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Improving Networks of Community Mental Health Services in the Asia-Pacific Economies

Lima, Peru | 16-19 July 2019

APEC Health Working Group

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Executive Summary

Mental health problems represent a serious developmental issue. At a global level, estimates show that one in five people have suffered from one or more mental disorders in their lifetime. These account for 9 of the 20 main causes of disability-adjusted life years (DALYs) and 10% of the global burden of disease worldwide, especially in middle- and low-income economies. It is worth mentioning that most of these economies are part of the Asia-Pacific region.

This problem can affect people throughout their lifetime, impacting mothers' health, for example, which affects their children's upbringing, leading to mental health problems that may come up at school and not be addressed in a timely manner. These difficulties have a negative impact on children's academic achievement as well as on their likelihood of finishing school, starting higher education and successfully entering the job market. Ultimately, this not only affects the well-being of individuals and their families, but it also has economic consequences for all economies. Mental health disorders around the world are expected to incur costs of over USD 6 trillion until 2030.

In this context, findings showed that an exclusively hospital-centered mental health system, based on the biomedical model, is not a cost-effective way of achieving the recovery and reintegration of an individual into society. Old health treatments and financing arrangements have not done much to overcome this problem. Moreover, 85% of people with severe mental health disorders are currently without treatment.

To address this problem, reforms have been introduced aimed at including and prioritizing a community-based approach for people's health in the world's various health systems. This approach favors the individual's recovery and focuses on improving coverage, access to services and the quality of mental healthcare for users by employing different methodologies. For example, using the community-based approach, the investment that would have been required to build a new psychiatric hospital can be used more cost-effectively to create multiple smaller facilities that provide more health services.

This approach implies strengthening the role of primary health centers, implementing community mental health centers and providing inpatient services for people with mental disorders at general hospitals, sheltered homes and psychosocial rehabilitation centers. This project highlights the importance of sharing these advances and using them to reflect critically on the achievements made in this area of health by APEC economies.

This project, HWG 02 2018A – Improving Networks of Community Mental Health Services in the Asia-Pacific Economies, was funded by the APEC Support Fund (ASF) General Fund and implemented by the APEC Health Working Group. The goal of this project was to:

1. Share experiences among Asia-Pacific economies and lessons learned from the implementation process of their community mental health services, including the systematization, management and coordination of these service networks.
2. Build the capacity of the mental health staff to implement intervention processes and evaluations to improve quality of care in community mental health service networks, as well as to systematize data for progress evaluations.

As a result of this project, a workshop was held in Lima, Peru, from 16 July to 19 July 2019. The contents of this workshop are presented in this report. Managers, public administrators, academic specialists and representatives of international organizations participated in this meeting. Representatives from the economies of Canada; Chile; People's Republic of China; Hong Kong, China; Indonesia; Republic of Korea; Malaysia; Mexico; the Philippines; Peru; Thailand and Viet Nam, as well as England as a Guest, also attended this workshop.

This report outlines the proposal for including mental healthcare in APEC economies' agendas and provides an overview of each Guest's issues. At the same time, it addresses community mental health models, psychosocial rehabilitation and financing implementation processes, strategies, and experiences. From a more theoretical approach, it describes the use of complex thinking systems in mental health planning. Finally, it gives a description of some investment

initiatives in vulnerable populations, strategies to remove stigma, and global challenges and opportunities, and it offers an approach to promoting mental health in all public policies of the region. Evaluating production and use can be observed as an overarching theme in the improvement experiences of community mental health services.

The workshop discussions produced a set of recommendations on financing, service organization, multisectoral action for the promotion and prevention of mental health disorders, advocacy, strengthening of human resources, improvement of research, and the use of evidence and information systems.

The workshop helped participants enhance their global and local thinking and become more aware of the complex relationship among mental health and all the developmental objectives, sectors and issues of the region.

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Glossary

APEC : Asia-Pacific Economic Cooperation
AUGE : Universal Access with Explicit Guarantees,
BSIC : Basic Stable Inputs of Care
CAMH : Center for Addiction and Mental Health
CPG : Clinical practice guidance
CRPD : Convention on the Rights of Persons with Disabilities
DALY : Disability-adjusted life year
GDO : Global Dementia Observatory
mhGAP: Mental Health Gap Action Program
NCD : Noncommunicable diseases
PAHO : Pan American Health Organization
PEPS : Patient Empowerment Program for Schizophrenia
PHC : Primary Healthcare
PIA : Initial opening budget, Presupuesto Institucional de Apertura
PSR : Psychosocial Rehabilitation
SDG : Sustainable Development Goals
SST : Social Skills Training
WHO : World Health Organization

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1. Introduction

About one in five people have suffered from one or more mental disorders in their lifetime. At a global level, these account for 9 of the 20 main causes of disability-adjusted life years (DALYs) and 10% of the global burden of disease, especially in middle- and low-income economies. It is worth mentioning that most of these economies are part of the Asia-Pacific region.

The impact these disorders have on individuals' development is worrisome. Education processes, community trust building, integration in the labor market, empowerment of rights and social cohesion are all affected. In addition, an economic loss of approximately USD 2.5 trillion is being inflicted each year, and this cost is expected to continue rising through 2030. Unfortunately, a great number of people with substance abuse problems or mental disorders do not receive adequate treatment in a timely manner.

Since old inpatient treatment models have failed to meet users' needs, several economies have considered implementing mental health services reform. This reform aims to strengthen mental health services at the first and second levels of care and implement networks of community mental health services. It is expected that this will increase the population's well-being and enhance the cost-effectiveness of investments to improve people's health.

In response to this issue, the project "Improving Networks of Community Mental Health Services in the Asia-Pacific Economies" (HWG 02 2018A) was funded through the APEC Support Fund (ASF) General Fund and developed in the Health Working Group Forum. The objectives of this Project were to:
1. Share experiences among Asia-Pacific economies and lessons learned from the implementation of their community mental health services, including the systematization, management and coordination of these service networks.
2. Build the capacity of the mental health staff to implement intervention processes and evaluations to improve the quality of care in community mental health services networks, as well as to systematize data for progress evaluations.

Within the framework of the project, an international workshop was successfully conducted in Lima, Peru from 16 July to 19 July 2019 and subsequently this report on the workshop was prepared. Several specialists from APEC economies participated in the workshop, fostering knowledge exchange as well as strengthening participants' ability to implement and evaluate community mental health services. These activities are expected to strengthen participants' leadership to improve the implementation of public mental health policies in their respective economies.

Experiences from APEC member economies: Canada; Chile; People's Republic of China; Hong Kong, China; Indonesia; Republic of Korea; Malaysia; Mexico; the Philippines; Peru; Thailand and Viet Nam were considered, as were experiences from England as Guest. This report collects the different approaches presented by the speakers, which included both academic and public administration perspectives. First, the status of mental health in each of these economies was described in detail and then implementation and rehabilitation strategies and models for both the general population and the vulnerable population were analyzed in depth. Additionally, problems such as stigmatizing attitudes that prevent rehabilitation were identified. Successful interventions to reduce stigma against patients were also presented.

Likewise, systemic and economic approaches were addressed in the analysis, which included mental health policies planning. Strategies and practices to obtain funds and invest them efficiently were also discussed. These experiences and approaches demonstrated that evaluation is a key aspect for the improvement of community mental health services, since they serve as important tools to persuade politicians and policy makers to prioritize and to invest cost-effectively in mental health.

Finally, the challenges and opportunities for community mental health in the 21st century were addressed, as well as the World Health Organization's proposal to integrate mental health in the development agendas of APEC economies.

In the discussion sessions, participants had the opportunity to express their point of view on how mental health had been integrated in the development agendas, as well as on the challenges and recommendations for the implementation and sustainability of community mental health in APEC economies. In those sessions, participants also reviewed issues of financing, service organization, multisectoral actions on promotion and prevention, advocacy, human rights, human resources, information systems, and research and evidence.

Figure 1: Participants of the workshop "Improving Networks of Community Mental Health Services in the Asia-Pacific Economies" (HWG 02 2018A). Lima, Peru.

2. What are the Threats to and Opportunities for Community Mental Health in the 21st Century?

Graham Thornicroft is Professor of Community Psychiatry at the Centre for Global Mental Health, Institute of Psychiatry, Psychology and Neuroscience, King's College London. He also works as a Consultant Psychiatrist at South London & Maudsley NHS Foundation Trust in a local community mental health team in Lambeth. He is a Fellow of the Academy of Medical Sciences, is a National Institute of Health Research Senior Investigator Emeritus and is a Fellow of the Royal Society of Arts, King's College London and the Royal College of Psychiatrists. He is the Director of the World Health Organization Collaborating Centre for research and teaching at the Institute of Psychiatry, Psychology and Neuroscience. He delivered a presentation entitled "What are the Threats and Opportunities for Community Mental Health in the 21st Century?"

The world's response to mental health problems has three major gaps. Unfortunately, a large majority of people across the world who have mental health conditions get little or usually no treatment. According to several world mental health surveys, this includes three conditions, including depression, anxiety and substance use disorder. In higher-income economies, up to 10%, 14% or 22% of people with these diagnoses, respectively, can get treatment, whereas in low-income economies, almost no individual can (Alonso et al., 2018). This issue represents a quantity gap of our mental health systems.

Additionally, people are provided with inadequate treatment or so-called "treatment supporting care." The conditions in which they receive this treatment often resemble terrible prisons more than places of therapy to support patients. This context is identified as the quality gap.

According to the latest version of the "World Health Organization's Mental Health Atlas" (WHO, 2017) the expenditure on mental healthcare contributes to between a quarter and a third of the impact of all health conditions around the world. The best economies do is dedicate about 5% of expenditure to mental health. In the worst cases, in some of the poorest economies in the world, less than 1% of the health budget is spent on mental health, despite the impact of mental health disorders on about a quarter of all health difficulties. This is the investment gap.

Although these three gaps represent significant challenges to all economies, it is important to identify opportunities in the field of global mental health as well. In this case, the development of a community- and hospital-based balanced care model is convenient. According to the analysis of Thornicroft & Tansella (Better Mental Health Care, 2009) based on summarized systematic reviews, there is no evidence that hospital only based care can provide reasonable care, nor that community care alone provides a proper spread of support. Therefore, the balanced model supports the idea that both hospital and community care models are required.

The question that naturally arises is in what mix, at which places and at what point in time should this model be implemented. For this matter, it is important to consider the basic principles that underpin the approach to community and hospital-based care. In this regard, location is a critical feature. In other words, people prefer to get help at or close to home. There are some exceptions though; for example, if patients present with a very rare condition, they might travel some distance to a specialist treatment center. However, local treatment options would be the top preference.

User-centered approaches are also necessary, as care and support should be specific to an individual, not generic when it refers to forms of intervention. The treatment plan should actively include these considerations and some of the elements may be the priorities and preferences of service users. It should also pay close attention to the views of caregivers.

The result is a balanced system that has a mix of both static and dynamic or mobile elements. Static referrers to facilities where staff go in the morning, sit, work and go home. Mobile elements include, for example, community mental health teams, crisis teams, emergency teams, the types of teams with the ability to go out to see patients at home or to see them in other places within the community.

To adapt this model, it is also critical to consider what can realistically be done according to the resource settings of each economy. Low-income economies' resources are approximately 1% or less of the mental health resources of high-income economies. Thus, different variants of this model are required, according to low, medium or high resources settings.

Figure 2: Low resource settings
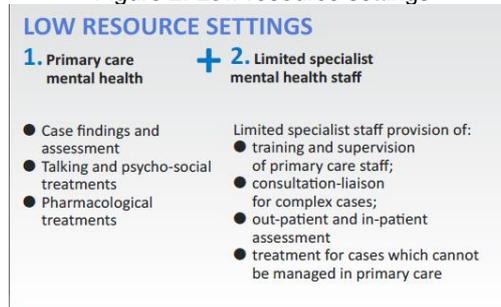
Source: Thornicroft, G., & Tansella, M. (2013). The Balanced Care Model for Global Mental Health.

In low resource settings, primary care is the key because that is the only part of the health system that provides anything near to enough volume or quantity to be able to relate to the most common mental disorders across the community. What specialists can do is treat a tiny number of the most complicated patients. They can also act as a multiplier to support, teach and supervise primary care staff in identifying and treating people with mental illness.

Figure 3: Medium resource settings
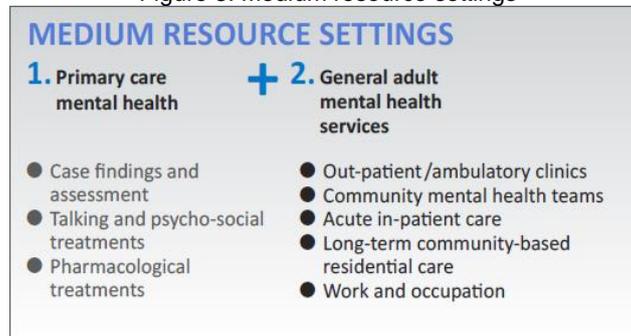
Source: Thornicroft, G., & Tansella, M. (2013). The Balanced Care Model for Global Mental Health.

In middle-income economies, resources may allow an extra layer called general adult services. Once again, this represents a mixture of hospital and community-based facilities.

Figure 4: High resource settings
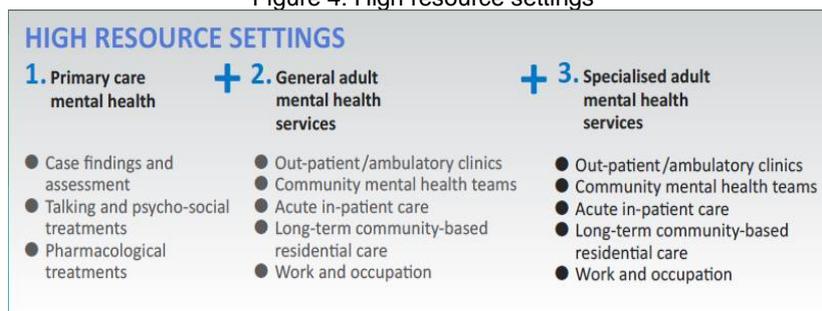
Source: Thornicroft, G., & Tansella, M. (2013). The Balanced Care Model for Global Mental Health.

In high-resource settings, additional and specialized elements can be added in five different categories: (i) Outpatient ambulatory care, though, interestingly, there is almost no evidence of

the effectiveness of this type of service. (ii) Community teams, for example, early intervention teams for people with psychosis. (iii) Acute in-patient care. (iv) Specialist community residential care. (v) Opportunities for work, employment, rehabilitation and social participation.

According to *The Lancet Commission on Global Mental Health and Sustainable Development* (Patel et al., 2018, p. 1595), a detailed 50-page compilation with all the latest evidence published in 2018, there are five leading grand challenges:

- Training packages to be able to deliver treatment in primary care.
- The reliable supply of effective elements of treatment packages, including psychotropic drugs.
- The training of primary care staff.
- Support for social inclusion for people with long term disabilities, especially those with a diagnosis of psychotic conditions.
- The strengthening of the whole health system for proper treatment, not just of mental illnesses for people with these conditions but also of the physical conditions of people with a mental illness. The neglect of that issue currently contributes to a decrease in life expectancy of 10 years on average across all mental health conditions, and 20 years on average for people with severe mental illness.

In many economies throughout the world, the mental health sector is leading the efforts to bridge the healthcare gaps described above. Many layers of community service have been reconfigured to provide better services. Patients and family members are increasingly being included in designing and implementing care plans. Similarly, the issue of comorbidity and multimorbidity is progressively being taken care of, since within the physical health sector, people with mental illnesses tend to be neglected and undertreated.

The World Mental Health Plan is coming to the end of its current period and has produced outstanding contributions to global mental health, including, for instance, the Mental Health Gap Action Program (mhGAP). It is drawn from the best evidence and it is being used in over 120 economies worldwide. For more information about the evidence that supports the community mental health approach, *The Oxford Textbook of Community Mental Health* and *Community Mental Health Putting Policy into Practice Worldwide* include valuable information from across the world.

3. Integration of Mental Healthcare into the APEC Economies' Development Agendas

Dr Andrea Bruni from the World Health Organization (WHO) delivered a presentation entitled "Integration of Mental Healthcare into the APEC Economies' Development Agendas" outlining challenges to and a road map for integrating mental healthcare into systems of care.

Mental health, neurological and substance abuse disorders are highly prevalent conditions. They are associated with high levels of disability and mortality and are an increasing cause of disease. Over the last 20 years, the incidence of these types of disorders has increased by nearly 50%, which represents a significant problem.

These disorders can be divided into three groups: mental and substance use disorders, which mainly affect youth and adolescents; suicide and self-harm, which also primarily affect youth and adolescents; and Alzheimer's and dementia, which principally affect older adults (Patel et al., 2018b, p. 1578). In the case of suicide, it is necessary to debunk the myth that this is more common among people from higher economic groups and in developed economies. More than 75% of suicides occur in low and middle-income economies (World Health Organization, 2015).

Economies are not working enough to respond to the needs of people with mental health disorders. This situation is exacerbated by limited human resources, as can be seen in the following image.

Figure 5: Mental health workforce breakdown per 100 000 population, by World Bank income group
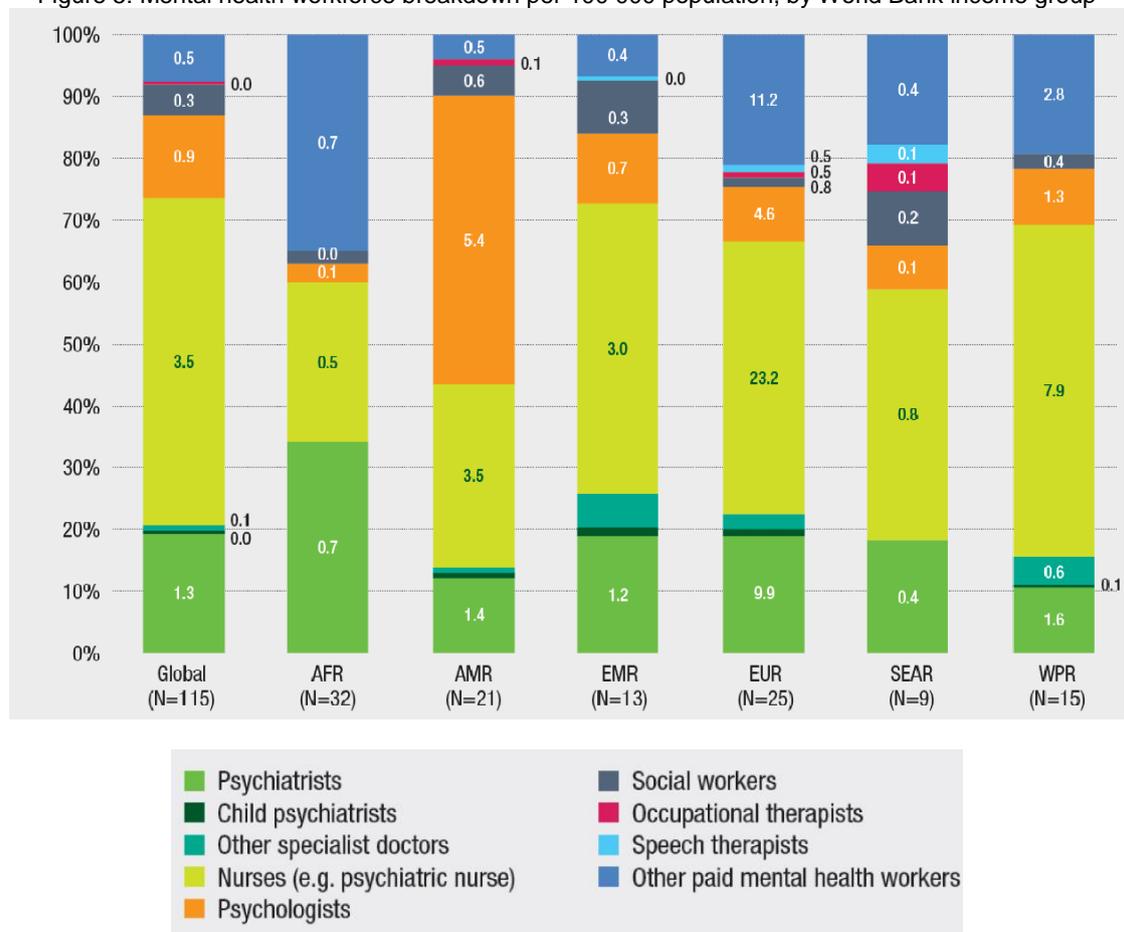
Source: Atlas of Mental Health, WHO 2017

For instance, the Americas have a dramatic scarcity of child psychiatrists with just 0.03 child psychiatrists per hundred thousand inhabitants (World Health Organization, 2018). This is less notable in Europe; in certain regions, this gap is nearly invisible. Compounding this scarcity of

human resources, mental health services are not well organized. There are many beds in psychiatric hospitals and few beds in general hospitals and community centers.

Human rights also contribute to this situation. People with mental disorders are frequently victims of severe human rights violations at psychiatric hospitals and general hospitals. This also takes place in settings where services are not available. People with severe mental disorders die up to 25 years earlier than the general population. Discrimination, stigma, and reduced access to physical and mental healthcare are also issues to be considered.

In summary, it is clear that it is necessary to take more action in mental health, and in order to achieve this, it is essential to invest more. There is evidence to show that investing in mental health makes sense. This is true for prevalent conditions such as depression and anxiety. A World Bank and WHO publication highlights that for each dollar invested in mental health, there is a return of between 3 and 4 dollars (Patel et al. 2018b, p. 1590). However, it is equally important to analyze the following: How should we invest in mental health?

Optimal mix of services in mental health

According to WHO (World Health Organization, 2003), the following image shows the Optimal Mix of Services for Mental Health.

Figure 6: Optimal Mix of Services for Mental Health
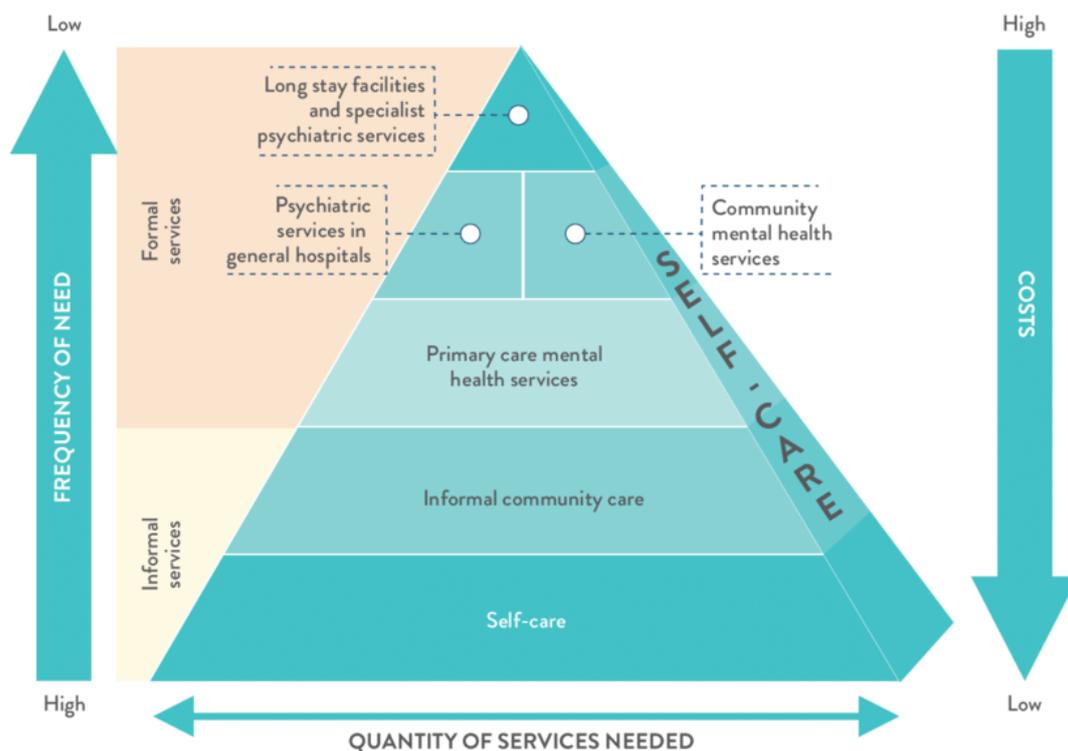
Source: WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health

This framework establishes five levels of care. The first two levels provide a broad foundation for self-care and informal community care, followed by a middle section of primary healthcare (PHC). This pyramid level integrates mental health in non-specialized care with general practitioners. The fourth level is divided into two sections: psychiatric services in general hospitals and community mental health services, which are centers with no beds but with at least one psychiatrist. On top of the pyramid, there are long-stay facilities and specialist psychiatric services.

The pyramid reads from top to bottom in terms of costs. In other words, the services listed at the top of the pyramid demand the highest costs and costs decrease lower in the pyramid. However, the pyramid reads from bottom to top in terms of frequency of need, with the most frequently needed services at the foundation of the pyramid.

As the model shows, the upper levels comprise of formal services and the lower levels encompass more informal services including self-care and community care, such as associations of users and family members. It is important to note that in this model primary care serves as the foundation of the formal services. Primary care has important repercussions when it comes to integrating mental healthcare as part of non-specialized care. This means that formal mental healthcare might not be offered by a psychiatrist or psychologist, but rather by general practitioners, family doctors or nurses.

The second level of the formal services section has two components. To the left, there are general hospitals, which also have small mental health units. Many general hospitals do not have psychiatrists and cannot admit patients. This is where the barriers caused by stigma are most likely to be encountered, as is the need to negotiate with authorities to include a psychiatric unit. The right side of the second level is community mental health services. For example, according to Law 29889, which set the path for the Peruvian mental health reform, this economy has many of these facilities, which are centers with no beds and one specialist (e.g., a psychiatrist).

Finally, the top level of the formal services section shows long-stay facilities and specialized psychiatric hospitals. As can be seen in the image, the recommendation is that this be the top and smallest part of the pyramid. However, the situation in many economies is different. What many economies do is invest most resources in the top part of the pyramid and too little in lower levels, even though only a small proportion of people require this specialized level of care. Moreover, this kind of service is much more expensive than others. This begs the question of why economies focus investment in this top level. In certain non-APEC economies, such as Italy, this top level of care does not even exist because of human rights violations.

Areas of action

According to this pyramid framework, it is highly recommended to take action on the organization of services and strengthening of capacities of general health professionals. This can help improve access to and quality of mental healthcare services. The Mental Health Gap Action Program (WHO, 2019) is a comprehensive program which aims to integrate basic components of mental health into primary healthcare. It focuses on tackling specific mental disorders like depression and psychosis; neurological conditions, such as dementia or epilepsy; as well as substance use disorders. The mhGAP initiative offers plenty of materials to facilitate its implementation, such as training manuals, intervention guides, videos, and a mobile app.

Financing is critical to transform policies into reality, reduce treatment gaps, and eliminate and reduce out-of-pocket payments. For this matter, science and evidence-based advocacy is needed to drive change and create impact in decision makers. To do so, strong information systems, research and evaluation are needed to close the evidence gap. Currently, the evidence is not relevant, appropriate or sufficient. It is imperative to build, present and use evidence at a public level. This is also relevant to public health.

Multi-sectorial action is a key component to mainstreaming mental health in all policies. Advocacy should raise awareness about the exceptional place which mental health occupies on the Sustainable Development Goals (SDG) agenda. The complex nature of mental health makes it a topic which not only relates to SDG No. 3 ("Ensure healthy lives and promote well-being for all at all ages") but also to every goal on the SDG agenda, such as:

- SDG 1: End poverty in all its forms everywhere.
- SDG 2: Zero hunger.
- SDG 4: Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.

- SDG 13: Take urgent action to combat climate change and its impacts.

Even priorities that seem to be far removed from the mental health topics, such as climate change, are interconnected with mental health. For instance, a publication from India showed that temperature increase has an indirect impact on suicide rates, since workers in the field know that if the temperature increases, the harvest will be much worse and they will not have enough food to provide for themselves and their families. This event affects food security and influences the decision of inhabitants to take their lives: an increase of one degree resulted in 10 suicides.

It is similarly important to improve mental healthcare quality. To do so, it is essential that services and policies align with the principles of the Convention on the Rights of Persons with Disabilities (CRPD). The WHO QualityRights Tool Kit (World Health Organization, 2012), provides a guide for assessing health services in terms of human rights and quality of services. This can be implemented in mental health services, such as psychiatric hospitals, as well as in general health services, such as general hospitals. It also offers a training package with training manuals for service users, family members, health professionals, human rights activists and mental health professionals.

The prevention of mental health disorders is essential for every health system. Since half of mental illness begins by the age of 14 and 10% and 20% of children and adolescents, respectively, experience mental disorders, WHO developed a "Child and Adolescent Module of mhGAP" to help tackle mental disorders early in life. Furthermore, WHO developed the initiative "Caregivers skills training" (World Health Organization, 2015) for training parents of children with autism or autism spectrum disorders.

