63% of responding countries) and housing support (58%) is provided by governments than low-income countries (4%). Globally, education, housing, employment and legal support is less than 35% of the reported support provided. In the African region, provision of housing support was not reported by any Member State, while in the South East Asia and Eastern Mediterranean regions, employment support is provided in 10% and 24% of Member States, respectively.

FIG. 4.4.1 Availability of government social support for persons with mental disorders, by World Bank income group

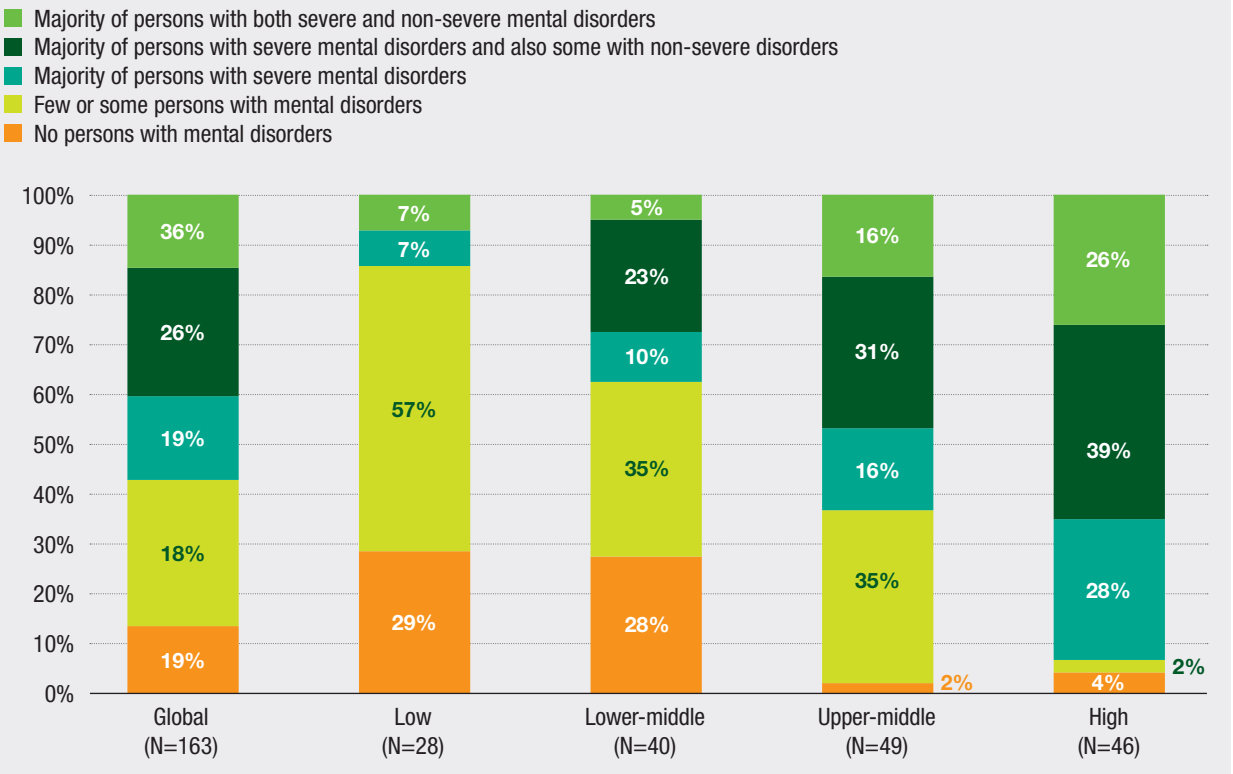
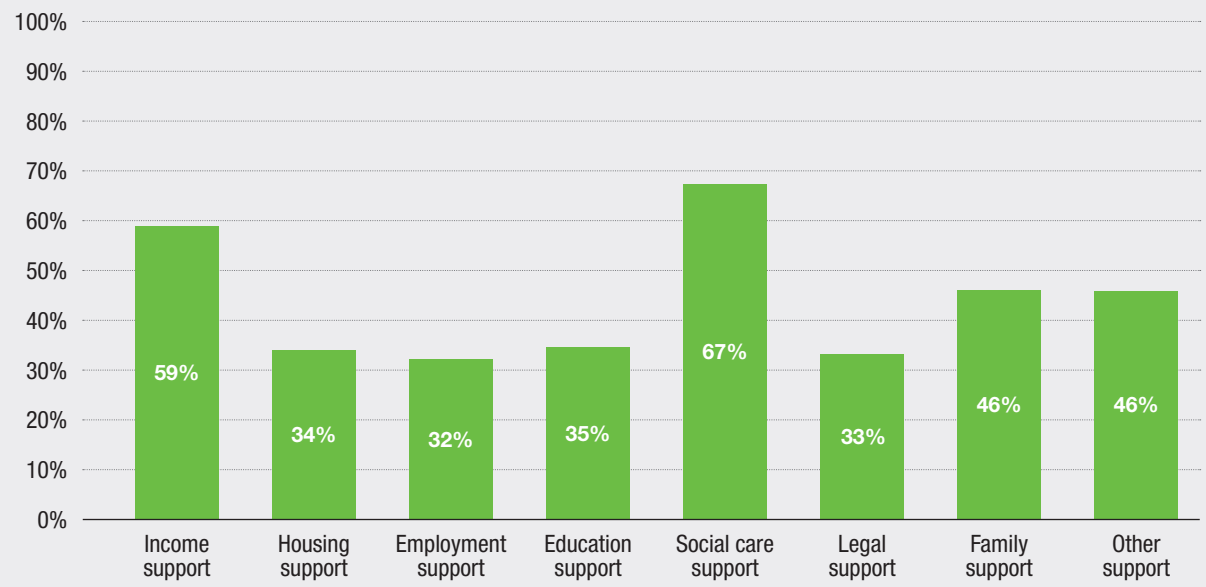


