W O R L D H E A L T H ORGANIZATION

ORGANISATION MONDIALE DE LA SANTÉ

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU RÉGIONAL DU PACIFIQUE OCCIDENTAL

REGIONAL COMMITTEE | WPR/RC65/5

Sixty-fifth session
Manila, Philippines
13–17 October 2014

28 August 2014

ORIGINAL: ENGLISH

Provisional agenda item 10

MENTAL HEALTH

More than 100 million people suffer from mental disorders in the Western Pacific Region. There are an estimated 500 suicides per day in the Region, making it among the top 10 causes of death in some countries and areas. Though generally underreported, depressive disorders are estimated to account for 5.73% of the Region's overall disease burden. Mental health disorders are often related to other diseases such as cancer, cardiovascular disease, diabetes, stroke, tuberculosis and HIV/AIDS. Overall, people with major depression and schizophrenia have a 50–60% greater chance of dying prematurely. In low- and middle-income countries, 76–85% of severe mental disorders go untreated, compared to 35-50% in high-income countries. Spending on mental health is less than US$ 2 per person per year globally, and less than US$ 0.25 per person in low-income countries.

Recognizing the heavy burden of mental disorders and importance of mental health, the Sixty-sixth World Health Assembly endorsed the *Mental Health Action Plan 2013-2020* in May 2013. Extensive consultations with Western Pacific Member States revealed the need for an implementation plan that considers the different stages of development of mental health service delivery systems. In response, the draft *Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific* (Annex 1) features a phased approach with core, expanded and comprehensive implementation options as a framework for prioritizing and accelerating policies and action.

The Regional Committee is requested to consider for endorsement the draft regional agenda.

1. CURRENT SITUATION

Mental, neurological and substance-use disorders account for an estimated 13% of the global disease burden. In the Western Pacific Region, more than 100 million people suffer from mental disorders. There are an estimated 500 suicides per day in the Region, making it among the top 10 causes of death in some countries and areas. Though generally underreported, depressive disorders are estimated to account for 5.73% of the Region's overall disease burden. Mental health disorders are often related to other diseases such as cancer, cardiovascular disease, diabetes, stroke, tuberculosis and HIV/AIDS. People with major depression and schizophrenia have a 50–60% greater chance of dying prematurely.

Providing quality mental health services remains a challenge in most countries. In low- and middle-income countries, 76–85% of severe mental disorders go untreated, compared to 35–50% in high-income countries. Spending on mental health is less than US$ 2 per person per year globally. That figure drops to less than US$ 0.25 in low-income countries. In many Pacific island countries, services, programmes and policies are not available to address the rising tide of mental health problems, such as suicide among young people.

Even when they exist, mental health services are often poorly resourced and too specialized. They are also often separate from the rest of the health-care system, which adds to discrimination and discourages health-seeking behaviour and early treatment. The availability of drugs and medicines for mental disorders in primary health care is notably low, in comparison to medicines for infectious and noncommunicable diseases. In addition, the use of medicines for mental disorders is restricted by the lack of health workers with the authority to prescribe them.

The harsh reality is that people with severe mental illness are often left to fend for themselves or locked up. Shackling and other forms of restraint are still common in parts of the Region. Some hospitals are more like prisons than health-care facilities. Patients' rights are routinely violated.

Civil society movements for mental health in low- and middle-income countries are not well developed. Organizations of people with mental disorders and psychosocial disabilities are present in less than half of low-income countries, compared to more than four out of five high-income countries.

In 2001, the Regional Committee for the Western Pacific endorsed a regional strategy for mental health. Mental health has continued to be a central topic of discussion during the annual meetings of Pacific island ministers of health since 2003. Since then, all countries in the Region have

participated in the ATLAS survey mapping mental health resources, but information still needs to be improved and expanded.

Progress has been encouraging in the Region. China, Fiji, Samoa and Tonga are developing mental health legislation and policies. Countries have recognized the importance of psychosocial needs during disasters and emergencies and have taken action in Australia, China, Fiji, Japan, Mongolia, New Zealand, the Philippines and Samoa. An increasing number of countries are participating in the Suicide Trends in At-Risk Territories (START) project. Consultations on the role of media in suicide prevention were organized in China, Hong Kong SAR (China), Japan, the Philippines, the Republic of Korea and Viet Nam. An assessment of mental health systems has been done using the WHO-AIMS (Assessment Instrument for Mental Health Systems) in China, Fiji, the Lao People's Democratic Republic, Mongolia, the Philippines, the Republic of Korea and Viet Nam. The Pacific Islands Mental Health Network (PIMHnet), supported by the New Zealand Aid Programme, has been a successful mechanism to facilitate and support cooperative and coordinated activities within and among Member States.