The fact that the average age of our population on the planet is increasing is also relevant to mental health, as more people experience age-associated disease. Every year nearly 10 million dementia new cases are recorded. The Dementia Plan for WHO (WHO, 2018c) outlines the following 7 pillars for responding to this issue:

- Dementia should be recognized as a public health priority. This involves having policies and strategic documents.
- Support for dementia caregivers.
- Dementia awareness and friendliness.
- Risk reduction: Many risk factors overlap with NCD (noncommunicable diseases) risk factors.
- Diagnosis, treatment, and care through mhGAP.
- Information systems.
- Research and innovation.

Additionally, the GDO Initiative (Global Dementia Observatory, WHO 2018) is a platform that provides a snapshot of dementia in different economies, as well as information about these pillars.

Despite their tragic consequences, emergencies also represent an opportunity to reform mental health systems. In the report "Building Back Better," there are 10 examples of improvements economies made to mental health services after going through such scenarios (World Health Organization, 2013). A particularly good case study is that of Sri Lanka, which required adequate mental health service before the tsunami. After the tsunami, with the emergency response and the resources allocated, mental health services were reformed. Additionally, it is also important to remark that there is a humanitarian version of mhGAP, build for responding to emergency and disaster (World Health Organization & Office of the United Nations High Commissioner for Refugees, 2015).

Suicide prevention is also a necessary area of action, through the elaboration of suicide prevention plans addressing the most vulnerable groups, including indigenous populations worldwide.

In conclusion, sustainable development is impossible without reflecting on the current state of mental health since its impacts are well connected to all sustainable development goals. Additionally, it is important to emphasize its economic relevance since responsibly managed mental health interventions are highly cost-effective.

4. Promoting and Protecting Mental Health in the Asia Pacific Region: Mental Health in all Policies?

Professor Vivian Lin is Executive Associate Dean at Li Ka Shing Faculty of Medicine at the University of Hong Kong. She has more than 30 years of experience in public health, with a variety of leading roles in policy and program development, health services planning, research and teaching, and senior administration in complex organizations. She delivered a presentation entitled "Promoting and Protecting Mental Health in the Asia Pacific Region: Mental Health in All Policies?"

In order to promote mental health in all public policies, it is necessary to shift from the individual perspective to the perspective of systemic solutions for prevention and protection. This means that every clinical encounter becomes an opportunity for change. For example, the situation of an abused refugee woman could be originated by climate change and has effects on her health. Or in the case of an ill elder, the pension system is also a determinant of his health condition. And finally, the case of a young suicide is as much a problem of mental health as it is of the education system.

The rapid changes in the Asia Pacific region will generate more of these situations that put people's well-being at risk. The analysis of the context points out that the region has great challenges in terms of workforce participation (absenteeism and presentism), productivity, social integration, the costs of mental disorders, youth and elderly suicide, women's suicide, aging and dementia, substance and alcohol abuse, gender violence, and the inequality generated by rapid urbanization.

The impact of climate change on the Pacific islands and the forced migration that this causes should not be forgotten. Furthermore, the region still has social inequalities, infectious diseases and health-related poverty. Therefore, it is important to clearly establish in the agenda that there is no health without mental health. To achieve this, it is important to work aligned with the Sustainable Development Goals (SDG) to facilitate the integration of health with its social determinants (World Health Organization, 2010).

Figure 7: Sustainable Development Goals

Sustainable Development Goals, s. f.

Figure 8: Social determinants of health and their relation to the Sustainable Development Goals
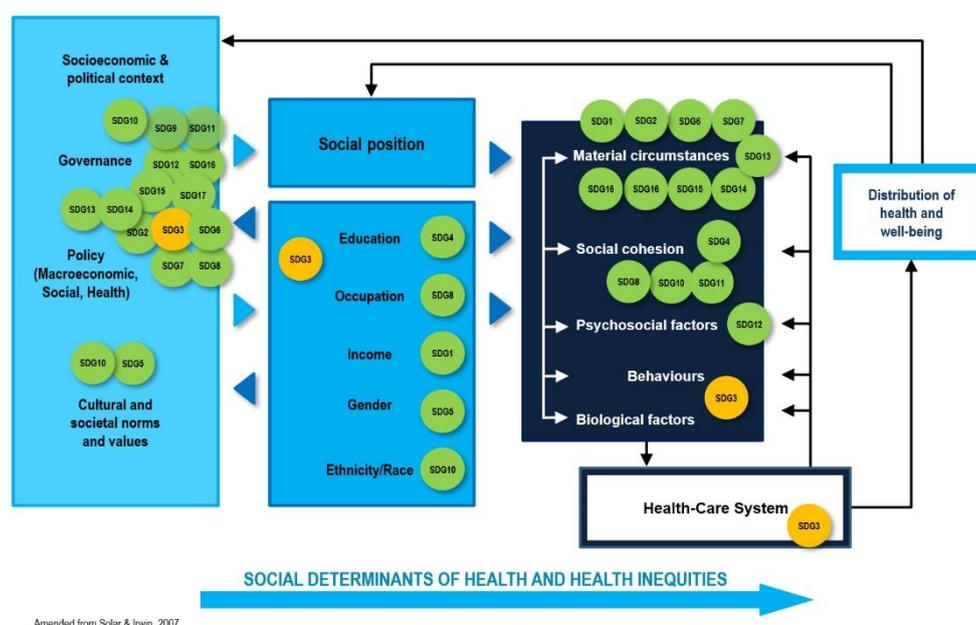
Source: Speaker's presentation copy. Amended from Solar & Irwin, 2007

It is recommended to work on the following systemic solutions that address challenges such as gender-based violence. This requires that first-level healthcare centers work in coordination with the police and the judicial system. For some economies this is strongly linked to a necessary judicial reform (World Health Organization, 2013 and 2014).

It is suggested that social and community mobilization be encouraged to advocate for rights and law enforcement. At the level of health governance, the participation of society is necessary to collectively address public health issues. The government complements this task with its role in monitoring and supervising health services so that they have the best possible impact on people's well-being.

For intersectoral governance, it is necessary to establish committees or senior officials who are able to coordinate across several ministries or government cabinets. In political negotiations, it is necessary to use evidence that is relevant to multiple sectors. In this way, it is possible for people with diverse interests to agree on certain goals, which greatly facilitates coordination (McQueen et al., 2012). The same is true for public policies that benefit everyone equally, such as universal education and health, redistribution through taxes, and quality employment (International Panel on Social Progress (IPSP), 2018). These policies are preconditions for good health and mental health.

In order to think about health in all public policies, the government must provide better public services, considering the complex interdependence between solutions and problems that exist in a health system. To measure them, it is important to set goals linked to a particular impact on people's well-being and to strengthen the entire legal framework necessary to achieve the Sustainable Development Goals. It is imperative that mental health be understood as a development issue.

5. What are the Mental Health Problems that Affect the Development of Economies?

5.1. Chile

The representative from Chile, Mr Cristian Montenegro, provided an overview of mental health in the Chilean economy while sharing significant milestones achieved on the road towards community mental health with the audience.

Chile has a population of 18 million inhabitants and has both a public health system and a privately run health system. While the private health sector provides care to the minority that can afford it, the public sector is usually overwhelmed providing services to 80% of the population.

Its epidemiological profile shows a high prevalence of chronic diseases and obesity. Some specific data that must be considered about Chile is that 22% of the population has experienced mental health problems in the past 12 months and neuro-psychiatric conditions determine 21% of disability-adjusted life years (Vicente P et al., 2002, p. 1366).

Depression rates are at 6%, affecting 2.1% of men and 10.1% of women. According to Mr Montenegro, only 18% of the population suffering from depression received treatment in the year 2018. Depression is most common in citizens between 45 to 54 years old (8.5%). According to 2017 figures, men are more likely to die by suicide (17 in 100,000 inhabitants) than women (3.4 in 1000,000 inhabitants). About 19% of the population receives mental health services in primary healthcare settings, with an average of 4.2 encounters per person (Ministerio de Salud - Gobierno de Chile, 2017).

A significant financial achievement was reached in the year 2004, when the Universal Access with Explicit Guarantees Plan (AUGE, for its Spanish initials) established universal access to healthcare with explicit entitlements for a list of mental health disorders, including dementia (Aguilera, 2015). The funding priorities determine that only some diseases are addressed.

As the chart below shows, the availability of mental health services has increased significantly. The number of primary health centers that provide mental healthcare increased from 472 in 2004 to 832 in 2012. The number of community mental health clinics increased from 38 to 83 during the same period (WHO, OMS-IESM, Ministerio de Salud de Chile & Universidad de Chile, 2014).

Table 1: Comparison of the total number of mental health facilities existing in Chilean public sector, 2004 and 2012.

	Year 2004	Year 2012
Primary Health Care Centers, which provide mental health care.	472	832
Rural health clinics, which provide mental health care	*	723
Community Mental Health Centers	38	83
Outpatient Psychiatric Care Units	58	53
Day Hospitals	40	45
Inpatient Short-Stay Psychiatric Units in general hospitals	17	23
Adolescent Short-Stay Psychiatric Units in general hospitals	1	8
Day Centers	25**	51
Psychiatric Hospitals	5	5
Homes and Protected Residential Facilities	103	199
TOTAL	**759**	**2022**

* In 2004 Rural Health Clinics only exceptionally provided care for people with mental diseases, therefore, this information were not gathered.

** In 2004 a more restrictive definition was used which did not include rehabilitation units, labor workshops and club houses

Source: Ministerio de Salud - Gobierno de Chile, 2014

The number of patients in psychiatric hospitals decreased between 2000 and 2012. Short stays in psychiatric hospitals decreased by 7.16%, while extended visits decreased by 38.5%. Medium-term stays, however, increased by 273.3% (WHO, OMS-IESM, Ministerio de Salud de Chile & Universidad de Chile, 2014).

Despite the progress that has been achieved, according to Mr Montenegro, Chile still needs 159 community mental health centers across the economy and there is currently a gap of 300 beds in intensive psychiatric care beds for adolescents. However, during the years 2010 to 2016, the budget increase for mental health has not been steady.

Chile's mental health strategy has been continuous, with few changes between one plan and the next. Each plan, however, incorporates the lessons learned during the implementation of the previous one. Although the plans set the path for the deinstitutionalization of mental health services, it is complicated to deal with the public pressure for quick answers, since—for some sectors of public opinion—psychiatric hospitalization could provide a rapid solution for disruptive and suicidal behavior. The main challenge is reconciling the solution of urgent problems with the ongoing reform.

At the moment, the government's concern is focused on the topic of public perception of mental health and social participation. There is an ongoing campaign to reduce stigma around mental health and to increase social participation. Public discussions managed to increase awareness of mental health. The mental health of secondary school and university students has become a prevalent topic in the media during the past three years. However, there is still need for funding for mental health non-profit organizations to ensure their autonomy and sustainability. The multi-sectoral nature of mental health public policies and its management are important challenges to the current health system.

5.2. People's Republic of China

The representative from the People's Republic of China, Dr Ning Ma, presented the state of mental health in this economy and the launch of a program that made a significant difference in the healthcare system.

The main problem faced by the People's Republic of China is the enormous demand for services due to its large population: 1.6 billion people. According to an epidemiological survey (Huang, Wang et al., 2019) from 2013 to 2015, the prevalence of mental disorders in people over 18 years old is 16.57%. The disease challenges caused by mental disorders and substance abuse represent 13% of the total load of non-communicable diseases. Data shows that depression, schizophrenia and dementia represent the top three mental health issues in the economy.

Figure 8: Prevalence of mental disorders in China
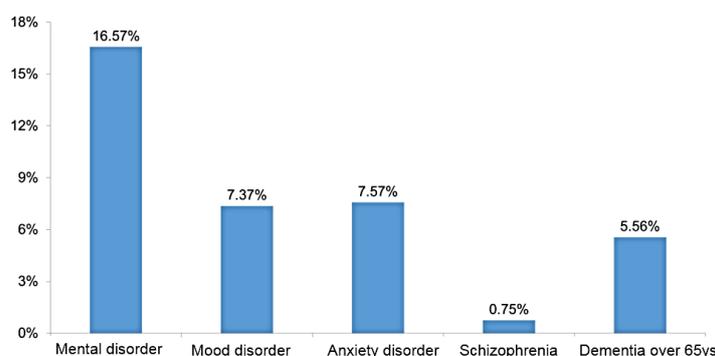
Source: Huang Y, et al., Lancet Psychiatry. 2019

The second issue in the People's Republic of China is that there are not enough workers, including in hospitals and community mental health centers. The *China Statistical Yearbook* (China Statistics Press, 2017) shows that at the end of 2017, there were about 30,000

psychiatrists and 70,000 psychiatric nurses in hospitals. Each psychiatrist has a heavy workload. In the past, there were fewer community-based mental health services in the People's Republic of China. For this reason, psychiatric hospitals and psychiatric units in general hospitals provided most mental health services.

To promote community mental health services, the Ministry of Health and the Ministry of Finance launched the National Continuing Management and Intervention Program for Severe Mental Disorders in 2004 (Good & Good, unknown), which is a program that aimed to integrate hospital and community services. This program had an initial annual funding of CNY 6.86 million per year. Currently, the annual funding is CNY 470 million per year.

Based on this experience, the central government launched a program called National Guide for Equalization of Basic Public Health Subsidies in 2009 (Yang, Sun, Wen, Zhang, Li, Hanson & Fang, 2016). Under this program, primary healthcare centers provide community-based follow-up services for patients with psychosis. The psychiatrist's role is to guide the community health mental workers so that they can collaborate.

However, specific issues remain regarding the community workforce. First, there are almost no mental health service centers in the community. Additionally, in each primary healthcare center, there is generally not at least one healthcare professional available to provide follow-up services for patients with psychosis. This is compounded by the fact that some staff engaged in mental health services work part-time. Finally, there are also few community rehabilitation service facilities.

Therefore, to deal with these problems, the Chinese government launched the National Comprehensive Mental Health Pilot Project for Mental Health (Zhang & Ma, 2017) in 2015, which outlined a multisectoral approach at the domestic, provincial and municipal levels. This program aims to provide comprehensive resources for patients with mental illnesses, including diagnosis, treatment, rehabilitation and live assistance.

A final problem is that mental health resources are distributed mostly in the eastern part of the People's Republic of China, and the resources, including human resources, available in the western part of the People's Republic of China are insufficient. The lack of public awareness surrounding mental health and elevated levels of stigmatization represent additional challenges. It is important to remark that due to the People's Republic of China's geopolitical conditions, the assessment of patients in mountain regions is not accurate.

5.3. Indonesia

The challenges that Indonesia's healthcare system generally faces include natural disasters, issues financing facilities, and infrastructure for the integration of territory. In Indonesia, the main percentage of change in DALYs (2017) from mental health disorders are caused by schizophrenia (1.05%), depression (0.62%), anxiety (0.4%) and bipolar disorders (0.51%). Children and adolescents are mainly affected by the following mental health problems and disorders:

•   Bullying
•   Anxiety
•   Depression
•   Autism Spectrum Disorder
•   Substance Abuse
•   Internet Gaming and Internet Addiction

According to the Indonesia Basic Health Research report (Agency of Health Research and Development Indonesia, 2013), the prevalence of schizophrenia and depression among the population older than 15 years old is 1.7% and 6.1%, respectively. Only 9% of people with depression receive adequate treatment.

In response to the population's mental health needs, the Indonesian government passed the Mental Health Law 18/2014 (Republic of Indonesia, 2014). This law emphasizes promotive,

preventive, curative and rehabilitative approaches to improving mental healthcare quality. Furthermore, it proposes a sustainable scheme that integrates the domestic and local Government efforts with the community. Additionally, the government has developed policies, guidelines and standards. For instance, mental health programs are integrated into medical schools to increase human resource capacity.

However, there are still significant barriers to the prevention and treatment of mental health problems, including stigma. The community often associates psychiatric disorders with psychosocial issues, spirit/ghost possession and black magic. There is a tendency to lump all psychiatric disorders into one category, calling the patient "Gila," which can be loosely translated as "crazy." Similarly, the lack of human resources, advocacy activities and surveillance systems as well as the limited available funding represent a burden to mental healthcare programs.

5.4. Korea

The representative from Korea, Dr Tae-Yeon Hwang MD, PhD, MPH from the National Center for Mental Health (NCMH), described the state of mental health in the Korean economy.

Dr Hwang is well known for developing and publishing about many psychosocial rehabilitation programs, including psychoeducation for patients and families as well as vocational and cognitive rehabilitation programs.

He is the current director of the Division of Mental Health Services and Planning at NCMH and works with the Department of Mental Health and the Ministry of Health and Welfare on the National Mental Health Act and Policy. Since 2018, he has also been the President of the Korean Association of Social and Community Psychiatry and Vice-Chair of the Korean Neuropsychiatric Association.

There are three ongoing noteworthy mental health issues in Korea. The first is the management of mentally ill patients who have a high risk of committing acts of violence towards their neighbors. Recently, a famous psychiatrist was killed by a schizophrenic patient during an outpatient visit. In another example, after being discharged, a schizophrenic patient started a fire in the forensic ward that killed many people.

The government plans to amend the Mental Health Act to strengthen case management assistance for mentally ill patients in the community and to prevent violence towards other individuals.

The second issue is that of involuntary admissions reinforced by the police, which occur when the patient shows an extremely high risk of violent behavior towards the neighborhood. Balancing the human rights of the mentally ill against the needs of public safety is a real issue in Korean mental health. Advocacy for mentally ill patients in the community is another factor that plays a role here.

The NIMBY ("Not in my backyard") phenomenon has also become more common recently. This expression encapsulates the stigma as well as the discrimination shown against mentally ill patients in the community. An example of this was when a group home was opened in the southern part of Korea, but neighbors protested its presence. Protesters argued against having mentally ill patients coming to live in the group home.

This aggravates another pressing issue: when the commission wants to open a community hospital in a city, there are often many apartments close to the site of the community hospital and neighbors also express resistance against the opening of the mental hospital. Next year a domestic legislative election will take place, and it is projected that new members of Congress might stop and then maybe open the hospitals.

The City Mayor canceled the opening of the mental hospital in the community, exemplifying a true problem in Korea. There must be a way to advocate for the mentally ill patients in the community and their families.

The third ongoing issue in Korea is the suicide rate. Korea ranks among the top five when it comes to suicide rates in OECD economies (OECD, 2010). Suicide is especially common among teenagers and high school students because of the pressure they experience to achieve academically. It also occurs when they graduate from college and university because can be difficult for students to find a job because of the economic recession.

Suicide among the elderly because of changes in the family structure represents another significant challenge. Traditionally, in Asian cultures such as those found in the economies of People's Republic of China; Japan and Korea, the son or the grandson usually takes care of the parents or grandparents However, this tradition is disappearing from Korea, and elders are often left living alone. The goal is to prevent suicide by strengthening the monitoring system and providing a hotline for older adults.

5.5. Malaysia

The representative from Malaysia, Dr Nurashikin Ibrahim, provided an overview of the state of mental health in that economy.

The Malaysian Ministry of Health conducted a domestic survey that shows that the prevalence of mental health issues among adults over 16 years old increased from 10.7% in 1996 to 29.29% (Ministry of Health, Malaysia, 2017). This suggests that 3 out of 10 adults currently suffer from mental health problems.

Figure 10: Trend of mental health problem among adults ≥16 years
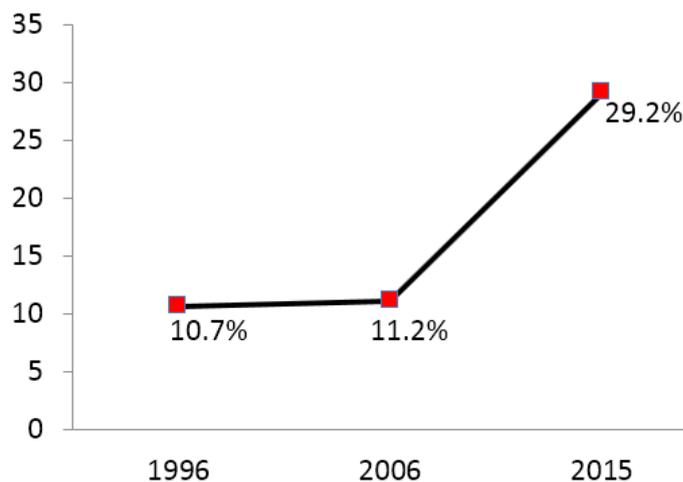
Source: Speaker's presentation

The prevalence of mental health problems is slightly higher in females than in males and in rural populations than in urban settings. A study conducted among students between 13 and 17 years old showed that one in five suffer from depression, two in five experience anxiety and one in ten feel stressed. Depression, suicidal ideation and suicide attempts have also increased over the past five years.

Figure 11: State of adolescents' mental health in Malaysia
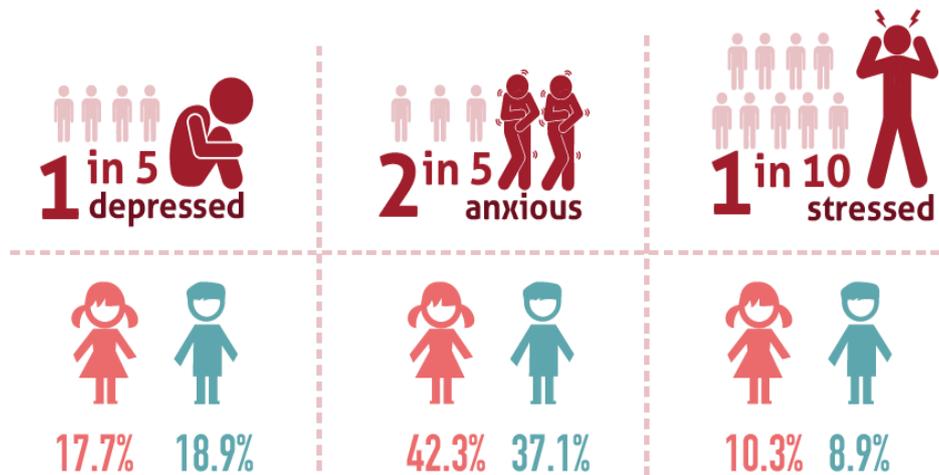
Source: Speaker's presentation

Depression is currently the leading cause of disability, not only in Malaysia but worldwide. In Malaysia, it accounts for 37% of all stated disabilities, with an economic burden projected to reach USD 25.3 million by 2030. Malaysia allocates 4.5% of its GDP to health. Only 1.3% goes to mental health expenditure, and this is mostly for treatment and medication, not prevention or awareness.

The mental health policy of Malaysia (Ministry of Health, Malaysia, 1998), amended in 2012, focuses on happiness, resilience and productivity. The community mental health program integrates mental health services into primary healthcare clinics. It organizes its work under five guidelines, including the promotion of mental health, prevention of mental disorders, early detection, treatment at primary healthcare and psychosocial rehabilitation.

Malaysia currently has 61 general hospitals, four mental health institutions, 1,001 health clinics, and 25 community mental health centers. Health Centers provide screening, treatment, rehabilitation and community services such as home visits. There are 400 registered psychiatrists, of which 181 work in universities or the private sector.

Figure 12: Mental health services
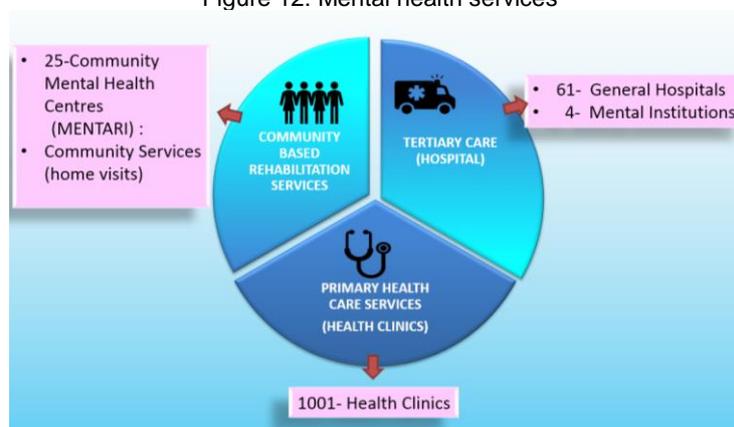
Source: Speaker's presentation

The mental healthcare program and the Ministry of Health have also collaborated with the Ministry of Education. In 2011, a program researched the level of stress, anxiety and depression in schools (Ahmad, MuhdYusoff et al., 2014) which led to allocating one counseling teacher for every 500 students.

The economy's primary healthcare system includes a program for young doctors and screenings for mental health problems at all ages, including autism and dementia screenings. Seventeen health clinics provide psychosocial rehabilitation services, while the remaining clinics focus on prevention.

Malaysia currently faces challenges posed by the stigmatization of mental health and mental illness. Other problems include a lack of human resources and the insufficient engagement of the community in activities aimed at promoting mental health.

To address these challenges, Malaysia is making efforts to engage stakeholders in awareness and advocacy initiatives and to intensify mental health promotion activities aimed at specific target groups. Other measures include capacity building activities among healthcare workers, NGOs and frontline workers, as well as strengthening the information systems surrounding mental health and collaborating with governmental and nongovernmental agencies.

Recent measures include the Let's Talk Malaysia initiative, which aims to reduce the stigma around mental health and improve the free health hotline run by the ministry. Malaysia has also put forward the National Strategic Action Plan on Mental Health 2020-25 and is attempting to decriminalize suicide.

5.6. Mexico

The two representatives from this economy, Dr Sol Durand and Dr Evalinda Barron, presented on the state of mental health in Mexico, explaining the fragmented system and the obstacles to restructuring.

Mexico's geopolitical condition is one of the barriers to establishing strategies for public mental health, as is the size of its population, which is 130 million citizens. Healthcare in Mexico is a fragmented sector that depends on the social security, federal, state and private subsystems. As a result, models of care in Mexico are often uncoordinated and redundant. Additionally, the mental health system has a strong emphasis on the third level of care (psychiatric hospitals), which in this fragmented context inevitably leads to inefficiency.

Funding for mental health in Mexico comes from only 2% of the general budget, and 80% of that 2% goes to the administrative management of patients in psychiatric hospitals. In comparison, the remaining 20% is earmarked for community interventions or mental health in hospitals. In other words, mental disorders are underfunded compared to all other diseases.

According to Dr Durand, there are only 4 community mental health centers in Mexico City. Across the economy, only a third of primary care centers have strict protocols for the detection and treatment of mental disorders. At the second level of care, there are general hospitals with a limited approach to mental healthcare and services.

The epidemiological situation of mental disorders in Mexico from 2003 shows that 14% were anxiety disorders, about 9.2% were issues with substance abuse and, finally, 9.1% were affective disorders. These percentages tended to increase in the following years (Medina-Mora, Borges, Lara, et al., 2013).

The suicide rate is also increasing in Mexico. From 2000 to 2016 it rose from 3.5 to 5.1 for every 100,000 people (The World Bank, 2020). Young people (15-29 years old) represented 41.3% of these suicides (PAHO, 2016). This economy previously committed to WHO to reducing these numbers by 10% by 2020, which seems an impossible goal. Suicide by hanging is the most common cause, and suicides are most frequent in males.

The global load of mental health related conditions is also increasingly affecting DALYs in Mexico. Substance use is also taking its toll on the Mexican population. Mental disorders are in eighth place among the list of causes of DALYs for 2017, while self-harm and violence take the third spot (IHME, 2018), as shown in the following graphic.

Figure 13: DALYs per 100 000, from 1990 to 2017

Mexico
Both sexes, All ages, DALYs per 100,000

1990 rank	2017 rank
1 Maternal & neonatal	1 Diabetes & CKD
2 Respiratory infections & TB	2 Cardiovascular diseases
3 Enteric infections	3 Self-harm & violence
4 Cardiovascular diseases	4 Neoplasms
5 Other non-communicable	5 Other non-communicable
6 Unintentional inj	6 Digestive diseases
7 Diabetes & CKD	7 Neurological disorders
8 Neoplasms	8 Mental disorders
9 Digestive diseases	9 Maternal & neonatal
10 Transport injuries	10 Musculoskeletal disorders
11 Self-harm & violence	11 Unintentional inj
12 Neurological disorders	12 Transport injuries
13 Mental disorders	13 Chronic respiratory
14 Nutritional deficiencies	14 Sense organ diseases
15 Musculoskeletal disorders	15 Respiratory infections & TB
16 Chronic respiratory	16 Substance use
17 Sense organ diseases	17 Skin diseases
18 Substance use	18 Nutritional deficiencies
19 Skin diseases	19 HIV/AIDS & STIs
20 Other infectious	20 Enteric infections
21 HIV/AIDS & STIs	21 NTDs & malaria
22 NTDs & malaria	22 Other infectious

Source: Speaker's presentation

Another significant issue in Mexico is that of care gaps. In general, 14 years pass between the beginning of symptoms and receiving adequate diagnosis and treatment because of problems surrounding care for patients. Only a few cases are detected in primary care, which means that most of the care is based on specialized treatment. This represents 80% of the treatment gap (Berenzon & Vargas-Huicochea, 2015).