FIG. 4.4.2 Main types of government social support provided for persons with mental disorders, global percentages



RESULTS ATLAS 2017

5. MENTAL HEALTH PROMOTION AND PREVENTION

5.1 MENTAL HEALTH PROMOTION AND PREVENTION PROGRAMMES

WHO recommends to Member States in the Mental Health Action Plan to 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.

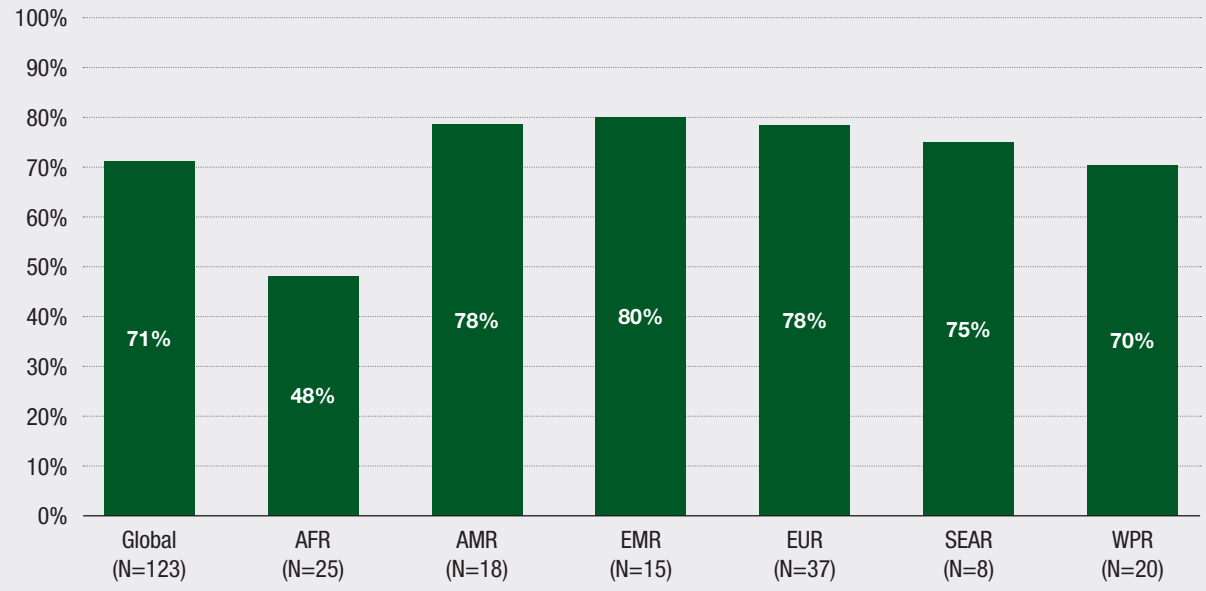
The inclusion of mental health in the Sustainable Development Agenda (SDGs), which was adopted at the United Nations General Assembly in September 2015, is adding more importance to Objective 3 of the Mental Health Action Plan. Goal 3 of the SDGs, is to ensure healthy lives and promote well-being for all, at all ages. Target 3.4 of the SDGs is by 2030 to reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Within the Target 3.4, the suicide rate is an indicator (3.4.2). Objective 3 of the Mental Health Action Plan concerns the implementation of strategies for promotion and prevention in mental health, including prevention of suicide and self-harm.

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

In Mental Health Atlas, 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.

In total, 123 out of 194 WHO Member States (63%) reported to have at least two functioning mental health promotion and prevention programmes, more than two thirds of the way to the 2020 Global Target of 80%. More than 70% of responding countries in all regions report they have at least 2 functioning programmes, with the exception of countries in the African region, where less than 50% of Member States report they have at least 2 functioning programmes (Figure 5.1.1). A total of 356 functional programmes were identified through the Mental Health Atlas 2017 questionnaire, with 114 of those

FIG. 5.1.1 Promotion and prevention programmes: Proportion of countries with at least 2 functioning programmes



in the European region (Figure 5.1.2). It is important to note that the questionnaire allowed Member States to report a maximum of five programmes. This indicator is showing a remarkable increase from the baseline of 2014, which was 80, 41% of all WHO Member States. This can be explained by Member States continuing and increasing investment in mental health prevention and promotion. It may also be explained by an improved reporting and completion rate for Atlas indicators in general. This question was included as an indicator for the first time in Mental Health Atlas 2014, so reporting may have improved with the enhanced availability of data regarding prevention and promotion programmes functionality in 2017.

