Regional Agenda for Implementing the **Mental Health Action Plan** 2013–2020 in the Western Pacific

*Towards a social movement for action on mental health and well-being*
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FOREWORD

In the Western Pacific Region, more than 100 million people are affected by mental disorders – many of which can be prevented or managed with cost-effective interventions. These interventions would improve the quality of life of those affected, as well as reduce the total disease burden. The resulting windfall would promote economic growth at community, national and regional levels.

The sixty-fifth session of the World Health Organization Regional Committee for the Western Pacific endorsed the Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific. The regional agenda guides WHO and Member States in implementing the Mental Health Action Plan 2013–2020. This guidance is provided through three strategic entry points: (1) a health systems approach; (2) a whole-of-government approach; and (3) a social movement approach to promote justice and equity for people affected by mental health disorders.

We must use the regional agenda to work towards a world where the fundamental value of mental health is duly recognized, where mental disorders are managed effectively and where all people may attain the highest possible standard of health and quality of life.

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EXECUTIVE SUMMARY

More than 100 million people are affected by mental disorders in the Western Pacific Region. Depressive disorders alone are responsible for 5.73% of the disease burden in the Region. Suicide is among the top 10 causes of death in some countries and areas. The huge treatment gap for people with severe mental disorders is a major public health concern and a challenge for most low- and middle-income countries. Many factors can threaten the overall psychological well-being of populations.

The Sixty-seventh session of the World Health Assembly endorsed the Mental Health Action Plan 2013–2020 (see Appendix I for the overview). To guide national action and regional collaboration in the Western Pacific Region, the sixty-fifth session of the Regional Committee endorsed the Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific.

The regional agenda features a phased approach to achieve the four objectives: (1) strengthen effective leadership and governance for mental health; (2) provide comprehensive, integrated and responsive mental health and social care services in community-based settings; (3) implement strategies for the promotion of mental health and the prevention of mental illness; and (4) strengthen information systems, evidence and research for mental health.

To address unique needs and distinct resources, three separate and phased settings were described to assist and inform the development of a road map for country-level implementation. Implementation options for core, expanded and comprehensive actions are provided. Core implementation options are proposed for countries and areas within the Region where a mental health system is absent or in an initial stage with limited resources. Expanded implementation options are indicated for countries that already have a mental health system in operation with reasonable resources, but where disparity is a major challenge. Comprehensive implementation options are indicated for countries that are further along in the development of a comprehensive mental health system and, therefore, closer to realizing the vision of the Mental Health Action Plan 2013–2020.

The Regional Agenda provides guidance for WHO, as well as for WHO’s support to Member States in developing appropriate responses that build on infrastructure and capacity for mental health programmes and services. Priorities for WHO regional
collaboration and country support include the following thematic areas: human resource development; depression, suicide prevention and severe mental disorders; and mental health in disasters and emergencies.

During consultations, frequent bottlenecks in implementation were identified: (1) lack or insufficiency of laws to protect the human rights of people with mental health disorders (protection from cruelty, inhuman treatment, torture and abuse); (2) lack of community resources that include the expansion of linked networks of health facilities and community resources for a range of mental health needs; (3) disease-oriented and curative-care approaches to mental health that are necessary but should be pursued in tandem with whole-of-society approaches for promotion of mental health and well-being; and (4) information systems that do not include or reflect mental health conditions and their impact on overall mental health outcomes.

**All-of-society and whole-of-government approaches are required to overcome the implementation challenges.**
1. Background

Mental, neurological and substance-use disorders accounted for 13% of the total global burden of disease. More than 100 million people are affected by mental disorders in the Western Pacific Region. Depressive disorders are pervasive – responsible for 5.73% of the overall disease burden in the Region – yet under-reported. Mental health disorders often affect and are affected by other diseases, such as cancer, cardiovascular disease, diabetes, stroke, tuberculosis and HIV.

It is estimated that there are more than 500 suicides per day in the Region. Suicide is among the top 10 causes of death in some countries and areas. People with major depression and schizophrenia have a 50% to 60% greater chance of dying prematurely. Globally, annual spending on mental health is less than US$ 2 per person and less than US$ 0.25 per person in low-income countries.