Regarding human resources, there are almost 5,000 psychiatrists in Mexico, 50% of whom work in public healthcare. Of this 50%, only 365 psychiatrists are child-adolescent psychiatrists, which means major cities often lack sufficient staff. 60% of all psychiatrists are found in the three main cities of Mexico City, Guadalajara and Monterrey, so care is unevenly available as a result (Berenzon & Vargas-Huicochea, 2015).

Some of the mental health research currently being carried out in Mexico includes:
- Animal models to study the cause of psychiatric disorders
- Neurobiology of mental disorders
- Substance use disorders
- Violence and the impact on mental health
- Epidemiologic and psychosocial impact of mental disorders
- Diagnostic and therapeutic alternatives for mental disorders in youth
- Biomedical technology for the study of the brain
- Psychosocial interventions for the prevention, identification and treatment of mental disorders

To address the mental health problems of the population, Mexico is in the process of reforming its entire mental health policy. In order to achieve this, the economy is currently working on strengthening primary care with the WHO mhGAP program. One example is the development of mental health services in general hospitals. Moreover, the population's understanding of addiction problems is changing to recognize that these issues go beyond the war on drugs. The proposal seeks to treat addictions as public health and mental issues with collaboration from all branches of government and to treat people with addiction problems within the health system. The Ministry of Health is now taking the lead on coordinating this initiative.

Work is also being done on the National Addiction Prevention Strategy called Juntos por la Paz to deal with psychosocial problems. All the secretariats are working together on this intersectoral program. For example, the Secretary of Public Education will modify the content of children's textbooks. There will also be training for teachers and training for parents. Programs such as "Mentalizarte," which is an app that uses the Instagram platform, are representative of initiatives to educate young people about mental health topics.

Furthermore, the Instituto de Salud para el Bienestar (Institute of Health for Wellbeing) will be created, which will centralize the funds that were previously allocated to public insurance. This is going to include a catalog of treatments and different medications, which is being expanded to include more mental issues.

Finally, the training of professional doctors will be improved. Medical professionals generally reviewed psychiatric issues during only three or four weeks of their training. After graduation, physicians could not remember much about this psychiatric training. Social workers and nurses also get little training on these matters. This lack of training could increase stigma and the lack of proper treatment. Training for healthcare providers will be improved with the support of the WHO- mhGAP instruments in order to offer more quality training to staff.

5.7. The Philippines

The representative from the Philippines, Dr Noel Reyes, described the state of mental health in this economy, focusing on legislation, resources and context.

In the Philippines, there are 0.001 mental hospitals and 0.083 mental health units in general hospitals per 100,000 people (WHO, 2019). Given this scarcity, it is not surprising that there is also a shortage of human resources. Psychiatry, as a specialty, is almost disappearing in the Philippines.

There is no data on the number of nurses and social workers in this field, but there are plenty of psychologists working in the mental health sector. Due to the positive global perception of the Philippines' primary care workers and the rapid turnover of trained mental health workers, there are issues with employee retention. After nurses and social workers are trained, they usually work in other economies.

In terms of financing, the government spends 0.2% of the total expenditures on mental health facilities (WHO, 2019). Since mental health care needs to be integrated into health services, most rural health units are using the mhGAP to assess and manage common mental health disorders. They hope to capacitate and equip more primary healthcare workers and non-specialists with the help of the mhGAP.

Although psychotropic medication is free to all patients through the Medicine Access Program for Mental Health (MAP-MH) of the Department of Health, the challenge is on the prompt provision or delivery to the service users. The Philippines has 7,614 islands and the logistics for bringing this medication to some of these islands is a problem and a challenge.

Another stumbling block is the fact that several information subsystems are currently being used in the Philippines, making it difficult to unify the data and statistics about the mental health system.

The community mental health model was initiated in individual island groups, such as Luzon, Visayas and Mindanao, where the emphasis was put on prevention of mental health problem and promotion of mental health and wellness at the community level. This included destigmatizing mental illness, erasing discrimination, the early detection of symptoms, community-based psychosocial rehabilitation, and preventing relapse.

There have been significant legal developments recently as well, including a standalone plan for mental health that was published in 2016. In 2018, the Philippines passed a mental health law, for which the corresponding implementing rules and regulations is also in place.

The Philippines' mental health act establishes the participation, roles and responsibilities of other government agencies, specifically the Department of Social Welfare and Development, Department of Education, and Department of Labor and Employment. This act stipulates the importance of including preventive and promotive mental health programs in elementary and secondary education curricula. It consists of the participation of private sectors and the promotion, prevention and rehabilitation of patients with mental health problems (Department of Health, the Philippines, Unknown).

Individuals and civil society are empowered through their representatives in the Philippine Council for Mental Health. They have a spot in the regular meetings and in the drafting of the Philippine Mental Health Act. Patients can form their own support groups and be recognized by the Philippine Council for Mental Health. They can participate in the development of legislation and of clinical practice guidelines for the treatment of psychiatric disorders.

Finally, there is also a forthcoming mental health research agenda in the works. There have been improvements in the psychiatric residency training program. In several psychiatric institutions and schools, training residents must be assessed before completing the program.

5.8. Thailand

The representative from Thailand, Dr Nattakorn Jampathong, provided information about suicide rates, data collection and climate change.

Thailand has a population of about 65 to 67 million inhabitants. It currently has 20 state-run psychiatric hospitals and one private psychiatric hospital. While the Strategy and Planning Division of the Ministry of Public Health asserts that the suicide rate of Thailand is not high (6 in 100,000), the WHO states that Thailand has a suicide rate of 16 per 100,000 inhabitants (WHO, 2017). This number is much higher than it is in other economies in Southeast Asia and is also higher than the official figure.

The government determines the suicide rate from death certificates. This could explain the difference between the data provided by the government and the WHO. It is also possible that some data is missing, and suicides could be underreported elsewhere in the world.

According to the Ministry of Public Health, the official suicide rate has been steady for the last eight years at around six suicides per 100,000 inhabitants, though it has been increasing slightly. The suicide rate is four times higher in men (10.29 in 100,000) than in women (2.5 in 100,000). Nevertheless, suicide attempts among women are four times higher. This disparity is explained by the effectiveness of the methods that men use.

Individuals over 30 years of age are most at risk. Suicide rates among adolescents and young people are below six in 100,000, while the rate is higher in older populations. Adolescent suicide, however, receives more media attention, which leads to misconceptions regarding the prevalence of suicide among teenagers and young adults.

Chiang Mai has the highest suicide rate among the elderly in Thailand. Overall, the north of this economy has the highest suicide rate at 10.54 in 100,000 inhabitants in 2016. Most individuals choose to commit suicide by hanging.

A seasonal suicide pattern repeats every year. The first six months of the year (January to June) bring 15 to 20% more suicides than the six-month period from July to December. Suicides peak in April, which is summer in Thailand. The rates rise again in July, albeit to a lower degree. Data shows that an increase of one degree Celsius in temperature leads to 0.05 more suicides per 100,000 inhabitants, which is equivalent to 20 to 30 suicides per year.

Among the working population, the leading cause of suicide in Thailand is problems with interpersonal relationships, such as arguments, scolding, love and jealousy. Together, these account for over 75% of suicides. Only 12.23% of suicides can be accredited to depression, while psychosis accounts for 11%.

In the elderly population, problems with interpersonal relationships account for 53% of suicides, while chronic illness leads to 23% of suicides. Depression is the cause of 17.7% of suicides within this group.

5.9. Viet Nam

The representative from Viet Nam, Dr Linh Trinh Thi Ngoc, described the state of mental healthcare in this economy.

In 2018, Viet Nam had a USD 210.2 billion GDP, which represented 0.4 of the world's economy. It has a population of 87 million people, 35.8% of whom live in cities. The average age in Viet Nam is 30.9 years, and 70% of the population is of working-age. There are 6.08 hospital beds per 100,000 people (Vuong, Van Ginneken, Morris, Ha & Busse, 2011).

Mental health needs are significant in Viet Nam as nearly 12 million people require mental health services, of which almost three million people have a severe mental health disorder. 34.3% of these patients suffer from anxiety and stress, 21.4% from depression and 14.2% from schizophrenia. Mental health problems have been increasing by 13.6% per year and 20% of students in primary school suffer from stress (Vuong, Van Ginneken, Morris, Ha & Busse, 2011).

In Viet Nam, 80% of people suffering from mental disorders do not seek treatment. There is only one psychiatric doctor per 100,000 patients. Viet Nam has more providers than most Southeast Asian economies, but the numbers are still quite low. Singapore, for example, has 3.5 doctors per 100,000 inhabitants.

Table 2: Mental health workers per 100,000 population 2014

Country	Psychiatrists in mental health sector (per 10,000)	Nurses working in mental health sector (per 10,000)	Social workers in mental health sector (per 10,000)	Psychologists in mental health sector (per 10,000)
Bahrain	4.84	22.69	0.74	0.74
Bangladesh	0.13	0.27	0	0.03
India	0.3	0.12	0.07	0.07
Indonesia	0.29	2.57	0.05	0.18
Laos	0.03	0.26	0	0
Malaysia	0.76		0.84	0.89
Myanmar	0.29	0.25	0.01	0
Pakistan	0.31	15.43	2.32	1.09
Philippines	0.46	0.49	0.07	0.07
Singapore	3.48	17.73	1.04	1.23
Sri Lanka	0.36	2.74	0.17	0.12
Thailand	0.87	4.46	0.34	0.72
Vietnam	0.91	2.92	0	0.09

Source: World Health Organization

The Vietnamese government has mental health initiatives in governance, investment, leadership and evidence. It follows four strategies, including the National Mental Health Strategy for 2015 to 2020 (vision to 2030), the National Strategy for Prevention and Control of NCDs 2014-2020, the Convention on the Rights of Persons with Disabilities (CRPD), and the Health Information System Development Strategic Plan 2014, which includes the National Survey of Mental Health. The sectors working on mental health issues include not only the Ministry of Health but also the Ministries of Social Affairs, Education and Training. Viet Nam also follows the guidelines of international partners, such as the WHO.

The government has four mental health objectives for the period from 2011 to 2020:

    a. Strengthening social protection centers to provide better care and rehabilitation
    b. Establishing community-based facilities for prevention and treatment
    c. Developing more and better human resources for social assistance and rehabilitation
    d. Improving public awareness of mental health issues

The health system in Viet Nam affords several advantages. For example, current legislation protects the rights of patients, and the government has made efforts to promote equal access to mental health services. Most psychotropic medicines are available at health facilities, and the mental health sector has formal links with other industries. Finally, mental health providers interact with primary care staff.

The health system's main weaknesses are inadequate mental health facilities and the current focus on urban hospitals instead of rural communities. The implementation of human rights legislation is still weak, and primary care providers do not receive sufficient training. Finally, family and consumer associations do not exist in Viet Nam, and the mental health information system is still insufficient.

In recent years, the government has tried to promote community-based treatment for mental health at the local level. The project establishes an integrated mental health network connecting the provinces and prioritizes raising public awareness, early detection and increasing access to treatment centers. This benefits patients and families from underprivileged backgrounds and remote areas. The project also ensures that serious mental health illnesses such as schizophrenia, epilepsy and depression are diagnosed and treated for free. Viet Nam complies with the WHO recommendations to reduce large scale psychiatric hospitals and provide community-based management to mentally ill patients.

Lessons from the past decade include the need for a legal process that protects people's human rights when it comes to mental illness. Mental health should be integrated into the general health system. Finally, stakeholders need collaborative networks to avoid fragmentation. These must include families, hospitals, community health workers, NGOs and traditional healers.

Prioritizing mental health services for people with severe and persistent mental disorders is vital. This priority requires strong leadership and the involvement of mental health professionals in policymaking. The overall mental health budget should also be increased.

6. Strategies and Processes for the Implementation of Community Mental Health Models

6.1. Implementation of Community Mental Health Services in Chile

Professor Ruben Alvarado is a psychiatrist with a Master of Public Health and a PhD in Psychiatry and Community Care. He is a professor and researcher of the Mental Health Program in the School of Public Health of the Faculty of Medicine of the University of Chile (Santiago, Metropolitan Region). He is the Director of several international collaboration networks, including RedeAmericas (the regional network for mental health research in Latin America), and the Consortium for Stigma Research in Mental Health and Substance Use Issues in the Americas.

The purpose of the presentation was to explain the reform of mental health services in Chile. It focused on understanding the key factors of the implementation process. This helped identify which elements are important for the stakeholders, within their culture and their context.

System: Current context

Chile has an estimated population of 17 million inhabitants, with a GDP of USD 25,000 per capita. Chile's Health System started in 1952, covering 95% of the Chilean population. It was created with a strong resemblance to the National Health System of England. It is important to mention that primary healthcare was integrated into Chile's Health System from the beginning. As shown in the diagram of the general health network below, the community is in an equal relation with primary healthcare, community mental health centers and services for hospitalized users.

Figure 14: Integrated Network of Mental Health Services in the General Health Network
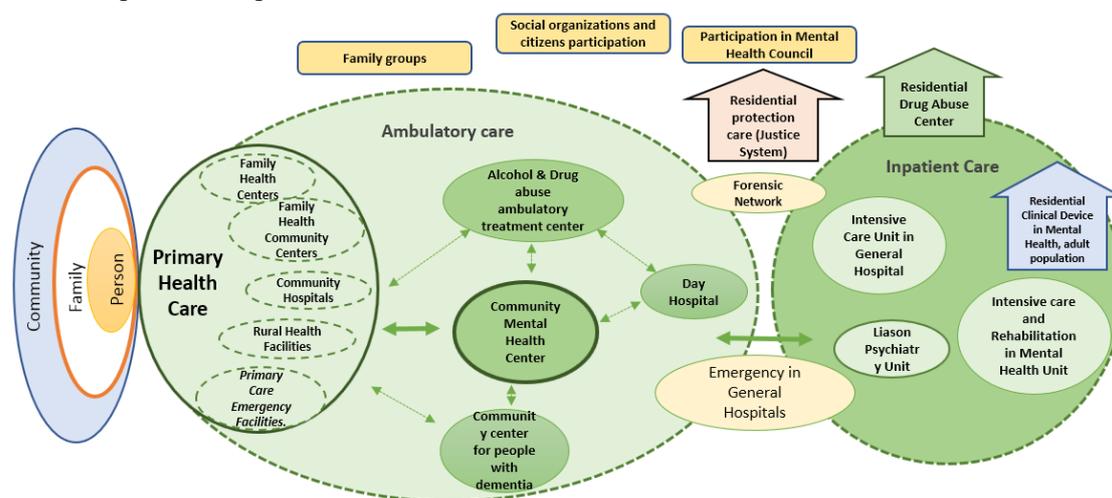
Source: Alberto Minoletti, Managing Mental Health System Complexity in Chile, conference delivered in the 13th Conference of the European Network for Mental Health Service Evaluation 2019 (ENMESH)

Community mental health centers have psychiatry services for adults and children and have psychologists, social workers, nurses and technical staff available. This improvement is at the core of Chile's reform process. Within a few years, this economy started adding day hospitals and specific units to provide treatment for people with drug and alcohol abuse problems.

Currently, 80% of healthcare services are provided within the public healthcare system and 20% within the private system, which works with private insurance companies and private healthcare providers. The private system is usually expensive, and most people cannot afford it, which is why the public healthcare system is essential. The development of a private system only happened 30 years ago, during the military dictatorship in Chile.

History

Chile has developed three mental health plans to guide its policies (MINSAL, 1993; MINSAL, 2000; MINSAL, 2017). In 1993, Chile started transforming some primary health centers created during the military dictatorship into community mental health centers. Urgent care did not exist at that time, nor did mental health programs within the primary care teams. The goal was to take advantage of the existing infrastructure and to start changing it to provide primary mental healthcare.

During the nineties, these pilot experiences carried out in the southern part of Santiago became guidelines for the rest of the economy. This model also served to identify the problem, barriers and mechanisms to proceed. This experience was helpful because it was adaptable to the rest of the economy.

After this first stage, the expansion of community centers took place. This process contributed to increasing coverage and proximity of services to the places where individuals live. At the same time, weaknesses were assessed. Community centers serve regions with approximately 21,000, 60,000 and 100,000 inhabitants. Each one of these community centers is associated with several primary care centers.

In 2001, Chile started incorporating mental health services into the first level of care, using a program to treat people with depression disorders. At the beginning, they started with 15 primary health centers, and after four years they were able to implement the program in all primary healthcare centers.

In 2019, this economy turned its attention to dementia and to the mental health of inmates. The first study of the prevalence of mental health issues in prison started, and Chile developed a unique system for providing mental healthcare to people in jail. Currently, Chile is developing specialized centers for people with dementia, and is also implementing mental healthcare in general hospitals.

Changing the care model

There are three psychiatric hospitals in Chile, two of which are in Santiago and one of which is in a region near Santiago. Part of this change included reducing the number of beds in these facilities, especially in one of them, despite some reluctance from representatives from the long term stay facility.

The work is still far from achieving the community model. For example, residences for individuals are available throughout Chile. However, upon further evaluation, it seems that the same practices as in psychiatric hospitals are repeated in some of the residences. Thus, there is a need to visit the centers, start working directly with the people and to transform the practices of care. There is still a need to change the mindset and identify patients as users and to develop to integrate new actors into their recovery, such as peers who are experts by experience.

Evaluations

Evaluations were a key element throughout the implementation process of the mental health reform in Chile. In the year 2002, the evaluation of the Depression Program in primary healthcare centers was carried out (Araya et al., 2003). The assessment showed the effectiveness and the difficulties of the program, as well as provided the cost of care per individual. It also pointed out the issues with the patient referral system. The data gathered from this evaluation proved essential when it came time to justify the program's budget with the Ministry of Finance, which then provided resources to expand the program to the whole territory.

In 2005, the government developed a tool to evaluate the service network standards and measure the degree of advancement of the reform throughout the year. First, they performed an initial evaluation, followed by an assessment of all the networks through the economy (Alvarado, Minoletti, González, Küstner, Madariaga & Sepúlveda, 2012).

This evaluation was followed by the Explicit Health Guarantees (GES, for its Spanish initials) assessment. GES policy mandates providing healthcare to people with specific disorders, such as schizophrenia (Ministerio de Salud, 2005), depression, substance abuse, bipolar disorders and Alzheimer. This evaluation aimed to see where the gaps in providing mental health services were in order to improve them. Specifically, it studied how the law worked in the domestic program for first-episode schizophrenia (Markkula et al., 2011).

The earthquake which took place on 27 February 2010 allowed the economy to design an instrument to evaluate the response capacity it had for the networks that corresponded to the areas surrounding where the earthquake had occurred (Vitriol et al., 2014).

In the context of the WHO QualityRights initiative to improve quality and promote human rights, a quality evaluation was performed in 2014 to identify the policies that had worked well in community mental health centers (Minoletti et al., 2015). A current project focuses on the evaluation of stigmas and innovative strategies to reduce them in primary care and community mental health teams.

With help of the evaluation model from Thornicroft and Tansella (1999), it is possible to do an assessment on the domestic, local and user dimension of the processes, analyzing their input, process and outputs. According to the assessment, community mental health services get better results than treatments in hospitals. Nevertheless, it also found some areas for improvement, such as general healthcare, use of the recovery approach and psychosocial interventions. In fact, there is also a lack of professionals who specialize in this topic.

The most recent domestic assessment stressed the importance of mental healthcare access inequalities. A specific technique was used to measure this subject within 700 communes of the economy. There is also an unequal distribution of human resources in day hospitals.

Almost ten years later, Chile is working to adapt the useful information gathered from previous experiences to bring them to other non-APEC economies in South America.

Necessary conditions

To conclude, it is important to reflect on the conditions that were necessary for this process. Two relevant documents were fundamental for the Chilean reform: The Declaration of Caracas in 1990 and the World Health Report (World Health Organization, 2002). They both guided Chile's policies up to these times, and informed the creation of Chile's three plans.

Alberto Minoletti, a leader of mental health reform, provided five strategies which guided the process: First, having a long-term vision divided into three plans. Second, integrating mental health as one more component of the primary health network. Third, increasing economic resources. Fourth, improving the response capacity of primary care centers, especially for common mental problems. And fifth, strengthening the evaluation information system to support faster decision making. The continuity of learning processes between the leaders and their students was equally important, as were the feedback contributions made to the mental health plans.

Scientific evidence identified the magnitude of the problem. This supports the idea that looking for cost-effective solutions and evaluation is critical to convincing politicians and needs to be done. If it is not done, it means political negligence. This data should also be shared with the team at the Ministry responsible for this issue to raise awareness on the topic and make it understandable. As the agreements with the Ministry of Finance demonstrate, it is important both to have clear evidence and to use that evidence effectively. Having efficient financial sustainability made it possible to extend the implementation of some programs. This means services in the community increased, healthcare services were delivered to users with common mental health disorders in primary healthcare centers, and the number of beds in psychiatric hospitals was reduced.

Another relevant factor is the role of sustained long-term leadership, which means maintaining the same team. Leaders need to communicate the decision-making process effectively and

detect emerging opportunities to negotiate political agreements. This negotiation does not take a large amount of time, but requires that the leader notice the opportunity, know why a new policy is relevant for the whole system and promote the consideration of mental health in it.

It is crucial to remark that leadership needs to combine participation meetings with groups, with individuals or with trips to visit locations where their teams can show their work or share experiences. It is highly recommended to build strong sustainable networks and strategic alliances at many levels within the Ministry, within governments and other external organizations.

6.2. Mental Healthcare Reform Process in Peru

Dr Yuri Cutipe delivered a presentation entitled "Mental Healthcare Reform Process in Peru" in which he described the economy's milestones and present situation.

Peru has a fragmented health system. Out of 32 million inhabitants, about 10 million people are covered by the insurance they receive from their employer, 20 million are covered by the state insurance and 2 million either have private insurance or do not have insurance. Politically, the economy is decentralized. Regional authorities are elected and have the responsibility for health services during their mandate. The role of regional authorities is important to consider for the implementation of service policy in a given economy.

Between the 1980s and the 2000s, Peru had an intense period of terrorism and political violence. Victims of violence and political violence that affected almost 90% of all the territories in the economy began to organize themselves (CVR, 2004). Citizens demanded rights and began the mental health reform process. The Peruvian government had to implement a plan to repair the damage. The victims of political violence demanded, housing, employment, health and, specifically, reform of the general health system including mental health.

In 2015, Law 29889 was approved. This was not a law specifically for mental health, but rather the amendment of one of the articles of the general health law that established the reform of mental healthcare, guaranteeing the rights of people with mental health issues. The Peruvian government was mandated to create mental health reform. This law also demanded a mandatory community mental healthcare model. This model meant a paradigm shift from the old hospital- and disease-centered model. It forced the providers to look outside the hospital's walls into the real determinants of the population's future.

The idea is to fight for the well-being of the person, shifting from a psychiatric hospital model based on isolation and social exclusion in which the person was considered simply an object of intervention. Peru has transitioned to a model in which the citizen is viewed as an individual with mental healthcare needs through the implementation of a network of services that follow an interdisciplinary teamwork logic with the expectation of the user's total recovery. This not only helps alleviate the person's suffering, but also makes it possible that they will legally make use of their rights like any other citizen.

This paradigm change influenced mental health managers to emphasize coverage and quality of care and to reexamine indicators, such as the rate of psychiatrists and psychologists per number of inhabitants and working hours. According to the new policy, the main goal was to increase mental healthcare coverage and improve the quality of care. This context makes it possible for persons with a mental disorder, especially a severe one, to be viewed from the perspective of social inclusion.

Before 2011, the population that received coverage through the state insurance system (SIS) had inadequate coverage of less than 10%. Between 2012 and 2014, the state insurance covered four conditions (depression, psychosis, alcoholism and anxiety) and increased the coverage to almost 14%. This was challenging because the system could only provide coverage at three psychiatric hospitals.

The state insurance, or funding, is not enough to pay for coverage if there are no services available. Since 2015, when the law was approved, the implementation of mental health services has started and the coverage has increased, growing to 17% in the first year and reaching 26.1% by 2018. In the year 2015, Congress passed a law to start the implementation of new services.

Figure 15: Annual care coverage for people with mental health problems.
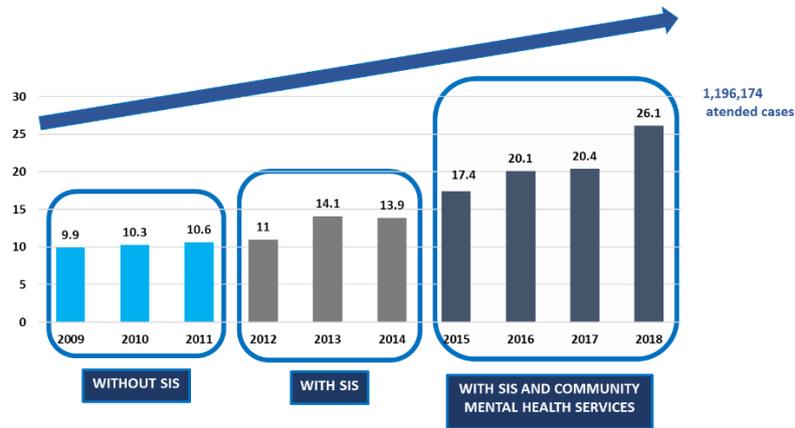
Source: OGTI – MINSA March 2019
Epidemiological Studies of Mental Health NIMH HDHN
Elaboration: Mental Health Technical Team, MINSA

By 2018, Peru reached 30% coverage in psychotic disorders.

Figure 16: Care coverage for people with psychotic disorders
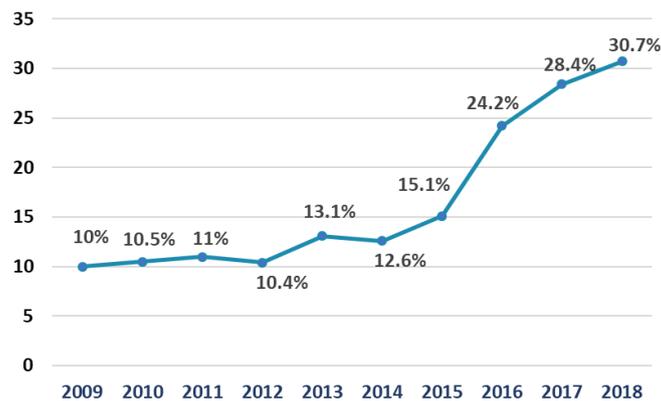
Source: OGTI – MINSA March 2019
Epidemiological Studies of Mental Health NIMH HDHN
Elaboration: Mental Health Technical Team, MINSA

From the point of view of the Peruvian government, this data is sufficient to ensure that the investment makes sense. It makes sense not only for the public treasury, but also for the population. This proves that Peru should have a reliable primary and secondary healthcare system, well distributed over the territory, available without cost to the patient. Compared with psychiatric hospitals, community mental health networks can develop homogeneously in all the economy's territories.

Healthcare networks need a balance of services in their territory. The bylaw of 2015 established an area of 100,000 people for each community mental health center, considering population, family and community-based organizations. Each of these actors works very closely with the general hospital, with the inpatient unit and with the day hospital, as well as with shelters, homes and residences for people who do not have a family and with a psychosocial rehab center. It is

essential to consider following these guidelines at psychiatric hospitals in Peru, otherwise people will have to travel many hours and kilometers and risk getting lost on the way to a rehab program in Lima.

Figure 17: Community mental healthcare networks integrated into the territorial organization of general healthcare networks
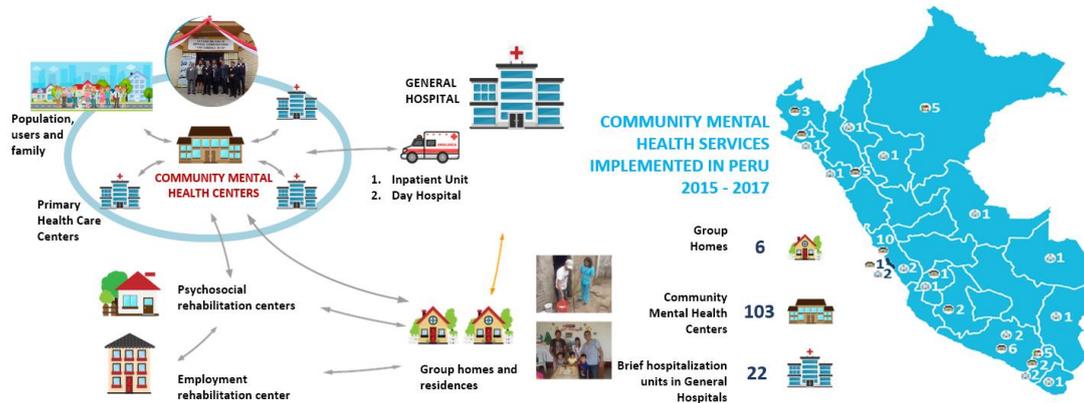
Source: Speaker's presentation

Peru presented some remarkable results as well. During the period between 2015 and 2019, there were six group homes. This year in September, the Government will open 54 additional group homes and have implemented 103 community mental health centers; in 2018 they implemented 75. By 2019, Peru has the funds and is opening 48 other mental health centers and adding eight units for hospitalization to the more than 100 general hospitals in Peru (MINSA, 2018).

