

**DRAFT**

**Regional Framework for  
the Future of Mental Health  
in the Western Pacific 2023–2030**



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**Abbreviations**

COVID-19	coronavirus disease
DALY	disability-adjusted life year
LMICs	low- and middle-income countries and areas
mhGAP	Mental Health Gap Action Programme
MHPSS	mental health and psychosocial support
NCDs	noncommunicable diseases
PICs	Pacific island countries and areas
PIMHNet	Pacific Islands Mental Health Network
SDGs	Sustainable Development Goals
UHC	universal health coverage
WHO	World Health Organization

## Executive summary

Good mental health is integral to the well-being of everyone. It enables people to realize their full potential, show resilience amid adversity, be productive across the various settings of daily life, form meaningful relationships and contribute to their communities. Promoting and protecting mental health is also critical to a well-functioning society. It fosters social capital and solidarity, which are essential during times of crisis. Advancing the mental health agenda contributes to the larger vision and goal of making the World Health Organization (WHO) Western Pacific Region the healthiest and safest in the world.

However, in the Western Pacific Region, over 215 million people suffer from mental health conditions. Home to a quarter of the world's population, the Western Pacific Region is large and diverse. A wide range of health system capacities exists across the Region, from highly advanced health systems to remote and small island communities. The Region also has a diverse range of social vulnerabilities and pressures that have significant implications on mental health. Rapid and unplanned urbanization, poverty and other economic pressures, the digitalization of lifestyles and increasing drug use are giving rise to various threats to mental health and well-being. The growing proportion of older adults in the Region is contributing to the rise in prevalence of dementia and other ageing-related mental health conditions. The Region is also home to some of the most climate-vulnerable countries and areas, exposing populations to climate-related anxiety and stressful living conditions from extreme weather events. These trends affect people of all age groups and backgrounds.

According to the *2019 Global Burden of Disease* report, disability-adjusted life years (DALYs) attributed to anxiety and depressive disorders, schizophrenia, Alzheimer's disease and other forms of dementia, and self-harm increased significantly in the Region from 1990 to 2019. Among those aged 10 to 39 years, DALYs from mental health conditions were higher than those attributed to sexually transmitted infections, chronic respiratory diseases, cardiovascular diseases and cancers. Indeed, suicide continues to be a leading cause of death among young people, and for every death, there are many more suicide attempts, creating lasting impacts among families and loved ones as well.

The emergence of the coronavirus disease (COVID-19) pandemic in 2020 has exacerbated these public mental health issues. Stay-at-home orders, school and work closures, economic uncertainty, and the general disruption of daily life have created an environment that magnifies pre-existing mental health stressors. The prevalence of anxiety and depression globally is estimated to have increased by more than 25% during the first year of the pandemic, with young people and women the most affected. The greatest increases in prevalence of common mental disorders were observed in areas that were highly affected by COVID-19. The pandemic has been a watershed moment that exposes the urgent need to correct systemic imbalances, promote greater cohesion within and between various systems, and respond collaboratively to enable the fullest expression of health and well-being.

Since the endorsement by Member States of the *Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific*, some progress in advancing the mental health agenda has been observed in the Region, particularly in terms of governance. As of 2020, all Member States in the Region who responded to the Mental Health Atlas survey had a stand-alone or integrated mental health policy or plan. However, the transition towards community-based care remains disappointingly slow. Mental health promotion and prevention programmes and activities have increased, but it is

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unclear whether this increase has translated into concrete impact. Based on a summative assessment of the Regional Agenda carried out at the end of its implementation period in 2020, the reorientation of the mental health paradigm away from a disease-oriented focus and towards community-based services and resources is an unresolved issue. Mental health promotion, service integration, mental health in emergencies and a heightened focus on the community were key themes Member States identified for the future of mental health during various dialogues and consultations.

At the global level, specific mental health targets were included in the Sustainable Development Goals, and the extended WHO *Comprehensive Mental Health Action Plan 2013–2030* was aligned with the global development agenda. In the Region, *For the Future: Towards the Healthiest and Safest Region* was endorsed by Member States during the seventieth session of the WHO Regional Committee for the Western Pacific. This visionary document advocates a systems approach supported by operational shifts that enable new ways of working. These developments provide the foundation for a transformative environment for the future of mental health.

Unfortunately, despite clear links between mental health and other social issues and areas of work, the leadership and vision behind mental health remain relatively narrow in scope, often overlooking critical opportunities to promote mental health beyond the health sector. Competing priorities and perspectives have led to an underemphasis on mental health and well-being, and, consequently, a lack of priority at all levels of governance. Emphasis on scaling up services while neglecting quality improvement perpetuates models of care that deepen stigma, delay appropriate health-seeking behaviour and can give rise to coercive practices. At the same time, while recent capacity-building initiatives to provide care in non-specialist settings have shown promise, the integration of mental health into primary health care, the lack of human resources and chronic underfunding are perennial health system challenges. Too many people living with mental health conditions are neglected, confined at home, placed in isolation or in circumstances that further exacerbate their condition.

Informed by a planning method known as backcasting, alongside dialogue and consultation, this new *Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030* extends the *For the Future* vision into the mental health agenda. The Regional Framework is envisioned to support Member States in designing national strategies, plans and policies on mental health, to strengthen political advocacy for greater resources and commitment, and to encourage coordination and collaboration among partners so that we can build back better and fairer, creating mental health systems that are more resilient to future health emergencies.

**Our shared vision for the future of mental health:** A region where people enjoy the highest level of mental health and well-being, grounded in social solidarity for a transformative environment that promotes mental health for all.

In order to achieve this vision, three directional strategies describe the way forward – in other words, what we will do – for the mental health agenda in the Western Pacific Region:

- **Refocus** the mental health agenda to include well-being and reaching the unreached through leadership that champions mental health in all policies and strategies generated from the grounds up that match solutions to the voiced needs of communities, supported by strategic communication and advocacy.

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- **Transform** mental health support and care into a community-based ecosystem of health and social services and innovations, enabled by an expanded and well-trained mental health workforce comprising specialists, non-specialists and social networks, delivering the full range of interventions, and underpinned by a responsive information system that drives impact.
- **Embed** mental health into the settings and journeys of daily life by engaging and empowering communities with tools and platforms that enhance protective factors and reduce risk factors across the life course, and by fostering social interventions and partnerships with co-benefits for mental health and other social sectors.

Four enabling strategies provide the basis for key actions that will transform this vision into reality – in other words, how we will do it:

- **Future-oriented decision-making.** Applying principles from implementation science and strategic planning (such as backcasting and other hypothesis-driven approaches) to redesign mental health services to ensure equity, early access to advice and care, and a continuum of care throughout the life course, supported by evidence, data and research to increase demand, acceptance and impact of mental health interventions.
- **Grounds-up approach.** Co-designing solutions that are grounded in the local context and shared community values, informed by insights from people with lived experience and everyday citizens, and animated by the dynamism and creativity of young people and the next generation of mental health professionals.
- **Community-based partnerships.** Applying community-based partnerships to mobilize the full range of community assets within an integrated mental health ecosystem; linking mental health to broader social, economic and political domains; and identifying champions that can drive intrasectoral and intersectoral partnerships for mental health (for example, education, social welfare, justice and labour) in key settings (for example, home, school, workplace, community and online).
- **Innovation for mental health.** Applying the full range of technological and social innovation to revolutionize all aspects of mental health, expand digital mental health, and reach the unreached or those excluded by the current health system.

This vision of the future of mental health calls for collaboration on a much wider scale than ever before, especially as the Region builds back better and fairer and moves forward from the impact of the COVID-19 pandemic. New paradigms, narratives and ways of working must be embraced, alongside the mobilization and empowerment of communities. Together, this can break intergenerational patterns and unfair social structures that perpetuate stigma and stand in the way of people achieving the highest level of mental health.

There is no health without mental health. The time is now for social solidarity behind mental health and well-being for all.

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# 1. Background

## 1.1 To be well is to have good mental health

Good mental health is integral to the well-being of everyone. It enables people to realize their full potential, remain resilient amid adversity, be productive across the various settings of daily life, and form meaningful relationships and contribute to their community. Good mental health is also critical to a well-functioning society. This is especially true during times of crisis, as demonstrated by the coronavirus disease (COVID-19) pandemic. Protecting and promoting mental health provide multiple co-benefits – for individuals, families, communities and societies.