The Regional Committee for the Western Pacific, at its fifty-second session in September 2001, endorsed a regional strategy for mental health. Mental health has been a central topic at the meetings of ministers of health for the Pacific island countries since 2003. Progress has been encouraging, but efforts need to be improved.

All countries and areas report the lack of human resources for mental health as an underpinning factor for the constrained response to the growing demand for programmes and services. While training and capacity-building within the health sector are of critical importance, advancing the agenda for mental health and well-being requires engagement with patients, their families and caregivers, communities and civil society partners. Promoting mental health and preventing mental illness require action among many different government agencies and sectors beyond health.

As different countries are at different stages of development of mental health-care service delivery, implementation options for the Mental Health Action Plan 2013–2020
can be prioritized based on country-specific contexts and needs. The regional agenda articulates a phased approach for core, expanded and comprehensive implementation options as a unique framework for prioritizing and accelerating policies and actions for mental health.
2. Strategic entry points for action in the Western Pacific Region

Based on epidemiologic evidence, reports on country actions and results of regional collaborative projects on policies and programmes, three strategic entry points for action were identified to expedite implementation of the Mental Health Action Plan 2013–2020 in the context of the Western Pacific Region: 1) health systems approach; 2) whole-of-government approach to priority conditions; and 3) social movement for mental health and well-being.

Regional agenda for implementing the Mental Health Action Plan in the Western Pacific (2013–2020)

- **SOCIAL MOVEMENT**
- **HEALTH SYSTEMS APPROACH**
  - Human resource development
  - Health service delivery
- **WHOLE-OF-GOVERNMENT APPROACH TO PRIORITY CONDITIONS**
- **MANAGEMENT OF PRIORITY CONDITIONS**
  - Depression
  - Suicide
  - Schizophrenia and bipolar disorders
  - Mental health in disasters and emergencies
2.1 Health systems approach

Human resource development and health service delivery constraints underpin the weak response to mental health conditions. Trained human resources are critically important to deliver mental health care in the context of universal health coverage. The Region is especially deficient in these resources: the median numbers per 100,000 population in the Region are lower than the world median for psychiatrists, psychologists, social workers and occupational therapists (WHO Mental Health Atlas, 2011). While specialists need to be increased, the immediate solution is to develop strategic plans for training, supervising and support for non-specialists to deliver essential mental health care. WHO’s mhGAP Intervention Guide and linked training material are already being used in a number of countries. These efforts must be scaled up.

In low- and middle-income countries, between 76% and 85% of people with severe mental disorders do not receive treatment. Those figures go from between 35% and 50% in high-income countries. The problem is compounded by the poor quality of care for those who do receive treatment. The majority of people with depression (up to 100% in many parts of the Region) remain untreated, despite the availability of effective treatments. The WHO Mental Health Atlas 2011 catalogues the scarcity of resources within countries for mental health, emphasizing the inequitable distribution and inefficient use of resources. In low-income countries, annual spending on mental health is less than US$ 0.25 per person. Stand-alone hospitals receive 67% of the resources allocated, despite poor health outcomes and human rights violations.

2.2 Whole-of-government approach to priority conditions

Beyond the health systems approach, the whole-of-government approaches are needed to address upstream determinants of mental health in relation to priority conditions.

Depression

Depression affects an estimated 350 million people in the world, accounting for nearly 6% of the overall disease burden in the Region. Depression is different from mood fluctuations and brief emotional responses to challenges in everyday
life. Especially when long-lasting and more intense, depression may become a serious health condition, causing people to suffer greatly and function poorly at work, school and at home. At worst, depression can lead to suicide. Raising awareness about depression in other sectors of government (e.g. education, labour, social welfare, law enforcement) and providing information about risk factors, early signs and symptoms and the availability of interventions to treat and manage depression can have a significant impact on health-seeking behaviour and early detection of depression.