The lessons learned from this process include the need to be creative, recognize the international experience and learn how to balance the services that populations need in each of the territories. For the Peruvian experience in the implementation of mental healthcare reform, it was critical to work closely with the Chilean Government through the Mental Health Directorate of the Ministry of Health. During these times, when social, political and mental health are valued, it is essential to understand that mental health treatment is expensive, but the government has a responsibility to provide care just as it does to provide education.

6.3. Proposal for a Transformation of Mental Health in Mexico

Dr Evalinda Barron delivered a presentation entitled "Proposal for a Transformation of Mental Health in Mexico" in which she provided background about a change for mental health in this economy.

The actual status quo in Mexico's mental health system presents several issues. On the one hand, the primary healthcare network is not well integrated with mental health services. Additionally, general doctors lack sufficient training, and there is not enough multidisciplinary teamwork. On the other hand, it seems that several government actions were focused on trying to tackle addictions problems with a "crime and punishment" approach, instead of considering substance abuse as a mental health issue. On a more macro level, there are problems with the integration of the health system as such. Federal and state government institutions do not develop an effective plan with well-defined roles and responsibilities due to their different (or lack of) regulative frameworks. Simultaneously, there is a problem with integrating the system, since private and state-run facilities operate within isolated subsystems.

The system faces fragmentation challenges due to the weak mental health leadership and institutional segmentation of mental health and addiction policy. The persistence of the psychiatric hospital model of care and the lack of results and impact evaluation of domestic

policy has also made it difficult to improve the budget gap. Stigma, discrimination, and the lack of integration of mental health services with human rights standards have also hindered providing high-quality services.

The first proposal in Mexico concerning mental health appeared in 1986 with the National Council Against Addictions (CONADIC, for its Spanish initials). Its work focused on combating addictions within a police framework. Their control activities were based on school talks, but, unfortunately, the services provided in schools were not well aligned with the healthcare system.

Afterward, the administration created in 1996 the Mental Health Coordination (CORSAME), in 2000, the Mental Health Services (SERSAME), and 2003 the Psychiatric Care Services (SAP). SAP provided federal services through 03 psychiatric hospitals and 03 community mental healthcare centers. Nevertheless, the work carried out in hospitals and community health centers outside its jurisdiction depends on each state, so the federal government could not properly regulate it.

In 2007, the creation of Medical Units of Care and Addiction Prevention (UNEME-CAPA) within CONADIC was a remarkable achievement. Those are units specialized in addiction distributed all over Mexico, which have staff including psychologists, social workers, and other professionals (Secretaria de Salud & Comision Nacional contra las Adicciones, 2015). Although the program was well established, there have been some issues during supervision.

Unlike precedent cases, where there were only isolated efforts to improve mental health services, there is currently technical and political consensus -even at a legislative level- to transform mental health. This initiative consists of a new system, guided by National Development Plan (Secretaria de Gobernacion, 2019) and the National Health Plan (Secretaria de Salud, 2019). According to the Alma Ata declaration, this system poses a strong emphasis on primary health care and its role in mental health services.

For this purpose, a new entity that depends on the Health Secretary will be created. It will gather all the functions that were previously distributed among the Psychiatric Care Services (SAP, for its Spanish initials), the National Council Against Addictions (CONADIC) and the National Council of Mental Health (CONSAME) under one entity. Consequently, the new National Commission of Mental Health and Addictions (CONASAMA) will lead all mental health tasks through regulation, financing, and services provision.

This proposal intends to create new Centers for Mental Health and Substance Abuse and establish a new mental health system where all mental health and addiction centers work together with multidisciplinary and specialized teams. Besides, training programs for healthcare providers -based on mhGAP- will be adapted and evaluated to meet the economy's domestic and regional needs. It plans to include follow-up and telementoring appointments with doctors to ensure that the mental health centers work correctly with the people from the community (Secretaria de Gobernacion, Unknown).

7. Psychosocial Rehabilitation in Korea: Principle and Practice

Dr Tae-Yeon Hwang delivered a presentation entitled "Psychosocial Rehabilitation: Principle and Practice." In this presentation he provided important information about the topic and also provided guidelines for rehabilitation treatment.

Standard care model and the rehabilitation model
The medical model considers psychotic disorders to be brain diseases. This diagnostically driven approach considers biological intervention and pharmacotherapy as the primary treatments. Their principal goal is to reverse the symptoms. In the setting of typical standard care, which principally focuses on symptoms, a patient that suffers from hallucinations might lose their job and have their social network break down. Because of this crisis, they will go to a hospital, where they will receive little psychosocial support and become isolated from society.

In this sense, the mental health reform recommends a transition from the medical treatment model to the rehabilitation model. This implies a paradigm and value shift to focus on the patient's function. Instead of suggesting hospitalization, it concentrates on individualized plans, community support, and building strengths instead of focusing on deficits. In the case of psychosis that produces chronic functional impairment, the user's strengths should inform the treatment. Training these skills will lead to lifestyle changes that will maximize the user's function in the community and lead to their reintegration into the community.

Definition, fundamental concepts, objectives and strategies
The WHO defined PSR (Psychosocial Rehabilitation) as the process that facilitates the opportunity for individuals to reach their optimal level of independent functioning in the community (World Health Organization, 1996). Anthony, Cohen & Farkas (1990) define it as "assisting persons with long-term psychiatric disabilities to increase their functioning so that they are successful and satisfied in the environments of their choice with the least amount of ongoing professional intervention."

One of the fundamental concepts of PSR is a sense of hope. Mental health professionals instill hope for recovery through a rehabilitation relationship. PSR should also focus on pragmatism, that means helping patients with their daily life. The third concept is skills-training to achieve community adjustment. The fourth is the integration of psychiatric treatment and rehabilitation as medication works best in conjunction with practical psychosocial interventions. The fifth concept is continuity of care, which warrants flexible, timely, and long-term support. The sixth concept is community integration by embracing the principle of normalization with the community's ongoing support. Finally, stressing the importance of individualized assessment increases the attention to the preferences of the users.

In addition to symptom reduction, PSR's objectives are the reduction of the effects of hospitalization, such as losing social skills and interpersonal networks and increased family and social support. The hierarchy of treatment outcomes for chronically mentally ill people places maintaining the stability of the symptoms as the principal outcome (Schooler et al., 1996) and recovering the functioning of the patient in the community as the highest outcome.

On an individual level, PSR strategies include psychiatric treatment, independent living and social skills training, psychological support to patients and their families, housing, vocational rehabilitation and employment, social support networks, and leisure. At a service and human resources level, PSR strategies include mental health policy, fund allocation, improvement of institutional and residential settings, training for staff, and quality assurance. At a societal level, the strategies are the improvement of legislation, consumer empowerment, improvement of public opinion and attitudes, and the removal of legal and informal barriers (World Health Organization, 1996.)

Recovery model and principles and objectives
The definition of recovery is that it is a "journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential" (SAMHSA, 2004). The model considers that patients can redefine themselves through life roles and relationships. In this sense, professional

interventions propel progress towards recovery by strengthening hope and optimism, empowerment, self-responsibility, insight and determination, spiritual strength, and self-help and social support.

How do psychosocial interventions work?
Psychosocial interventions involve non-pharmacologic interventions. These interventions aim to decrease symptom severity or distress, avoid hospitalizations and improve psychosocial function. They aim to teach new skills and help individuals take greater control over their lives. Some of the evidence-based practices in PSR include assertive community treatment, family intervention/psychoeducation, supported employment, skills training and illness self-management, cognitive interventions (cognitive therapy and cognitive rehabilitation), and integrated treatment of substance use disorders and severe mental illness.

The first functional outcome in PSR is skill acquisition, which leads to success in psychosocial rehabilitation. The second is the performance of constituent skills, allowing patients to solve social problems and acquire instrumental skills. Finally, community outcomes have to do with developing a social network and living independently in the community.

Decision making model
In this respect, it is essential to understand the four decision-making models that contribute to fostering the user's autonomy. In the Paternalistic Model, the doctor has all the information and selects the therapy. The patient can only accept this decision. In the Shared Decision-Making Model, the doctor shares all the information and treatment options. They can recommend options but decide on the therapy with the patient. In the Informed-Choice Model, the doctor shares all the information but does not make a decision.

The ideal sequence of the Shared Decision-Making Model involves the doctor communicating that there is a decision pending and offering to make the decision together with the patient. The doctor should also communicate the existence of different options and provide sufficient information. After obtaining a response from the patient, the doctor will negotiate and arrive at a shared decision. Finally, they will draw a plan for the implementation of the decision. This process involves verbal communication and non-verbal communication. The following framework of the Ladder of Engagement helps to understand the patient's involvement in designing the program:

Figure 18: Ladder of engagement
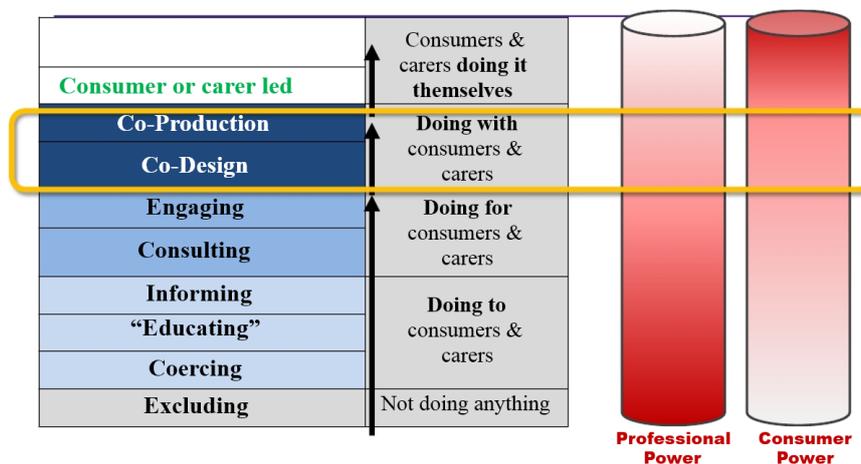
Source: Speaker's presentation copy

Psychosocial and community mental health programs in Korea
In Korea, according to Dr Hwang, most case managers are psychiatric nurses. 70% of the services are direct, involving psychoeducation, outreach programs to homes and job sites, individual counseling and social and familial support. 30% of the services are indirect and include community networking, referral services or social security entitlement.

Assertive community treatment involves a multidisciplinary team that shares responsibility for the patients. It is a 24-hour, 7-day-a-week program. It has a small staff to patient ratio of less than one to ten. This allows these teams to provide highly individualized services and uninterrupted care.

Figure 19: The integrated community care system for people with mental disorders
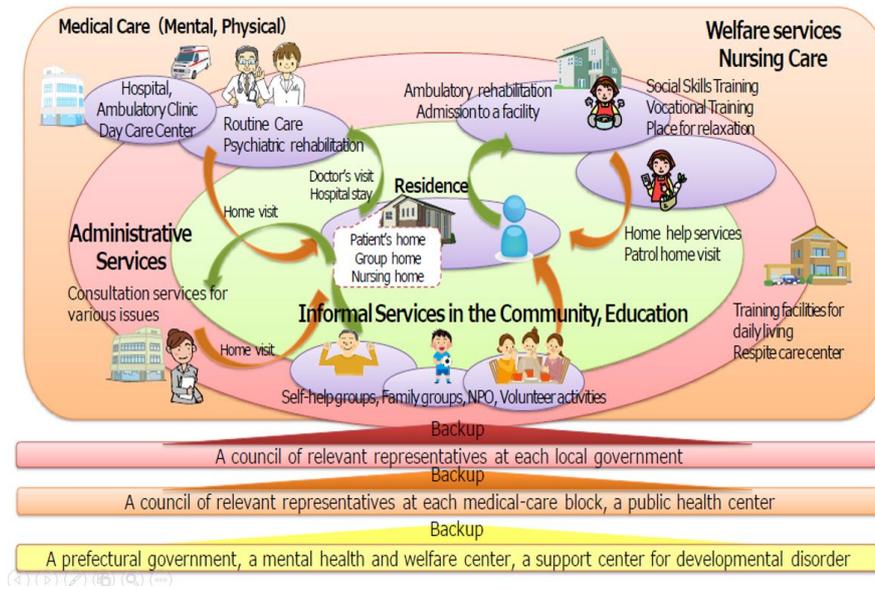
Source: Speaker's presentation copy

Social skills training
One of the community care system elements is the Social Skills Training (SST), which is usually conducted in groups, although it can also include individualized skill training. It involves teaching skills in a standardized format.

    a. Establish a rationale for learning the skill
    b. Break the skill into components and discuss each
    c. Demonstrate the skill in a role play
    d. Engage a client in a role play to practice the same skill
    e. Elicit positive feedback from other group members and provide feedback about steps of the skill that were performed well
    f. Provide corrective feedback for next time
    g. Repeat with new skills and situations and engage other clients

The timeline of personal goal attainment during group SST involves, first, being able to remain in the group for the entire session. Then, the focus is on participating in role-plays, the basic conversation skills module, and the friendship and intimacy module. Eventually, the patient might date another patient and even become engaged.

Patient empowerment program for schizophrenia
Service workers and family associations developed the Patient Empowerment Program for Schizophrenia (PEPS) with a pharmaceutical company's support (Woo et al., 2018). Since antipsychotics might have physical side effects, PEPS provides relevant information to users, so the program helps them think about physical illness and mental illness together.

Family psychoeducation comprises a group of multiple families that gathers once a week for a total of eight to ten sessions. It provides information that is useful for daily life with people with schizophrenia. Family psychoeducation allows for an extended community stay, lower utilization of in-hospital services, reduced anxiety and increased stability and predictability of the family environment (Liberman, 2009).

Vocational rehabilitation

According to the Korea Employment Agency for the Disabled, mentally disabled patients have a 19.1% employment rate. They have a much lower employment rate than people with other types of disability, such as those with physical (45%) or visual (42%) disabilities. Some programs offer mentally ill or disabled patients the opportunity to work in factories, gas stations and bakeries.

The vocational rehabilitation programs connect the mental healthcare system to the job market. The spectrum of services for the mentally and developmentally disabled involve training about work tasks, prevocational training, transitional employment and supported education, among others. The hypothesized outcomes of vocational rehabilitation are generating employment and income for the patient. The distal outcomes are symptom reduction and increasing the life satisfaction of the patient.

Supported employment has competitive employment as its goal. It consists of a rapid job search without lengthy pre-employment training, the integration of rehabilitation and mental health, attention to users' preferences and continuous assessment.

Cognitive rehabilitation

Green & Nuechterlein (1999) developed the Complex Model, which shows how antipsychotic medications or cognitive/behavioral interventions influence basic neurocognition, such as vigilance, working memory and executive functioning. Neurocognition is very important for the functional outcome of the patient in the community. The emotional perception or coping skills developed by the patient are particularly important for the ultimate functional outcome in the community.

Cognitive rehabilitation is the therapeutic process of improving patient capacity to process and use incoming information to increase their everyday function. It aims to restore cognitive function and use compensatory techniques. It has three basic approaches, including a general stimulation approach, a functional adaptation approach and a process-specific approach.

In focused attention training, patients perform tasks like finding the differences between two photographs, which helps the cognitive rehabilitation of the chronically ill mental patient. They can also find specific images within a drawing or classify products according to the shop where they should be sold. Many cognitive remediation programs are now computerized.

In community-based PSR, the key interfaces between the community mental health service system and other health services include public health services, education and vocational programs, social services and residential services.

Figure 20: Key interfaces between community mental health service system and other health services
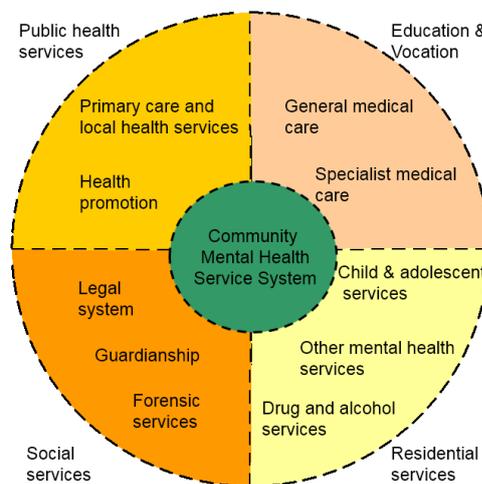
Source: Speaker's presentation copy

A combination of public and private collaboration is usually in charge of managing community mental health centers. The public health center provides the mental health budget. Then, they create a contract with the private sector, university or a mental hospital. This is because there are no trained mental health providers in the public health center. Private trained mental health professionals provide comprehensive mental health services at the community centers.

Community mental healthcare centers now include psychosocial medication programs. More recently, they have incorporated emergency or intervention services. The support of the government and local services allows the expansion of psychosocial rehabilitation programs. The total number of members increased by 28% between 2002 and 2006.

The paradigm shift from the Stabilization Model to the PSR Model involves moving from a limited vision for recovery to psychosocial rehabilitation and from focusing on stabilization to focusing on recovery. It also implies promoting active participation from the patient instead of passive participation and is patient-centered instead of clinician-centered.

8. Funding Strategies for Community Mental Health Networks

8.1. Achieving Sustainable Funding for Community Mental Health Networks

Professor David McDaid is an Associate Professorial Research Fellow in Health Policy and Health Economics at the Personal Social Services Research Unit at the London School of Economics and Political Science. He delivered a presentation entitled "Achieving Sustainable Funding for Community Mental Health Networks."

Underinvestment

A paper from the Pan-American Health Association published in 2019, from Vigo, Kestel et al Lancet called "Public Health" states that one of the reasons mental health does not obtain the resources it needs is the mistaken perception that mental health problems are a disease, a disorder or a group of disorders that have no impact on mortality. Mental health indeed has an enormous impact on mortality and leads to decades of lost life expectancy. Still, there is a perception, especially in economies with minimal resources, that the focus should be on immediately life-threatening illnesses.

Figure 21: Substantial contribution to years lived with disability

Source: Pan American Health Organization. The Burden of Mental Disorders in the Region of the Americas, 2018. Washington, D.C.

Context: Mental health spending

New Zealand is the APEC economy that spends the most on mental health as a share of its health budget (around 9%). In England, about 10% of the budget is spent on mental health, and some other European economies spend similar amounts. This rate might be ideal as a benchmark for funding, but some agree that it depends on how the money is spent. The US and Canada spend about 8% of their public health budgets on mental health and this rate goes up to 9.2% in some places. APEC economies from Asia, such as the Philippines, are already spending about 9.3% of their health budget on mental health.

Figure 22: Mental health spending in the Americas

Figure 1: Mental health spending *vs* GDP per capita
$β_2$=0·68 (95% CI 0·24–1·13). Linear model: Ln(% of government health expenditures spent on
MNSS)=0·68 × Ln(GDP) +−5·6; R²=0·26; p=0·0036. MNSS=mental, neurological, and substance use disorders,
and self-harm. GDP=gross domestic product.
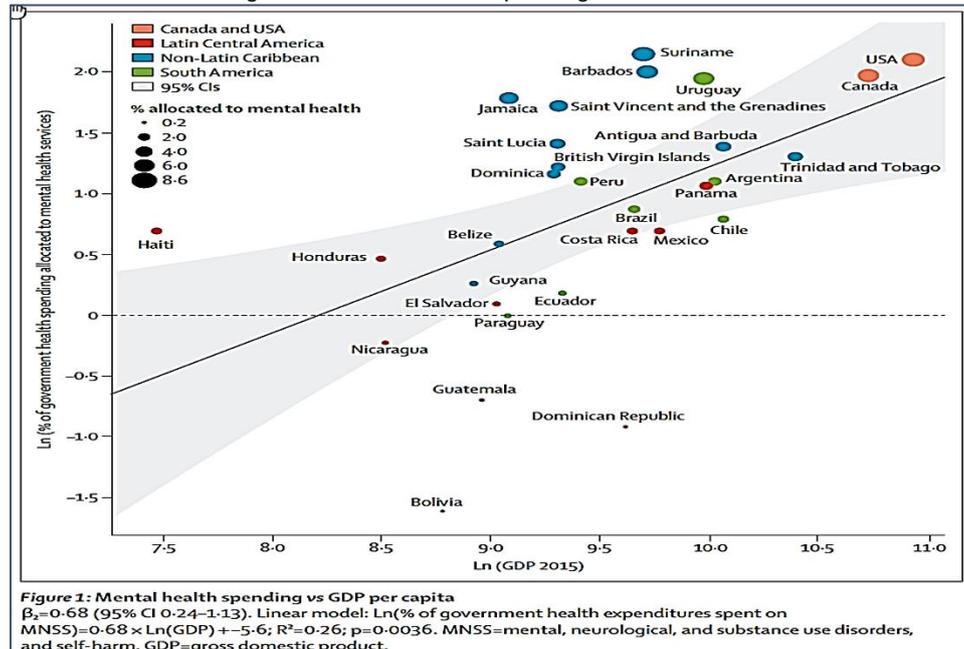
Source: Vigo, Kestel et al Lancet Public Health 2019

Not just about overall level of funding but how funding is used: Challenges

Economies usually compare the relative contribution of mental health problems to the burden of disease, but this perspective represents only one part of the picture. However, as the evaluation shows, it not only depends on the fact of spending the money but how it is spent. Hence, there is a need for fairness but also balanced funding. It is also fundamental to think about the responsibility for prevention costs and financing incentives to better integrate mental health into primary care.

There are different challenges that impact funding sustainability. What most people are worried about is if mental health receives its fair share of funds. Due to the change of paradigm, people also worry about rebalancing care, which means if funds are being shifted away from hospitals to community-based services. It is also important to fund mental health promotion and disorder prevention activities adequately. They are also essential for future funding as they can be studied to generate evidence on their effectiveness and return. In terms of management, it is critical to foster better integration of mental health services into primary care, as well as the shared management of physical and mental health problems.

Hospitals

However, there are certain barriers to the balanced care approach. For example, funds can be locked in hospitals, and it is not easy to release those funds. There is a series of incentives to maintain high bed occupancy. When a hospital closes, it does not mean the money transfers immediately to community mental health services, and this closure could be used as an excuse to reduce the budget. However, there should be an effort to transfer those funds. Also, it is important to note that hospitals may be a large employer in the area.

In England, social security and welfare payment systems are crucial. This system means that people get small amounts of money to live independently, and this was also used to move funds not only to healthcare but to other areas, such as social care. However, legislation and rules are needed to make this possible. This funding was also provided by other institutions such as Social Housing Associations.

It is probable that to rebalance the mental health system, reduce the number of hospital beds and increase community mental health services, more funds will be needed. Hospitals need to stay open while community mental health services are being developed.

Nowadays, England is going through a process to reduce the number of hospital beds. This process started in the 1960s, but closures did not happen until the late 1980s. This change is only evident on a large scale. For example, it takes about two years to close a hospital, move the funds from the hospital, and another five or six years to sell the hospital. The workforce is also something significant and retraining, voluntary redundancy and retirement should all be considered. Another issue was that primary care was not involved adequately, and there was not enough support. People ended up in the criminal justice system or returning to the hospital system because the community's support was absent.

Different financing mechanisms to support mental health available but context important to decide on approach

The purpose of the Emeralds project is to look at the organization of mental health systems. It looks at financing issues and performs a detailed analysis of how the financing works in several economies. The team looks at different potential mental health financing frameworks and develops an algorithm adapted to each economy's context. For instance, this is the framework for Uganda:

Figure 23: Emerald project´s conceptual framework for sustainable mental health financing. Emerald project´s mental health financing algorithm, adapted to the Ugandan context.

Fig. 1 Emerald project's conceptual framework for sustainable mental health financing. Emerald project's mental health financing algorithm, adapted to the Ugandan context
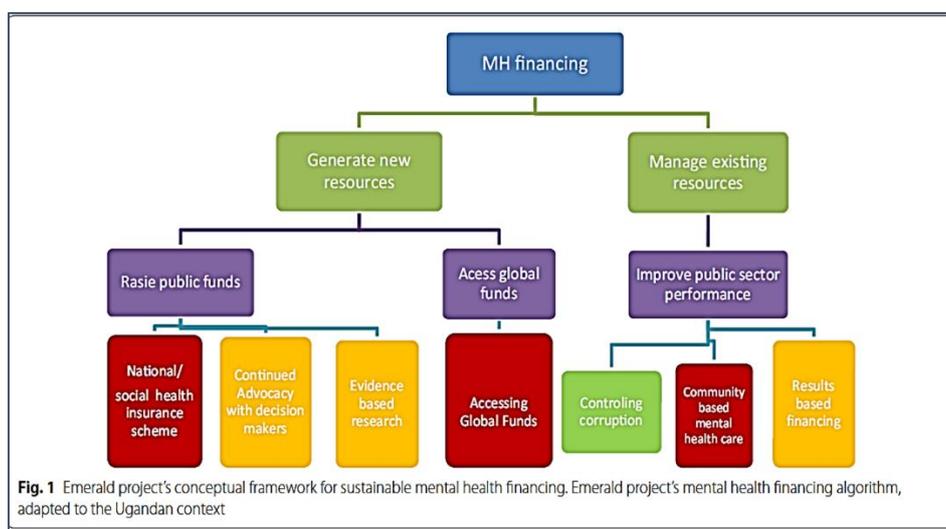
Source: Ssebunnya *et al. Int J Ment Health Syst (2018) 12:74*

According to the framework, Uganda's choices are between trying to raise public funds to social insurance, more lobbying, advocacy with decision-makers, or having more evidence-based research to persuade people to investments in mental health. Alternatively, they can try and access global funds, global funds for mental health.

Uganda is an economy that has limited ability to raise money through taxation for health. So, they decided that the most feasible alternative for Uganda was thinking about advocacy with decision-makers. They also emphasize the importance of corruption: How to make sure the existing money for mental health goes to mental health? How to minimize corruption? How to invest in community mental health care? How to link investment to evidence on things that work?

Flexible financing

In several European economies, mental health expenses are allocated to individual service users. Individuals do not always see a psychiatrist, but rather psychologists, or they take alternative therapy or non-clinical appointments. This budget for these services is more flexible, as it provides users the power to make more decisions about how they spend on their mental health.
Flexible financing could present significant opportunities. For example, in England, primary care doctors are paid extra money to manage the physical health of mental health users. This care

includes regular screenings and routine check-ups. This model is a different type of primary care because money is linked to individuals rather than to the budget for hospitals.

Financing of intersectoral actions

This lesson learned showed that there is a need for intersectoral financing. For example, this could involve having an organization such as the Ministry of Education agree to provide more funding for school mental health. This improves the outcomes for children in schools and the educational results (McDaid, Park, 2016).

Certain legal devices are needed to make this happen. This proposal acknowledges certain barriers, such as fragmented and cross-sectoral responsibility for implementation, funding actions, limited incentives for the non-health sector to invest in mental health and a lack of awareness of the importance of health and well-being in sectors.

On the other hand, some other factors could be significant to make this possible, including developing shared policy goals, building partnerships across sectors, legal, regulatory and financial mechanisms, providing evidence-based short-, mid- and long-term benefits and highlighting sector-specific benefits of action using their language.

Efficient use of existing resources: task-shifting

Task shifting is also at stake because there is no need to assign psychiatrists everywhere. Sustainability means sharing some of the tasks, as it has been shown in the Healthy Activity Program in India, where a behavioral intervention delivered by lay counsellors in primary care settings provided cost-effective outcomes (Weobong, Weiss et al. 2017).

Moral and economic imperatives for greater investment in community mental health services

Awareness of the impact of not taking action also represents a significant challenge, as does mentioning long-term community impacts (Bloom, Cafiero et al., 2011; Chisholm, Sweeny et al., 2016). The presence of poor mental health drives a further 50% increase in costs for treatment of type 2 diabetes, according to the *Five year Forward View for Mental Health* (2016); this is why investing early in mental health to prevent problems makes a difference.