Informed by a planning method known as backcasting and co-created through dialogue and consultation, this new *Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030* builds on the vision delineated in *For the Future: Towards the Healthiest and Safest Region*. *For the Future* is the shared vision for the work of WHO, Member States and partners to improve health and well-being in the Region, as well as the Region's implementation plan for the WHO global *Thirteenth General Programme of Work 2019–2023*. The Regional Framework is envisioned to: support Member States in designing national strategies, plans and policies on mental health; strengthen political advocacy for greater resources and commitment; encourage coordination and collaboration among partners; and help build back better and fairer towards mental health systems that are more resilient to future health emergencies.

The shared vision of the Regional Framework is anchored by these cross-cutting principles:

- Health equity and the right to health, aligning with the goals and aspirations of universal health coverage (UHC) towards health for all.
- Inclusion, early intervention and a recovery-oriented approach that empowers people at risk of or living with a mental health condition to pursue the fullest expression of life.
- Multisectoral and cross-sectoral engagement, recognizing the inherent value of all voices and perspectives in advancing the mental health agenda.
- Country context, respecting local wisdom and insight, including indigenous paths towards healing.

## 1.2 Mental health in the Western Pacific Region

Home to a quarter of the world's population, the Western Pacific Region is large and diverse with some 1.9 billion people in 37 countries and areas that span a third of the distance around the globe. A wide range of health system capacities exist across the Region, from highly advanced health systems to remote and small island communities. The Region also has a diverse range of social vulnerabilities and pressures that have significant implications on mental health. These trends affect people of all age groups and backgrounds.

### Mental health trends and risk factors

More than half of the people in the Western Pacific live in cities, and that proportion is expected to rise even more as the Region urbanizes very rapidly.<sup>1</sup> Cities and the built environment can confer many advantages that promote health and well-being.<sup>2</sup> However, unplanned urbanization and poor urban



governance can also lead to poor mental health due to social isolation, unsafe living areas, limited access to green and open spaces, and the daily stress associated with overcrowding, broken transport systems and limited mobility, among other risk factors.<sup>3,4</sup>

At the same time, the combination of longer life expectancies and declining fertility rates is increasing the proportion of older people in the Region. In some countries, these demographic shifts are progressing at an alarming rate and contribute to the growing prevalence of dementia and other ageing-related mental health conditions.<sup>5,6</sup> Older adults are also at increased risk of experiencing loneliness and social isolation, which have been linked to poor physical and mental health, further increasing the risk of developing dementia, depression and other comorbid diseases.<sup>7</sup> These large-scale changes in the age composition of the population and its corresponding impact on the prevalence of mental health conditions are increasing demand for integrated health and social services and exerting pressure on social systems and families.<sup>8</sup>

Consumer demand and expanding access to the internet also fuel the digitalization of lifestyles across the Region. In several countries in the Western Pacific, over 80% of internet users are active on social media. While digital mental health holds tremendous potential, the growing digital divide can lead to further inequities.<sup>9,10</sup> Furthermore, toxic online interactions are direct threats to mental health;<sup>11</sup> widespread misinformation or disinformation in the digital environment can also lead to confusion and distress.<sup>12</sup>

Poverty and other economic pressures – such as sudden job loss due to the pandemic, financial insecurity and the lack of social safety nets – can lead to significant distress and worry. There is a well-documented cycle between poverty and poor mental health.<sup>13</sup> Chronic exposure to adversity due to poverty and other hardships makes people more likely to develop mental health conditions such as depression and anxiety.<sup>13</sup> Once established, poor mental health decreases productivity and is a risk factor for poor overall health, perpetuating a vicious cycle of poverty and disease that is very difficult to break.<sup>13</sup> Approximately 400 million people live in extreme poverty in the Asia Pacific region, trying to make ends meet on less than US\$ 1.90 a day.<sup>14</sup> On top of their daily struggle, people living in poverty face tremendous structural disadvantages when trying to access health care, especially mental health care. Oftentimes, these individuals are hidden, excluded and unreached by current programmes and services,<sup>15</sup> contributing to further social polarization and health inequity.

More than 269 million people worldwide had a history of psychoactive drug use in 2018, with an estimated 36 million people living with a drug use disorder.<sup>16</sup> Globally, every year, more than a half million deaths can be attributed to drug use; over 70% of these deaths are related to opioids, with over 30% caused by overdose.<sup>17</sup> In Asia and Oceania, 84 million people had used drugs in 2018.<sup>16</sup> This has a direct cost to society from loss of productivity, premature mortality and increased health-care expenditure. Furthermore, substance use is linked to increased risk of criminalization and incarceration.<sup>17</sup> These conditions compound the risk of developing mental health conditions such as substance dependence and mood disorders,<sup>18</sup> and can lead to risky behaviour among young people in particular.<sup>19</sup> Ultimately, drug use can trigger substantial suffering and lead to impairment in personal, family, social, educational, occupational and other vital areas of functioning.

Finally, the Region is also home to some of the most climate-vulnerable countries and areas in the world.<sup>20</sup> Extreme weather events and other environmental hazards can lead to large-scale health emergencies and complex humanitarian crises, causing widespread mental distress and suffering.<sup>21</sup>

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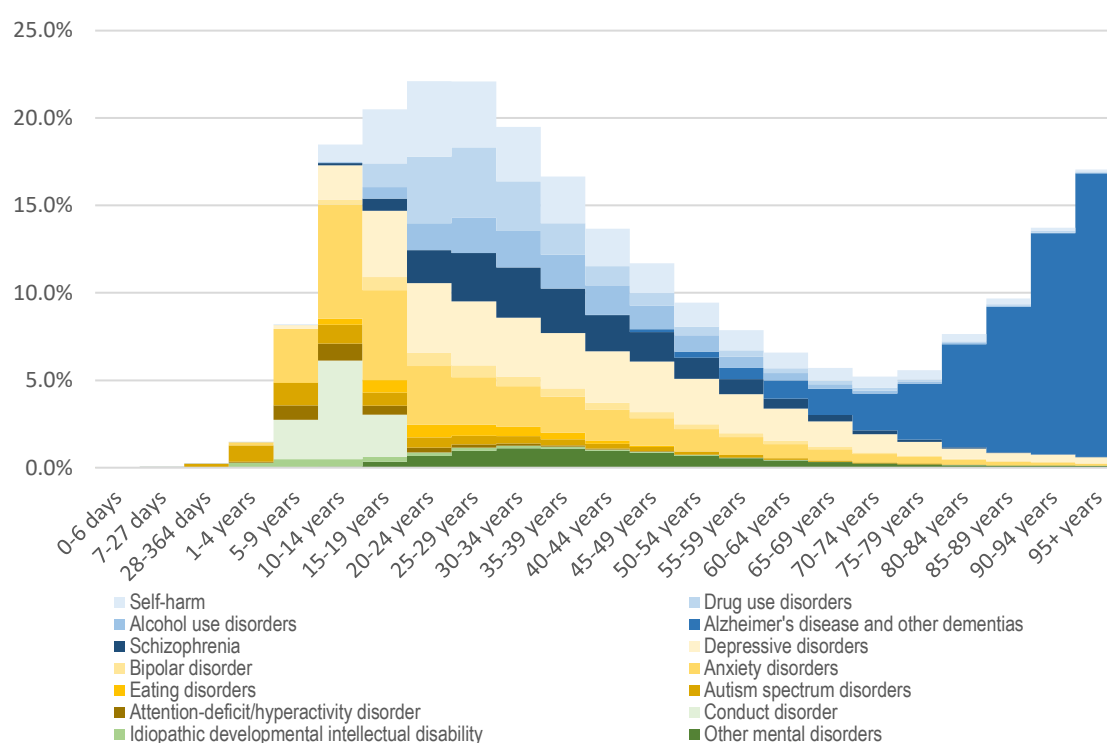
Small island and coastal communities are facing an uncertain future due to rising sea levels, leading many to feel anxious and afraid for the sustainability of their way of life.<sup>22</sup> The increasing occurrence of extreme weather events due to climate change also contributes to flooding and stressful living conditions in cities. Poor urban communities are especially affected, further compounding threats to their mental health.<sup>20</sup>

All of these trends and contexts highlight that – alongside increasing services – action within broader social, economic and natural environments is necessary to truly promote and protect the mental health and well-being of the people of the Western Pacific Region.