Still, much work remains to be done. Recognizing the heavy burden of mental disorders and importance of mental health, the Sixty-sixth World Health Assembly endorsed the *Mental Health Action Plan 2013-2020* in May 2013. Extensive consultations with Member States revealed the need for an implementation plan that considers the different stages of development of mental health service delivery systems. In response, the draft *Regional Agenda for Implementing the Mental Health Action Plan (2013–2020) in the Western Pacific* (Annex1) features a phased approach with core, expanded and comprehensive implementation options as a framework for prioritizing and accelerating policies and action. The plan provides a broad menu of implementation options for mental health policies, programmes and plans for Member States.

2. ISSUES

The draft *Regional Agenda for Implementing the Mental Health Action Plan (2013-2020) in the Western Pacific* provides context-specific actions to address recurrent and underlying issues in mental health:

2.1 Countries are at different stages of development of mental health service delivery.

Different countries are at different stages of development of mental health-care service delivery systems. As such, there are varied options for implementation of the global *Mental*

Health Action Plan (2013–2020). Guidance is needed to support prioritization of evidence-based interventions that will help build a cohesive mental health service delivery system over time. The draft *Regional Agenda for Implementing the Mental Health Action Plan (2013–2020) in the Western Pacific* takes into account the development level of countries in prioritizing and accelerating policies and actions for mental health.

2.2 Human resources are insufficient; service delivery is limited.

The number of specialized and general health workers dealing with mental health is grossly insufficient. In many parts of the Western Pacific Region, one psychiatrist exists per 200 000 people. Mental health-care specialists qualified for psychosocial interventions are even scarcer. The lack of human resources limits the ability to deliver services. Strategic human resource development to improve mental health services might include integration of mental health management in primary health care and general hospital care.

2.3 Vertical approaches to mental health are ineffective.

Stand-alone mental health programmes have proven of limited effectivity. A health systems approach to mental health is characterized by accelerated efforts to promote understanding of the psychosocial dimensions of disease in the context of human rights. Prevention, empathy, support and care may be built into primary, secondary and tertiary levels with adequate referral and follow-up mechanisms in the community. Mental health needs can be addressed in all public health programmes for maternal and child health, cancer, cardiovascular disease, diabetes, strokes, HIV/AIDS, disability, violence and injuries, tuberculosis and substance abuse.

Policies to phase out long-term hospital stays must be put in place, with funding redirected to community resources and primary health care. Linkages and referral systems between hospitals and communities are needed.

2.4 Multisectoral engagement with stakeholders and communities has been limited.

Ministries of health play a key role in articulating the severity of the problem, and the need for compassionate approaches that place people at the centre of health-care systems. There is also 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 stigma, discrimination and other barriers to quality health care. As civil society movements have limitations, efforts to enable and engage

with communities and strengthen existing groups can help build momentum for social change. Ministries of health may also interact with other relevant sectors, including education, labour and welfare for mental health promotion.

3. ACTIONS PROPOSED

The Regional Committee is requested to consider for endorsement the draft *Regional Agenda for Implementing the Mental Health Action Plan (2013–2020) in the Western Pacific.*

ANNEX 1

DRAFT

Regional Agenda for Implementation of the Mental Health Action Plan (2013-2020) in the Western Pacific

World Health Organization
Western Pacific Region

Annex 1

Annex 1

TABLE OF CONTENTS

Page

I. Background 11

II. Strategic entry points for action in the Western Pacific 11

III. Priority implementation options for countries and areas in the Western Pacific 17

IV. Priority actions for WHO regional collaboration and country support 23

V. Frequently encountered implementation bottlenecks and strategic stakeholders who can make a difference 26

VI. Toward a social movement for mental health and well-being 29

Annex 1

Annex 1

I. Background

Mental, neurological and substance use disorders accounted for 13% of the total global burden of disease. More than 100 million people suffer from mental disorders in the Western Pacific Region. Depressive disorders are pervasive and yet under reported and are responsible for 5.73% of the overall disease burden in the Region. 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. Persons with major depression and schizophrenia have a 50% to 60% greater chance of dying prematurely than the general population. Globally, annual spending on mental health is less than USD$ 2 per person and less than USD$ 0.25 per person in low income countries.