Figure 24: Presence of poor mental health drives a further 50% increase in costs
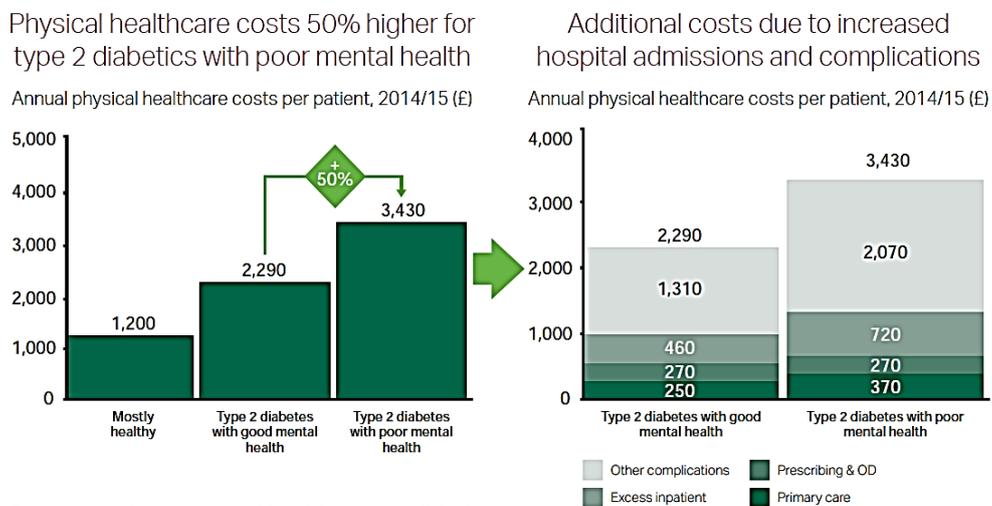
Source: Hex et all, 2012; APHO Diabetes Prevalence Model for England 2012; Long-term conditions and mental health: The cost of co-morbidities, The King´s Fund

Finally, it is important to show the return on investment. It makes a difference in persuading policymakers to invest in mental health and in securing funding. In different economies around the world, return on investments showed positive figures of between USD 3 and USD 5 for depression and anxiety disorder (Chisholm, Sweeny et al., 2016). The factors considered to reach these numbers were, for example, the cost-effectiveness of investing in awareness and prevention of mental health problems. This value is not only about the health system but also about saving human lives. The moral case and the investment case are complementary and could provide more significant results in community mental health services.

Table 3: Costs and benefits of scaled up treatment of depression and anxiety disorders, 2016-30

	Low-income countries (N=6)	Lower middle-income countries (N=10)	Upper middle-income countries (N=10)	High-income countries (N=10)	All countries (N=36)
Total population of countries analysed (millions, 2013)	443	2215	2101	992	5751
Depression					
Total investment (net present value, US$ million)	517	7164	20338	63503	91522
Average annual investment (net present value, US$ per person)	0·08	0·34	1·12	3·89	1·50
Health returns (averted prevalent cases)	6150311	25989404	25607740	15750268	73497723
Health returns (healthy life-years gained)	2234781	15692290	11414429	7567211	36908711
Economic returns (US$ millions)	1190	18799	52732	157022	229744
Value of health returns (US$ millions)*	991	21679	56435	178588	257694
Benefit to cost ratio (economic returns)	2·3	2·6	2·6	2·5	2·5
Benefit cost ratio (economic and value of health returns)	4·2	5·7	5·4	5·3	5·3
Anxiety disorders					
Total investment (net present value, US$ millions)	304	3797	8966	42668	55735
Average annual investment (net present value, US$ per person)	0·05	0·16	0·52	2·44	0·88
Health returns (averted prevalent case)	3395363	1659719	12980180	12077053	45052316
Health returns (healthy life-years gained)	416232	2220716	1711767	1604069	5952783
Economic returns (US$ millions)	824	11578	26691	129705	168797
Value of health returns (US$ millions)*	181	2966	8453	40409	52009
Benefit cost ratio (economic returns)	2·7	3·0	3·0	3·0	3·0
Benefit cost ratio (economic and value of health returns)	3·3	3·8	3·9	4·0	4·0

*Healthy life-years gained multiplied by GDP per person multiplied by 0·5.

Table 2: Costs and benefits of scaled up treatment of depression and anxiety disorders, 2016–30

Source: Chisholm et al 2016 Lancet Psychiatry

8.2. Budgetary Evolution of the Mental Health Program in Peru

Dr Victor Bocangel delivered the presentation entitled "Budgetary Evolution of the Mental Health Program in Peru." In this presentation, he remarked about funding mental health in this economy and its relationship with the primary system of care.

Until 2012, it was impossible to identify the resources destined for mental health, as they were combined with other health services budgets. Changes began in 2008, when a legal event took place in which the Constitutional Court ordered a citizen to be placed at a hospital, although hospitals refused to accept the patient because the hospital's role at that time was only to provide service and rehabilitation (Tribunal Constitucional, 2008).

Under these circumstances, the central government had to develop a strategy to provide care for this type of patient. As a result, the government mandated the Ministry of Economy and Finance to allocate the necessary funds for the implementation of mental health policies and it mandated the Ministry of Health to define a domestic mental health policy.

Initially, the plan was to build psychiatric hospitals. The cost of this would have been about PEN 300 million for one psychiatric hospital (about USD 100 million). The idea was to build this facility to host this type of patient. However, in discussions with the Ministry of Health, a new approach was chosen to solve this problem based on evidence-based-public health policy, instead of following the old paradigm of building several hospitals.

With a budget of PEN 300 million, Peru could have built a hospital, but instead chose to implement mental health programs nationwide. That meant 25 regional governments have implemented these community mental health centers using this budget.

These budget programs can be evaluated by performing assessments, and by now the program is mature enough to make an impact assessment, to make adjustments and to consider the best mechanisms to strengthen it and to scale this program up to the domestic level. There is 30% coverage and the goal is to reach above 70% coverage.

Figure 25: Evolution of the initial opening budget (PIA, by its Spanish initials) allocated to mental health control and prevention, in millions of PEN
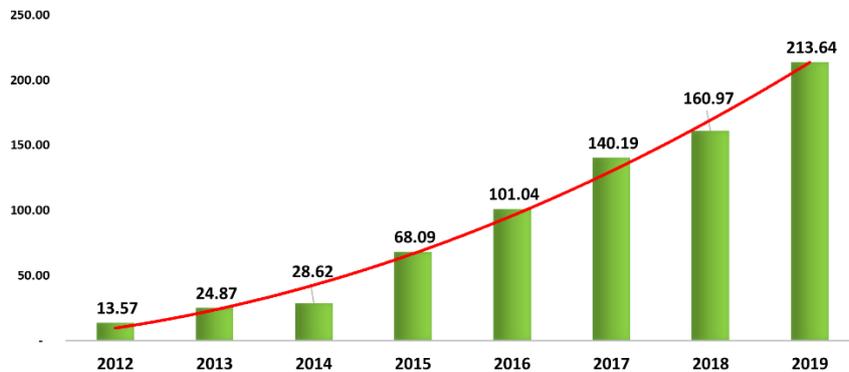
Source: Speaker's presentation copy

In the budget law for the 2012 fiscal year, a PEN 13 million budget was included. For 2013, this figure was PEN 24 million, for 2014, PEN 28 million. 2015 marked a turning point because a program was created to control and prevent mental health diseases. That same year, the budget increased to PEN 36 million. It has currently reached PEN 213 million.

This growth in the budget happened because resources were allocated by the central government from public treasury resources. The budget for the control and prevention for mental health grew from PEN 39 million in 2012 up to almost PEN 300 million in 2019. This budget evolved due to partnerships between the Ministry of Economy and Finance and the Ministry of Health to decrease the risk of mental health issues. This matter is defined as a priority for Peru.

The budget information is transparent and it belongs to the Ministry of Economy and Finance. The information about the evolution of the allocated funds is up to date; this information is transparent in Peru for all three government levels, including local, domestic, and regional government. Any citizen can access this daily updated information to see the execution of the budget.

Table 4: Website with detailed information about the mental health budget execution.

Source: Portal de Transparencia Económica-Ministerio de Economía y Finanzas
https://apps5.mineco.gob.pe/transparencia/Navegador/default.aspx?y=2020&ap=ActProy

9. Applying Complex System Thinking to Mental Healthcare

Professor Luis Salvador-Carulla is the head of the Centre for Mental Health Research at the Research School of Population Health, College of Health and Medicine, Australian National University (ANU) in Canberra. Dr Salvador-Carulla delivered a presentation entitled "Interdisciplinary Evidence-Informed Mental Health Public Policy: Use of Modelling for MH Planning."

Context: Asia Pacific Region

The Asia Pacific Region is the fastest-changing region in the world. It is currently experiencing huge economic and technological development and growth, population growth, migration and mega-urbanization. These are all factors that affect mental health. Another factor specific to the region that impacts mental health is trauma.

The world has 33 megacities with 10 million or more inhabitants each. Most of these are located in the Asia Pacific region. Other important megacities are located in Latin America. Lima, for example, is predicted to become one of the major megacities in the world by 2030. This growth trend has a large impact on how economies should plan their mental health systems. They should focus not just on how to provide mental health for the inhabitants of megacities, but also for those living in rural areas.

Figure 26: The world´s new megacities
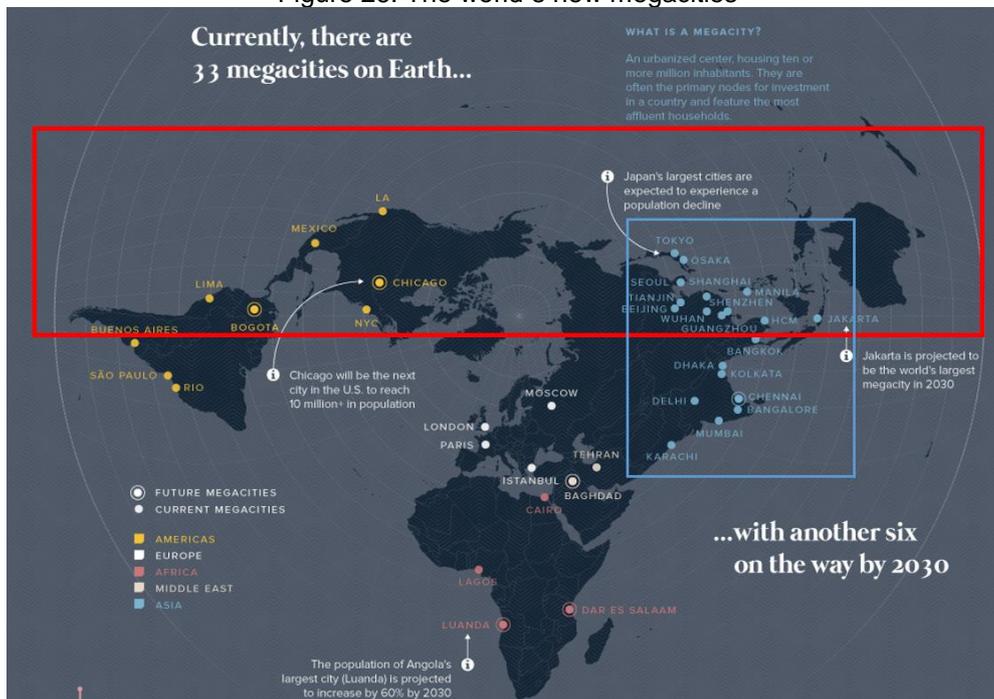
Source: Speaker's presentation copy

Climate change also has a strong impact. People's Republic of China is one of the APEC economies that will be most affected by these changes. Climate refugees are also an increasing problem in the Pacific islands. This has a major impact on the mental health of the inhabitants of the region and is directly related to trauma. Another aspect that impacts mental health is homicide, particularly in Latin America. Honduras, El Salvador and Colombia are among the hardest hit by this problem.

Figure 27: Climate change: Impact in the Asia Pacific Region

Source: Fernandez et al., 2015
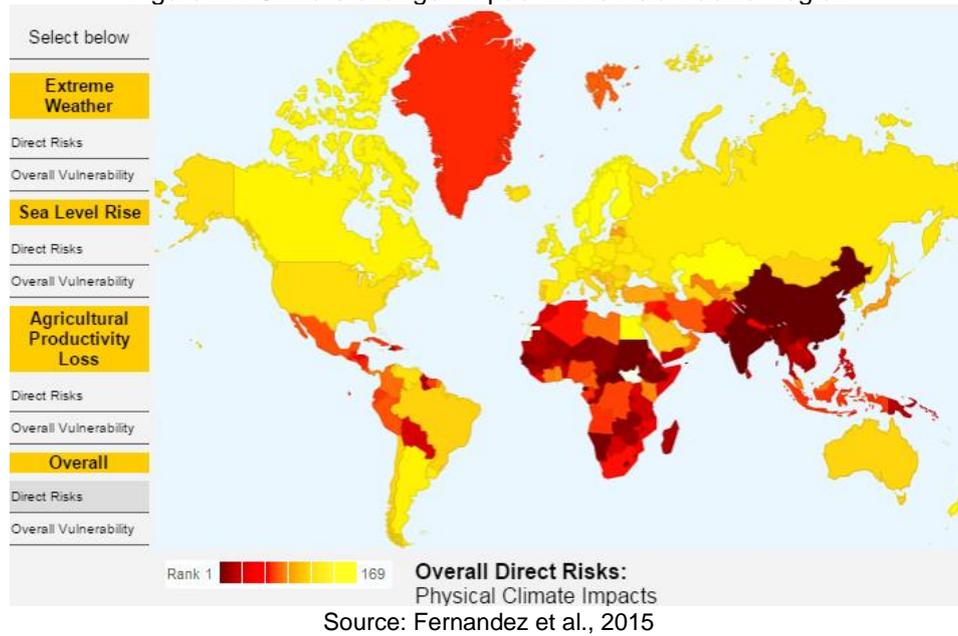
Healthcare access and quality in the Asia-Pacific region have improved since 1990, although there are still major problems in the Pacific islands. Mental health, however, lags behind other aspects of the general healthcare of the population in the Asia-Pacific region.

The 2017 Asia-Pacific Mental Health and Integration Index shows that the mental health burden in the Asia-Pacific region has worsened, while all other health provisions have improved. Mental illness is the second largest contributor (10%) to years lost due to disability in the Asia-Pacific region. Less than half of those affected receive medical treatment. This percentage includes the high-income economies of the region. In low and middle-income economies, however, the discrepancy in access to care is over 85%.

Table 5: Asia-Pacific Mental Health Integration Index

Rank	Country	Score
1	New Zealand	94.7
2	Australia	92.2
3	Taiwan	80.1
4	Singapore	76.4
5	South Korea	75.9
6	Japan	67.4
7	Hong Kong	65.8
8	Malaysia	54.1
9	China	45.5
10	Thailand	44.6
11	India	29.4
12	Philippines	25.5
13	Vietnam	20.6
14	Indonesia	16.7
15	Pakistan	12.8

Source: The Economist Intelligence Unit, 2016

There is a high level of disparity in access to healthcare. The economies with the highest percentages of access are New Zealand and Australia, followed by Chinese Taipei; Singapore; Republic of Korea; Japan, Hong Kong, China; Malaysia; People's Republic of China; Thailand; India (non-APEC economy) and finally the Philippines; Viet Nam; Indonesia and Pakistan.

The South Pacific region requires a major mental health reform similar to what happened in the USA, UK, and Europe in the 1960s and 1970s. It also needs to consider the mistakes made in previous reforms. One of these problems is the lack of documentation, which complicates understanding the progress that has already been achieved. Information technologies for evaluation, monitoring and surveillance are crucial to this task.

Guidelines

The *APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific*, developed by the APEC Life Sciences Innovation Forum and the APEC Health Working Group, the PAHOs *Plan of Action on Mental Health 2015-2020* (Pan American Health Organization, 2014) and the *Regional Agenda for Implementing the Mental Health Action Plan in the Western Pacific* (World Health Organization & Regional Office for the Western Pacific, 2015) offer guidelines on how to approach these problems. It provides a paradigm for a cross-sectorial approach that looks not only at health but also at social care, employment, justice, housing and education. It also focuses on depression, suicide, schizophrenia, bipolar disorders and mental health in disasters and emergencies.

The Roadmap seeks to strengthen effective leadership and governance. To do so, it considers social services and services from other sectors in the community and focuses on mental health promotion and prevention.

Economies need to develop common standards of evaluation. The mental health sector has some methodological challenges as it involves complex scenarios with diverse factors. A system thinking approach can be useful under these circumstances.

Complexity

A 2009 document published by the World Health Organization (De Savigny et al., 2009) states that health systems are complex, not linear and that they tend to self-organization. They are also time-dependent and context-dependent. These factors limit the capacity of traditional statistics. A complex approach considers different causalities, as well as the context, to model the mental health system.

Health systems are complex, uncertain and dynamic. Mental health services add complexity, due to their ambiguity and multisectoral nature. Furthermore, this requires that policy makers think globally and locally to be able to understand and use the information to guide evidence-informed planning.

To tackle this challenge, complex mental health systems require different interventions, such as decisions support systems, interdisciplinary decision analytics, use of tacit knowledge, models that help to provide some context comparability and analysis of technical efficiency. Altogether, these help policymakers achieve greater system understanding and improve the resource allocation of management.

Around the world, economies fluctuate between a system thinking and a linear approach to healthcare planning. Some areas like Basque Country in Spain and Scotland have now adopted the complex system approach for health planning.

Use of evidence

In order to get meaningful knowledge for changing the health system, the systemic thinking approach has modified the way we understand evidence. In comparison to the approach of evidence-based medicine, where evidence was considered the meta-analysis of randomized control trials, systems thinking complements facts and data with scientific experts' knowledge.

In other words, it also considers hours of experience, planning, working in services, designing services, experimental knowledge, observations and studies, context analysis, expert knowledge, and the experiential knowledge of consumers.

Figure 28: From evidence-based to evidence-informed policy
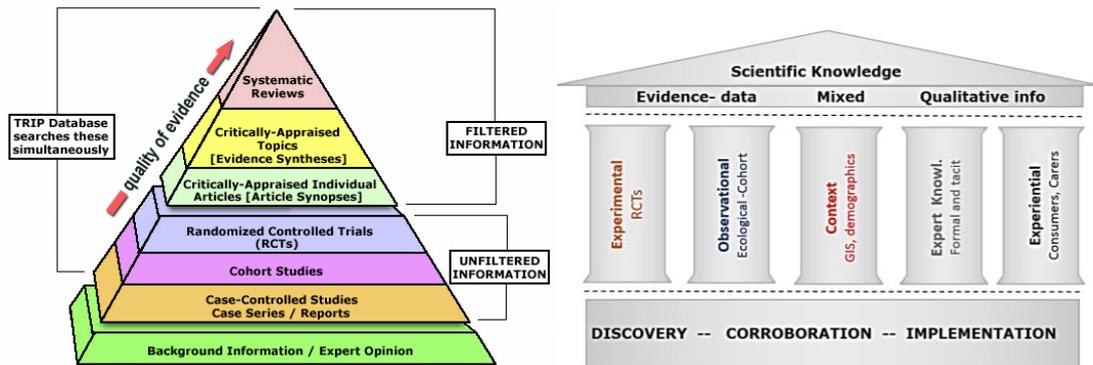
Source: Salvador-Carulla et al., 2017

Evidence-based healthcare has evolved into 'evidence-informed policy' by adding big data and local context information as well as into 'knowledge-guided policy.' Experts guide knowledge-guided policy through proper information and data analysis processes. An evidence-informed rather than evidence-based health policy acknowledges that policy-making is an inherently political process in which evidence is only one of the factors to consider (World Health Organization, 2018.)

The real implementation of policies happens in a wide and complex context. Therefore, the balanced interaction of intervention, implementation and context is essential to improve the chances of a successful mental health program (Bate et al., 2014). Besides, scientific evidence often has to compete with beliefs, personal interests, political considerations, traditions, past experiences and financial constraints. This challenge requires information that is visually correct and tantalizing.

Expert-based cooperative analysis

One critical question for decision analytics in policy design is how to transform the tacit knowledge of the experts into formal knowledge. The fact is that experts' domains are often very different. They need to use different visualization techniques for different experts. According to this interdisciplinary process, it is critical to not just provide information to a data analyst, an epidemiologist, a mathematician or an engineer. These professionals are working with a knowledge engineer throughout the whole process to get to the proper meaning of the analysis and the data.

Figure 29: Expert-based cooperative analysis (EbCA)
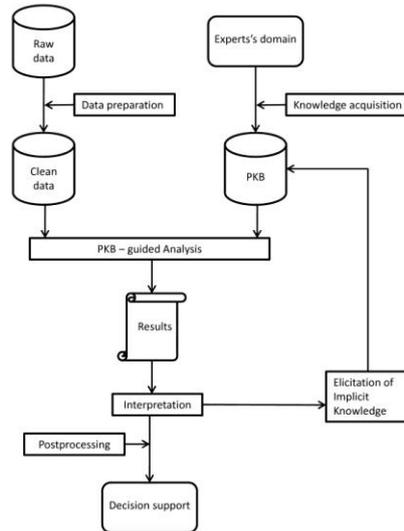
PKB: Prior knowledge base

Source: Gibert et al., 2010

In an expert-based cooperative analysis, a domain expert "A" (Mid-processing) would work throughout the whole process in the discovery of knowledge with domain experts "B" *(end-users),* and with the domain experiencers "C" *(end-users)* who work particularly in the co-design and co-creation of policies.

Organizational research

Health systems are dynamic social organizations of people, institutions and resources that deliver healthcare to meet the needs of the target populations. A system thinking approach analyzes the many interconnected agents, including humans and non-humans, that need to work together for the whole to function successfully.

Since health systems are defined as dynamic social organizations of people, institutions and resources that deliver healthcare, it is important to take into account the organizational dimension of mental health planning. Organizational research by Deming (1986) proposes four questions that should be asked by any organization:

1) Do you know how good you are? – Requires a model of references and a mapping of current services.

2) Do you know where you stand relative to the best? – Requires a list of comparators and benchmark analysis.

3) Do you know where the variation exists? – Defines indicators, provides values and ranges that are locally meaningful, recognizes the reasons for variation and identifies bad versus good variation.

4) Do you know the rate of improvement over time? – Provides criteria by developing models, monitoring systems and conducting comparative efficiency analysis.

Design, planning and monitoring mental health systems

The main goal of designing, planning, and monitoring mental health systems is to identify ways of improving resource allocation and management of mental health services through benchmark analysis and greater system understanding. This also reduces uncertainty and increases information about the health system by identifying critical determinants of efficiency within a system.

The specific questions that were posed in different projects include:

- Does the jurisdiction, whether it be an economy, region or local district, have the right number of services and places in hospitals, or supported accommodation in the community?
- Are these the right number of services in the right places?
- Does the region have the right mix of services between health and social care? Between hospital and community care? Between private and public care?
- Does the region have the right mix of staff in the services?
- What is the impact of the planning strategy or the intervention on the overall efficiency of the mental health system we are trying to improve?
- What is the relationship and the impact of the changes in the health systems on other key sectors of mental health, such as social care, housing, employment and justice?
- What is the relationship between the results provided by the simulation models and the results and recommendations drawn from the official plans made by a policymaker or stakeholders?
- What is the relationship between the response provided by the simulation model with the results and recommendations from the actual world implementation of changes in the system?

Decision support systems

In order to improve decision-making processes, it is necessary to have decision support systems. These are computer-based tools that provide valuable information for analysis. These tools function with help of models that are mixed, qualitative and quantitative components of the system. In order to develop these models, it is necessary to use indicators and scenarios to represent possible futures for one or more components of the system. According to the type of modeling techniques employed, it is possible to incorporate more indicators.

Healthcare ecosystem analysis

Healthcare ecosystem research applies the knowledge obtained in environmental sciences to healthcare. It incorporates systems dynamics, context analysis, health economics and knowledge discovery from data. This decreases research waste and guides decision making in complex environments.

Figure 30: Health ecosystems: Drivers of outcomes
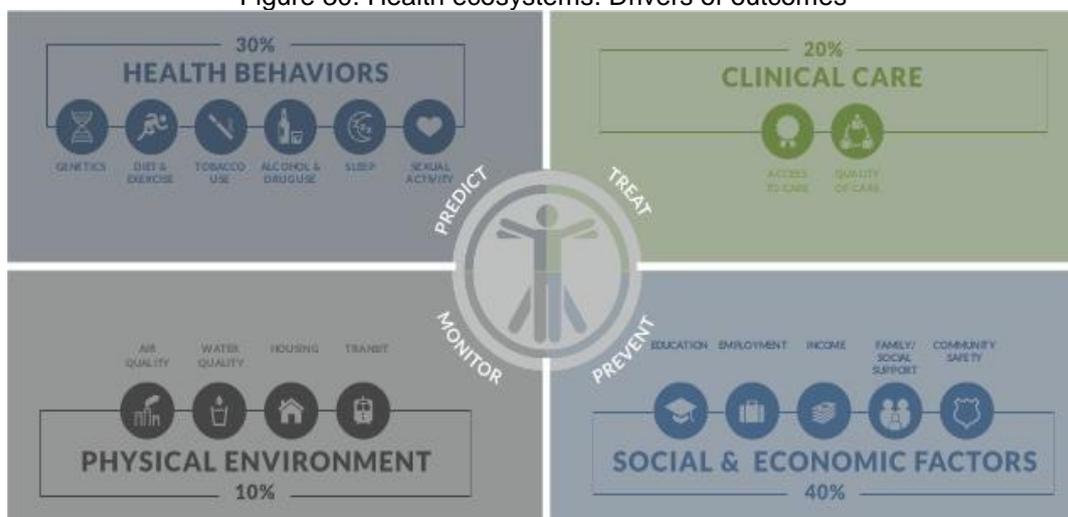
Source: Cascadia Capital LLC, 2016

The Healthy Mental Ecosystem framework allows researchers to model meta-healthcare services in small areas, regions or economies. This facilitates calculating the effect of, for

example, increasing the number of psychiatrists in a region or choosing to strengthen the work of nurses or psychologists instead of psychiatrists.

Benchmark analysis

A healthcare ecosystem analyses the context, in a way that makes it possible to compare different contexts and learn from each other. Under this approach, for instance, it is not possible to assume that the same policy will work for all in lower- middle-income economies unless it is possible to understand the typology of the diversity of mental health systems.

Figure 31: A typology of mental healthcare based on top-down information (WHO-AIMS)
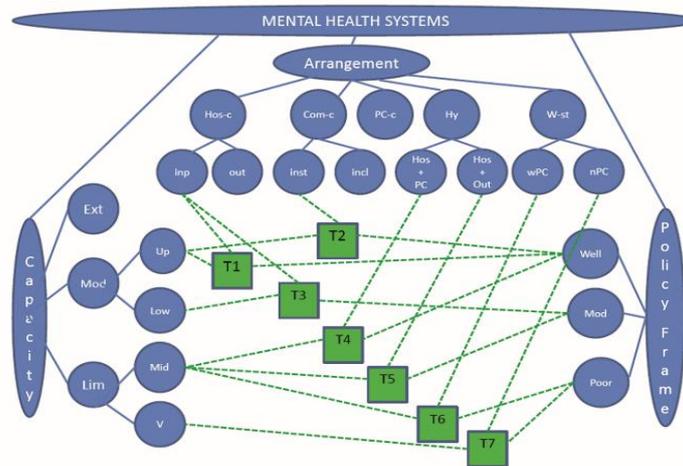
Source: Speaker's presentation copy

Table 6: Care capacity, care arrangement and policy framework of mental health systems

Types of Mental Health Systems (MHS)	Block	CIBR-class	Main Qualifiers			Number of Countries by WHO Regions*	Income level *
			Care Capacity	Care Arrangement	Policy framework		
T1	I. Moderate MHS	CL	Upper-moderate	Hospital-centred, inpatient oriented	well	1 EURO	Upper-middle
T2		C6	Upper-moderate	Community-centred with institutional LTC	well	3 AMRO	Upper-middle
T3		C22	Lower-moderate	Hospital-centred, inpatient oriented	moderate	7EURO+ 5AMRO	Lower-middle
T4	II. Limited MHS	C21	Mid-limited	Hybrid: hospital+primary care	moderate	4 WPRO	Lower-mid &Low
T5		C20	Mid-limited	Hospital-centred, outpatient oriented	moderate	6 EMRO	Lower-middle
T6		C19	Mid-limited	Weak-structured, with primary care	poor	8 SEARO	Lower-mid & Low
T7		C18	Very-limited	Weak-structured, with limited primary care	poor	7 AFRO+ 1EMRO	Low

Source: Speaker's presentation copy

This was the case when Dr Salvador-Carrulla suggested providing the system's dynamic approach to this analysis to 42 low- and middle-income economies around the world in order to identify typologies of mental healthcare in low- and middle-income economies. One of the tasks for this complex endeavor was working with the experts to identify the relevant indicators and reducing the number of critical indicators needed to understand each type of system from 100 to 19.

The healthcare ecosystem research also incorporates improved visualization tools. Visualization tools have an important role in supporting mental health policies (Chung et al., 2020). Since they are critical to elicit expert knowledge, recognize patterns, and make decisions under uncertainty conditions. As a medium, they communicate complex data in a visual format that -in its best form- can be understood by different targets, such as consumers, patients, clinicians, managers, planners and policy makers. Researchers should evaluate the quality and efficacy of visualization tools to ensure they convey the proper information for the reader.