**Suicide**

In 2012 it was estimated that more than 500 suicides occur each day in the Region. These figures do not include suicide attempts and deliberate self-harm, which are up to 20 times more frequent than suicide. Some Western Pacific countries have experienced significant increases in suicide rates in recent years, particularly among youth in the Pacific. Although traditionally suicide rates have been highest among elderly men, suicide behaviour among young people and among women has become a major concern in the Region. The way media reports suicide among celebrities may lead to “copycat” behaviour among at risk individuals. Hence, media and public information sectors of government can play a big role in appropriate reporting of suicide cases in support of suicide prevention.

**Schizophrenia and bipolar disorders**

In most countries, people with severe mental illness such as schizophrenia or bipolar disorders are not identified or provided with appropriate treatment or care. They are left to fend for themselves or locked up. Chaining and restraining patients are still commonly practised in some health facilities in the Region. Some hospitals are more like prisons than health-care facilities. Patients are abused, and their rights are violated. National policies and plans are needed to phase out long-term hospital stay, particularly for patients with severe mental illness. Ministries of health must work with ministries of finance and local governments to redirect funding towards community-based services, integration of mental health into general health-care settings and linking hospitals to community resources.

**Mental health in disasters and emergencies**

The Western Pacific Region is disproportionately prone to earthquakes, tsunamis, typhoons, floods and other natural disasters, which have resulted in enormous
loss of lives and serious damage and destruction to health infrastructure and health systems. Mental health interventions and psychosocial support have to be a part of immediate and long-term responses to disasters and emergencies. Disasters also provide a unique opportunity for policy-makers to recognize and address broader mental health and psychosocial needs of the community, and for building and rebuilding mental health systems to provide comprehensive, integrated and responsive mental health care and services in community-based settings.

2.3 Social movement

Ministries of health play a key role in articulating the severity of the problem and the need for compassion in approaches that place people at the centre of health-care systems. There is a strong role that civil society, especially organizations for people with mental disorders and psychosocial disabilities, their families and support groups as well as mental health service delivery providers can play in overcoming stigmatization and discrimination, as well as other barriers to quality health care. As civil society movements are limited, efforts to enable and engage with communities and strengthen existing groups may help build momentum for social change. Ministries of health may also interact with other sectors such as education, labour and welfare for mental health promotion.
3. Priority implementation options for countries and areas in the Western Pacific Region

Recognizing the magnitude of mental disorders and the importance of mental health, the Sixty-sixth World Health Assembly adopted the *Mental Health Action Plan 2013-2020* in May 2013. All 194 Member States committed to take action to improve mental health and to contribute to the attainment of a set of agreed global targets.

The action plan focuses on four key objectives:

**OBJECTIVE 1.** Strengthen effective leadership and governance for mental health

**OBJECTIVE 2.** Provide comprehensive, integrated and responsive mental health and social care services in community-based settings

**OBJECTIVE 3.** Implement strategies for promotion and prevention in mental health

**OBJECTIVE 4.** Strengthen information systems, evidence and research for mental health
Each country has unique needs and distinct resources that can be directed to better services for the mentally ill, as well as programmes to promote mental health and well-being. The actions proposed for Member States are to be considered and adapted, as appropriate, to national priorities and circumstances in order to accomplish the objectives. Based on information generated by the Mental Health Atlas and other situational analysis exercises, three separate and phased scenarios were described below to assist and inform the development of a road map for the implementation of the mental health action plan at country level. The implementation options for core, expanded and comprehensive actions are provided around the four objectives of the Mental Health Action Plan.

Core implementation options

They are proposed for countries and areas within the Region where a mental health system is absent or in an initial stage with limited resources. Generally mental health needs are not addressed in this scenario.

Expanded implementation options

They are set out for countries that already have a mental health system in operation with reasonable resources, but disparity remains a major challenge.

Comprehensive implementation options

They are set out for countries that are further along in their development of a comprehensive mental health system and, therefore, closer to realizing the vision of the Mental Health Action Plan 2013–2020.

The vision, cross-cutting principles, goal and objectives elaborated in the global Mental Health Action Plan 2013–2020 are fundamental to the development and implementation of this action plan at multiple levels.
Priority implementation options for countries and areas in the Western Pacific Region

OBJECTIVE 1.  Strengthen effective leadership and governance for mental health.

CORE IMPLEMENTATION OPTIONS

1. Organize a core group of advocates or “champions” for mental health to advocate for human rights and raise awareness on the impact of stigmatization and discrimination.

