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Global mental health: how are we doing?

The World Health Organization (WHO) has just launched the 2017 edition of the Mental Health Atlas, consisting of updated information from nearly 180 countries[1].

Data from the Atlas are used to monitor mental health policies, laws, programmes and services across WHO Member States[2,3], and to track progress in the implementation of the WHO's Mental Health Action Plan 2013-2020[4]. Additionally, Atlas 2017 is particularly relevant as 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[5].

With the aim of stimulating the global mental health community to make further progress in relation to mental health policies, laws, programmes and services, we present here the main findings of Atlas 2017, and describe progress towards the achievement of the four objectives of the Mental Health Action Plan.

The production of Atlas 2017 followed a strict methodological process, involving development of a questionnaire and an associated completion guide, management of an online data collection system, validation of information and responses, liaison with Member States and WHO Regional and Country Offices, as well as analysis and interpretation of data[1].

A total of 177 out of 194 WHO Member States (91%) completed, at least partially, the Atlas questionnaire, with a submission rate above 85% in all WHO Regions.

In terms of mental health governance, 72% of Member States reported to have a standalone policy or plan for mental health, and 57% to have a standalone mental health law. Importantly, 94 countries, i.e. 68% of those that 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. Similarly, 76 countries, i.e. 75% of those that 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.

In terms of financial and human resources for mental health, Atlas 2017 shows that the 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, with extreme variation, from below 1 in low-income countries to over 70 in high-income countries.

Wide variation was also observed in terms of number of mental health beds, which range from below 7 in low- and lower middle-income countries to over 50 in high-income countries per 100,000 population. Similar variation was documented for child and adolescent beds, which range from below 0.2 in low- and lower middle-income countries to over 1.5 in high-income countries.

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

As far as progress towards the achievement of the four objectives of the Mental Health Action Plan is concerned, Atlas 2017 highlighted the following:

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). The proportion of countries fulfilling this target slightly increased from 45% (Atlas 2014) to 48% (Atlas 2017) of all WHO Member States.

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). The proportion of countries fulfilling this target slightly increased from 34% (Atlas 2014) to 39% (Atlas 2017) of all WHO Member States.

Target 2: Service coverage for severe mental disorders will have increased by 20% (by the year 2020). Although Atlas 2017 made a substantial effort to increase the reliability of data, service coverage for severe mental disorders was not computable. The treated prevalence for psychosis, bipolar disorder and depression was 171.3, 41.0 and 95.6 per 100,000 population, respectively.

Target 3.1: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes (by the year 2020). The proportion of countries fulfilling this target increased from 41% (Atlas 2014) to 63% (Atlas 2017) of all WHO Member States.

Target 3.2: The rate of suicide in countries will be reduced by 10% (by the year 2020). According to WHO data on suicide, suicide rate slightly decreased from 11.4 to 10.5 per 100,000 population from 2014 to 2017.

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). The proportion of countries fulfilling this target slightly increased from 64 countries, 33% of all WHO Member States (Atlas 2014), to 71 countries, 37% of all WHO Member States (Atlas 2017).

A number of limitations should be recognized when examining Atlas 2017 data. A first limitation is that some countries were not able to provide data for a number of indicators. For example, data on service coverage and utilization were not available for many countries, possibly due to the still limited implementation of national information systems.

Second, although a large number of countries submitted questionnaires for both Atlas 2014 and Atlas 2017, the list of countries completing both data points within each of the questions was sometimes different. This adds some constraints to comparisons of data over time between the two Atlas versions.

Third, 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. It is nevertheless important to note that the process of country-level mental health data collection, started by WHO in 2000 in partnership with WHO Member States, has progressively improved in terms of quality and quantity of information, and is expected to make further progress over the next years.

This continuous effort has also contributed to consolidate an epidemiological and evaluative culture among WHO Member States, which is a major achievement considering the important public health choices that countries are continuously required to make[6]. The next important step is that countries start to use the data they collected to improve their mental health system and to monitor progress.

Data included in the Mental Health Atlas 2017 demonstrate the commitment of countries to track progress towards the implementation of the WHO's Mental Health Action Plan 2013-2020. Progressive development is being made in relation to mental health policies, laws, programmes and services across WHO Member States.

Findings from Atlas 2017 suggest that the global targets established by the Mental Health Action Plan will be reached only if there is a collective global commitment that leads to substantial investment and expanded efforts at country level in relation to mental health policies, laws, programmes and services across WHO Member States.

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Global trends in high impact psychiatry research

The utility of psychiatry research, when indexed as the number of times it is cited by other researchers, is most centrally predicted by the impact factor of the publishing journal[1]. In keeping, scientists' track record in high impact journals is directly related to academic promotions and merit increases in academic psychiatry institutions[2], and the acquisition of research funding[3]. Thus, much pressure exists for psychiatric researchers to publish their research in high impact psychiatry journals.

Trends in high impact psychiatry journals are therefore important to examine. This is especially true when considering that psychiatry is thought to be particularly vulnerable to publication bias. While studies have noted possible biases in the preponderance of underpowered studies stemming from phar-