Definition and commensurability

Usually, mental health systems have different units of analysis. As a result, it is difficult to make a comparison like with like. Its indicators are difficult to merge, and they have terminological variability. Names of services do not always reflect their main activity, or names of the same services vary across jurisdictions. To tackle this issue, Dr Salvador-Carulla and his team developed an instrument for the standardized classification of services for long-term care called "Description and Evaluation of Services and Directories in Europe for Long Term Care" (DESDE-LTC) (Salvador-Carulla, 2011). Moreover, the instrument also helped to code and mapped mental health care in 34 countries. In Australia's particular case, it enhanced the comparison of 13 public health networks through 20 atlases of mental health.

It is crucial to develop a shared terminology and apply digital health technologies and information technologies to build the capacity of the mental health system in APEC member economies. To achieve this goal, it is useful to use the experience of the local atlases of mental health.

Atlas of Mental Health

An example of this type of work is the *Atlases of Mental Health Care*, which provide comprehensive description and visualization of the structure of the provision of care in specific areas. They can be national, regional or local. They are not highly detailed but aim to provide a comparative approximation with compartments for benchmarking. They provide a snapshot of the services available to a defined target population at a single point in time, following a whole health integrative approach. The atlases gather information on all the services that are available for the target population, including education, justice, housing and others. This generates international coding that can compare service provision across jurisdictions and economies.

This system allows a comparison between extremely dissimilar areas, such as cities in Helsinki in Finland, Donostia-San Sebastian in Spain, and Canberra in Australia. Researchers are constantly incorporating new cities into the system. Maps facilitate a single snapshot of the characteristics of care provision in each area.

Figure 32: The mental health pattern of care for adults
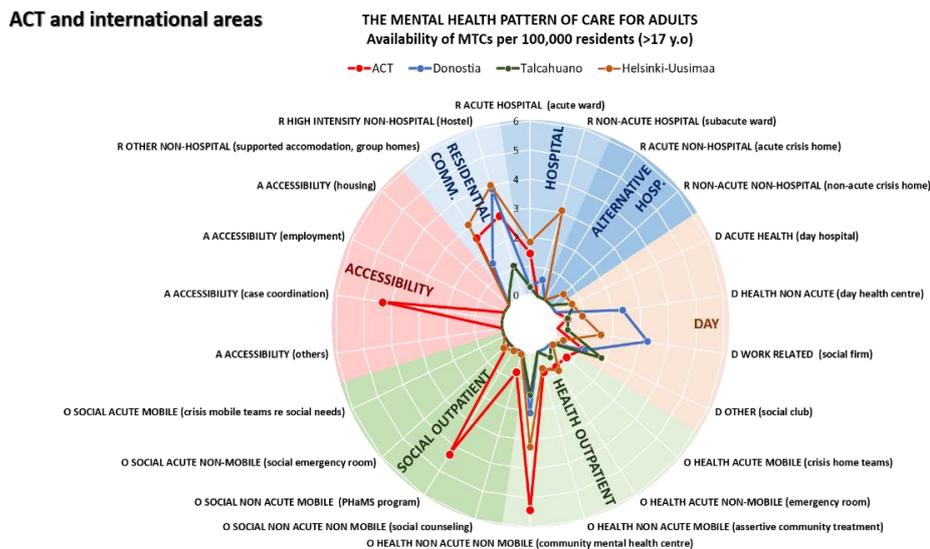
Source: Speaker's presentation copy

They allow for a global comparison of, for example, the care provided in urban areas to the care provided in rural areas. This means that there is not a single model of mental healthcare, but rather specific models for different areas. It implies analyzing local data to provide information that is relevant globally.

The local atlases of mental health started as part of a European project in 1994 that compared the cost-effectiveness of rehabilitation services in six European economies. They aimed to identify service availability and capacity to help decide how to allocate funding and resources.

The experience in non-APEC economies with very little available information, as was the case with Romania and Bulgaria 20 years ago, shows that the key is not to reach a definite truth but to reduce uncertainty. While many attempts have failed, understanding error and failure is critical to improving the systems.

For developing the atlas, there are some key elements to review, including the following:

Analyzing expenditure
For example, in Australia, most organizations state that they have a person-centered system for the integrated mental healthcare needs of the community. An analysis of expenditure, however, finds that most resources go to hospital care. The system is skewed to hospital care for mental health when compared to other high-income economies. Researchers should pay attention to the money flows to recognize the real drivers of the system.

Differentiating between frameworks and models
The World Health Organization pyramid is a framework to understand the components of mental healthcare provision. It is not a model. Complex models add quantitative information to conceptual frameworks. They allow us to respond to complex questions, such as those regarding the proper balance and location of services.

Understanding the context
To understand the context of a healthy ecosystem, it is necessary to know what jurisdictions are relevant for mental health. Researchers can use this data to understand what is happening in different sectors and the area. Pharmaceutical companies have truly understood the importance of the healthcare ecosystem, which means that the drug industry processes a lot of information before the public health sector does.

Developing an index
This means including spatial analysis of social fragmentation and depression in an area. Doing so helps to map the depression rates of an area to identify cold spots and hot spots of higher levels of depression related to social fragmentation. In the case of Australia, the hotspots are located farther away from the coast. This is related to poverty and deprivation, social fragmentation, diabetes, chronic disorders and mental health.

Figure 33: Spatial analysis of the social fragmentation (SFI) and depression in Adelaide (Australia)
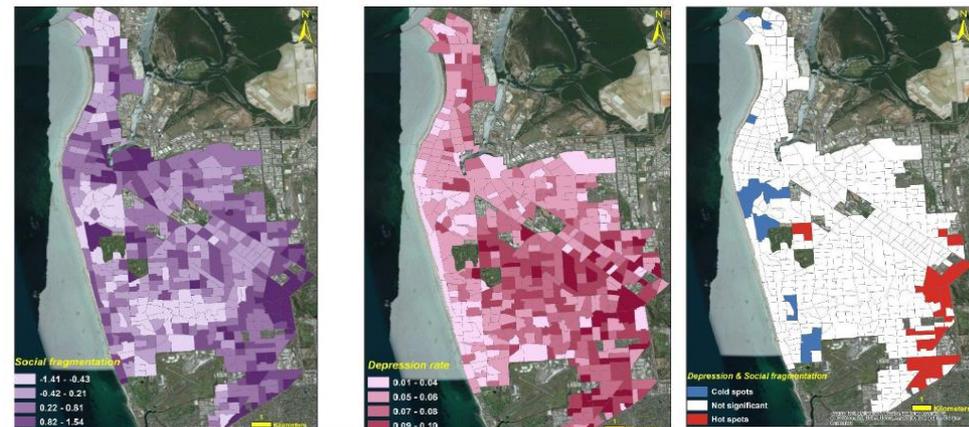
Source: Bagheri et al., 2019

Mapping prevalence

Another example relates to mapping the prevalence of dementia in a city and the related social fragmentation to identify the location of the nursing homes. The approach also accounts for the differences in quality, as not all nursing homes are the same in all areas. The ones that work in highly socially fragmented environments will face major problems. General indicators tend to obscure this level of information.

Defining terminology

Extremely dissimilar buildings, infrastructures and institutions can receive the same name. Establishing the definition of "hospital," for example, can take years. A highly advanced urban hospital and rural hospitals in the same economy function in very different ways but receive the same name. The inclusion of data from other economies makes it even more difficult. There is a huge problem with terminological variability in health service research. The name of the service does not always reflect the activity provided. Researchers need to develop a taxonomy and international classification of services that allow them to overcome this problem.

Considering commensurability

Commensurability is the notion that any test needs comparable units of analysis. The problem is that services are extremely dissimilar. They are subject to local laws and regulations, opportunities, individuals, unforeseen changes and other considerations. This requires smaller units of analysis, called Basic Stable Inputs of Care, or BSIC.

Using taxonomies

A common taxonomy can be used to code and map services around the world. To do so, the first step is to map an area and conduct an analysis of the geographical information systems and a spatial analysis of the social, demographic and physical factors, like workability, green spaces and others. The next step is to identify the services providing care in the area for the target population. Then, it is important to look at the macro- and meso-systems to identify their characteristics, including their clinical teams. This micro-system is labeled with the taxonomy, which allows researchers and policymakers to compare basic teams across different jurisdictions.

This system has been used in 34 economies. 71 international studies have generated data that provides a prior knowledge base of care provision around the world. This facilitates comparing the balance of care according to a target population.

In Canberra, the system revealed flaws in the system and showed disbalances of care between health and social care. Another finding was that, in Sydney, healthcare governmental organizations provide most of the care, in North Perth and Canberra, NGOs provide most healthcare.

10. Implementation of Community Mental Health Programs for Vulnerable Populations
10.1. Investment in Mental Health Programs for Young People

Professor David McDaid delivered a presentation entitled "Investment in Mental Health Programs for Young People" and remarked on the importance of taking care of younger and vulnerable populations in an economy.

Mental health issues start early in life, and by the time an individual reaches their mid-twenties, 75% of mental health problems are already developed. Investing in actions that prevent mental illness early in life helps support people's psychological problems. This is also related to the education received. It could avoid issues such as dropping out school, which has a significant impact on physical and mental health and social behavior (Kim-Cohen, Caspi et al., 2003).

Figure 34: Age of onset lifetime mental disorder
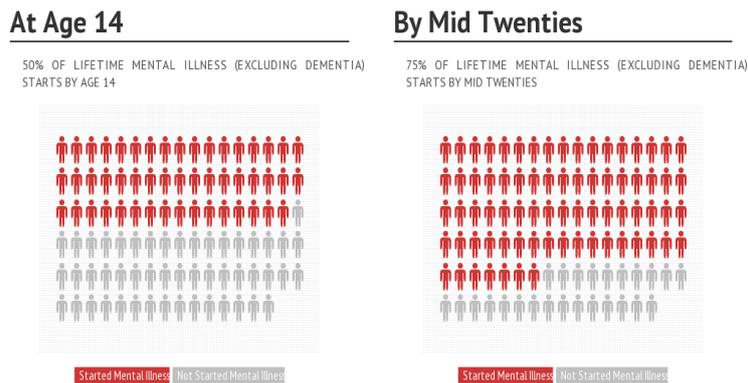
Source: Kim-Cohen et al 2003; Kessler et al 2005, 2007

There are three aspects to address. The first is the promotion of mental health in schools, a program called "Mental Health First Aid," which has already been implemented in England and could be implemented in other contexts. This program consists of training teachers in every school to better understand mental health, recognize the risks in young people and deal with those risks. Alongside this program, there is an evaluation called the WISE Project that assesses the Mental Health First Aid program in schools to improve the teachers' and students' wellbeing, as it has been proven that teachers' wellbeing is associated with the wellbeing of the students (Harding, Morris, Gunnell et al., 2019).

Another fact is that children with mental health problems cost the educational system more, so there are indeed profound economic impacts on education. An analysis of young people with psychosis carried out in Australia shows the importance of keeping and supporting young people's education, as it makes a significant impact on their life chances. In England, the data shows the correlation between achieving proper qualifications among young people and having a good lifetime productivity return. This data has allowed modeling the benefits and costs avoided by adverse psychosis-events that were avoided, including school disruption.

Figure 35: Return on investment: Short term health impacts
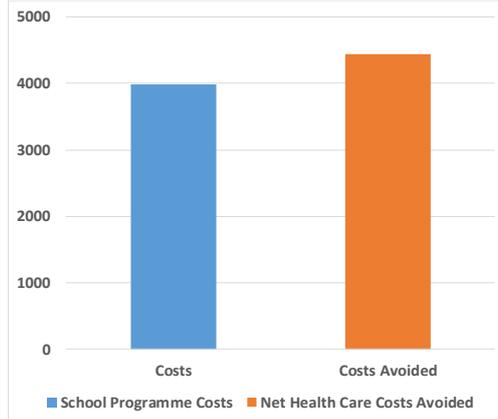
Figure 36: Health and education benefits
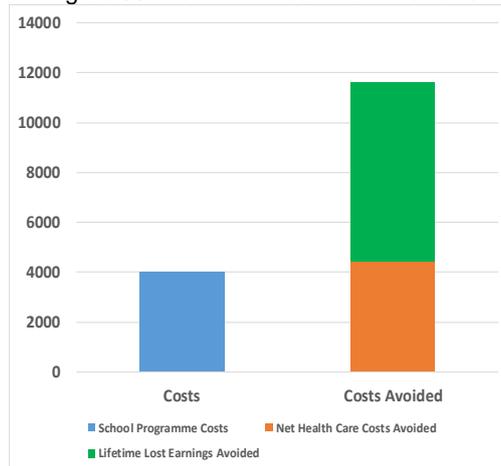
The second aspect to focus on is tackling bullying, as this is recognized as an issue affecting students' mental health and impacting students' educational achievements. Studies have shown that addressing this issue reduces traditional and cyber-bullying, which improves the students' lifetime and ends up being cost-effective for the system, as the intervention is not expensive. The long-term outcome is an improvement in adult life for children that are not bullied during their schooling, which is also a return on the investment, as shown in England (Public Health England, 2017).

Table 7: Short and long-term costs averted and wealth gained through a school ani-bullying program (200 pupils)

	Age 7-8	Age 8-9	Age 9-10	Age 10-11	Age 50	Total Cost / Saving
Incremental cost of KIVA intervention	£320.00	£115.94	£112.02	£108.23		£656.20
CAMH cost	£0.00	-£83.02	-£111.54	-£126.31		-£320.87
GP cost	-£0.60	-£0.83	-£0.96	-£1.01		-£3.41
Pupil Absenteeism	-£128.82	-£142.59	-£158.27	-£162.08		-£591.76
Self-Harm	£0.00	-£30.50	-£40.97	-£46.40		-£117.87
Lost Adult Earnings to Age 50					-£2,931.71	-£2,931.71
Health Service Costs to Age 50					-£970.76	-£970.76
Lost Wealth Accumulation to Age 50 (Savings)					-£15,332.40	-£15,332.40
Lost Home Ownership					-£76,047.43	-£76,047.43
Total cost consequences (savings if negative value)*	-£129.42	-£256.94	-£311.74	-£335.80	-£95,282.30	-£96,316.20
Total costs (savings if negative value)**	£190.58	-£141.00	-£199.72	-£227.57	-£95,282.30	-£95,660.01
Overall Return per Pound Invested	£0.40	£0.89	£1.27	£1.58	£146.78	£146.78
Intense Bullying Victimisation Free Years Gained	2.89	3.26	3.69	3.85		13.68
Average Annual School Age Bullying Cases Avoided						6***

*Sum of additional costs incurred or costs averted as a result of intervention. The cost of the intervention is not included in these figures
** Sum of all additional costs incurred or costs averted as a result of intervention, including the cost of intervention.
***25.71 additional cases of any bullying avoided over four years

Source: McDaid, D., Hopkin, G., Knapp, M., Evans-Lacko, S., & Gan, C. (n.d.). The Economic Case for Prevention in Young People's Mental Health: Bullying. 16.

The last aspect is poverty alleviation. This includes studying the association between mental health, poverty, and people's access to opportunities in six economies by providing different kinds of assistance. The programs have specific objectives to improve young people's mental health in poor circumstances in those economies. The data from those studies and programs are being analyzed to identify the investment needed to improve the students' life chances (London School of Economics and Political Science, 2018).

Table 8: Chances-6 research activities

Dataset	Sample and age range	Mental health measures	Life chances measures	Associated intervention
Malawi school, income, and health risk impact evaluation (2007-2010), 4 waves	Cluster RCT of 3,810 schoolgirls (aged 13-22) from a rural town	General Health Questionnaire-12, Mental Health inventory 5	Dwelling characteristics, household assets and durables, shocks and consumption	Randomised to: (i) unconditional cash transfer, (ii) conditional cash transfer or (iii) nothing
South African National Income Dynamics Study (2008-ongoing), 5 waves	Nationally representative panel survey of households (n=28,000 at baseline) age 15+	Centre for Epidemiological Studies Depression Scale (CES-D-10)	Employment, educational attainment, income, expenditure, assets consumption, debt, savings	Staggered child support grant (age 0-18), Disability grant, Old age pension
Pelotas cohort – Brazil (2004-2010), 2 waves	99% of live births in the urban area of Pelotas, during 2004 (n=3,721)	Development and Well-Being Assessment (DAWBA)	Income, educational achievement, substance abuse, SES ascertained from data linkage	Linkage to Bolsa Familia CCT programme
Encuesta Longitudinal de la Universidad de Los Andes - Colombia (2010-ongoing)	Nationally representative sample of Colombian households with youth supplement (n=10,000)	EQ-5D, father's and mother's self-reported depression, agreement to add mental health measure in 2019	Income, employment, consumption; educational achievement; access to financial services, substance use	Cash transfer program "Familias en Acción" & social programmes
CBT and cash transfers among young men in Liberia (2010-2011), 2 waves	999 men (aged 18-35) living in Monrovia at high risk for criminal behaviour	Anti-social behaviour including aggression, impulsiveness, five-factor personality inventory	Income, assets, expenditure, criminal behaviour	Randomly assigned: 25% cash only, 28% CBT only, 25% both, 22% neither
Progresa/ Oportunidades, Mexico (1997- 2012) 4 waves	6,786 households	Previously published depression index, subjective well-being	36 parameters on micro-entrepreneurship income, labour supply, expenditures, social status	Cash transfer, conditional on child school attendance & preventive healthcare use

Source: Speaker's presentation copy

The goal is to replicate this model in six economies after revising the evidence. This creates an opportunity to invest in the mental health of young people in APEC members and collaborate with the UK to improve young people's mental health, as there is still much work to do.

10.2. Incorporating "Experts by Experience" into Community Mental Health Programs

For this intervention, Professor Ruben Alvarado delivered a presentation entitled "Incorporating 'Experts by Experience' into Community Mental Health Programs." He provided valuable information about suicide- and psychosis-prevention models from Chile.

Suicide prevention program: CLAN

Due to the high suicide rate among young people (Echevarri, Maino et al., 2015) the Chilean government decided to develop a strategy called the "National Program for Suicide Prevention" (Subsecretaria de Salud Publica, 2013).

Figure 37: Suicide mortality rate in population aged 10-19 years, observed between 2000 and 2008 and estimated for the years 2010 to 2020
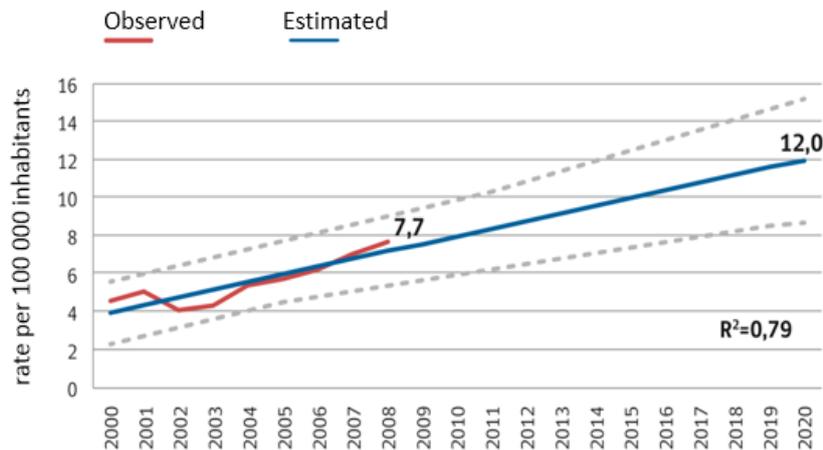
Source: DEIS, Objetivos estratégicos 2010-2020, MINSAL

The fourth component of this strategy required incorporating preventive programs in educational establishments, although there had been no previous recorded experience with doing so. As a result, the team decided to use technology to appeal to the target population. They also formed an expert panel of seven adolescents, considering the importance of gender and minority diversity.

The panel of experts participated throughout the development process, elaborating the visuals, model and social components of the platform (developing psychological and social skills with the tool) in order to avoid creating a tool that alienates its users. Their main functions were to go out, speak, empathize with others' experiences, go to some cultural activity and learn from mental health modules. The team discovered that the education sector, as well as technology development, have each their own pace.

The platform ran through a pilot trial with a control and intervention group in three schools with 500 students. It was successful among adolescents and teachers because they had a tool to address mental health issues. It significantly reduced the suicide rate, self-stigmatization and anxiety symptoms (Mascayano, Schilling & Jorquera, 2018).

Figure 38: Online counseling

Source: Speaker's presentation copy

Peer-to-peer support group for psychosis

For years, Chilean specialists have looked to develop more community-focused healthcare services. That means to emphasize the psychosocial and communitarian approach and not only the biomedical.

Despite the progress in treating psychosis with help of critical time interventions (Alvarado, Schilling & Jorquera, 2015), it is still a challenge to help users come out of psychotic episodes. Stigma is usually associated with this process, and it may hinder the wellbeing of patients. For this task, they turned to the CTI-intervention approach, adding a new "experts by experience" component.

The experts by experience are people who have experienced the issue, have learned from and reflected on this experience, and are interested in helping others living through it. In this case, they were people who had suffered from psychosis events and they went through a process of selection, training and supervision (Agrest et al., 2019).

In the first step of the intervention, the expert and user establish a relationship and define objectives. They also design a crisis plan in case of psychotic episodes. In the second phase, the program is launched and the expert monitor compliance with achievements. The last stage is focused on building upon users' autonomy, and the expert and the user meet with less frequency.

Results have consistently shown that the intervention group's users achieve better results regarding the quality of life and global functioning than the control group. The process revealed that peers have a perspective that professional and community mental health workers cannot deliver. Perspective is essential for recovery. This intervention's positive experience has also empowered the participants as social actors and expanded users' understanding of civil and social rights. However, it remains a challenge to achieve widespread acceptance of the experts by experience program by community mental healthcare teams.

11. Stigma and Power Dynamics
11.1. Combating Stigma in Healthcare: What we have Learned and what we have to Share

Dr Bianca Lauria-Horner is an associate professor at Dalhousie University, Department of Psychiatry, and past Primary Mental Healthcare Education Leader. She is a member of the Mental Health Commission of Canada research/training team and a Primary Care Mental Health Consultant.

Dr Lauria-Horner delivered a presentation entitled "Combating Stigma in Healthcare: What we have Learned and what we have to Share."

The Mental Health Commission of Canada defines themselves as a catalyst for change which identifies gaps in mental health. This non-profit organization funded by the federal government works on several key areas, such as stigma, workplace mental health strategy, recovery, peer support and suicide prevention, among others. It grew out of a recommendation in the first domestic report on mental health (2007). The Commission's "Opening Minds" initiative (Mental Health Commission of Canada, 2006) identifies successful anti-stigma programs through scientific evaluation and promotes them. This initiative works mainly with four target groups: healthcare providers, youth, the news media and the workforce.

Stigmatization includes demeaning treatment, patronization, humiliation, threats of coercive treatment, being left out of decisions, being given insufficient information and patients being told that they should not expect to see recovery. Stigma negatively impacts the patient's wellbeing, creating barriers and delays to seeking help, early termination of treatment and a fragile state of mental and physical health.

In order to measure stigmatization, the initiative used an "Opening mind scale" (Chen, Stuart et al., 2014) for healthcare professionals. This assesses three dimensions of stigma, including attitudes, preference for social distance and help-seeking/willingness to disclose among healthcare professionals.

Research from Corrigan et al., (2014, p. 37) shows that the roots of stigma in healthcare providers lie in the pessimism about recovery. They feel that what they do does not matter, they have a lack of skills/confidence, a lack of awareness of their own prejudices and the tendency to see the illness before the person (this becomes exacerbated when there is compassion fatigue/burnout).

It is important to learn the needs of healthcare professionals. Lack of skills and confidence matter. During practice, if healthcare workers seem anxious, they might ask the wrong questions and it becomes difficult to work with patients or users.

Lack of awareness, prejudices and a tendency to see the illness before the person is another issue. When providers experience burnout, they feel overwhelmed; patients become a file rather than a person experiencing a troublesome circumstance. This situation makes it less possible to be vulnerable to the other.

Through this analysis, "learning needs" for tackling stigma were identified (Beaulieu et al., 2017, p. 328). To meet these needs, programs addressing stigma should:

    a. Include social contact in the form of personal testimony from a trained speaker who has lived experience of a mental illness
    b. Employ multiple types or points of social contact
    c. Focus on behavior change by teaching skills that help healthcare providers know 'what to say' and 'what to do'
    d. Engage in myth-busting
    e. Emphasize and demonstrate recovery
    f. Use an enthusiastic facilitator/instructor who models a 'person-first' approach to set tone and guide program messaging

When programs include all six elements, healthcare providers perform significantly better. Additionally, the individual analysis of these ingredients showed that when item (a) from the list above (one of the multiple forms of social contact) or item (e) (emphasizing recovery) was included in the program, patients also performed significantly better than those programs that did not add these ingredients (Knaak et al., 2014, p. 24).

Social contact requires contact-based education. It means hearing a person's story from a place of recovery and letting the speaker direct his/her narrative by providing an "equal status" between speaker and provider. This form of interaction develops a different intention and context, where the provider is also a learner and not merely a "fixer."

The second key ingredient implies multiple forms or points of social contact. Various types of communication could include a person sharing their story in a live interaction or this could be previously recorded. It could include several stories or occur at several time points.

Myth-busting emphasizes and demonstrates recovery, as does an enthusiastic facilitator who uses a person-first focus. In addition to analyzing causes and learning needs, the program identifies vital strategies for successful program implementation and proposes effective programs for replication and scaling up:

Figure 39: Process model for designing and delivering successful anti-stigma programs for healthcare providers
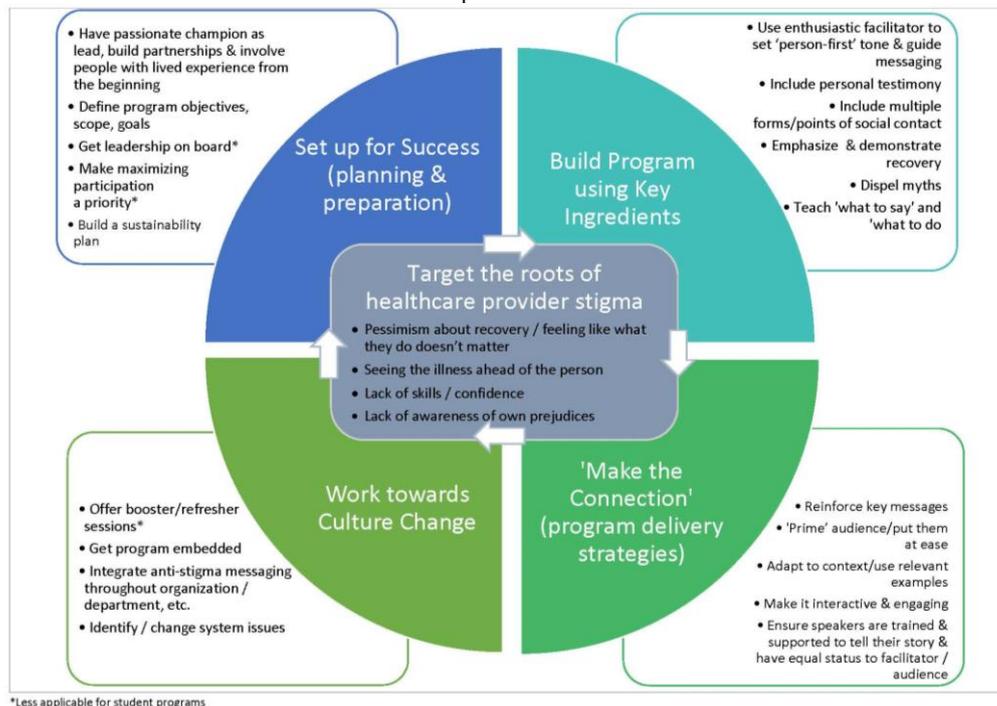
Source: Speaker's presentation

Through its research, Opening Minds has identified many evidence-based programs available for sharing and implementation, which are classified into four main program models:

- Workshop model (short interventions)
- Skills-based model
- Intensive social contact model
- Workplace model

All the programs that have shown to be effective are available for replication and scaling up.

One of the skills-based models for healthcare providers is the Adult Mental Health Practice Support Program (AMHPSP). It consists of three workshop sessions of 3.5 hours each. The primary care providers and the entire office staff are invited. Staff is still allowed to see their patients before or after the 3.5-hour sessions, depending on if the sessions occur during the morning or afternoon. Periods of about 6 to 8 weeks take place in between, where the staff gets to practice what they have learned immediately (*Evaluation of a Mental Health Physician Support Program in Nova Scotia - Full Text View - ClinicalTrials.Gov*, 2017).