2. Develop, strengthen or enhance a national law to protect the rights of people with mental health disorders.

3. Develop a social and awareness campaign against cruelty, torture, degrading treatment and abuse of mental health patients.

4. Ensure that people with mental disorders and psychosocial disability and their caregivers are given a formal role in the process of developing policies and programmes.

5. Advocate for a budget for mental health policy development.

6. Develop or review and revise national mental health policy and plan.

Key deliverables

a. Develop national law and policy.

b. Raise public awareness.

c. Identify active “champions”/policy advocates.

d. Engage patients and civil society groups.

e. Ensure equal access to quality care.
EXPANDED IMPLEMENTATION OPTIONS

1. Establish a national mental health programme led by higher-level government official with a mechanism for engagement and participation of other sectors to address mental health and human rights.

2. Monitor implementation of laws to protect the rights of people with mental health disorders.

3. Convene, engage and build consensus for sustained campaigns against cruelty, torture, degrading treatment and abuse of mental health patients.

4. Provide logistical, technical and financial support for organized advocacy groups and civil society partners.

5. Monitor and evaluate the implementation of policies and legislation to ensure compliance with the Convention on the Rights of Persons with Disabilities and other international/regional human rights instruments.

6. Organize an independent body to monitor implementation of laws to protect the rights of people with mental disorders.

7. Set up mechanisms for tracking expenditures and gaps for mental health policy development and implementation in health, education, employment, criminal, justice and social services.

8. Develop capacity for sustainable funding for mental health.

9. Build and support local capacity for mental health policies.

10. Involve people with mental and psychosocial disorders and their care-givers in decision-making and review of the mental health policy, plan, service, etc.

Key deliverables

a. Establish a multisectoral national mental health programme led by higher-level government officials.

b. Monitor and evaluate the implementation of policies and legislation to ensure compliance with international human rights instruments.

COMPREHENSIVE IMPLEMENTATION OPTIONS

1. Mainstream mental health and the rights of people with mental disorders and psychosocial disabilities into other sector policies, including poverty reduction and national development.
2. Repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders or psychosocial disabilities.

3. Sustain funding support for and work with the private sector on initiatives to improve and implement mental health policies.

**Key deliverables**

   a. Include mental health in national development plans.

   b. Develop mechanisms for whole-of-government and whole-of-society approaches to improving mental health.

**OBJECTIVE 2.** Provide comprehensive, integrated and responsive mental health and social care services in community-based settings.

**CORE IMPLEMENTATION OPTIONS**

1. Develop a phased and budgeted plan for closing long-stay psychiatric institutions.

2. Map out and develop linked networks of community resources and services led by local governments, including the local players from government, nongovernmental organizations, faith-based groups and other stakeholders that provide community-based mental health services.

3. Develop a communications plan to inform the public regarding a linked network of community resources for mental health.

4. Provide outpatient mental health services and inpatient mental health unit in all general hospitals for priority mental health disorders and other conditions, for example, depression, anxiety, suicide/self-harm, psychosis, epilepsy, dementia, drug and alcohol use disorders, among others.

5. Ensure that basic drugs and medicines for priority mental health disorders and conditions are on the national essential drug list and available, accessible and affordable across the country.
6. Provide mental health and psychosocial support for disaster-affected populations.

7. Strengthen the referral system and links between the community, primary health care and specialized services to ensure continuity of care.

8. Plan, develop and fund training for: mental health staff, primary health-care, community health workers, police, etc. to provide mental health and social care in the community.

9. Integrate mental health into primary health care by training doctors and nurses.

10. Provide psychosocial interventions such as psycho-education for patient and family.

**Key deliverables**

a. Phase out long-stay psychiatric care.

b. Strengthen community resources and services.

c. Provide outpatient mental health services in general hospitals.

d. Ensure basic drugs and medicines are accessible and affordable.

e. Strengthen capacity for mental health in primary health care.

**EXPANDED IMPLEMENTATION OPTIONS**

1. Review and revise social health coverage schemes to ensure that services for mental health are covered.

2. Establish interdisciplinary mental health teams to support people with mental disorders and their families/caregivers in the community.