### The public health burden of poor mental health

In the Western Pacific Region, more than 215 million people suffer from mental health conditions. Data from the *2019 Global Burden of Disease* report indicate a steady rise in the public health burden from mental health conditions in the Region from 1990 to 2019.<sup>23</sup> Disability-adjusted life years (DALYs) attributed to anxiety and depressive disorders, schizophrenia, Alzheimer's disease and other forms of dementia, as well as self-harm, increased significantly during this period.<sup>23</sup> DALYs from mental health conditions were higher compared to those attributed to sexually transmitted infections, respiratory disease, cardiovascular disease and cancers among those aged 10–39 years.<sup>23</sup> Among children and adolescents, DALYs attributed to anxiety and conduct disorders have increased, with DALYs attributed to eating disorders increasing among older adolescents. Adults aged 55 and older experienced a dramatic increase in DALYs due to Alzheimer's and other forms of dementia (Fig. 1).

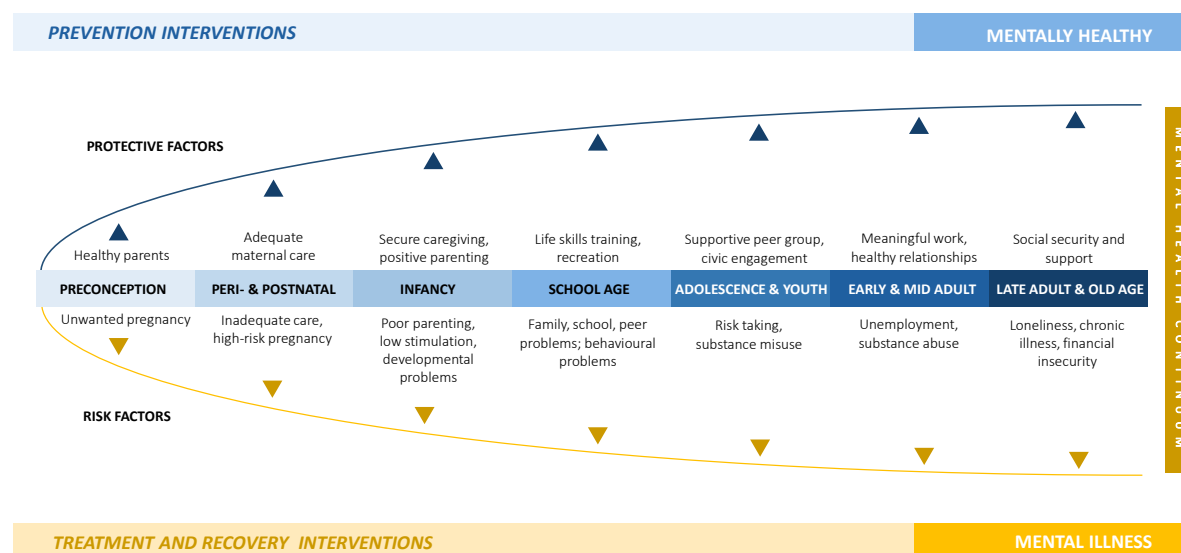
**Fig. 1. Percentage of total DALYs for mental disorders and dementia by age group, 2019**



Source: GBD Compare [online database]. Seattle: Institute for Health Metrics and Evaluation; 2022 (<https://vizhub.healthdata.org/gbd-compare/>, accessed 31 May 2022).

These data highlight the challenges of promoting and protecting mental health across the life course (Fig. 2). For example, children conceived and born during adverse circumstances are at increased risk of developing mental health problems later in life. These circumstances could include experiencing poverty, being the result of an unwanted pregnancy, and having mothers who received poor maternal care and lacked parenting skills.

**Fig. 2. Potential trajectories of mental health throughout the life course**



Source: Adapted from Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553–98. doi:10.1016/S0140-6736(18)31612-X.

Childhood and adolescence are critical stages of development when young people develop skills in self-control, social interaction and learning, alongside forming their identity. Adverse childhood experiences, such as family conflict at home or bullying in school, can cause trauma and have a damaging effect on these core cognitive and emotional skills. Common mental disorders, such as depression and anxiety, and behavioural disorders are among the leading causes of poor mental health and disability among young people.<sup>24</sup> Early intervention is key to addressing the mental health crisis facing young people, especially in the wake of the COVID-19 pandemic and its impact on the educational, social and economic milieu. Unfortunately, despite the enormous need and the clear dividends from early intervention, young people are faced with various barriers to accessing timely support and care.<sup>25</sup>

Wider social and economic circumstances also have an impact on the choices and opportunities for adolescents as they transition into adulthood. The mental health of adults is protected by meaningful work and healthy relationships, and social security and social support are essential to maintaining good mental health later on in life. On the other hand, substance use, financial insecurity, chronic illness, loneliness and social isolation are examples of risk factors for poor mental health during adulthood.

Different interventions spanning prevention, treatment and recovery are therefore necessary to address the complex and dynamic interactions of multiple risk and protective factors at different stages of life.

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### **Preventing and monitoring suicide in the Western Pacific Region**

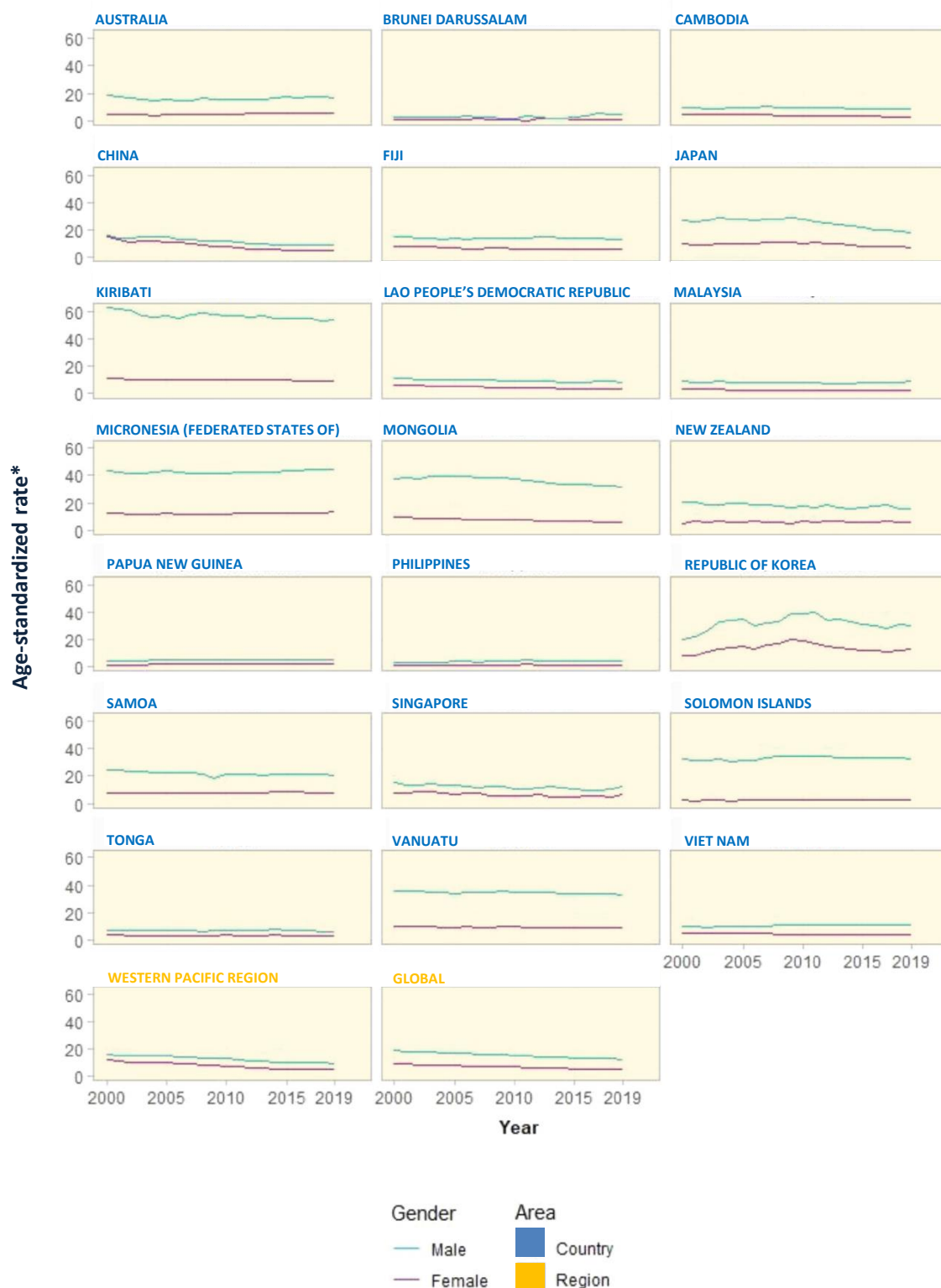
In 2019, approximately 703 000 people died due to suicide globally, and one out of four of these deaths occurred in the Western Pacific Region (Fig. 3).<sup>26</sup> Suicide is a major public health issue across a wide range of settings from highly developed to small Pacific island countries and areas (PICs). Suicide rates in some countries in the Western Pacific are among the highest in the world.<sup>26</sup> The risk of suicide is particularly concerning among young people in PICs. For every death due to suicide, there can be 20 times as many suicide attempts.<sup>27</sup>