The Regional Committee for the Western Pacific, at its fifty-second session in September 2001, endorsed the 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.

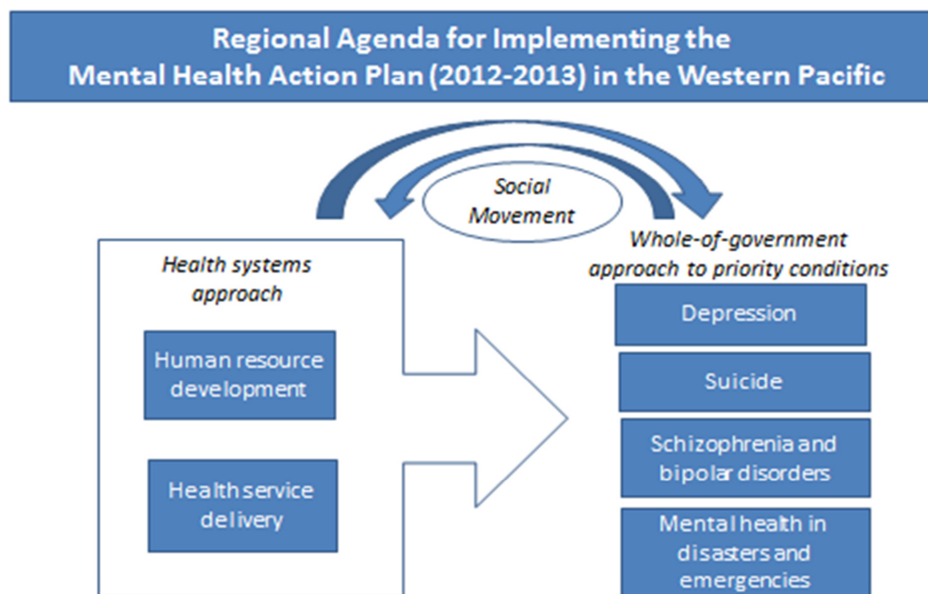
All countries and areas report the lack of adequate human resources for mental health as an underpinning factor for the constrained response to the growing demand for mental health programmes and services. While training and capacity building within the health sector is of critical importance, advancing the agenda for mental health and well-being requires engagement with patients, their families and carers, communities and civil society partners. Promoting mental health and preventing mental illness requires 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 of the Mental Health Action Plan (2013-2020) can be prioritized based on country specific contexts and needs. *The Regional Agenda for Implementing the Mental Health Action Plan (2013-2020) in the Western Pacific* articulates a phased approach for core, expanded and comprehensive implementation options as a unique framework for prioritizing and accelerating policies and action for mental health.

Annex 1

II. Strategic entry points for action in the Western Pacific

Based on the analysis of epidemiologic evidence, reports on country actions and results of regional collaborative projects on policies and programmes, three strategic entry points for action are 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.



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 is lower than the world median for psychiatrists, psychologists, social workers and occupational therapists (WHO Mental Health Atlas, 2011). While specialists needs 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; scaling up of these efforts is needed.

In low and middle income countries, between 76% to 85% and in high income countries, between 35% to 50% of persons with severe mental disorders do not receive treatment. 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 within 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. Sixty-seven per cent of the financial resources are allocated to stand-alone mental hospitals, despite poor health outcomes and human rights violations.

2) Whole-of-government approach to priority conditions

Beyond the health systems approach, 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, labor, social welfare, law enforcement) and providing information about risk factors, early signs and symptoms and 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 and an increase in suicide rates. 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, persons suffering from severe mental illness like schizophrenia or bi-polar 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 is still commonly practiced in some health facilities in the Region. Some of these hospitals are more like prisons than health-care facilities. Patients are abused, and their rights are violated. National policies and plans are needed to to phase out long-term hospital stay, particularly for patients with severe mental illness. Ministries of health need to work with ministries of finance and local governments toward redirecting 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 Region is disproportionately prone to earthquakes, tsunamis, typhoons, floods and other natural disasters, which have resulted in enormous loss of life and serious damage and destruction to health infrastructure and health systems. Mental health interventions and psychosocial support has to be a part of immediate and long-term responses to disasters and emergencies. Disasters also provide a unique opportunity for public and policy makers to recognize and address broader mental health and psychosocial needs of community, and for rebuilding or building mental health system to provide comprehensive, integrated and responsive mental health care and services in community-based settings.