3. Include mental health into national task force for disaster and emergency preparation, response and recovery.

4. Integrate mental health into undergraduate curricula in different disciplines.

5. Develop community-based social care services, such as home care and support, community-based rehabilitation, supported housing and supported employment.
**Key deliverables**

a. Include mental health service coverage in health financing scheme.

b. Establish interdisciplinary mental health teams.

c. Integrate mental health in national disaster preparedness, response and recovery plans.

d. Incorporate mental health into curricula for health professionals.

e. Emphasize recovery as the goal of mental health services.

**COMPREHENSIVE IMPLEMENTATION OPTIONS**

1. Develop training programmes to engage service users and family members/caregivers with practical experience, such as peer support workers.

2. Develop financing mechanisms to enable nongovernmental organizations, faith-based and other community groups to provide community-based and self-help care.

3. Develop and fund highly specialized government teams to anticipate and address mental health in emergencies and disasters.

4. Mental health programme should be integrated with other programmes, such as disabilities, HIV/AIDS, NCDs, antenatal and postnatal care and other medical conditions, etc.

5. Develop sub-specialty services such as forensics, dual diagnosis, child and adolescent mental health, etc.

**Key deliverables**

a. Provide support and training for family members and caregivers.

b. Provide funding support to enable service delivery by community-based organizations.

c. Develop highly specialized teams for deployment to disaster areas.

d. Integrate mental health into other disease control programmes.

e. Provide specialized treatment for vulnerable groups.
OBJECTIVE 3. Implement strategies for promotion and prevention in mental health.

CORE IMPLEMENTATION OPTIONS

1. Convene a multisectoral group of stakeholders including educators, social workers, organized groups of artists, athletes, the media, leaders in culture and art to develop a national mental health promotion plan of action.

2. Use international good practices on educating the public, school- and workplace-based programmes, sports, culture and the arts to build resilience and promote mental health, adapting/contextualizing into the sociocultural situation.

3. Increase public, political and media awareness of the magnitude of the problem, and the availability of effective prevention strategies.

4. Increase mental health awareness among the health professionals to decrease stigmatization and discrimination.

5. Identify systems, programmes, projects or activities in which suicide prevention advocacy could be initially integrated (for example, general mental health promotion activities, school programmes, workplace safety, primary health care, drug and alcohol abuse programmes, helplines and others).

**Key deliverables**

a. Develop and implement national mental health promotion plan.

b. Partner with the media on mental health promotion.

c. Integrate suicide prevention with existing programmes and activities.

EXPANDED IMPLEMENTATION OPTIONS

1. Develop national legislation on mental health promotion to standardize evidence-based interventions in schools, workplaces and other settings.

2. Develop training programmes for mental health promotion.

3. Provide support for mental health workers’ own well-being.

4. Create career tracks for mental health promotion among health workers.
Key deliverables

a. Adopt legislation/policy to scale up evidence-based mental health promotion.

b. Provide systematic training for mental health promotion.

c. Develop and implement national suicide prevention strategy and plan.

COMPREHENSIVE IMPLEMENTATION OPTIONS

1. Include mental health promotion in health-financing schemes.

2. Create quality standards for treatment of behavioural problems, including harmful use of alcohol, tobacco dependence and substance abuse.

3. Develop, implement and evaluate comprehensive national strategies for the prevention of suicide.

Key deliverables

a. Include mental health promotion in health-financing scheme.

b. Develop quality-assured interventions for behavioural problems and substance abuse.

c. Evaluate national suicide prevention strategies.

OBJECTIVE 4. Strengthen information systems, evidence and research for mental health.

CORE IMPLEMENTATION OPTIONS

1. Review literature and identify leading causes of morbidity and mortality linked to mental health problems and issues.

2. Develop a task force that will develop a phased approach to including mental health within health information systems.

3. Select one or two indicators to monitor over a five-year period and slowly increase the number of mental health indicators reported on a national basis.

4. Include mental health in the national objectives for health research.
**Key deliverables**

- Establish a baseline from existing source.
- Develop and implement a plan to include mental health indicators in national health plan.