Over and above the regional distribution of these programmes, programmes were categorised according to their geographical scope (national, regional, district, community) and their ownership/management (government, NGO, private, jointly managed). The majority of reported functional programmes are national programmes (76%) and managed by government (66%). This may be explained through the fact that these programmes, as well as other data reported in the questionnaire, are reported by national governmental focal points. Functional prevention and promotion programmes managed jointly between the government and other partners represent 20% of total functioning programmes reported. 12% of reported functional programmes are managed by NGOs, while those managed by private sector represent only 2% of programmes reported. Functional programmes implemented at either district or community level represent only less than 10% of total functioning programmes reported (Data not shown).

Looking across the types of programme reported on, a high proportion (40%) could be described as mental health awareness or anti-stigma programmes (Figure 5.1.3). The next most common types of programme were suicide prevention programmes (12%) and school-based promotion interventions (10%). Other programmes such as Early Childhood Development/Stimulation programmes, Violence Prevention programmes, Parental/Maternal Mental Health Promotion programmes and Workplace Mental Health Promotion programmes represent 7% of reported functional programmes.

FIG. 5.1.2 **Promotion and prevention programmes (N=356): Regional breakdown**

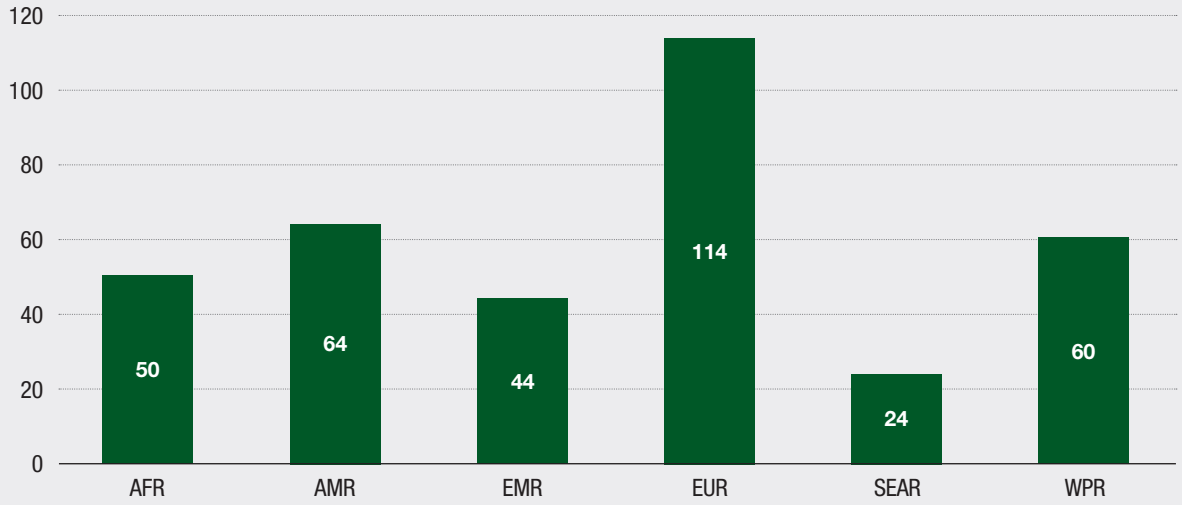
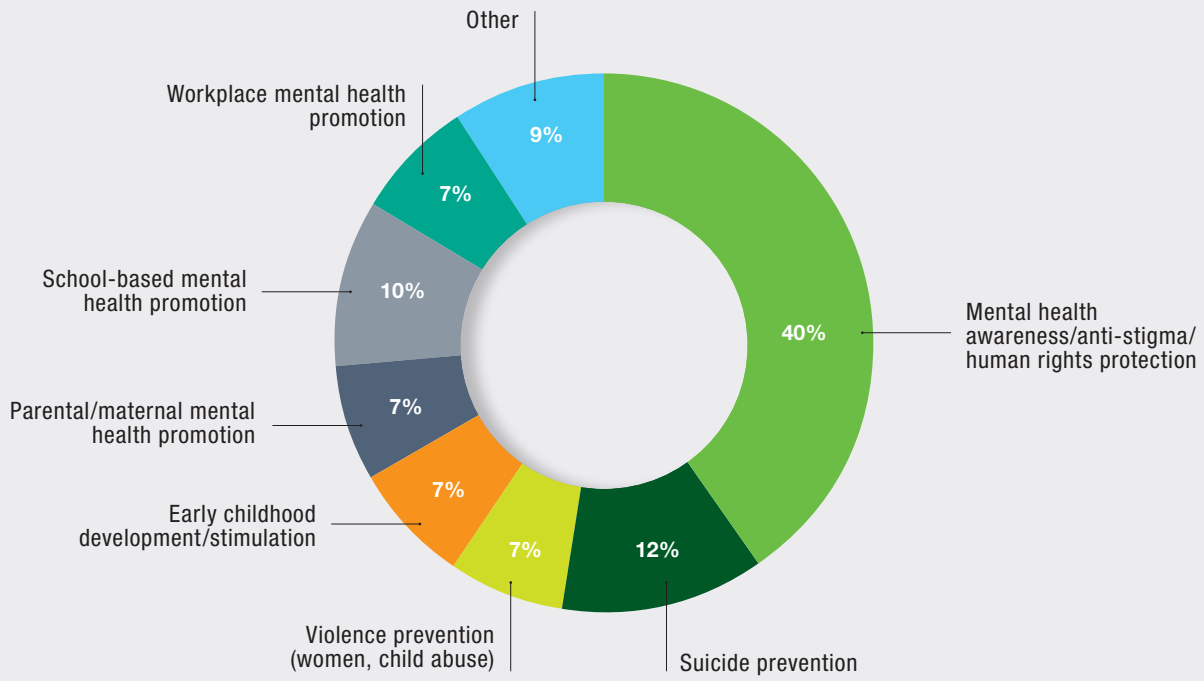