3) Social movement

Ministries of health play a key role in articulating the severity of the problem, the need for compassion as part of approaches that place people at the centre of health-care systems. But 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 overcome stigma and discrimination as well as other barriers to

quality health care. As civil society movements are limited and not well-developed, efforts to enable and engage with communities and strengthen existing groups can help build momentum for social change. Ministries of health may also interact with other relevant sectors such as education, labour, and welfare for mental health promotion.

III. Priority implementation options for countries and areas in the Western Pacific

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 WHO's 194 Member States committed to taking 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:

(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 promotion and prevention in mental health and;

(4) strengthen information systems, evidence and research for mental health

Each country has unique needs and distinct resources that could 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 specific national circumstances in order to accomplish the objectives. Based on information generated by the Mental Health Atlas and other situation analysis exercises, three separate and phased scenarios were described below to assist and inform the development of a roadmap for implementation of Mental Health Action Plan at country level. The illustrative implementation options for core, expanded and comprehensive actions are provided around the four objectives of the Mental Health Action Plan.

- **Core implementation options** are proposed for countries and areas within the Region where a mental health system is absent, or is in an initial stage but where

Annex 1

there are limited resources. Generally speaking, in this scenario mental health needs are not currently attended to.

- **Expanded implementation options** are set out for countries that already have a mental health system in operation, with reasonable resources, but where disparity remains to be a major challenge.
- **Comprehensive implementation options** are set out for countries that are further along in their development of a comprehensive mental health system, and are therefore moving closer towards realising the vision of the Mental Health Action Plan 2013-2020.

The vision, cross-cutting principles, goal, and objectives elaborated in the Mental Health Action Plan (2013-2020) are fundamental to the development and implementation of action plan at multiple levels.

Annex 1

Priority implementation options for countries and areas in the Western Pacific			
Objective 1: **Strengthen effective leadership and governance for mental health**	**Core deliverables:** 1. Develop national law and policy 2. Raise public awareness 3. Identify active "champions" who advocate for policy 4. Engage patients and civil society groups	**Expanded deliverables:** 1. Establish a multi-sectoral national mental health programme led by higher level officials of the government **2.** Monitor and evaluate the implementation of policies and legislation to ensure compliance with international human rights instrument	**Comprehensive deliverables:** 1. Include mental health in national development plans **2.** Develop mechanisms for whole-of-government and whole-of-society approaches to improving mental health
Implementation options	• 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. • Develop, strengthen or enhance a national law to protect the rights of persons with mental health disorders. • Develop a social and awareness campaign against cruelty, torture, degrading treatment and abuse of mental health patients. • Ensure that people with mental disorders and psychosocial disability and their carers are given a formal role in the process of developing policies and programmes.	• Establish a national mental health programme led by higher level official of the government with a mechanism for engagement and participation of other sectors to address mental health and human rights. • Monitor implementation of laws to protect the rights of people with mental health disorders. • Convene, engage and build consensus for sustained campaigns against cruelty, torture, degrading treatment and abuse of mental health patients. • Provide logistical, technical and financial support for organized groups of advocates and civil society partners. • Monitor and evaluate the implementation of policies and legislation to ensure compliance with the Convention on the Rights of Persons	• Mainstream mental health and the rights of persons with mental disorders and psychosocial disabilities into other sector policies including poverty reduction and national development. • Repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders or psychosocial disabilities. • Sustain funding support for and work with the private sector on initiatives to improve and implement mental health policies.

Annex 1

	• Advocate for a budget for mental health policy development. • Develop or review and revise national mental health policy and plan	with Disabilities and other international/regional human rights instrument. • Organize an independent body to monitor implementation of laws to protect the rights of people with mental disorders • Set up mechanisms for tracking expenditures and gaps for mental health policy development and implementation in health, education, employment, criminal, justice and social services • Develop capacity for sustainable funding for mental health • Build and support local capacity for mental health policies. • Involve person with mental and psychosocial disorders and their care-givers in decision making and review of the mental health policy, plan, service, etc.	