**EXPANDED IMPLEMENTATION OPTIONS**

1. Develop a 10-year mental health surveillance programme and identify key indicators to be measured as well as national and local targets for treatment and care.

2. Fund and provide training for mental health data collection, by strengthening the current information systems.

3. Recognize outstanding practices in settings-based interventions that are able to document changes in indicators and achievement of targets.

4. Integrate mental health items into other surveys and census questionnaires such as STEPS.

**Key deliverables**

- Develop a continuous mental health surveillance plan.
- Integrate mental health items into other surveys and census questionnaires.

**COMPREHENSIVE IMPLEMENTATION OPTIONS**

1. Ensure reporting on mental health in all health facilities and feedback to all stakeholders. Periodically publish the data and make it available for use.

2. Monitor and gradually increase investments in mental health based on national objectives for health.

3. Enable other sectors, e.g. defense and security, education, law and order, justice systems among others, to develop agency-wide mental health plans and programmes with regularly measured indicators and outcomes.

**Key deliverable**

- Use population-based and facilities data to inform mental health policy and programme implementation.
4. Priority actions for WHO regional collaboration and country support

WHO will continue to support Member States in developing responses based on a phased approach that builds on infrastructure and capacity for mental health programmes and services. Priorities for regional and country support include the following.

4.1 Health systems approach

Human resource development

1. Collect, compile and analyse and disseminate good practices on using non-specialists in delivering essential mental health care.

2. Adapt and expand mhGAP training material to suit health systems within the countries.

3. Support national and subregional collaboration to expand training, supervision and support to non-specialists in delivering essential mental health care and in evaluating these programmes systematically.

4. Expand training opportunities for psychiatrists, clinical psychologists, social workers and occupational therapists.

5. Develop strategies to address human resource migration out of low- and middle-income countries.
Health service delivery

1. Support national initiatives in the development, strengthening, updating, monitoring and evaluation of policies and laws in line with evidence, good practices, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

2. Develop, sustain and strengthen mental health networks and partnership mechanisms, such as the Pacific Island Mental Health Network, and facilitate development of a community network for mental health among Asian countries.

3. Develop comprehensive human resources for a full range of community based mental health care and services that respond to the various levels of need, including review and reform of curricula of undergraduate and graduate mental health education for health workers (including nurses and non-registered health workers) and organization of a regional fellowship programme to provide in-service training and re-orientation for current workforce.

4.2 Whole-of-government approach to priority conditions

Depression

1. Develop technical tools based on evidence and good practices for health workers to identify and manage depression in their routine practices of working with various health conditions and in different settings, e.g. schools, workplaces, communities, etc.

2. Facilitate organization of a regional business and private sector network aimed at including depression prevention and management and crisis intervention as key components of workplace well-being programmes.

3. Sustain and strengthen regional collaborative networks – such as the Asia-Pacific International Research and Education Network – for bridging the gaps between policy, service, research and education devoted to improving the lives of people with depression.
Suicide prevention

1. Continue the Suicide Trends in At-Risk Territories (START) project for systematic recording of fatal and non-fatal suicidal behaviours, and the development of flexible and appropriate, cross-cultural interventions for suicidal behaviours.

2. Develop and implement a variety of media-centred approaches to suicide prevention aimed at increasing awareness and constructive public discussion of mental health.

3. Develop a programme for building leadership and technical capacity for countries that need to formulate and implement comprehensive national strategies for the prevention of suicide.

4. Collect and disseminate evidence and good practices for prevention of suicidal behaviours among young people and work with ministries that focus on youth activities.

Schizophrenia and bipolar disorders

1. Collate best practices on identification of people with severe mental illness such as schizophrenia or bipolar disorders.

2. Support enactment of legislation and policies to protect the human rights of patients with mental health problems, and ban chaining and restraining of patients in health facilities.

3. Support mechanisms to report and address patients’ reports of abuse and violations of human rights.

4. Build capacity to enact national policies and plans towards phasing out long-term hospital stay, particularly for patients with severe mental illness.

5. Identify and disseminate models in which ministries of health work effectively with other ministries, such as justice and law enforcement, on addressing needs of individuals inappropriately incarcerated or detained with severe mental illness.