Lack of data due to absent or poor-quality information systems further contributes to the problem.<sup>23</sup> Reliable suicide mortality statistics are currently only available in high-income countries in the Region. Australia, Japan and the Republic of Korea maintain national hospital-based registries. For low- and middle-income countries and areas (LMICs), suicide mortality is usually estimated through statistical modelling where data are available. As for suicide attempts and self-harm, only Australia has a dedicated self-harm monitoring system that collects data at the level of the emergency department.<sup>26</sup>

### **Vulnerable populations and mental health**

Vulnerable populations that are unreached by health systems, programmes and services are disproportionately burdened by mental health conditions and mental distress. Populations living in remote, hard-to-reach rural areas, in closed settings such as prisons, and in institutional settings such as orphanages and nursing homes have a higher prevalence of mental health conditions, but less access to mental health services and psychosocial support. In addition, there is a growing list of at-risk groups that face very specific threats to their mental health (for example, migrants, refugees, young people, older people, post-conflict survivors, gender and sexual minorities) who require more proactive outreach and tailored interventions but are also often excluded by current care pathways. The stigma and discrimination that trans and gender-diverse people experience in health-care settings, for example, are well documented.<sup>28</sup> Stigma and discrimination present significant barriers to accessing health services and increase the risk of mental distress, self-harm and suicide (Box 1).<sup>29,30</sup>

Fig. 3. Age-standardized suicide rates by gender in the Western Pacific Region, 2021



\* Death rate per 100 000 estimated resident population as of 30 June (mid-year).

Source: WHO Global Health Estimates [online database]. Geneva: World Health Organization (<https://www.who.int/data/global-health-estimates>, accessed 31 May 2022).

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### Box 1. Reaching the unreached and mental health

Among the thematic priorities of *For the Future: Towards the Healthiest and Safest Region* is reaching the unreached, highlighting the need to protect vulnerable populations, especially in settings where health systems are weak and any progress in improving public health remains fragile.

In the context of mental health, unreached populations are disproportionately burdened by poor mental health due to: disparities in access to health and social services; higher overall exposure to stress, stigma and adversity; low mental health literacy and delayed health-seeking behaviour; and structural barriers that hinder the fullest expression of health and well-being.

For example, in populations that live in remote, hard-to-reach rural areas, there is a higher prevalence of common mental disorders coupled with fewer resources (for example, health-care infrastructure and workers, caregivers for older people) and increased exposure to risk factors (for example, heavy alcohol consumption and alcohol dependence). The lack of palliative and maternal care in rural areas also illustrates the links between weak health systems and poor mental health outcomes, contributing to reduced quality of life among patients with chronic illness, increased risk of postpartum depression and increased depressive symptoms among people living with HIV. Gender roles also contribute to these disparities, with the risk of suicide higher among men in rural areas due to pressures arising from rural-to-urban migration, economic insecurity, climate change and cultural norms that discourage appropriate health-seeking behaviour.

Populations that are displaced from their home environments, either through migration or as a consequence of conflict or complex humanitarian emergencies, represent another example of the negative impact of health inequities on mental health. In general, migrant populations have poorer mental health and more frequent suicidal ideation or attempts compared with the host population. Social isolation and loneliness, stress associated with acculturation and poor working conditions increase the risk of poor mental health. Limited mental health literacy, language and cultural barriers, and the absence of social safety nets (for example, health insurance) limit access to health and social services among migrants. Asylum seekers in detention facilities present with an extremely high prevalence of self-harm and mental health conditions compared to asylum seekers in community-based settings.

Examples of evidence-based strategies for reaching the unreached include: mobilizing traditional and spiritual or religious leaders who can help reduce stigma and other barriers to access; harnessing social capital in rural areas to maximize the protective and supportive impact of psychosocial interventions; and deploying digital mental health apps to overcome language barriers and logistical constraints in remote settings.

To substantively reduce mental health inequities, reaching the unreached must be at the core of the mental health agenda. It is vital that unreached populations be recognized and strategies that are responsive to their specific context be developed.

### Mental health during the COVID-19 pandemic

The COVID-19 pandemic has exacerbated these public mental health issues. Acting as both a mirror and a lens, since 2020, the pandemic has brought into sharper focus pre-existing inequities, while exposing populations to high levels of stress and adversity. Stay-at-home orders, school and work closures, economic uncertainty, and the general disruption of daily life have created an environment that magnifies all of these pre-existing mental health stressors.<sup>31</sup> At no other point in recent history has a single event caused nearly everyone to feel some form of distress and need for support. It is estimated

that the global prevalence of anxiety and depression increased by more than 25% in the first year of the pandemic, with young people and women particularly affected.<sup>32</sup> The greatest increases in prevalence of common mental disorders were observed in areas that were highly affected by COVID-19, based on recorded mobility data and daily infection rates. Social isolation due to restricted mobility during the pandemic was a major driver of the increased prevalence of common mental disorders. Loneliness,<sup>32,33</sup> fear of infection, personal suffering, grief after bereavement, and financial worries were also contributing factors.<sup>32</sup>

Available data on deaths due to suicide did not indicate a significant change in rates since the pandemic began. However, data did indicate a potentially higher risk of suicidal behaviour among young people. Loneliness, a positive COVID-19 diagnosis, and physical and mental exhaustion – among health workers in particular – increased the risk for suicidal thoughts.<sup>32</sup> It is important to note that available data were collected during the early phase of the pandemic and mostly from high-income countries. Further study is needed to accurately capture the full extent of the pandemic's impact on suicidality and suicide mortality, especially in LMICs.

Unfortunately, at a time when so many people required support, the pandemic also disrupted the provision of mental health and social services.<sup>34</sup> According to a global rapid assessment conducted from June to August 2020, essential psychosocial support was lacking in many places, with community-based activities and services for vulnerable groups particularly affected. On the other hand, telemedicine was the most frequently reported strategy to overcome these service disruptions.<sup>34</sup> Based on limited data, psychological interventions that were evaluated were found to be effective in preventing or reducing pandemic-related mental health problems (Box 2).<sup>32</sup>

Overall, the state of mental health in the Region remains a picture of uneven progress and unfulfilled potential. Varying levels of readiness to address emerging mental health issues and mental health in emergencies are apparent, while gaps in research and evidence are holding back progress in policies and programmes. The promise of significant breakthroughs in addressing common mental disorders, child and adolescent mental health, suicide prevention, care for people living with dementia, and the control of substance use has not been realized.

**Box 2. Psychosocial and community interventions during the COVID-19 pandemic in the Western Pacific Region: a scoping review**

The COVID-19 pandemic necessitated the rapid development and implementation of mental health and psychosocial support (MHPSS) programmes to address pressing psychosocial needs. A scoping review carried out from May to July 2020 synthesized available evidence from published and grey literature on non-pharmacological intervention programmes utilized as part of the immediate mental health and psychosocial responses in the Western Pacific Region.