The "Opening Minds" initiative also targets youth and the general population. During the "HeadStrong" summits (*HEADSTRONG | Mental Health Commission of Canada*, n.d.), the Commission trains students representing their school with their teacher. Participants share their stories, challenge their own beliefs and develop activities to bring back to school so that the leaders and the teachers can implement the anti-stigma messaging throughout the year.

Figure 40: The mental health continuum model
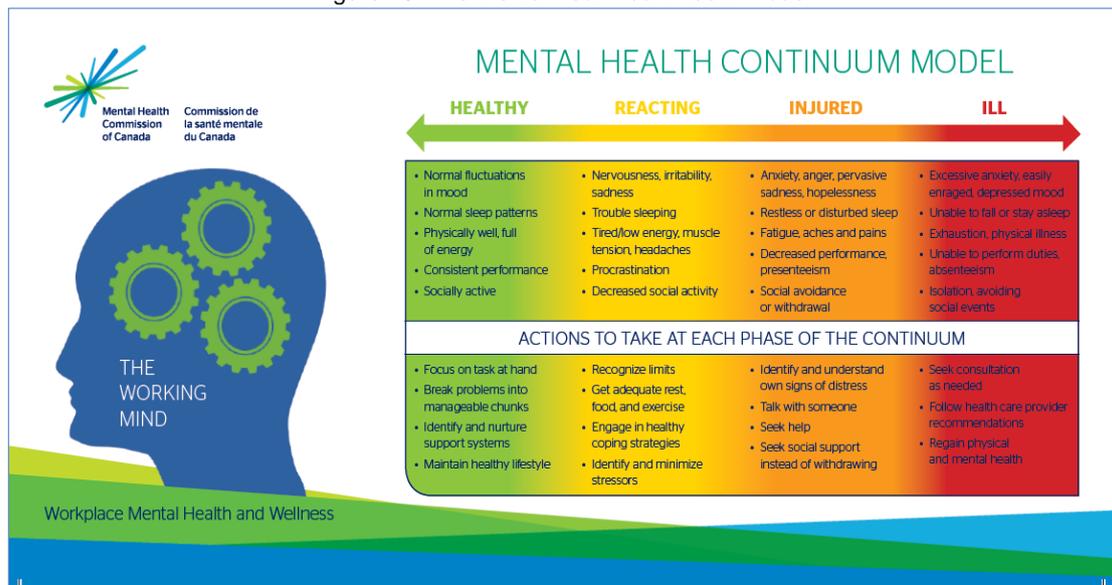
Source: Speaker's presentation

This initiative also provides the "Working Mind" program (Mental Health Commission of Canada, 2018), where it is possible to target the general population's help-seeking behavior. This program offers interpretative tools to understand the user's mental health and more accurately recognize it as a continuum, outside the healthy-sick dichotomy through a sequence of colors with different meanings. This program helps to reduce stigma because it allows users to identify their symptoms and moods, as well as offering them coping strategies and resources.

One of the keys to all of these programs is that they have shown to be effective in increasing resiliency.

11.2. Combating Stigma in Health Services in Mexico: Developing an Online Course for Health Professionals

Dr Jazmin Mora Rios has a PhD in Psychology from the Faculty of Psychology of the National Autonomous University of Mexico. She is a researcher in Medical Sciences attached to the Directorate of Epidemiological and Social Research of the National Institute of Psychiatry "Ramón de la Fuente." She is a member of the National System of Researchers (level 1). She currently participates as a teacher of the Specialty in Mental Health taught by the National School of Nursing and Obstetrics (UNAM).

She gave a presentation entitled "Combating Stigma in Health Services in Mexico: Developing an Online Course for Health Professionals" about an approach developed to adapt instruments to cultural context and decode stigma in Mexican society.

One of the main issues that Mexico deals with is the stigmatization of mental illness in different groups. A team lead by Jazmin Mora Ríos (2012) did a study as a part of a larger cross-cultural project conducted by research teams from Canada and Mexico based on a mixed-methods approach. Because of the negative impact on patients, family and society, this study considered all stakeholders, including patients, family, healthcare professionals, and the general population. First, the study proposed a cultural adaptation of instruments to measure stigma and mental illness. It used the DDS, ISMI, OMI instruments, an expert panel and proofreaders for the transcultural adaptation. Semi-structured interviews and questionnaires were applied to analyze the narrative and construct categories to generate knowledge from the local narratives.

Figure 41: Methodological approach for the semantic adaptation of stigma measurements
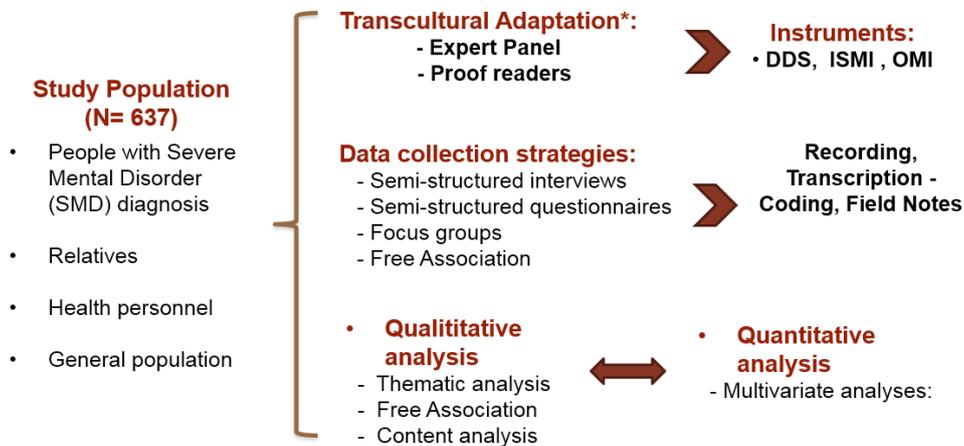
Source: Speaker's presentation copy, Mora-Rios, J., et al., (2013). Adaptación semántica de tres mediciones de estigma. Salud Mental.

The main findings centered on identifying stigmatizing attitudes towards patients from different sources, especially from the primary healthcare staff, which was not addressed by Mexican civil organizations.

Patients said that they had been the object of stigma due to their illness (Mora-Rios et al., 2013, p. 1; Mora-Rios et al., 2016, p. 600). Specifically, they felt that primary healthcare staff treated them with:

- Indifference: giving priority to the care of other patients
- Denying attention
- Scolding
- Holding patients responsible for their condition
- Patronizing attitudes
- Health staff assigned nicknames and qualifications to patients
- Infantilization: treating users using diminutives.

It also identified that patients with schizophrenia and addictions felt the most discrimination. These findings belong to an extended context in which social stigma leads to a lack of recognition of human rights. This structural discrimination has impacted the funding of public policies, resulting in a lack of resources for providing training to staff. Therefore, they are causing inadequate care practices, creating emotional distress and leading to a lack of treatment adherence in patients.

To deliver a solution to this problem, the team developed an evidence-based intervention, working with focus groups including healthcare personnel to reduce and suppress stigmatizing attitudes. The 40-hour online course addressed the following topics to raise awareness:

- What do we know about mental health?
- Stigma and discrimination in care
- Expressions of stigma in health services
- What can we do?

● Recommendations

The first experience of this intervention included 108 participants and helped them modify their attitudes. It also strengthened the positive behaviors of people who already demonstrated appropriate attitudes towards people with mental health diseases. Carefully designed videos helped them understand the stigmatizing experiences of the users in the doctor-patient interaction. Some improvements need to be made to address other topics such as gender, human rights, labor inclusion and the implementation of the program in the curricula of other professionals. This experience shows that it is essential to include the local participants to develop an anti-stigma strategy.

Figure 42: Online course for health professionals
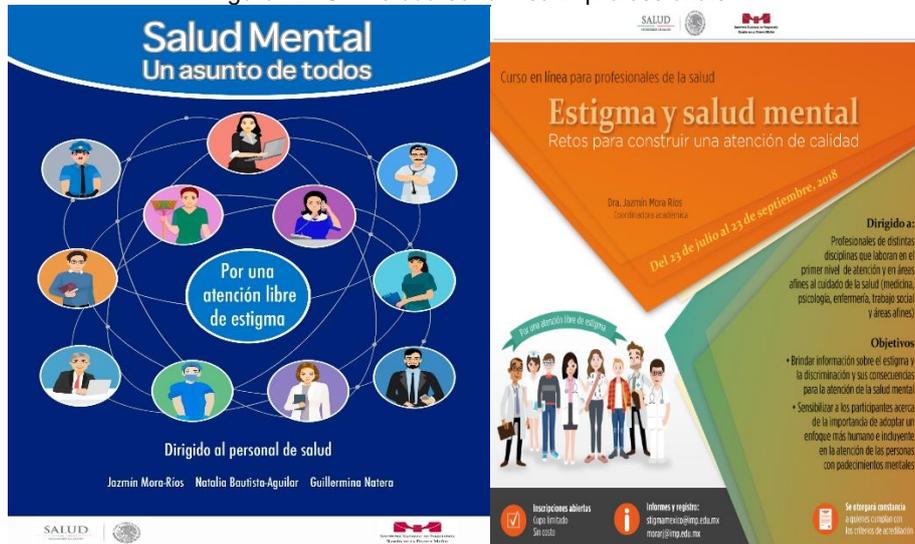
Source: Speaker's presentation copy

11.3. Preventing Stigma and Discrimination Related to Mental Health and Drug Use Problems and Promoting Recovery-Oriented Practices in Primary Healthcare in South Lima, Peru

Dr Ines Bustamante is a Psychologist from the Pontifical Catholic University in Peru (PUCP). She has a master's in public health from Cayetano Heredia Peruvian University as well as a PhD and Master of Health Science from the School of Public Health of the Johns Hopkins University. Her research interests include adolescent global mental health, sexual and reproductive health, STDs, HIV/AIDS, drug use, and the evaluation of health promotion interventions and prevention programs targeted at children, adolescents and youth. In this opportunity, she delivered the presentation entitled "Preventing Stigma and Discrimination Related to Mental Health and Drug Use Problems and Promoting Recovery-Oriented Practices in Primary Healthcare in South Lima, Peru."

Program and intervention details

Several economies are currently working on how to strengthen the networks of primary healthcare. This intervention was designed in this context, establishing to reduce stigma among healthcare workers at primary healthcare centers and promote recovery among users (MHIN, 2016). This action had a positive impact on the care of people with mental illness. It could improve individuals' mental health and quality of life and, as a result, this could contribute to social inclusion, employability, and productivity. It was conducted by the Public Health School of the Universidad Peruana Cayetano Heredia in collaboration with the Center for Addiction and Mental Health (CAMH) of Canada, and the Ministry of Health. Grand Challenges Canada funded it.

The intervention was based on Opening Minds' analysis and the experience of the Centre for Addiction and Mental Health in Toronto, Canada. They have done remarkable work on studying stigma prevention strategies with the help of panels of experts who have looked at the evidence to identify the most effective strategies and elements of interventions. They have also produced theoretical and conceptual frameworks that were useful for the intervention.

Figure 43: Stigma prevention strategies -Theoretical and conceptual framework
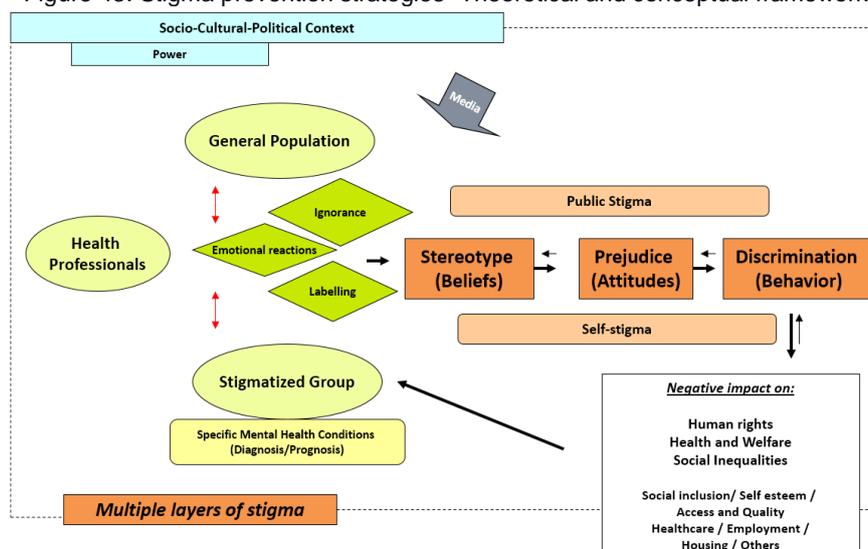
Source: Speaker's presentation copy and *Arboleda-Florez & Sartorius, 2008; Corrigan PW., 2005.*

Analysis before the intervention

It is very important not just to implement an intervention that was successful in another economy but also to adapt it to the local setting. It was essential to have this qualitative study first to measure all the issues surrounding healthcare providers and stigmas. These included identifying the type of stigma and attitudes towards recovery. Before the intervention, the team did some focus groups and interviews with healthcare providers, service users and families to

better understand their perception of stigma and healthcare. Different instruments were used, some of which were from the "Opening Minds" program.

Intervention

The intervention had five main components:

1. Development of a team of leaders (champions)
2. Innovative contact-based training (Sapag et al., 2017, p. 1479)
3. Raising awareness
4. Art-based activities for recovery
5. Analysis of internal policies and procedures

The intervention had a team of champions in each of the healthcare centers. It is crucial to include a team of six or seven healthcare providers such as physicians, psychologists, social workers, and people who work in other roles. Due to its importance as a decision maker, one team member was always the center's head.

An innovative training based on social contact was fundamental to develop the attitudes and capabilities of healthcare providers. Providers received an 18-hour training led by psychiatrists or psychologists, which also included case-based workshops to increase healthcare providers' feelings of competence through the mhGAP skills-set. Trainers explained how stigma works and help providers develop self-awareness of their discursive practices. Furthermore, they focused on how to diagnose, treat, and refer a patient. Videos of patients and posters were also used to raise awareness among healthcare providers.

Recovery activities based on art are a branch of social contact. The idea was to involve different groups to think about what stigma is, what is recovery, and do a piece of art about it. Most of them decided to work on a painting. There were exercises for healthcare providers, users and care promoters that are volunteers and who are from the community that works in healthcare services.

Figure 44: Art-based activities for recovery

Source: Speaker's presentation

Finally, this program included analyzing healthcare centers' policies and procedures. Their main goal was to provide recommendations that strengthen healthcare centers' procedures to decrease stigma and discrimination against people with mental health and addiction problems since the Ministry of Health develops process flowcharts that are not always being used.

Results

After the intervention, the researchers performed assessed participants. From a quantitative perspective, the intervention reaches to decrease stigma compared to control groups. The qualitative analysis shows that if participants believe that a user with mental disorders can recover, the stigma lessens. Healthcare providers with this attitude are also more willing to help users because they feel more capable and not just refer them to a specialist center. In this sense, it is critical to change attitudes towards recovery, considering the organizational approach.

Lessons learned

Besides the contact-based elements mentioned before, it is decisive to work with the health system and authorities. Since interventions need to be adapted and developed according to the local reality, local teams are the most reliable partners to adjust the interventions to all stakeholders' real needs. Thus, it is necessary to listen carefully to the users' needs by continually promoting a user-centered approach. It is also critical to focus on improving the organizational climate, specifically how to improve the relationship between healthcare providers.

11.4. Community Mental Health Centers: Spaces of Reconfiguration of Knowledge, Psychological and Psychiatric Power

Dr Humberto Castillo is a physician from the National University of Trujillo with a master's in management in Health from Cayetano Heredia University, and a Diploma in Political Sciences, FLACSO, Quito, Ecuador. He received his Doctor of Medicine degree from Cayetano Heredia University. His research interests include mental health and human development and human resources in health. He delivered a presentation entitled "Community Mental Health Centers: Spaces of Reconfiguration of Knowledge, Psychological and Psychiatric Power."

It is important to understand the differences between psychiatric hospitals and community mental health centers in order to grasp the dynamics of power and knowledge displayed in mental healthcare services. Through the organization of spaces, the architecture of psychiatric hospitals makes us feel different by being in a waiting room and being observed from the reception desk. It also makes a difference in the doctor's office, where confessional power dynamics occur, assigning roles of cognoscible and cognoscenti subjects to the doctor and the patient. In this context, the patient and the doctor agree to play different hierarchical roles, with different moral and epistemological statuses (Santos & de Sousa Santos, 2010, pp. 1–3).

Figure 45: Waiting room and medical practice at the National Institute of Mental Health Honorio Delgado-Hideyo Noguchi
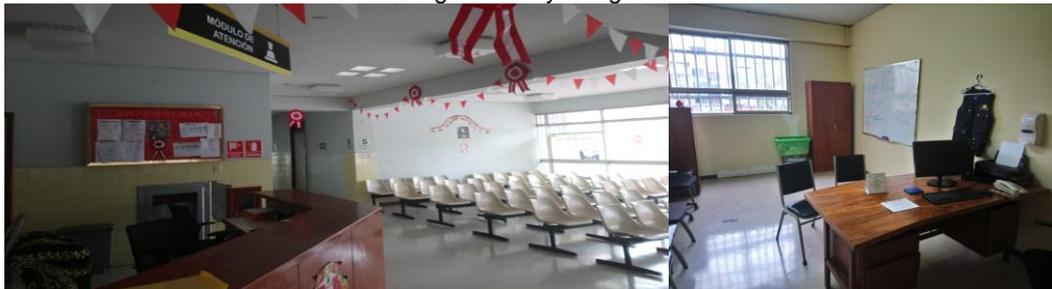
Source: Speaker's presentation copy

In this setting, the patient may be analyzed out of his or her context and social group identity. The patient's suffering, as depicted in his or her narrative, is classified and isolated into categories for diagnosing, forecasting and prescribing behaviors and medications. Finally, diagnoses are compiled, classified and aggregated into epidemiological indicators, including rates, ratios, regression results and other constructs.

This way of organizing individual narratives into data and information could be understood as a looking glass to understand reality. This process delivers knowledge about a global health system with the same issues as almost one in five people suffer from mental health diseases. The model does not help to differentiate the local diversity of people's mental health.

In contrast, the community mental health approach tries to democratize the dynamics of power. It levels the relationship between doctor and patient because it considers all participants' experiences and knowledge to better understand suffering through care groups and participatory assessments. As a result, all participants are part of a learning experience and do not have to lose their collective identity. The results have shown that this perspective towards

mental health delivers more results in less time, increasing efficiency. It also helps to build trust, which is the cornerstone of every community (World Bank Group, 2016).

Figure 46: Welfare groups and participatory diagnosis – Community Mental Health Center Nancy Reyes Lima.

Source: Speaker's presentation copy

12. Results
12.1. Results of Presentations

The need to improve mental health systems, considering that little is still being done at the medical, economic and rights levels, shall be the starting point for understanding the integration of mental health services into APEC's economic development agendas.

At the global level, problems were classified into quality, quantity and investment gaps. Evidence shows that both the inpatient and community mental health services approach must be complemented. This balance provides cost-effective services. It is therefore necessary to provide tailored-made local treatment options and consider caregivers' perspectives. The solutions for each economy need to be staggered according to income levels and shall be based on the first level of care.

Major challenges remain, such as training of primary care staff, ensuring treatment components are provided and supporting the social inclusion of people with long-term disability. The entire health system must be strengthened, focusing not only on mental health but also on physical illnesses affecting people with mental health problems.

In particular, the Asia-Pacific region faces health challenges related to urban land development, climate change, emerging diseases, civil unrest, migration and financial barriers to access to quality healthcare. For this reason, it is important that APEC economies understand that mental health has different nuances, according to distinctive realities. The diversity of APEC members economies means each economy needs to work out solutions at a local level. However, it is essential to realize that mental health is a developmental issue, which requires considering preconditions for people's good physical and mental health. For this matter, the Sustainable Development Goals agenda provides a framework to understand the interdependence of social determinants and the necessary multisectoral action required.

It is also worth mentioning that the process of urbanization in the region is a "double-edged" process, the analysis of which should emphasize the development of healthy cities. This can be achieved by identifying existing prosperous initiatives and adapting them to each reality with a pragmatic approach. They can be developed by proposing a strategic plan with achievement indicators to inform the population about their progress. These indicators shall be prioritized in accordance with their impact on public welfare.

The critical mental health situation can be improved by using the WHO's optimal mix of services pyramid, which addresses costs, needs and complexities of services required to improve the mental health of the population. On the other hand, various initiatives of the WHO Mental Health Gap Action Program (mhGAP) aimed at filling mental health gaps are also available.

Understanding the challenges facing individual economies

To better understand how to improve the current situation, the development of mental health systems in several APEC economies was outlined during this program. All of the presenters agreed with the fact that there are acute problems of supply and demand of mental health services. On the one hand, the demand is exacerbated as mental health problems increase in the domestic burden of diseases rankings and affect the wellbeing and productivity of individuals, as reflected in the calculations of lost years of healthy life. On the other hand, the lack of resources and underinvestment result in serious difficulties to cover the increasing demand.

In the case of Malaysia, three out of ten adults have mental health problems and there are difficulties in meeting the demand for mental healthcare services due to the low budget provided for them. This economy is one of many examples in which currently there is more spending on treatment and medication than on prevention and promotion. This generates a lack of efficiency in the use of resources due to the high investment in psychiatric hospitals and the fact that only marginal budget percentages are dedicated to integrating mental health into primary level of care or to community care centers. Like several economies, they face problems with stigmatization of users and lack of human resources.

A similar case is presented in Viet Nam where authorities are focusing their efforts on the difficulties experienced by many people currently seeking help for mental health issues. There are few human resources available and the emphasis is on urban hospitals rather than rural community centers.

In the case of Viet Nam, important regulatory frameworks that promote multisectoral initiatives have been developed, such as the domestic strategies focusing on mental health, on the prevention and control of non-communicable diseases, and on the health information system.

Viet Nam, and APEC members economies such as the People's Republic of China, Indonesia, Peru and the Philippines also present difficulties to offer coverage and access to mental health services across their complex territories. Some economies, like Peru and Mexico, have additionally a centralized distribution of specialized human resources for mental health, which aggravates the health professionals' gap.

As in the cases mentioned before, Indonesia's main difficulties are mental health financing, infrastructure and territorial integration. Improvements include the Mental Health Law as well as policies, guidelines and standards that promote the quality of mental health services.

Besides issues on financing and territorial healthcare governance, some economies, such as Mexico and Peru, have also faced issues with system fragmentation. In the case of Mexico, the health system additionally faces a high demand for health services due to the size of its population. The budget is insufficient to meet this demand and is allocated directly to psychiatric centers. Human resources are centralized and mental health problems and suicide are increasing, as are disability-adjusted life years (DALYs) for substance abuse-related problems. Moreover, at present, the waiting time for symptom detection, diagnosis and treatment is not ideal.

Throughout APEC members, it is clear that the perception of mental health plays an important role, as beliefs and traditions also influence decision making processes and recovery outcomes within the community. Stigma, for instance, may hinder the community's ability to think in a sustainable manner about long term solutions for real user's reintegration, for instance.

Stigma is also one of the main concerns facing Korea's mental health sector. Korea faces serious barriers to achieving a balance between sick patients' rights and public safety. One example of this is how to handle the integration of patients with mental health problems considering the risk of violence for their neighbors. This makes it difficult to eliminate stigma and devote advocacy efforts to incorporating mental health services into the community. Likewise, this economy also faces the challenge of reducing suicide rates—caused by social pressure—among young people and older adults.

Thailand is also an economy which addressed the problem of suicide among its population. The challenge of addressing the suicide rate in Thailand is compounded by the fact that there are discrepancies between the suicide data collected by the government and the data collected by the WHO. Thailand's representative described how the seasons of the year can influence the rise in suicides, which raises the question of the indirect impacts of climate change on mental health.

Additionally, it is indispensable to think about the importance of robust information systems in order to gather precise and consistent information on the situation of the mental health. The lack of these kinds of systems generates problems with producing, using and evaluating evidence. One of the most important challenges faced in the Philippines is the need to unify data and produce system-wide statistics. Furthermore, this economy has human resources retention challenges and faces logistical problems because it is difficult to adequately distribute medication in a territory made up of many islands.

Steps made towards facing these challenges/lessons learned

The mental health law and plan stand out as key achievements for the Philippines, with the involvement of both the private and public sectors including labor and education. Various representatives have been empowered on the mental health council. In addition to this, medical residents have been encouraged to develop research on this topic.

Progress has been made in Malaysia by developing a domestic mental health policy focused on happiness, resilience and productivity as well as a 2020 to 2025 mental health strategic plan. Programs have also been developed in collaboration with the education sector to analyze stress, anxiety and depression in students and to provide mental health counsellors for students. Commitment and awareness of mental health stakeholders have been promoted, including programs to reduce stigma and decriminalize suicide.

In the case of the People's Republic of China's economy, the problems that arise from the great demand for mental health services and the workforce needed to satisfy that demand were addressed in a number of ways. At a program level, programs and projects were improved by integrating a community-based approach into hospital services and increasing the budget for this. These programs also seek to involve the government in a multisectoral manner, at all levels, to offer comprehensive services from patients' diagnosis to their rehabilitation. A good example of this is the follow-up care provided to patients with psychosis.

Strides have been made in Mexico when it comes to raising awareness among the younger population. This includes an initiative to use social networks to educate youngsters on mental health issues.

In Chile, 22% of the population has experienced mental health problems in the last 12 months. Its state-run health system is constantly overstressed because almost 80% of the population uses it. The strength of this economy's process lies in the continuity between three mental health plans and its evaluation. These included lessons learned from previous plans, thus generating a feedback process.

Chilean strategies and processes for the implementation of community-based mental health models were examined in depth. The starting point of this experience was 1993, when no mental health program was included as part of the primary healthcare teams. Additionally, at that time Chile suffered from access inequalities and unequal distribution of human resources. At that time, patients' recovery was focused on the biomedical approach.

Important lessons were learned from the implementation of community-based mental health networks nationwide, such as the importance of producing and using evidence and service evaluation. Such information shall be used in a timely fashion during the political decision-making process. Chile trains its mental health sector leaders to negotiate at more political levels. Likewise, they have identified that leadership is strengthened through networks and strategic alliances both inside and outside the ministries of health.

With a fragmented health system and the demand for access to health rights, Peru managed to make progress by modifying the general health law, by virtue of which a mental health reform was declared mandatory. As a result, the hospital- and illness-focused model transitioned to a people's recovery-focused model, encompassing mental health determinants and rights protection. This model was shown to be more cost-effective and achieved a greater coverage and quality of care through a territorial approach.

In the case of Mexico, mental health services were not widely available at the first level of care. There is a lack of coordination between educational and health sectors, as well as a lack of centralized leadership to direct initiatives in each state. Facing the problem of addictions, specialized working units have been created and distributed throughout the economy. Through political and technical consensus, a proposal was made to design a new system in which all mental health and addiction centers work together with multidisciplinary and specialized teams. This represents a major achievement, since their addictions framework was only influenced by the criminalization perspective.

In the case of Korean psychosocial rehabilitation, limitations were identified when the medical model focuses exclusively on symptom reduction. To overcome these limitations, progress was made in understanding that recovery implied maximizing functionality and successfully reintegrating individuals into the community. This requires giving them a sense of hope, pragmatically helping them solve everyday problems and offering them skills training. This process emphasizes community support rather than hospitalization, individualized recovery plans, and patients' and their families' involvement in the decision-making processes to provide more autonomy for users.

To provide vulnerable populations with services, the Chilean experience involved peer-designed interventions. In the case of young people's suicide problems, a panel of adolescent experts was invited to design an app to prevent suicide. This approach was also extremely helpful in the use of experts by experience (people who had been through psychotic events) to assist people who were coming out of psychosis. As revealed by the experts, people who experience psychosis are often victims of stigmatization even after their psychotic episodes.

To remove stigma, Canada launched the "Opening Minds" initiative that encourages research on anti-stigma programs. Its mission is to know which initiatives work and why they work. The essential components for an intervention to work were outlined and these programs were made available to the public.

The experience of Mexico shows the importance of a cross-cultural adjustment of measurement instruments to address this problem locally. In the specific case of Mexico, identifying stigmatizing attitudes towards patients in primary healthcare centers was key since this was the first time this target audience had been researched. Improved attitudes towards patients were seen following a 40-hour online course in which interaction with patients was developed.

In the case of Peru, emphasis was given also to the experience of interventions to reduce stigmatizing attitudes of health workers in first level of care centers in the south of Lima. Key ideas from the Opening Minds initiative were adapted. These interventions help to understand how healthcare providers, users and their family perceive stigma. Furthermore, the importance of empowering leaders (champions) in healthcare centers, as well as of providing activities in which those involved can express what they feel about stigma through art were mentioned. Finally, the importance of providing users with information about treatment processes was emphasized.