6. Identify and disseminate good models and systems for provision of drugs and medications for people with severe mental illness during disasters and emergencies.
Mental health in disasters and emergencies

1. Share best practices and consolidate lessons learnt from mental health interventions delivered through non-specialized health workers in the aftermath of large disasters in the Region.

2. Organize a regional technical resource group for mental health responses to disasters and emergencies to promote evidence-based interventions and provide assistance to resource-limited countries during disasters.

3. Develop mechanism to support disaster-affected areas to rebuild and reorient mental health systems for comprehensive, integrated and responsive mental health care and services in community-based settings.

4. Support national initiatives and subregional collaboration for integration of mental health components and response into disaster preparedness, response and recovery.
5. Frequently encountered bottlenecks and stakeholders that can make a difference

Ministers of health, national mental health programme managers and heads of mental health services in hospitals must serve as advocates for policy, facilitators for action and catalysts for changing the way society perceives and responds to mental health problems. The consultation on Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific has identified frequent bottlenecks to implementation for consideration by Member States in updating their national mental health policies, programmes and plans.

Implementation bottleneck 1

Lack or insufficient laws to provide services and protect the human rights of people with mental health disorders from cruelty, inhuman treatment, torture and abuse. Legislators and human rights advocates must be engaged to develop enlightened laws and policies that reposition mental health in the context of overall health-care delivery and social development.

Violation of human rights of people living with mental health problems is rooted in ignorance and fear that is further reflected by the absence of laws or policies. There are a lot of misconceptions about mental health disorders. The growing body of knowledge and evidence about effective interventions needs to be aggressively advocated to national leaders. When policy-makers and health system managers do not understand the importance of the rights of people with mental health problems,
it is not likely that interventions will be scaled up to meet the growing demand for services and programmes.

National laws grounded in protection of human rights of people with mental health problems are a requirement for developing responsive health systems in the first instance, and later whole-of-government as well as whole-of-society approaches to meeting the psychosocial needs of a population.

Implementation bottleneck 2

Lack of community resources for mental health including the expansion of linked networks of health facilities and community resources for a range of mental health needs. Local governments, cities, municipalities, provinces, districts and villages can create opportunities for patients, family members, civil society organizations, advocates, nongovernmental organizations and faith-based groups to provide essential information, feedback and resources for care and support to complement improvements in treatment, services and care.

Adverse events at any stage of the life-course may increase the risk for a range of mental health conditions. When the equilibrium of well-being is challenged, issues and problems may occur, and normal coping mechanisms with social and family support may suffice. In other instances, support and care from health systems and the community are required. Depression for example, may need a combination of interventions in health facilities and in community settings.

A systematic and phased shift from long-stay mental health hospitals towards networked services with referrals and links to community resources – including short-stay inpatient care and outpatient care in general hospitals, mental health interventions in primary health-care facilities, day care and supported housing – signals important steps towards breaking down barriers that result in stigmatization and discrimination and paves the way for greater understanding and genuine care for people with mental illness.

Community resources need to be made available to individuals with severe mental disorders, including schizophrenia and bipolar disorders. City, state, provincial, municipal, district and village officials are key stakeholders that can serve as catalysts for change.
Disease-oriented and curative-care approaches to mental health are necessary but should be pursued in tandem with whole-of-society approaches for promotion of mental health and well-being. Educators, social workers, organized groups of artists, athletes, as well as leaders and visionaries in culture and art play a crucial role in social change and mental health promotion.

While there are severe and debilitating mental health conditions, disorders and diseases (e.g. depression, suicide, anxiety, dementia, among others that deserve highly specialized attention in the health system), poor health outcomes and compromised quality of life from these diseases and other less-severe conditions are rooted in social, political and economic inequalities that are reflected in the way health-care systems are organized, financed and managed.

From a public health perspective, there are a wide range of mental health concerns that might be better addressed through preventive approaches, settings-based programmes and risk-reduction strategies, rather than focusing only on improvement of curative and treatment service delivery models. Suicide prevention, for example, needs to be approached from a mental health promotion perspective.