FIG. 5.1.3 Promotion and prevention programmes (N = 349): Main types of programme

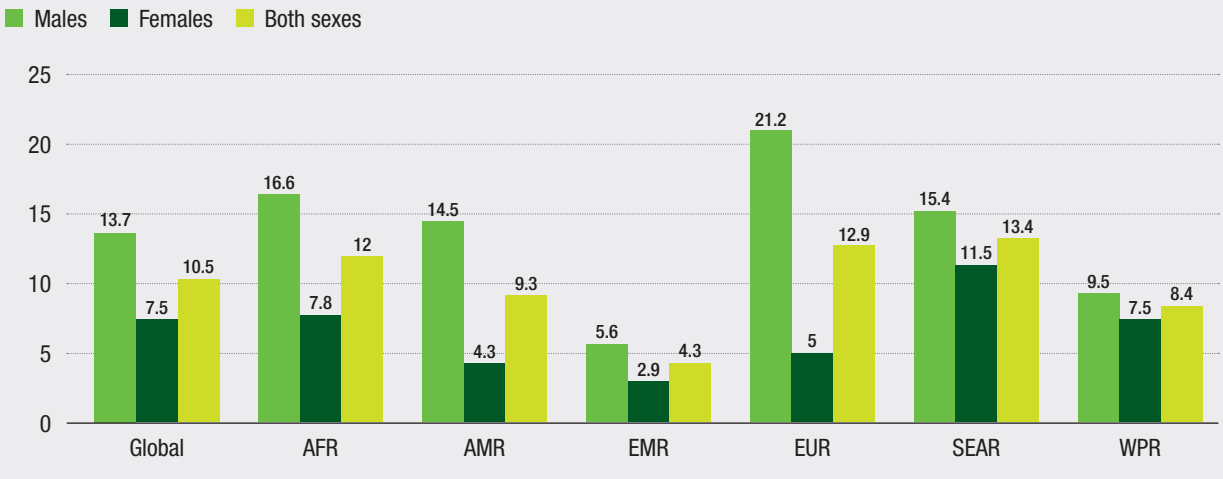


5.2 SUICIDE PREVENTION

A particular prevention priority in the area of mental health concerns suicide, which accounted for an estimated 793 000 deaths in 2016 (WHO, 2018). Target 3.2 of the Mental Health Action Plan 2013–2020, calls for a 10% reduction in the rate of suicide in countries by 2020. The UN Sustainable Development Goals (SDGs) include target 3.4 to address non-communicable diseases and mental health with an indicator to reduce suicide mortality by a third by 2030.

The global age-standardized suicide rate in 2016 was estimated to be 10.5 per 100 000 population. Figure 5.2.1 provides age-standardized suicide rates in different regions of the world in 2016 using WHO Global Health Estimates (WHO, 2018) available on the Global Health Observatory. Rates are highest in the WHO European, South-East Asia, and African regions.

FIG. 5.2.1 Age-standardized suicide rates per 100,000 population, by region, 2016



Mental Health Atlas 2017, asked countries to report on the availability of a suicide reporting system system. Out of 148 Member States who responded to this question, 59% reported the availability of suicide mortality data from a vital registration system. The reported responsible bodies for ascertainment of suicide include: medico legal authorities (49%) who ascertain suicide, followed by a coronial system (21%) (Data not shown).

Member States were also asked whether they had a national suicide prevention strategy. Results show that currently close to 10% of low- and lower-middle income countries have a stand-alone government-adopted strategy, while about one-third of upper-middle and high-income countries report having such a strategy. This means that there has been a slight increase in the number of countries reporting having a national suicide prevention strategy since the Mental Health Atlas 2014. In addition, there are some countries with a national framework, national programmes for specific sub-populations, or where suicide prevention is integrated into the mental health or other health plan.