Annex 1

Objective 2: **Provide comprehensive, integrated and responsive mental health and social care services in community-based settings**	**Core deliverables:** 1. Phase out long-stay psychiatric care 2. Strengthen community resources and services 3. Provide out-patient mental health services in all hospitals 4. Ensure basic drugs and medicines are accessible and affordable 5. Strengthen capacity for mental health in primary health care	**Expanded deliverables:** 1. Include mental health service coverage in health financing scheme 2. Establish interdisciplinary mental health teams 3. Integrate mental health in national disaster preparation, response and recovery plan 4. Incorporate mental health into curriculum for health professionals	**Comprehensive deliverables:** 1. Provide support and training for family members and carers 2. Provide funding support to enable service delivery by community based organizations 3. Develop highly specialized teams for deployment to disaster areas 4. Integrate mental health into other disease control programmes 5. Provide specialized treatment for vulnerable groups
Implementation options	• Develop a phased and budgeted plan for closing long-stay psychiatric institutions. • Map out and develop linked network of community resources and services led by local governments to include the local players from government, nongovernmental organizations, faith-based groups and other stakeholders that provide community-based mental health services. • Develop a communication plan to inform the public of the existence of a linked network of community resources for mental health. • Provide outpatient mental health services and in-patient mental health unit in all general	• Review and revise social health coverage schemes to ensure that services for mental health are sufficiently covered. • Establish interdisciplinary mental health teams to support people with mental disorders and their families/carers in the community. • Include mental health into national task force for disaster and emergency preparation, response and recovery. • Integrate mental health into undergraduate curriculum in different disciplines. • Develop community based social care	• Develop training programmes to engage service users and family members/carers with practical experience as peer support workers. • Develop financing mechanisms to enable nongovernmental organizations, faith-based groups and other community groups to provide community-based and self-help care. • Develop and fund highly specialized government teams to anticipate and address mental health in emergencies and disasters. • Mental health programme should be

Annex 1

	hospitals for priority mental health disorders and other conditions, e.g. depression, anxiety, suicide/self-harm, psychosis, epilepsy, dementia, drug and alcohol use disorders, among others. • Ensure that basic drugs and medicines for priority mental health disorders and conditions are in the national essential drug list and are available, accessible and affordable across country. • Provide mental health and psychosocial support for disaster affected populations. • Strengthen the referral system and links between the community, primary health care and specialized services to ensure continuity of care. • 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. • Integrating mental health into PHC by training general doctors and nurses. • Provide psychosocial interventions such as psycho education for patient and family.	service such as home care and support, community-based rehabilitation, supported housing and supported employment.	integrated to other programmes, such as disabilities, HIV/AIDS, NCDs, antenatal and postnatal care and other medical conditions etc. • Develop sub-specialty services such as forensic, dual diagnosis, child adolescence mental health

Annex 1

Objective 3: **Implement strategies for promotion and prevention in mental health**	**Core deliverables:** 1. Develop and implement national mental health promotion plan 2. Partner with media on mental health promotion 3. Integrate suicide prevention into existing programmes and activities	**Expanded deliverables** 1. Adopt legislation/policy to scale up evidence based mental health promotion 2. Provide systematic training for mental health promotion 3. Develop and implement national strategies for suicide prevention	**Comprehensive deliverables** 1) Include mental health promotion health financing scheme 2) Develop quality assured interventions for behavioural problems and substance abuse 3) Evaluate national suicide prevention strategies
Implementation options	• 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. • Use international good practices on educating the public, school-based and workplace-based programmes, sports, culture and the arts to build resilience and promote mental health, adapting/contextualizing into the sociocultural situation. • Increase public, political and media awareness of the magnitude of the problem, and the availability of effective prevention strategies. • Increase mental health awareness among the health professional to decrease stigma and discrimination among them. • Identify existing systems, programmes,	• Develop national legislation on mental health promotion to standardize evidence-based interventions in schools, workplaces and other settings. • Develop training programmes for mental health promotion • Provide support for mental health workers' own wellbeing • Create career tracks for mental health promotion among health workers. • Move towards the development and implementation of national strategies for effective management and prevention of suicidal behaviours	• Include mental health promotion in health financing schemes • Create quality standards for treatment of behavioural problems including harmful use of alcohol, treatment of tobacco dependence and substance abuse. • Develop, implement and evaluate comprehensive national strategies for the prevention of suicide