There is a growing body of evidence pointing to opportunities to build and promote psychosocial well-being, build resilience, enhance protective factors and provide health programmes and services through interventions embedded in the work of education, social welfare, labour, faith-based organizations and communities. These include recreation, sports and athletics, cultural forms of expression such as music and dance, visual arts, martial arts, gardening, exploring nature, meditation, mindfulness and relaxation, community service programmes and volunteer work, among others.
Implementation bottleneck 4

Information systems do not include or reflect mental health conditions and their impact on overall mental health outcomes. Researchers, health system analysts, national planners, demographers, statisticians, academicians, epidemiologists may be engaged to systematically generate data to measure progress and impact of interventions through national health and demographic surveys, health information systems and national health accounts.

Specific global targets and indicators have been set to monitor implementation, progress and impact. The targets include updating of policies, plans and laws, as well as developing multisectoral mental health promotion programmes. Measurable targets have also been set, including a 20% increase in service coverage for severe mental disorders and a 10% reduction in national suicide rates by 2020.

In order to measure progress, information systems at all levels of the health-care delivery system as well as in communities, must include mental health indicators in routine reporting. Research is needed on specific issues and effectiveness of policies and laws. The need for surveillance for specific disorders varies from country-to-country, but basic data-gathering is needed in all countries.
6. Towards a social movement for action on mental health and well-being

There is no health without mental health.

Health as a human right requires governments to develop health-care systems and judicial systems that are responsive to the growing burden of mental illness. All-of-society and stakeholders can contribute to country-specific strategies to make a difference in the lives of millions of people with mental health problems and their families.

Member States with more developed mental health service delivery models may share their experiences with others that are working to enhance their capacities.

For countries in the early stages, actions on policies and programmes in the context of primary health care and community resources are of critical importance. Prevention and mental health promotion may be built into the work of all sectors and all institutions of society. Mental health and well-being are fundamental to achieving the highest possible levels of health for all people in the Western Pacific Region.
APPENDIX 1. OVERVIEW OF THE MENTAL HEALTH ACTION PLAN 2013–2020

Vision
A world in which mental health is valued, promoted, and protected, mental disorders are prevented and persons affected by these disorders are able to exercise the full range of human rights and to access high-quality, culturally appropriate health and social care in a timely way to promote recovery, all in order to attain the highest possible level of health and participate fully in society and at work free from stigmatization and discrimination.

Goal
To promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders.

• Cross-cutting principles

Universal health coverage
Regardless of age, sex, socioeconomic status, race, ethnicity or sexual orientation, and following the principle of equity, persons with mental disorders should be able to access, without the risk of impoverishing themselves, essential health and social services that enable them to achieve recovery and the highest attainable standard of health.
Human rights

Mental health strategies, actions and interventions for treatment, prevention and promotion must be compliant with the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.

Evidence-based practice

Mental health strategies and interventions for treatment, prevention and promotion need to be based on scientific evidence and/or best practice, taking cultural considerations into account.

Life course approach

Policies, plans, and services for mental health need to take account of health and social needs at all stages of the life course, including infancy, childhood, adolescence, adulthood and older age.

Multisectoral approach

A comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health, education, employment, judicial, housing, social and other relevant sectors as well as the private sector, as appropriate to the country situation.

Empowerment of persons with mental disorders and psychosocial disabilities

Persons with mental disorders and psychosocial abilities should be empowered and involved in mental health advocacy, policy, planning, legislation, service provision, monitoring, research and evaluation.

• Objectives and targets

To strengthen effective leadership and governance for mental health

Global target 1.1: 80% of countries will have developed or updated their policy/plan for mental health in line with international and regional human rights instruments (by the year 2020).

Global target 1.2: 50% of countries will have developed or updated their law for mental health.
To provide comprehensive, integrated and responsive mental health and social care services in community-based settings

Global target 2: Service coverage for severe mental disorders will have increased by 20% in the year 2020.

To implement strategies for promotion and prevention in mental health

Global target 3.1: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes by the year 2020.

Global target 3.2: the rate of suicides in countries will be reduced by 10% (by the year 2020).

To strengthen information systems, evidence and research for mental health

Global target 4: 80% of countries will be routinely collecting and reporting at least a core set of mental health indicators every two years through their national health and social information systems (by the year 2020).