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APPENDIX A
ATLAS 2017

PARTICIPATING COUNTRIES AND CONTRIBUTORS

WHO Member States	WHO region	World Bank income category	Contributors to Atlas 2017
Afghanistan	EMR	Low	Bashir Ahmad Sarwari
Albania	EUR	Upper-middle	Emanuela Tollozhina
Algeria	AFR	Upper-middle	Mohamed Chakali
Angola	AFR	Lower-middle	Massoxi Adriana G. Vigário
Antigua and Barbuda	AMR	High	Teri-Ann Joseph
Argentina	AMR	Upper-middle	Andre Blake
Armenia	EUR	Lower-middle	Samvel Torosyan
Australia	WPR	High	Natasha Cole
Austria	EUR	High	Alexander Grabenhofer-Eggerth
Azerbaijan	EUR	Upper-middle	Fuad Ismayilov
Bahamas, The	AMR	High	Eugenia Combie
Bahrain	EMR	High	Eman Ahmad Haji
Bangladesh	SEAR	Lower-middle	Faruq Alam
Barbados	AMR	High	Joy St. John
Belarus	EUR	Upper-middle	Alexander Startcev
Belgium	EUR	High	Pol Gerits
Belize	AMR	Upper-middle	Eleanor Bennett
Bhutan	SEAR	Lower-middle	Mindu Dorji
Bolivia (Plurinational State of)	AMR	Lower-middle	Boris Flores Viscarra
Bosnia and Herzegovina	EUR	Upper-middle	Drazenka Malicbegovic
Botswana	AFR	Upper-middle	Patrick Zibochwa
Brazil	AMR	Upper-middle	Quirino Cordeiro Junior
Brunei Darussalam	WPR	High	Jacob John
Bulgaria	EUR	Upper-middle	Hristo Hinkov
Burkina Faso	AFR	Low	Somda Kuessome Paulin
Burundi	AFR	Low	Joselyne Miburo, Jérôme Ndaruhutse
Cambodia	WPR	Lower-middle	Chhit Sophal
Cameroon	AFR	Low	Menguene Laure
Canada	AMR	High	Sarah Lawley
Cape Verde	AFR	Lower-middle	Aristides
Central African Republic	AFR	Low	Caleb Kette
Chad	AFR	Low	Bolsane Egip
Chile	AMR	High	Mauricio Gomez Chamorro
China (People's Republic of)	WPR	Upper-middle	Leilai YI
Colombia	AMR	Upper-middle	Jose Fernando Valderrama Vergara
Comoros	AFR	Low	Aboubacar said Anli
Congo (the)	AFR	Lower-middle	Kitembo Lambert
Cook Islands	WPR	Upper-middle	Valentino Wichman
Costa Rica	AMR	Upper-middle	Allan Rimola Rivas
Côte d'Ivoire	AFR	Lower-middle	DELAFOSSE
Croatia	EUR	Upper-middle	Neven Henigsberg
Cuba	AMR	Upper-middle	Carmen Borrego
Cyprus	EUR	High	Yiannis Kalakoutas
Czech Republic (the)	EUR	High	Petr Winkler
Denmark	EUR	High	Sine Almholt Hjalager
Dominican Republic	AMR	Upper-middle	Angel Almanzar
Ecuador	AMR	Upper-middle	Roberto Enriquez Anaya
Egypt	EMR	Lower-middle	Hisham Ahmed Ramy