Annex 1

	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, help-lines, and others)		
Objective 4: **Strengthen information systems, evidence and research for mental health**	**Core deliverables** 1. Establish baseline from existing source 2. Develop and implement a plan to include mental health indicators in national health plan	**Expanded deliverables** 1. Develop a continuous mental health surveillance plan 2. Integrate mental health items into other surveys and census questionnaires	**Comprehensive deliverables** 1. Use population-based and facilities data to inform mental health policy and programme implementation 2. Develop mental health information systems to support other sectors to monitor and address mental health
Implementation options	• Review available literature and identify leading causes of morbidity and mortality that are linked to mental health problems and issues. • Develop a task force that will develop a phased approach to including mental health within the current health information systems. • Select one or two indicators to monitor over a five-year period and slowly increase the number of mental health indicators that will be reported on a national basis. • Include mental health in the national objectives for health research.	• Develop a ten-year mental health surveillance programme and identify key indicators that will be measured as well as national and local targets for treatment and care. • Fund and provide training for the mental health data collection, by strengthening the currently available information systems. • Recognize outstanding practices in settings-based interventions that are able to document changes in indicators and achievement of targets. • Integrate mental health items into other surveys and census questionnaires such as STEPS	• Ensure reporting on mental health in all health facilities and national process for feedback to all stakeholders. Periodically publish the data and make it available for use. • Monitor and gradually increase investments in mental health based on national objectives for health. • 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 that have indicators and outcomes that are regularly measured.

IV. Priority actions for WHO regional collaboration and country support

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

1) Health systems approach

Human resource development

1. Collect, compile and analyze and disseminate good practices on using non-specialists in delivering essential mental health care.
2. Adapt and expand mhGAP training material to suit the health systems within the countries.
3. Support national and sub-regional 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 right instruments.
2. Develop, sustain and strengthen mental health networks and partnership mechanisms such as the Pacific Island Mental Health Network and facilitate the development of a network for community 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 curriculum of undergraduate and graduate mental health education for health workers and organization of regional fellowship programme providing in-service training and re-orientation for current workforce.

Annex 1

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, (ASPIRE 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 engage with youth.

Schizophrenia and bipolar disorders

1. Collate best practices on identification of individuals with severe mental illness like schizophrenia or bi-polar 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 on abuse and violations of human rights.

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

5. Identify and disseminate models where Ministries of health work effectively with other ministries like justice and law enforcement on addressing needs of individuals who suffer from severe mental illness who are inappropriately incarcerated or detained.

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

Mental health in disasters and emergencies

1. Share best practices and consolidate lessons learned 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 when disasters arise.
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 sub-regional collaboration for integration of mental health components and response into disaster preparation, response and recovery

Annex 1

V. Frequently encountered implementation bottlenecks and strategic stakeholders who 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 frequently encountered bottlenecks to implementation for consideration of 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 persons 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 context of overall health care delivery and social development.***

Violation of human rights of persons 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 need to be aggressively advocated to national leaders. When policy makers and health systems 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 that are 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, 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 that complement improvements in treatment, services and care.***

Annex 1

Adverse events at any stage of the life course may increase the risk for a range of mental health conditions these may be acute or chronic. Oftentimes 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 toward provision of 'networked services' with referrals and links to community resources including short-stay in patient care and outpatient care in general hospitals, mental health interventions in primary health care facilities, day care and supported housing – signal important steps toward breaking down barriers that result in stigmatization and discrimination and paves the way for greater understanding and genuine care for persons 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 who can serve as catalysts for change.

Implementation bottleneck #3: 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 as well as other less severe conditions are rooted in social, political and economic inequities that are reflected in the way health care systems are organized, financed and managed.

From a public health perspective, there is 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.

Annex 1

In recent decades there has been 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 might include but not be limited to 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 systems 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 agreed upon as a way to monitor implementation, progress, and impact. The targets include updating of policies, plans and laws as well as development of multisectoral mental health promotion programmes. Measurable targets have also been agreed on 20% increase in service coverage for severe mental disorders and a 10% reduction in suicide rate in countries by 2020.

In order to measure progress, it is critical that information systems at all levels of the health care delivery system as well as in settings of the community, begin to include mental health indicators in routine reporting. Research on specific issues and effectiveness of policies and laws are needed. The need for surveillance for specific disorders will vary from country-to-country, but some basic data-gathering is needed in all countries.

VI. Toward a social movement for mental health and well-being

The definition of health includes 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 relevant stakeholders can contribute to country specific strategies that will serve as "game-changers" that can make a difference in the lives of millions of individuals and families who suffer from mental health. Member States that have highly developed mental health service delivery models can share their experiences with other countries that are just starting. For countries that are just starting, action 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 is fundamental to achieving the highest possible levels of health for all people in the Western Pacific.

Annex 1