The general adult population was the primary intended beneficiary for nearly half the interventions documented in the review. The second-largest proportion of interventions addressed the needs of those directly affected by COVID-19, including front-line workers and people in isolation and quarantine. Interventions for populations identified as most likely to require intervention were less prominent in this review. For example, few interventions addressed gender-based violence, migrants and minority populations, gender and sexual minorities, people with chronic illnesses, psychiatric inpatients and older people.

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The most common modality across interventions was remote delivery, with most programmes consisting of hotline services and chatlines. Crisis hotline interventions were either repurposed and scaled up for the COVID-19 response or developed specifically to address current MHPSS needs. Anonymous crisis support hotlines are useful for timely front-line mental health support. In addition to hotlines, “telemental health” provided psychological interventions offered by trained or lay mental health counsellors via a digital platform. “Telepsychiatry” has been in development for some time now, and the COVID-19 pandemic is likely to further promote the use of this intervention medium.

Another promising mental health intervention was self-help, whether it was guided or unguided, or delivered via written materials or through a structured digital programme. Self-help interventions are of low intensity and appropriate for use among the wider population that may experience low to moderate symptoms of mental ill health. Additional programmes that were underutilized were peer-support interventions, mass communication programmes and the engagement of local healers in the delivery of interventions.

Further work is needed to establish intervention programmes that are inclusive of all populations within the Western Pacific Region, including international migrants and various subpopulations within countries. In addition, few programmes included in the review incorporated any plans for evaluation or scale-up of an intervention following the COVID-19 period. Collaboration across multiple sectors was also not apparent in the review. Nearly all programmes were delivered as stand-alone programmes. In the current pandemic, the extent to which multisectoral collaboration existed to deliver programmes is unclear. Given the rapid onset of the pandemic, this type of collaboration may not have been feasible. However, given the links between broader social determinants of health and well-being that are likely to influence the continuing development of mental health problems in the community, action across sectors is warranted.

### 1.3 The current approach to mental health is leaving too many behind

In 2013, Member States endorsed the *Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific*. Since the endorsement, some progress in advancing the mental health agenda has been observed, specifically in terms of governance and legislation. According to the *Mental Health Atlas 2020* survey, all responding countries had either a stand-alone or integrated mental health plan or policy, and 79% had a mental health law.<sup>35</sup> To address priority conditions – for example, depression, schizophrenia, suicide risk and mental health in emergencies – Member States have introduced and scaled up training and capacity-building activities, such as the Mental Health Gap Action Programme (mhGAP), developed national plans and strategies, invested in mental health facilities, and conducted research and health education activities.<sup>1</sup> More than half have at least two national, multisectoral mental health promotion and prevention programmes. School-based mental health and COVID-19-related activities were the most common forms of mental health promotion initiatives reported in 2020.<sup>35</sup>

However, the recent Atlas survey also indicated that the transition towards community-based care remains disappointingly slow, and the provision of quality mental health care in many settings is still limited, depriving too many people across the Region of rights-based health care and support. While there has been an increase in mental health promotion and prevention programmes and activities, it is unclear whether this increase has translated into actual impact. Half of patients discharged into the community do not receive a regular follow-up visit.<sup>35</sup> The median number of mental health nurses, psychiatrists, social workers and psychologists in the Region is 7.4, 1.5, 1.0, and 0.8 per 100 000



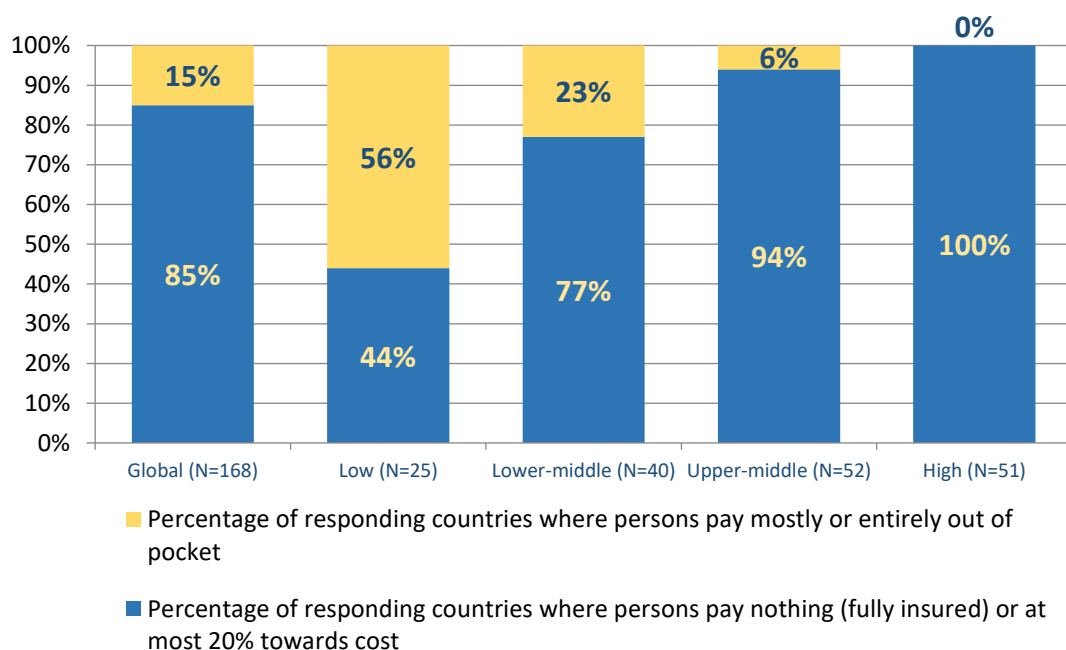
population, respectively.<sup>35</sup> The numbers of social workers and psychologists are extremely low in LMICs in Asia and in PICs.<sup>35</sup>

The previous mental health plan, the *Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific*, also identified frequent bottlenecks to updating national mental health policies, programmes and plans. Based on a summative assessment that was carried out at the end of its implementation period in 2020, the reorientation of the mental health paradigm away from a disease-oriented focus and the expansion of community services are unresolved issues. Other bottlenecks that were identified during the summative assessment include fragmented service delivery stemming from inadequate policy support and human resources, and under-prioritization of the social determinants of mental health. Furthermore, Member States expressed the view that mental health promotion, service integration, mental health in emergencies and a heightened focus on the community should be key themes reflected in future strategic documents.

Despite the significant burden of poor mental health and the growing clamour for more action and investment, as a whole, this area of work remains undervalued, underfunded and under-prioritized – median government expenditure on mental health in the Region is US\$ 6.40 per capita and varies significantly among countries.<sup>35</sup> In LMICs in Asia, median government expenditure on mental health is only US\$ 1.40 per capita.<sup>35</sup>

According to the *Mental Health Atlas 2020*, 56% of low-income countries reported that payment for mental health services is mostly or entirely out of pocket (Fig. 4). This proportion is even higher for payments for psychotropic medication; 71% of low-income countries reported that these payments are mostly or entirely out of pocket as well. In stark contrast, all high-income countries reported that mental health services were fully covered by insurance or that patients paid at most 20% of the cost. For psychotropic medication, 98% of high-income countries reported the same (Fig. 5).