WHO Member States	WHO region	World Bank income category	Contributors to Atlas 2017
El Salvador	AMR	Lower-middle	Arturo Carranza Rivas
Equatorial Guinea	AFR	Upper-middle	Alicia Oyensue
Eritrea	AFR	Low	Ghidewon Yirgaw
Estonia	EUR	High	Ingrid Ots-Vaik
Ethiopia	AFR	Low	Dereje Assefa
Fiji	WPR	Upper-middle	Irene Lata
Finland	EUR	High	Helena Vorma
France	EUR	High	Emmanuelle Jouy
Gabon	AFR	Upper-middle	Mbungu Mabiala
Gambia (the)	AFR	Low	Bakary Sonko
Georgia	EUR	Lower-middle	Ekaterine Adamia
Germany	EUR	High	Robert Schlack
Ghana	AFR	Lower-middle	Priscilla Elikplim Tawiah
Greece	EUR	High	D.Ploumpidis, K. Moschovakis
Grenada	AMR	Upper-middle	Tomo Kanda
Guatemala	AMR	Lower-middle	Ninette Alburez de von Ahn
Guinea	AFR	Low	Kemo Soumaoro
Guinea-Bissau	AFR	Low	Jeronimo Enrique Te
Guyana	AMR	Upper-middle	Util Richmond-Thomas
Haiti	AMR	Low	René Dormesant
Honduras	AMR	Lower-middle	Carolina Padilla
Hungary	EUR	High	Tamas Kurimay
Iceland	EUR	High	Ingibjörg Sveinsdóttir
India	SEAR	Lower-middle	Sujeet K. Singh
Indonesia	SEAR	Lower-middle	Antony Azarsyah
Iran (Islamic Republic of)	EMR	Upper-middle	Ahmad Hajebi
Iraq	EMR	Upper-middle	Emad Abdulrazaq
Ireland	EUR	High	Michael Murchan
Israel	EUR	High	Daphna Levinson
Italy	EUR	High	Teresa Di Fandra
Jamaica	AMR	Upper-middle	Maureen Irons-Morgan
Japan	WPR	High	Toshihiro Horiguchi
Jordan	EMR	Lower-middle	Fateen Janim
Kenya	AFR	Lower-middle	Simon Njuguna Kahonge
Kiribati	WPR	Lower-middle	Arite Kathrine Kauongo
Kyrgyzstan	EUR	Lower-middle	Sabira Musabaeva
Latvia	EUR	High	Toms Pulmanis
Lebanon	EMR	Upper-middle	Rabih El Chammay
Liberia	AFR	Low	F. Boffa Washington
Libya	EMR	Upper-middle	Amjad Shagrouni
Lithuania	EUR	High	Ona Davidoniene
Luxembourg	EUR	High	Juliana D'Alimonte
Madagascar	AFR	Low	Raharinvo Mbolatiana
Malaysia	WPR	Upper-middle	Nurashikin Ibrahim
Maldives	SEAR	Upper-middle	Saneefa Hassan Manik
Mali	AFR	Low	Cheikna Tounkara
Marshall Islands	WPR	Upper-middle	Marita Edwin
Mauritania	AFR	Lower-middle	Yahafdou El Mouhab
Mauritius	AFR	Upper-middle	Ameenah Sorefan

WHO Member States	WHO region	World Bank income category	Contributors to Atlas 2017
Mexico	AMR	Upper-middle	Guadalupe Del Carmen Villegas Perez
Micronesia (Federated States of)	WPR	Lower-middle	Benido Victor
Monaco	EUR	High	Dominique De Furst
Mongolia	WPR	Lower-middle	Kazantseva Elena
Montenegro	EUR	Upper-middle	Aleksandra Raznatovic
Morocco	EMR	Lower-middle	Maaroufi Abderahman
Mozambique	AFR	Low	Palmira Fortunato dos Santos
Myanmar	SEAR	Lower-middle	Tin Oo
Namibia	AFR	Upper-middle	Celia Kaunatjike
Nauru	WPR	Upper-middle	Albertina Barandonga
Nepal	SEAR	Low	Mohammad Daud
Netherlands (the)	EUR	High	Paulien Seeverens
New Zealand	WPR	High	Barry Welsh
Nicaragua	AMR	Lower-middle	Roger Montes Gonzalvez; Guillermo
Niger	AFR	Low	Boureima Abdou
Nigeria	AFR	Lower-middle	Alison Abdullahi
Niue	WPR	Lower-middle	Thomas Pita
Norway	EUR	High	Gitte Huus
Oman	EMR	High	Amira Al Raidan
Pakistan	EMR	Lower-middle	Fareed Aslam Minhas
Panama	AMR	Upper-middle	Ricardo Goti
Paraguay	AMR	Upper-middle	Mirta Mendoza Bassani
Peru	AMR	Upper-middle	Miguel Angel Hinojosa Mendoza
Philippines	WPR	Lower-middle	Gerardo Bayugo
Poland	EUR	High	Marek Stańczuk
Portugal	EUR	High	Álvaro Carvalho
Qatar	EMR	High	Susan Clelland
Republic of Korea (the)	WPR	High	Hyo Yeong Yu
Republic of Moldova (the)	EUR	Lower-middle	Jana Chihai
Romania	EUR	Upper-middle	Botezat Antonescu Ileana
Russian Federation	EUR	Upper-middle	Anna Korotkova
Rwanda	AFR	Low	Frederic Nsanzumuhire
Saint Kitts and Nevis	AMR	High	Tomo Kanda
Saint Lucia	AMR	Upper-middle	Alicia St Juste
Saint Vincent and the Grenadines	AMR	Upper-middle	Diana Bailey
Samoa	WPR	Upper-middle	George Tuitama
Sao Tome and Principe	AFR	Lower-middle	Marta Maria Posser da Costa Neto
Saudi Arabia	EMR	High	Abdulhameed A. Al-Habeeb
Senegal	AFR	Low	Aida Sylla
Serbia	EUR	Upper-middle	Dusica Lecic-Tosevski
Seychelles	AFR	High	Gina Michel
Sierra Leone	AFR	Low	A Wurie
Singapore	WPR	High	Lay Tin ONG
Slovak Republic	EUR	High	Ivan Doci
Slovenia	EUR	High	Matej Vinko
Solomon Islands	WPR	Lower-middle	Orotaloa
Somalia	EMR	Low	Zeynab Ahmed Noor
South Africa	AFR	Upper-middle	Melvyn Freeman, Sifiso Phakathi
South Sudan	AFR	Low	Atong Ayuel, Joseph Lou K. Mogga