Peru also presented the epistemic limitations of the exclusively psychiatric approach considering it occurs within a power dynamic in which the patient's situation is analyzed in a decontextualized manner. Given this difficulty, the experience developed in community mental health centers was presented as spaces to build trust. There, patients' experiences and knowledge are viewed as a valuable way to understand their suffering and a collective learning experience is created.

The importance of adequate financing

When analyzing financing strategies for community mental health networks, emphasis was placed on the importance of focusing not only on how much it is spent but also on carefully considering on what and how it is spent. With this aim, using evidence to present arguments with economic and moral approaches was recommended.

This could be seen in the experience of England, in which decision makers needed to understand the impact that mental health has on mortality and on the years of life lost. This dispels the myth that mental health has no impact on mortality, which often affects prioritization in health policies. Just as it can be effective to account for the long-term impacts on education, the labor market and social cohesion, investing in mental health promotion and prevention through job interventions and suicide prevention has been shown to have a cost-effective return in low-income families or people living alone. This is also true for timely investment in depression and anxiety problems in children.

It is important to consider delegating responsibilities and sharing mental health financing. For example, prevention programs can be financed collaboratively with the ministries of education. Another optimization measure is linking financing to individuals and not only to institutions. In this way, users are given the flexibility to determine on which type of treatment to spend. In order to fill the gaps in human resources, it is crucial to consider investing in task shifting.

Young people's experiences were presented to better understand investment in community mental health programs in vulnerable populations. In 75% of cases, mental health problems begin between the ages of 15 and 20. According to the English experience, applying interventions such as training school teachers to tackle mental health problems, providing poverty alleviation instruments and implementing anti-bullying measures are good opportunities to invest in young people's mental health.

In the case of Peru's financing, until 2012 there was no way to clearly differentiate the resources used in mental health. Based on a Constitutional Court decision, a policy and strategies were designed to cover patients' needs. An analysis then showed that constructing more psychiatric hospitals was not the most cost-effective option. Using a more scientific and evidence-based approach, community mental health centers were instead promoted. These have achieved a 30% coverage, resulting in a greater decentralization than that obtained by psychiatric hospitals. Likewise, transparency of spending has been improved using web portals where the public can learn about the resources allocated to mental health.

Frameworks for approaching mental health planning

Current challenges in the Asia-Pacific region include rapidly changing technological and economic advances, megacities, migration, climate change, the high homicide rate in Latin America and the burden of mental health morbidity. Therefore, it is crucial to evaluate the applicability of the systemic approach to mental health planning.

Unlike the linear approach, the systemic approach considers different causes, contexts and histories to develop mental health system models. So far, there are two health systems that have sought to integrate this approach, one from the Basque Country of Spain and one from Scotland. This approach uses not only evidence-based organizational research and policies, but also evidence-informed ones. The public policy formation process is inherently political. It is made up of factors such as beliefs, personal interests, political considerations, traditions, past experiences, budget constraints and evidence. This means that evidence is considered as one factor that can shape public policy, but it is not the only one.

For this reason, to influence decision-making, it is as important to work with the media to communicate complex data as it is for the society and experts to understand it. An example of this type of data visualization is the Mental Health Atlas.

These processes require an interdisciplinary approach, such as the "expert-based cooperative analysis" approach in which professionals from different disciplines participate in policy design and creation. Models designed to provide solutions require an understanding of real-world conditions, which are always local ones. From this point, typologies of mental health systems can be developed to help compare their performances.

Evaluation, understood as the assessment of structures, inputs, process, outputs and impacts of programs, plans and policies in mental health, seems to be an underlying concern when it comes to improving community mental health services. Since it can offer common standards through its research methodologies and offers versatile local and international comparisons, it is a tool with great compelling power. Strictly technical, as well as economical perspectives, properly communicated, can be used as a call for action.

In the experience of Chile, evaluation served as a tool to persuade policy makers to put depression treatment programs in the primary care level, since they demonstrate to be effective. During the process it was shown that it is politically negligent to not produce and use evidence and evaluation to establish a common language and articulation with politics. Most of all, in

cases of early prevention programs in schools, where prevention shows a win-win situation from the moral and cost-evaluation standpoint.

It is important to expand the scope of evidence use for evaluation. It is necessary to integrate different kinds of knowledge of interdisciplinary teams, in order to have a more comprehensive understanding of the decision-making process, on a technical level as well as on a political level. Being able to communicate correctly evaluation is important for the interdisciplinary work as well as to benchmark different local realities. This will enable decision-takers and managers to learn to think locally and globally the improvement of community mental health services.

Key takeaways

As APEC economies try to tackle the mental health problems of their populations, they have to manage complex issues, such as extremely limited financial and human resources, the violation of the human rights of people with mental disorders, which leads to a decrease of life expectancy, and the fact that economies are investing most of their resources in long-stay facilities and specialist psychiatric services, even though a minority of the population will actually use these facilities and services. Consequently, most of the very informative presentations given by the representatives from Chile; People's Republic of China; Indonesia; the Philippines; Korea; Malaysia; Mexico; Viet Nam and Thailand identified the need to position mental health as a priority within the health agenda of APEC economies.

Mental health challenges are global. It is very probable, however, that solutions to these challenges lie in the community. For these reasons, it is crucial to think about mental health as a global challenge with local solutions and to take up this challenge fully aware of what did not work in the past.

When it comes to finding solutions, it is necessary to use common sense while also incorporating evidence and the search for evidence-based solutions. Additionally, human rights should be the driving force behind these solutions.

Mental health is far more challenging than other disciplines, in the sense that there is no single solution that works for everyone. Given that there is no single answer to the needs of people with mental disorders, diverse measures are needed to respond to this issue adequately. It is easier to identify what should not be done in mental health because previous measures were not necessarily correct. It is much more challenging to find proper solutions, which is the reason why economies work together periodically in workshops/events like the one described in this report.

12.2. Workshops
During the workshop sessions, event participants discussed the questions of positioning mental health on agendas, priority actions for cooperation between economies, and strategies for the sustainability of community mental health. The following are the participants' proposals, classified into different topic areas.

First workshop group activity: Integration of mental healthcare into the APEC economies' development agendas

How to position mental health as a priority within the health agenda and the development agenda of APEC economies?

Using information on mental health impacts for decision making
- Political interest and budget. Research to know the impact of mental health issues.
- Strengthen epidemiological surveillance due to mental health's impact on disability.
- Research to show the impact of mental health issues.
- Discuss costs to influence the decision-making process: Social costs, burden of disease, and the cost-effectiveness of services and interventions.
- Discuss social implications of mental health problems: How key performance indicators are affected by mental health problems.
- Life expectancy: how it is affected by mental health problems.
- Develop research projects to show mental health's impact.
- Demonstrate to government authorities that mental health impacts are as important as physical health.
- Develop situational analysis to compare several issues to analyze the lost years of life due to disability and the increase of mental disturbances. This information would help raise awareness in the decision-makers.

Multi-sectorial dialogue
- Bring forward a forum for dialogue about multisectoral planning.
- Take mental health out of the medical-only approach, involve other sectors.
- Make mental health everyone's business. Putting mental health in all public health programs.
- Make other specialties and sectors participate in mental health.
- Intersectoral collaborations: To bring mental health issues to other sectors besides the health sectors such as education, labor, social inclusion.
- Improve dialogue between the Ministry of Finance and the Ministry of Health.
- Connect different strategies to the mental health strategy.

Advocacy
- Social media use for mental health advocacy.
- Involve social media and social figures, such as public figures, celebrities or spiritual leaders.
- Identify critical windows for mental health advocacy, such as post political conflict scenarios, crises, disasters or violence issues. For instance, violence against women in Peru and Mexico.
- Emphasize the importance of mental health to policy makers and leaders.

Stigma
- Bringing information to the people.
- Give people well-founded information to reduce stigma and to develop empathy towards people with mental disorders.
- Raise awareness among the health sector and the community in order to break the stigma on mental health. There is still a lot of resistance to giving this topic its place on the agenda.

Preventive approach
- Point out educational issues, such as the number of stressed students and teachers affected by mental health problems.
- Make the impact of mental health on children visible. Considering mental health aspects in all children development policies.
- Promoting a comprehensive and preventive approach focused on the user, his/her family and his/her community.

Universal Healthcare
- Understand universal access to mental health as an indicator of how advanced and civilized a society is.
- Provide equal services to vulnerable populations.

Empower users
- Empower user organizations and associations so that they speak to policy makers and leaders.
- Use and listen to population demands regarding their mental health issues, such as reducing working hours due to their direct impact on mental health.

Indicators
- Develop and use qualitative and quantitative mental health indicators to measure an activity's impact, efficiency and mistakes.

Systems fragmentation
- Reducing health system fragmentation. Some subsystems in the private sector are not covering mental health issues.

International affairs
- Use of international frameworks.

Legal standards
- Strengthen the mental health legislation.

What are the priority actions to strengthen collaborations between APEC economies? On what levels? (political, advocacy, services, training, research, information systems, community participation, etc.)

Share information
- Use a digital hub to share information about the economies.
- Develop data sharing platforms between economies.
- Exchange experiences.
- Offer systematization of experiences and public policies, to identify and learn from the economies' approaches to mental health.
- Use telemedicine and exchange experiences among the APEC members economies.
- APEC could share updates on economies' mental health situations.

Research
- Develop research funding opportunities for all APEC economies.
- Provide mental health literacy training and provide grants to researchers to help other economies.
- Open research channels, such as virtual libraries with the participation of APEC members economies.
- Strengthen research to carry out quantitative and qualitative studies.

Training
- Strengthen policy makers' capabilities.
- Strengthen skills, exchanging experiences through internships between APEC members.

- Increase training to primary care staff.

Declarations
- APEC could develop a declaration on mental health to advocate at the highest levels.
- APEC members economies should make a statement based on the guidelines of the Declaration of Caracas (1990).

APEC meetings and working groups
- APEC meetings could also focus on mental health issues
- Strengthen (virtual) working groups and set goals for regular assessment between APEC members.

Integrate mental health in all plans
- Integrate the mental health agenda in all the plans and cooperation endeavors.
- Strengthen community participation: build support networks with the active participation of the community.

Stability
- In the political field: promote stability of economies' mental health policies in spite of changes of government.
- International policies that will protect mental health and implement mental health regulations to ensure the continuity of these programs.

Cooperation
- Promote collaboration between academic institutions and policy makers.

Policy dialogue
- Promote continuous policy dialogue between APEC members economies and community-based organizations.

Anti-stigma
- APEC could launch an anti-stigma campaign.

Advocacy
- Launch mental health advocacy spaces with multiple economies.

Assessment
- Offer quantitative and qualitative information like satisfaction surveys regarding the mental healthcare services.

Education
- Improve the awareness of mental health. Strengthening the capabilities of education staff (teachers) through changes in the curricula that integrate the community approach in mental healthcare.

Second workshop group activity: Challenges for the implementation, strengthening and sustainability of community mental health services

Examples of implementation of community mental health services

- People's Republic of China: Implement peer support for psychosis.
- Viet Nam: Local volunteer groups the provide a space of social inclusion for people with psychosocial disabilities. They talk and share feelings, and the group provides opportunities with jobs and meaningful activities. Indonesia has similar experience: "Empowerment House."
- The Philippines: Tele-psychiatry (Geography is a major factor/problem).
- Integration, awareness and alliance with social actors.
- Active community participation.
- A clearly delineated and effective strategy with primary healthcare centers.
- Dissemination of mental health reform and regulations.
- Healthcare managers training and commitment to mental health issues.
- Schools with teaching counseling, funded by the Ministry of Health and by the Ministry of Education. Implementation of community mental health centers.
- Improve the territorial distribution of health services through health clinics and family doctors.
- 25 Community Mental Healthcare Centers.
- Screening interventions at the community.
- Community mental health centers in Peru:
    - Callao 3
    - Cusco 5
    - East Lima 5
- Mental health and addiction hospitalization units in Peru:
    - Cusco 1
    - Day hospital
    - East Lima 1

What were the barriers to the implementation and sustainability?

Human Resources
- High turnover rate of human resources.
- Lack of trained human resources in community mental health.
- Gap in human resources, especially in the provinces.
- Lack of enough professionals to deliver psychotherapies.
- Health professionals claim to not have the time required to provide mental health consultations.
- Insufficient human resources.
- Difficult at the beginning to find a good environment.
- Finding volunteers.
- Physical health teams do not routinely do mental health screening for patients.

Management
- Administrative inflexibility and inefficiencies for the implementation of community mental health services.
- The reference and counter-reference healthcare systems are not effective. Nonspecialized professionals tend to refer patients that they could manage.
- Lack of clear job descriptions for staff roles in community mental health services.
- Assignment of tasks that have little to no relation to mental healthcare.
- Problem with accountability: who is accountable if something wrong happens.

Acceptance of the new model
- Persistence of the biomedical model.
- Compatibility issues: Community mental healthcare center indicators are measured in the long term and not in the short term, as considered by the biomedical model.
- Lack of awareness and knowledge of the community mental healthcare model.
- At the beginning, some general practitioners did not believe in the new model. Nurses, specialists and family members did not believe patients could provide peer-to-peer support services.
- Stakeholders do not believe in dedicated teams, only in broad services teams.

Budget
- Insufficient budget allocation.
- Improper use of the budget allocated to mental health (by Regional Governments and Management).
- The community mental health services are not entirely covered by state funding. They have to raise their own funds. This limits their capacity to implement local, customized solutions.
- Financial support to buy ingredients to make products.
- Trying to find a place to provide service. But in Beijing places are very expensive.

Priority and political interest
- Political self-interest of authorities.
- Political instability.
- Political priorities.
- If it is not a priority for the local authority, incomplete services are provided: The local government provides the technology (hardware). However, a health professional and a technical person are also necessary (human resources).
- Little attention of authorities and political managers to the decision-making process regarding mental health.

Technology
- Reluctance of the people to use technology. Lack of confidence.
- Sustainability of the technology. If equipment network is not fast, it will harm the whole process of telepsychiatry.

Infrastructure
- Inadequate infrastructure.
- Lack of infrastructure.

Stigma
- Stigma still undermines decisions.
- Strong cultural barrier, stigma: no prior experience and lack of confidence.
- Social stigma.

Drug Supply
- Supply deficiency of psychotropic drugs in primary care.

Users empowerment
- Poor dissemination of mental health services and users' rights.

Geography
- Geography can jeopardize peripheral professional support.

Measuring
- Lack instruments to measure the activities of the community mental healthcare centers.

Network
- Difficulties in network coordination.

Training

- Lack of training in community mental health approaches.

Assessment
- Big challenge: Mental health programs for different population groups are fragmented (elderly, young). Financial resources go to each program; however, it is hard to have a general evaluation.

What solutions did you/could you find for implementation and sustainability?

Advocacy
- Involvement of local, regional and national government promoting community participation in the implementation of mental healthcare centers.
- Outsiders may be more effective at convincing stakeholders.
- Compel decision makers—at a regional and local level—to be more sensitive to community mental health.

Integration in the workforce
- Demonstrate the value of their work: Show products or souvenirs manufactured by users of the community mental health center to authorities.
- Make alliances with local businesses.
- Work with provincial labor departments.

Intersectoral
- Intersectoral partnership and effective strategies.
- Intersectoral work for cost absorption. Educational interventions for addictions and mental health are going to be funded by the Ministry of Education.
- Get support from health, labor and police sectors.

Training
- Mental health literacy and training for all healthcare providers.
- Training on community mental health approaches for primary health teams.
- Professional development on the subject of community mental health, designed for interdisciplinary teams and delivered digitally.

User-friendly environment
- Extend the official time dedicated to mental health consultations.
- Provide user-friendly mental health problem screening tools for service users that they can answer themselves, without the need for a professional.
- People can self-refer themselves to coaches: mindfulness approach.

Assessment
- Create instruments to evaluate and measure the activities carried out by community mental healthcare centers.
- Elaboration of a situational diagnosis and/or baseline of mental community healthcare centers.
- Monthly assessment of general health team management of local cases by a psychiatrist.

Human Resources and Training
- Local and regional internships. Managers and health personnel training.
- Increase training for mental health professionals focused on the community mental health model.
- Create a network of volunteers in the province.
- The "Clinical and Social Accompaniment" is a program that strengthens the capacity of non-specialized teams in the community mental health centers' areas of influence.

Family
- Involve the family. Involve the caregivers in the planning, implementation and delivery of care.
- Allow family members to participate and learn from what users can do.

Legal
- Local, domestic and international legal support.
- State regulations or laws specifying the involvement of national, regional and/or local government.

Research
- Develop research.
- Evidence-generating research on the impact of community mental health services.

Lessons learned
- Gather lessons learned to serve as a model for replicating successful experiences and avoiding errors.
- Systematize implementation experiences.

User empowerment
- Empowerment of the association of users and relatives at the domestic level.
- Enhancing user's responsibility for their own mental health is achieved by all the services delivered.

Community
- Collaboration with society. For instance: associations of people with disabilities.
- Involve peer support groups.

Government commitment
- Commitment from the national government. Demonstrate effectiveness at pilot level and then scale up.

Awareness
- Awareness raising.

Stigma
- Stigma programs for all people involving professionals and people with lived experiences.

Prevention and promotion
- Prevention and promotion are now done by general teams.

Technology
- Use of telehealth technologies.
- Present data to municipal health officer (majors), so that they are aware of the real scope of mental health problems. This helps in funding technologies (telemedicine).

Network integration
- Strengthening integration of healthcare networks.
- Unburdening central administration to place psychiatrists in remote areas.

Funding
- Increased funding to continue the implementation of the mental healthcare network.

Workers empowerment
- Formation of the National Association of Workers in Mental Health Services.

Third workshop group activity: Recommended strategies for APEC – Sustainability of community mental health programs

What strategic mechanism should be proposed to APEC for the sustainability of community health programs?

Road Map
- The APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific is ending in 2020 and there is a need for feedback regarding the anti-stigma campaign at the employment programs. This would provide economies with important information about what experiences are successful in terms of implementation and which can be adapted to each one.
- Build, strengthen and improve, taking the existing Roadmap as a starting point.
- Consider developing a wellbeing fund in terms of a wellbeing agenda upon which wellbeing is defined based on the culture's concept of wellbeing, focusing on prevention and promotion of health rather than treatment. Additionally, demonstrate how other sectors profit from mental health improvement.

Research
- In terms of research, it is important to point out that mental health research is usually included in a larger, non-specific research agenda. APEC should support funding for local research in terms only of mental health and not in other research funding, to develop multicentric studies.
- Create a joint budget—with measurable goals—to promote research projects.
- Promote research in community mental health.

Data and statistics
- Reduce the underreporting of detection and diagnosis of mental illnesses.
- Improve data and statistics reports to consider production as well as the quality and performance of healthcare services.
- Collecting data: There is a need to know what type of data is available within the APEC economies, for example, a profile of mental health in each economy.

Prevention and promotion
- Update the strategy and promote the prevention and promotion approach.
- Consider the entire population when it comes to how to prevent disease or dementia. Hence, address problems of better housing, a better education system that already includes some form of mental health education for students in its curriculum. Better employment, less violence, etc.
- Improve teachers' career preparation so they can be prepared to address the mental health issues of their students.

Funding
- When it comes to funding, APEC is not obliged to provide funding, but economies could propose, facilitate and organize a meeting of finance managers from each economy to promote and to advocate for mental health, to consider this matter a priority when it comes to supporting the program.
- Strengthen legal and financial support for the sustainable development of community mental health.

Benchmark, exchange of information and best practices
- Consider benchmarking community mental health services. To understand what is happening in this economy, in terms of problems with suicide, drug addiction, etc. It could be necessary to create a database about the implementation of mental health programs.
- Take the best practices from every economy.
- Create a mental health hub and give the responsibility to a particular economy to coordinate the database, standardize information and describe shared issues.

- Regarding APEC economies, there are different models of implementation for community based mental health services of each one, so there is probably a need to have a common questionnaire so every economy can answer the same question.
- Create a sharing platform to build a community mental health network and exchange experiences along with research projects.

Best practices
- Standardize assessments and elaborate qualitative and quantitative indicators to identify the best public policies.

Multisectoral work
- Mental health should be present in all policies. Mental health should be a component also in policies that are not directly related to the healthcare sector, such as education, justice or labor policies.
- Take domestic action on community mental health with an intersectoral approach, engaging stakeholders from the educational sector, and make them participate in the promotion and prevention of mental health.

Information
- Information interventions for a broad audience and over more extended periods.
- Use updated evidence-based scientific information to raise awareness about community mental health. The Schools of Public Health could effectively disseminate findings to the healthcare staff.

Evidence-based interventions
- Develop evidence-based intervention programs to reduce stigma and promote social integration.
- Elaborate intervention plans in community mental health adapted to each economy and designed to monitor short-, medium- and long-term goals.

Workforce
- Invest in the workforce.
- One possible strategy: there is a need to expand beyond health organizations. There is a need to collaborate and involve foreign affairs offices of each economy to have goals to secure the intersectoral collaboration of each economy.

Public-private partnerships
- Consider discussing a private-public partnership, where the private sector may be able to fund certain matters and probably provide resources.

Alliances
- Strengthen strategic alliances and align their efforts to common goals.

Fragmented systems
- Integrate fragmented health systems to improve mental healthcare access (especially relevant for Peru and Mexico).

Empower users
- Engage diverse stakeholder groups and empower healthcare users.

Primary healthcare
- Strengthen primary healthcare and integrate their services with community-based mental health.

13. Participants' experience

According to the participants' opinion, the diversity of international decision-makers helped enrich the discussions with various viewpoints. The presentations enhanced the participants' understanding of commonalities and differences regarding the different mental health systems, such as planning and evaluation. They found out that the economies have common challenges and barriers, such as the lack of priority in political agendas due to the low political engagement and the weak mental health legislation.

It is a significant achievement for the participants, as leaders, to be aware that they share the same concerns about mental health, regarding:

- high mental disorders prevalence and their increased burden to health systems
- insufficient resources and their inadequate allocation in hospitals
- lack of human resources and the difficulties in the implementation of community mental health programs.

Recognizing that participants from Latin America and Asia -despite the significant cultural differences- share a common ground, as APEC member economies, was central for their experiences in this workshop. This enabled participants to learn from each other's experiences. Their improved understanding of APEC economies' mental health systems promoted also to reflect on their own system from another perspective.

The participants noticed that several economies share a common trend towards community-oriented services that are closer to users. These services are ideally designed to understand diverse users' contexts and how they construct the meaning of their lives within their communities. Further, it was possible to distinguish different development stages and grasp the critical role that organizational culture plays in this process.

The workshop facilitated asking questions that will require further inquiry, such as the nuances of key concepts like "task-shifting" in each system. It also set the path for learning from systems outside the APEC member economies, such as those that already went through mental health reforms.

Additionally, participants put into practice multiperspective thinking. They considered a macro-approach, where economies share many features, meso-, micro-, and nano-perspectives where each mental health system's characteristics were differentiated. They learn how some economies operationalize things at a service delivery level and an individual practitioner level. The presentations and discussions enhanced system thinking, considering elements beyond the mental health systems and taking into account different contexts.

The visit to the Community Mental Health Center in La Victoria benefited participants since they learn how to handle mental health gaps with a multidisciplinary team. They described the Center as an example to be followed. This experience encouraged participants to also share their best practices.

Figure 47: Visit to Community Mental Health Center in La Victoria (Lima)

The workshop offered some opportunities for future work. Participants highly valued the expert's network since it will contribute to exchange strategies to prioritize mental health in the world health and development agendas and construct a web of knowledge.

After the workshop, international collaboration began through some representatives of the Chilean, Mexican, Australian, and Peruvian economies. The representatives worked in different projects, focusing in research topics on community mental health policies, strengthen competences in systemic evaluation, and evaluation studies of mental health networks.

Participants identified the need to develop common approaches, terminology, and analysis methods to improve effectiveness and fill the service provision gaps. Also, they point out that it was essential to continue engaging the society as a whole, with all their different actors, institutions, and resources. The goal of the all-policies-approach must be clear: achieving a higher quality of life, happiness, and meaning. Moreover, groups like the "experts by experience" should be included in this ambitious task, since they deeply understand what it means to go through stigmatizing experiences. Therefore, they complement some deficiencies in the mental health system.

All participants acknowledge that it is necessary to fulfill the citizens' needs to the best and help communities organize themselves to construct their mental health. This endeavor represents a long journey that requires flexibility and impact orientation.

In conclusion, participants emphasize the need to do more of these events within the framework of the APEC Mental Health Working Group, considering that the Forum pragmatic approach favors systemic reflections oriented towards economic and human development.

Figure 48: Discussions and presentations during the Workshop

14. Conclusion and Recommendations

As discussed in the report, it is clear that the mental health problem seriously affects APEC economies and that it should be understood as a developmental issue, along with the Sustainable Development Goals and the region's rapid urban land development. In this context, various stakeholders, multiple causes and different contexts are linked to this great challenge.

The analysis shows that what has been done so far is not enough, in terms of quantity, quality and investment. There is a high demand for mental health services. There are not enough human resources or a sufficient budget to cope with that demand. In some economies, there is a significant amount of turnover among staff or human resources are centralized in few cities. Furthermore, some health systems have fragmentation problems, which hinder access to health services. Despite the need for reform, many politicians and managers are still set on the old biomedical and hospital-focused model.

Many important stakeholders involved in the decision-making process believe in myths. One of the myths is that mental health has no impact on life expectancy, which is proven to be false. Likewise, at the management and care levels, the myths that strengthen stigmatization affect users.

Relevant aspects, such as the onset of mental health problems during youth are not prioritized in the agendas, although most mental health problems begin between the ages of 15 and 20. As a result, people's quality of life is reduced throughout their lives, affecting their education, their ability to coexist with society, their labor integration and their productivity.

There are various issues that must be addressed to improve quality of life by means of better mental health services.

Thanks to an approach focused on the user's social determinants in the community, community mental health stimulates recovery because it involves users in the decision-making process and fosters their functionality and integration into the society, giving them hope and the ability to handle their daily lives. All this makes users feel valued by their community despite the old stigmas.

Given these positive results, mental health centers should be strengthened using this approach, so they continue to consider users' and caregivers' opinions. Valuing patients' experience and knowledge builds up a collective awareness that creates trust. This approach should also address the physical diseases of people with mental health disorders.

It is important to design, analyze, select and adapt interventions and tools, as has occurred with those that are already available: the Mental Health Gap Action Program (mhGAP) of the WHO, and the "Opening Minds" program from the Mental Health Commission of Canada (MHCC). It is important to continue identifying what works, study why it works and disseminate these tools so that they are adapted to each context.

Furthermore, costs, needs and complexities of users' healthcare should be analyzed and prioritized to determine the emphasis the reform has put on mental health systems. The systemic approach can be used in the planning process since it considers different causes and contexts. In this approach, evidence is one element, together with beliefs, traditions, experiences, history, political considerations and budget limitations. Therefore, said approach considers different disciplines and local information. This framework makes it essential that the data be correctly visualized and communicated to the society and experts.

It is necessary to conduct research, collect evidence and evaluations, and use this information extensively for the design of public policies. Similarly, it is important to train mental health leaders to negotiate policies, as well as to build networks and strategic alliances inside and outside the ministries of health.

Using evidence is essential to visualize the impact of mental health on education, health, employment, productivity and people's mortality. Managers need to analyze their budget not

only at a general level but also at a specific level by reviewing in detail what it is being spent on and how it is being spent.

For this reason, it has become evident that there is a great need for investment in mental health prevention and promotion through interventions targeted towards young people, both in schools and outside of them. It is also recommended to work on systemic solutions that address challenges such as gender-based violence. This task requires the coordination of various levels of public and private sectors, including health, education and employment.

It has also been shown that strengthening legislation, policies, plans, guides and standards can help guarantee access to financing but that it is necessary to follow them up with learning feedback processes that go beyond political volatility. Similarly, it is useful to focus planning on coverage, quality and cost-effectiveness, without forgetting the territorial approach.

It is important to foster advocacy that promotes changing mental health stakeholders' mindsets. With this goal, the general and the specialized communities need to be informed about stigmatization problems that affect patients' recovery. Empowerment of patients is important because they need to know about their rights and be able to ask politicians to introduce policies for their problems.

It is essential to guarantee universal access to health and strengthen the entire primary care system. At the human resources level, it is important to provide healthcare staff with more training, as well as to facilitate the use of task shifting to meet the high demand for mental health services.

Discussions suggest that APEC economies should have platforms to share and compare their data, experiences, assessments and updates of public policies with the aim of creating a learning space outlining best practices for the Asia-Pacific region. This would ideally include funding mental health research and continuing to hold working meetings to which specialists from the various economies' ministries of finance and economics are invited, in order to strengthen those efforts' economic sustainability.

Finally, the mental health component of the "The Healthy Asia Pacific Roadmap 2020" initiative should be assessed to continue consolidating objective achievement. Thus, it is advisable to evaluate the mental health topics in the economies' various policies and in the non-binding documents of the Forum.

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