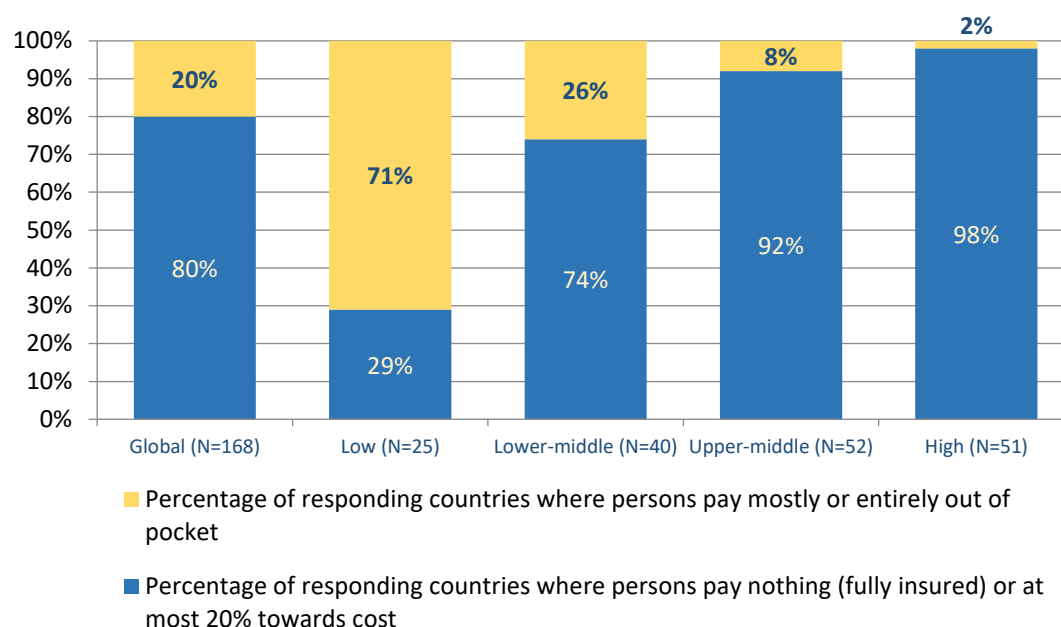
**Fig. 4. Source of payment for mental health services, by World Bank income group, 2020**



Source: Mental health atlas 2020. Geneva: World Health Organization; 2021.

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**Fig. 5. Source of payment for psychotropic medications, by World Bank income group, 2020**



Source: Mental health atlas 2020. Geneva: World Health Organization; 2021.

Fundamentally, these imbalances reflect several interrelated themes and factors. For example, the links between mental health and its more upstream determinants – poverty, exposure to adversity, family and social environments, etc. – are poorly understood by decision-makers and the public. As a result, the ways that mental health is shaped by social factors remain largely hidden and not fully appreciated. Oftentimes, it is only during episodes of acute crisis or distress that the magnitude of these relationships is revealed.

On 13–14 July 2021, WHO convened an expert consultation on the future of mental health in the Western Pacific. The meeting gathered mental health experts from across the Region representing various mental health-related disciplines. At the conclusion of the meeting, experts called for concerted action to address the following issues in order to advance the mental health agenda in the Region:

**The need for emphasis on promoting mental health and well-being in addition to addressing mental health conditions.** Promoting mental health and improving well-being have not been a priority at all levels of governance. Competing priorities and perspectives within the mental health community itself have resulted in inconsistent and unclear communication and advocacy. Mental health promotion campaigns and initiatives are not designed for impact and often do not progress beyond raising awareness around mental health conditions.

In addition, the focus of actions and interventions has traditionally been on providing treatment for people living with mental health conditions. This leaves too little attention and resources for promoting the mental health and well-being of the whole population, failing to recognize that all people at all stages of life have mental health needs and rely on conducive environments and societies to maintain or improve health.

It is therefore critical for interventions to reduce risk factors and enhance protective factors throughout the life course to increase opportunities to experience good mental health, alongside preventing mental health conditions. Adding more voices to conversations around mental health and grounding interventions in local context through a grounds-up approach that includes people with lived experience, the next generation of mental health professionals and young people, among others, can help reorient the overall policy environment.

**An emphasis on scaling up services while neglecting quality improvement.** Mental health resources remain concentrated in institutionalized settings that provide specialized care, instead of community-based settings where the need is much greater and resources can be utilized more efficiently. Unfortunately, the overreliance on institutional care also perpetuates negative stereotypes associated with mental health care. These stereotypes delay appropriate health-seeking behaviour and can lead to coercive practices. People living with mental disorders are sometimes perceived as threats to their own communities, giving rise to violations of their human rights and the denial of services. Instead of receiving care and support, too many people living with mental health conditions are neglected, confined at home, placed in isolation or in circumstances that further exacerbate their condition. Limited data on the mental health status of vulnerable populations make it difficult to design appropriate interventions and demand accountability. Poor mental health literacy also contributes to low self-efficacy and a lack of agency among people living with mental conditions or experiencing mental distress.

The integration of mental health services into primary health care remains a challenge. Limited capacity and the absence of a systematic approach to reforms in service delivery are widespread. Service fragmentation contributes to the lack of priority for mental health services. At the same time, mental health services are often excluded from health financing schemes, such as private and publicly funded health insurance plans. This is a significant barrier to accessing services, especially among populations with limited financial capacity (for example, poor people, young people and people with disabilities) who are also at higher risk for developing mental health conditions.

Limited human resources are another perennial issue. The full potential of task-shifting approaches is not being met due to multiple factors, such as an overburdened primary health-care workforce, a lack of confidence in non-specialist health workers to deliver basic mental health interventions, and approaches to training and capacity-building that do not take full advantage of technology. Furthermore, the historical reliance on specialist services has perpetuated an overly biomedical approach to mental health care. This has led to the marginalization of other health and social workers, restrictive professional licensing regulations, and the underutilization of evidence-based psychological, complementary or community-led treatment modalities.

**The narrow focus and scope of mental health.** Despite clear linkages between mental health and other social issues and areas of work, the leadership and vision behind mental health remain relatively narrow in scope, often overlooking critical opportunities to promote mental health beyond the health sector. Stigma remains pervasive and entrenched in many cultural attitudes and practices due to a long history of misinformation and the persistence of false beliefs and narratives – policy leadership outside the mental health sector is influenced by these narratives as well. Political leadership for mental health often does not take into account the full scale of the burden of disease, including its social and economic impact, and the evidence behind cost-effective interventions. Conflicting demands and messages from stakeholders are counterproductive to effective political advocacy. Mental health also competes with

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other issues in terms of resources and attention. As a result, mental health is rarely top-of-mind among political leaders and decision-makers. Where mental health policies and legislation are in place, insufficient human and financial resources significantly undermine their implementation.

Finally, significant gaps in information systems for mental health exist at national and subnational levels. This makes it difficult to accurately estimate the true burden of disease and the impact of programmes and interventions. At the global and regional level, mental health indicators are often unable to reflect the complexity of mental health issues on the ground.















### 1.4 A strategic opportunity for the future of mental health

*For the Future: Towards the Healthiest and Safest Region* articulates WHO's vision of public health and its priorities for the years to come in the Western Pacific. Endorsed by Member States in 2019, it highlights the importance of mental health across the different thematic priorities, for example, health security, noncommunicable diseases (NCDs) and ageing, climate change and the environment, and reaching the unreached.<sup>36</sup> It also advocates a systems approach to public health, supported by operational shifts that underlie new ways of working and enable WHO to deliver stronger support to Member States.<sup>36</sup>

This vision of the future is already reflected in the next generation of regional frameworks, some of which have clear interlinkages with mental health. For example, recently endorsed regional frameworks on healthy ageing and school health, and forthcoming strategic guidance documents on reaching the unreached, NCDs and primary health care, all have components that are directly linked to mental health. Other programmes of work complement the mental health agenda and establish a clear mandate for multisectoral collaboration and a whole-of-region response.

At the global level, specific mental health targets are included in the Sustainable Development Goals (SDGs) under SDG 3 on good health and well-being.<sup>37</sup> In addition, there are clear links between broader mental health determinants and the rest of the SDGs (Table 1). The Lancet Commission on global mental health and sustainable development has outlined strategic directions that underscore the contributions of mental health to achieving a fairer, healthier and more sustainable future for all (Appendix 1).<sup>38</sup>

**Table 1. Proximal and distal determinants of mental health across the Sustainable Development Goals**

PROXIMAL AND DISTAL FACTORS					
<b>HEALTH</b> Proximal: Mental health literacy, health service access Distal: Primary and specialist mental health care, universal health coverage					
<b>DEMOGRAPHIC</b> Proximal: Age, ethnicity, sex Distal: Community diversity, gender equality					
<b>ECONOMIC</b> Proximal: Income, debt, assets, employment, food security Distal: Recessions, inequality					
<b>NEIGHBOURHOOD</b> Proximal: Safety and security, housing, overcrowding, recreation Distal: Infrastructure, built environment					
<b>ENVIRONMENT</b> Proximal: Trauma, violence Distal: Natural disasters, industrial disasters, war and conflict, climate change, forced migration					
<b>SOCIOCULTURAL</b> Proximal: Individual social capital, social participation, social support, education Distal: Community social capital, social stability, culture					
					
					

Source: Adapted from Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. *Lancet*. 2018;392(10157):1553–98. doi:10.1016/S0140-6736(18)31612-X.