WHO Member States	WHO region	World Bank income category	Contributors to Atlas 2017
Spain	EUR	High	José Rodriguez
Sri Lanka	SEAR	Lower-middle	Chithramalee de Silva
Sudan	EMR	Lower-middle	Hoyam Ibrahim
Suriname	AMR	Upper-middle	Bharti Manurat
Swaziland	AFR	Lower-middle	Violet D. Mwanjali
Sweden	EUR	High	Martin Jeppsson
Switzerland	EUR	High	Lea Meier
Syrian Arab Republic	EMR	Lower-middle	Ramadan Mahfouri
Tajikistan	EUR	Lower-middle	Khurshed Kunguratov
Thailand	SEAR	Upper-middle	Chosita Pavasuthipaisit
The former Yugoslav Republic of Macedonia	EUR	Upper-middle	Antoni Novotni
Timor-Leste	SEAR	Lower-middle	Helder Juvinal Neto da Silva
Togo	AFR	Low	Kolou Dassa
Tonga	WPR	Upper-middle	Pita Pepa
Trinidad and Tobago	AMR	High	Lawrence Jaisingh
Tunisia	EMR	Lower-middle	Wahid Melki
Turkey	EUR	Upper-middle	Ugur Ortac
Uganda	AFR	Low	Ndyanabangi Sheila
Ukraine	EUR	Lower-middle	Serhii Shum
United Arab Emirates (the)	EMR	High	Muna Al Kuwari
United Kingdom of Great Britain and Northern Ireland (the)	EUR	High	Shipton-Yates
United Republic of Tanzania (the)	AFR	Low	Ayoub Magimba
United States of America (the)	AMR	High	Mary Fleming
Uruguay	AMR	High	Jorge Quian
Uzbekistan	EUR	Lower-middle	Grigoriy Kharabara
Vanuatu	WPR	Lower-middle	Jerry Iaruel
Venezuela (Bolivarian Republic of)	AMR	Upper-middle	Xiomara Vidal
Vietnam	WPR	Lower-middle	La Duc Cuong
Yemen	EMR	Lower-middle	Mohammed Yahya Alashwal
Zambia	AFR	Lower-middle	Friday Nsalamo
Zimbabwe	AFR	Low	Dorcas Shirley Sithole

Associate Members, Areas and Territories*	
Anguilla	Aisha Andrewin, Maeza Demis-Adams
Sint Maarten	Irad Potter
Tokelau	Silivia Tavite
West Bank and Gaza Strip	Samah Jabr
American Samoa	Motusa Tuileama Nua
Bermuda	Anna Neilson-Williams
British Virgin Islands	Irad Potter
Cayman Islands	Janett Flynn
China, Hong Kong, SAR	Kellie SO
Curaçao	Beulah Mercera
French Polynesia	Mathis
Kosovo	Besnik Stuja
Macao	Chi-Veng HO
Montserrat	Marguerite Joseph, Donique Layne
Northern Mariana Islands, Commonwealth of the	Glenda Sablan George
Turks and Caicos Islands	Alicia Malcolm

* Associate Members, Areas and Territories were not included in the WHO regional and World Bank income group analyses. However short descriptive profiles of each of these countries as well as all participating WHO Member States will be published in the WHO Mental Health and Substance Abuse website.

Note: Although care has been taken to include names of all contributors, information on any omissions or inaccuracies can be communicated to WHO Secretariat at mhatlas@who.int.

ATLAS 2017

GLOSSARY OF TERMS

TYPES 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. Usually these facilities are independent and standalone, although they may have some links with the rest of the health care system. The level of specialization varies considerably: in some cases only long-stay custodial services are offered, in others specialized and short-term services are also available (rehabilitation services, specialist units for children and elderly, etc.)

- Includes: Both public and private non-profit and for-profit facilities; mental hospitals for children and adolescents only and mental hospitals for other specifics groups (e.g., elderly) are also included.
- Excludes: Community-based psychiatric inpatient units; forensic inpatient units and forensic hospitals. Facilities that treat only people with alcohol and substance abuse disorder or intellectual disability without an accompanying mental disorder diagnosis.

Psychiatric ward in a general hospital:

A psychiatric unit that provides inpatient care for the management of mental disorders within a community-based facility. These units are usually located within general hospitals, they provide care to users with acute problems, and the period of stay is usually short (weeks to months).

- Includes: Both public and private non-profit and for-profit facilities; psychiatric ward in general hospital; psychiatric unit in general hospital, community-based psychiatric inpatient units for children and adolescents only; community-based psychiatric inpatient units for other specific groups (e.g. elderly).
- Excludes: Mental hospitals; community residential facilities; facilities that treat only people with alcohol and substance abuse disorder or mental retardation.

Mental health community residential facility:

A non-hospital, community-based mental health facility that provides overnight residence for people with mental disorders. Usually these facilities serve users with relatively stable mental disorders not requiring intensive medical interventions.

- Includes: Supervised housing; un-staffed group homes; group homes with some residential or visiting staff; hostels with day staff; hostels with day and night staff; hostels and homes with 24-hour nursing staff; halfway houses; therapeutic communities. Both public and private nonprofit and for-profit facilities are included. Community residential facilities for children and adolescents only and community residential facilities for other specifics groups (e.g. elderly) are also included.

- Excludes: Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or intellectual disability; residential facilities in mental hospitals; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind (e.g. nursing homes and rest homes for elderly people, institutions treating neurological disorders, or physical disability problems).

Mental health day care facility:

A facility that typically provides care for users during the day. The facilities are generally: (1) available to groups of users at the same time (rather than delivering services to individuals one at a time), (2) expect users to stay at the facilities beyond the periods during which they have face-to-face contact with staff (i.e. the service is not simply based on users coming for appointments with staff and then leaving immediately after the appointment) and (3) involve attendances that last half or one full day.

- Includes: Day centres; day care centres; sheltered workshops; club houses; drop-in centres; employment/ rehabilitation workshops; social firms. Both public and private non-profit and for-profit facilities are included. Mental health day treatment facilities for children and adolescents only and mental health day treatment facilities for other specifics groups (e.g. elderly) are also included.

- Excludes: Facilities that treat only people with a diagnosis of alcohol and substance abuse disorder or intellectual disability without an accompanying mental disorder diagnosis; generic facilities that are important for people with mental disorders, but that are not planned with their specific needs in mind; day treatment facilities for inpatients are excluded

Mental health outpatient facility:

A facility that focuses on the management of mental disorders and the clinical and social problems related to it on an outpatient basis.

- Includes: Community mental health centres; mental health ambulatories; outpatient services for specific mental disorders or for specialized treatments; outpatient clinics located in mental hospitals or general hospitals ; mental health outpatient departments in general hospitals; mental health policlinics; specialized NGO clinics that have mental health staff and provide mental health outpatient care (e.g. for rape survivors or homeless people). Both public and private non-profit and for-profit facilities are included. Mental health outpatient facilities for children and adolescents only and mental health outpatient facilities for other specifics groups (e.g. elderly) are also included.

- Excludes: Private practice; facilities that treat only people with alcohol and substance abuse disorder or intellectual disability without an accompanying mental disorder diagnosis.

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 mental health facility defined for this instrument (community-based psychiatric inpatient unit, community residential facility, forensic inpatient unit, mental hospital).

- Includes: Residential facilities specifically for people with intellectual disabilities, for people with substance abuse problems, or for people with dementia. Included are also residential facilities that formally are not mental health facilities but where, nevertheless, the majority of the people residing in the facilities have diagnosable mental disorders.

OTHER TERMS USED

Admissions:

The number of admissions in one year is the sum of all admissions to the facility within that year. This number is a duplicated count; in other words, if one user is admitted twice, it is counted as two admissions.

Mental health legislation:

Legal provisions related to mental health. These provisions typically focus on issues such as: civil and human rights protection of people with mental disorders, treatment facilities, personnel, professional training, and service structure.

Mental health plan:

A detailed scheme for implementing strategic actions that addresses the promotion of mental health, the prevention of mental disorders, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles and objectives defined in the policy.

Mental health policy:

Mental health policy is an organized set of values, principles and objectives for improving mental health and reducing the burden of mental disorders in a population. It defines a vision for future action.

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, professional and paraprofessional psychosocial counsellors, special mental health educators, and auxiliary staff.

- Excludes: This group does not include general staff for support services within health or mental health care settings (e.g. cooking, cleaning, security).

Patients treated in a mental hospital:

(a) the number of patients in the mental hospital at the beginning of the year plus (b) the number of admissions during the year.

Patients treated in a community residential facility:

(a) the number of users in the facility at the beginning of the year plus (b) the number of admissions to the facility during the year.

Patients treated through a mental health day treatment facility:

The number of users with at least one attendance for treatment at the facility within the year.

Patients treated in a mental health outpatient facility:

The number of users with at least one outpatient contact with the facility. A contact refers to a mental health intervention provided by a staff member of a mental health outpatient facility, whether the intervention occurs within the facility or elsewhere.

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.

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 a formal training in psychology at a recognized, university-level school for a diploma or degree in psychology.

Social worker:

A professional having completed a formal training in social work at a recognized, university-level school for a diploma or degree in social work.

Nurse:

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

Occupational therapist:

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

User/consumer/patient:

A person receiving mental health care. These terms are used in different places and by different groups of practitioners and people with mental health conditions.

The Mental Health 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 Mental Health Atlas 2017 is remarkably significant as it is providing information and data on the progress towards the achievement of objectives and targets of the Comprehensive Mental Health Action Plan 2013–2020.

For more information, please contact:

Department of Mental Health and Substance Abuse
World Health Organization
Avenue Appia 20
CH-1211 Geneva 27
Switzerland

Email: mhatlas@who.int

http://www.who.int/mental_health/evidence/atlasmnh/en/

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