In line with the *2030 Agenda for Sustainable Development*, the *WHO Comprehensive Mental Health Action Plan* was extended to 2030 with updated targets and implementation options for Member States (Appendices 2 and 3).<sup>39</sup> The new *Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030* is aligned with the global *Mental Health Action Plan* and complements the four action areas of leadership and governance, service delivery, promotion and prevention, and information systems. It is also aligned with the key themes and messages from the *World Mental Health Report* published by WHO in 2022. The strategies and actions outlined in this new Regional Framework will also contribute to meeting the targets and objectives of the global *Mental Health Action Plan*, while taking into consideration the specific challenges and opportunities in the Western Pacific.

This new Regional Framework also builds on and complements other global goods and initiatives, providing a platform for integration and adaptation according to the regional and country context. These include: the *Convention on the Rights of Persons with Disabilities*; initiatives endorsed by the World Health Assembly to manage autism spectrum disorders, coordinate country action on epilepsy and foster a public health response to dementia; other related strategies and key references, such as the report of the WHO Director-General on the public health dimension of the world drug problem and the forthcoming global alcohol action plan (2022–2030); and flagship WHO mental health programmes, such as QualityRights and mhGAP.

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Against the backdrop of the global mental health movement, as well as the impact of a global pandemic on society and daily life, the development of this new Regional Framework for the future of mental health presents a strategic opportunity to radically transform existing approaches to mental health. Enabled by new thinking and ways of working, the Regional Framework will present a new approach that is fit for the future, while providing new impetus to building back better as the Western Pacific moves forward from the pandemic.

### 1.5 How this Regional Framework was developed

The journey towards this new Regional Framework began in 2020 with a regional consultation on the implementation of the global *Mental Health Action Plan* to review and propose updated targets, indicators and implementation options. From 2020 to 2022, while simultaneously responding to the psychosocial impact of the pandemic, WHO has been actively shaping the agenda for the future of mental health, capitalizing on the increased attention to mental health created by COVID-19.

Since then, WHO has convened a series of key activities with various stakeholders – for example, a regional symposium on mental health promotion in the COVID-19 era with the next generation of mental health professionals (Box 3) and a side event during the seventy-second session of the Regional Committee for the Western Pacific. Nineteen experts representing various mental health-related disciplines and WHO collaborating centres were convened for an expert consultation on the future of mental health. The participants consisted of clinicians (such as psychologists and psychiatrists), researchers, programme managers, public health specialists and mental health advocates. The sixth meeting of the WHO Pacific Islands Mental Health Network (PIMHNet) was also convened in 2021 (Box 4). These activities were followed by a series of dialogues with all Member States in 2022 and high-visibility communication campaigns to ensure a process that is dynamic, inclusive and conducive to co-creating a vision for the future of mental health in the Region.

The outcome of this nearly three-year journey is an ambitious new vision for the future and strategies that reaffirm the primacy of mental health to overall health, well-being and social development.

#### **Box 3. Promoting mental health during the COVID-19 era**

On 15 November 2020, WHO, together with Keio University, convened a regional youth symposium on mental health promotion in the COVID-19 era to exchange approaches and experiences in mental health promotion and psychosocial support for vulnerable populations – for example, people with pre-existing physical and mental health conditions, front-line and other essential workers, older adults and young children – during the COVID-19 pandemic.

Data shared during the symposium described the profound impact of the pandemic on mental health and well-being: as many as one in three people experienced mild to moderate symptoms of anxiety, depression or distress during the early months of the pandemic. The negative impact of COVID-19 on mental health was further exacerbated by disruptions in community-based mental health activities and services. The highest levels of disruption were observed for caregiver programmes, school mental health programmes, home or community outreach services, and services for children and adolescents.

Speakers from Japan, Mongolia, the Philippines and Vanuatu shared a variety of mental health promotion approaches and interventions. Some common themes included: the use of multimedia materials (for example, videos, leaflets, books, posters and social media) to disseminate key messages; proactive community

engagement to mobilize community resources and social capital; the use of telemedicine, crisis lines and other remote platforms for service delivery; and specific interventions targeting vulnerable populations (for example, front-line health workers).

Despite the negative impact of the pandemic, participants also recognized the unique opportunity to advocate for greater resources for mental health and to support innovation in mental health promotion and service delivery. Participants also acknowledged the need to integrate MHPSS into national COVID-19 response and recovery plans and engage with the next generation of mental health professionals, as well as the youth sector more broadly, as countries build back better to ensure the resilience of mental health systems to future health emergencies.

#### **Box 4. Nurturing a Pacific islands mental health community**

Established in 2007, the Pacific Islands Mental Health Network (PIMHNet) was launched to improve communication, coordination and cooperation among mental health leaders and stakeholders in PICs. The Network convened its sixth meeting on 23–24 November 2021 during the ongoing threat of the COVID-19 pandemic to their fragile mental health systems.

During the meeting, PIC Member States shared lessons from the COVID-19 response, including progress towards improving their national mental health capacity. Several countries and areas showcased investments in new or expanded mental health facilities, expanded training opportunities for their workforce, the launch of new services such as telemental health, and various approaches to community engagement through different forms of media. Most participants agreed that there is now increased attention to mental health and some reduction in stigma among the public.

Participants also shared their vision of the future of mental health in the Pacific. Central to this vision is a Pacific model of mental health and healing that is accessible, person-centred, culturally appropriate and inclusive. It is also critical for the mental health sector to embrace new ways of working with other sectors, understanding that strategic partnerships will be key.

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## **2. For the future of mental health in the Western Pacific Region**

### **2.1 The strategic imperative to integrate mental health and public health**

There is now broad agreement that mental and physical health are inseparable from each other, and that underlying systems and social and political factors exert a tremendous influence on every individual's health and well-being.<sup>38,40–42</sup> The prevention, treatment and care for mental and physical ill health also share many of the same principles, such as the value of early intervention and a collaborative approach that involves multiple service providers and complementary services.<sup>43</sup> Health is a unitary concept: physical wellness is incomplete without mental wellness, and vice versa. Individual health is also closely tied with the health of the community and the surrounding environment.

However, stigma and the undervaluing of mental health are barriers to achieving true parity. Mental health expenditure accounts, on average, for less than 2% of government budgets for health, less than 1% of global development assistance for health,<sup>35</sup> and no more than 4% of global health research funding, very little of which supports work in LMICs and the evaluation of public mental health interventions.<sup>44</sup>

These imbalances are even more glaring in light of the impact of the COVID-19 pandemic on the systems and social factors that underlie both mental and physical health. For example, the concept of “syndemics” has been invoked – calling attention to the confluence of health problems interacting synergistically within the wider environment, along with social and political factors, to worsen health and social outcomes.<sup>45</sup> Mental health conditions, after all, increase the risk of developing communicable and noncommunicable diseases and suffering from intentional or unintentional injuries. At the same time, comorbid physical health conditions often complicate the management of mental health conditions, worsening their overall prognosis.

COVID-19 has created a watershed moment for public health, calling attention to the urgent need to correct systemic imbalances, promote greater cohesion within and between various systems, and respond collaboratively to enable the fullest expression of health and well-being.<sup>38,46</sup>

It is imperative for public health and mental health to come together to take advantage of this moment and the political momentum it has catalysed for mental health in particular. Mutual benefits are anticipated when mental health is integrated into health policies and services.<sup>47</sup> Integration of psychosocial interventions in other health programmes – for example, HIV prevention and control, tuberculosis, women's health, children's health, nutrition, cancer control and healthy ageing, to name a few – will strengthen health systems overall and improve health outcomes in target populations. These synergies are already reflected in recent regional frameworks and strategic guidance documents on healthy ageing, school health, reaching the unreached, NCD control and primary health care endorsed by Member States. Apart from articulating direct links between mental health and other areas of work, these documents also highlight the strategic value of collaboration across specialties and sectors to advance the mental health agenda.

Public and mental health practitioners, researchers and policy-makers must be united in purpose, working hand in hand with people with lived experience and their families to ensure that mental health is central to wide-scale efforts to secure health by advancing social policy and practice. A reorientation of the public policy environment towards mental health and well-being is therefore necessary to



encourage social interventions and social movements that allow health and well-being to flourish. Success in this work depends on political commitment, community support and partnerships that will drive its implementation. Leadership, strategic communication and sustained advocacy will be key.

The work behind Health in All Policies and UHC, and the exciting frontiers offered by digital mental health, open up many possibilities for delivering and developing interventions, engaging various community voices and people with lived experience, and building the capacity of the next-generation mental health workforce. There is much that can be learnt when these bridges are built and the public health and mental health fields converge to build back better and fairer. Integration is vital for the future of everyone's mental health and well-being.

## **2.2 Expanding the mental health paradigm to include socio-structural factors**

Over the last 20 years, the discourse around the social and structural dimensions of mental health has expanded tremendously. This is best embodied by the wealth of evidence highlighting the importance of social determinants, and the relationships between mental health and various upstream determinants and risk factors as previously described.<sup>48</sup>

Within the mental health-related discourse, “social” is typically thought of along two lines – the *socio-relational* and the *socio-structural*. The first dimension, the socio-relational, refers to the relationships of people with others, such as family members, close friends, colleagues and the wider society. The capacity to form and nurture these relationships is essential to good mental health and well-being. The second dimension, the socio-structural, involves the often fixed social structures, organizations or institutions that operate in society and have a profound influence on the experience of daily life. These include prevailing social and cultural norms, political and economic systems, labour markets, built environments, the prevailing peace and order situation, etc. – all of which are directly related to the upstream determinants of mental health.<sup>48</sup>

While both dimensions have an impact on mental health and well-being, predominant approaches to mental health care and support have tended to focus on the socio-relational aspect.<sup>49</sup> By embracing a wider definition and understanding of mental health – one that considers the intersecting social, relational, structural and systemic drivers that form a sociopolitical economy of mental health – a more balanced and complete approach to mental health care and support is also made possible. Changing these definitions is necessary in order to change the response.<sup>50</sup>

People are not separate from their environments. These environments can either foster or hinder good mental health and well-being. Until mental health approaches address the full range of mental health determinants, including individual biology alongside socio-relational and socio-structural dimensions, mental health programmes, while necessary, will remain insufficient.<sup>51</sup> This is especially evident for the unreached, or populations that exist at the margins of society. These populations face multiple hardships and adversities in their day-to-day lives, arising from unfair social structures that routinely place them at a disadvantage and increase their risk of experiencing mental distress and developing mental health conditions.<sup>13</sup> Transforming mental health care to encompass health and social interventions and embedding mental health into communities – encompassing the daily reality and experience of all people – are crucial to promoting, protecting and restoring mental health and well-being.<sup>48</sup>

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Expanding services in this manner will require building on existing partnerships with social services, as well as increasing complementarity and overall quality improvement. With this as the starting point, we can acknowledge the progress achieved thus far, while encouraging a more balanced and comprehensive approach that fully integrates biomedical, psychosocial and sociocultural perspectives and interventions into a broader ecosystem of social care oriented towards well-being.

This change in paradigm must involve all levels of government and across different sectors of society. Promoting mental health beyond the health sector involves securing high-level political buy-in from other sectors and transforming these commitments into actual programmes and services in communities in order to change people's lives for the better. Mental health is a shared agenda and responsibility – everyone has a role in reshaping these systems and structures.

The future of mental health calls for a new paradigm and a transformative environment that benefits the mental health of all.

### 2.3 Social solidarity and the future of mental health

The way people think about mental health differs across and within countries and communities. It can also differ depending on whether they live with a mental health condition of one type or another or if somebody close to them has that experience. Despite these differences, the connections that provide support – found among people and within families, communities and societies – are a universal human need, but not equally available to all.<sup>52</sup> Respect for these connections supports a community life built on human rights and provides the foundation for social solidarity.

Disruption of these connections has been a central feature of the COVID-19 pandemic and its subsequent impact on the mental health and well-being of people worldwide. The profound disruption caused by the pandemic to daily life is well-documented, represented by dramatic images of empty streets and public spaces, classrooms devoid of students, shuttered businesses, and mandatory physical distancing and mask wearing. Such measures, while necessary to prevent further infection, have led many to feel isolated and distressed.<sup>53</sup>

Over time, however, these same conditions have also given rise to unprecedented acts of community action and solidarity. These include neighbourhoods self-organizing to support each other and especially the most vulnerable, spontaneous celebrations and accolades dedicated to the bravery of front-line and other essential workers, volunteerism enabled and sustained by the internet, and the myriad ways people have reached out to reconnect and provide psychosocial support despite staying physically apart. Against the backdrop of a catastrophic global pandemic, these examples serve as reminders of the innate resilience found within people and communities, and the vital role of social capital and solidarity during crises.<sup>53</sup>

Social solidarity springs from a collective concern for the well-being of others, underscoring the interdependence of each member of society, and thus providing the motivation to act for the benefit of others.<sup>54</sup> Fostering social solidarity is essential to helping societies heal and recover from the pandemic. It is a critical aspect of achieving good mental health – and when communities work together on shared activities for the betterment of their environments, symptoms of mental ill health are also reduced.<sup>55</sup> It is also crucial for the future of the mental health agenda. The call for a transformative environment to promote the mental health and well-being of all cannot be realized without mobilizing the broadest

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possible support united by a shared sense of purpose. Rooting these actions in social solidarity also promotes equity and social justice, as it emphasizes looking after the welfare of marginalized segments of society – or reaching the unreached – in particular.

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### 3. The way forward

#### 3.1 A shared vision of the future co-created by the people of the Western Pacific Region

Mental health is central to the health and well-being of all people, and the flourishing of communities and societies. Promoting and protecting mental health is, therefore, essential for the future of the Western Pacific Region. The strategies and actions contained in this Regional Framework aim to foster a transformative environment for mental health and well-being in the Western Pacific.

**Vision:** A region where people enjoy the highest level of mental health and well-being, grounded in social solidarity for a transformative environment that promotes mental health for all.

In order to achieve this vision, three directional strategies describe the way forward – in other words, what we will do – for the mental health agenda in the Western Pacific Region (Fig. 6):

- **Refocus** the mental health agenda to include well-being and reaching the unreached through leadership that champions mental health in all policies, and strategies generated from the grounds up that match solutions to the voiced needs of communities, supported by strategic communication and advocacy.
- **Transform** mental health support and care into a community-based ecosystem of health and social services and innovations, enabled by an expanded and well-trained mental health workforce comprising specialists, non-specialists and social networks, delivering the full range of interventions, and underpinned by a responsive information system that drives impact.
- **Embed** mental health into the settings and journeys of daily life by engaging and empowering communities with tools and platforms that enhance protective factors and reduce risk factors across the life course, and by fostering social interventions and partnerships with co-benefits for mental health and other social sectors.

Four enabling strategies provide the basis for key actions that will transform this vision into reality – in other words, how we will do it:

- **Future-oriented decision-making.** Applying principles from implementation science and strategic planning (such as backcasting and other hypothesis-driven approaches) to redesign mental health services to ensure equity, early access to advice and care, and a continuum of care throughout the life course, supported by evidence, data and research to increase demand, acceptance and impact of mental health interventions.
- **Grounds-up approach.** Co-designing solutions that are grounded in the local context and shared community values, informed by insights from people with lived experience and everyday citizens, and animated by the dynamism and creativity of young people and the next generation of mental health professionals.
- **Community-based partnerships.** Applying community-based partnerships to mobilize the full range of community assets within an integrated mental health ecosystem; linking mental health to broader social, economic and political domains; and identifying champions that can drive intrasectoral and intersectoral partnerships for mental health (for example, education, social welfare, justice and labour) in key settings (for example, home, school, workplace, community and online).

- **Innovation for mental health.** Applying the full range of technology and social innovation to revolutionize all aspects of mental health, expand digital mental health, and reach the unreached or those excluded by the current health system.

### Unpacking the key actions

Evidence already exists for many effective public mental health interventions, but their implementation in the community and the familiarity and acceptability of these interventions to target end users remains a challenge. Grounding solutions in local contexts and shared community values can improve the design and delivery of programmes and increase the demand, acceptance and impact of these interventions. Future-oriented decision-making involves backcasting and other hypothesis-driven approaches to enable breakthroughs by introducing new perspectives and challenging convention.

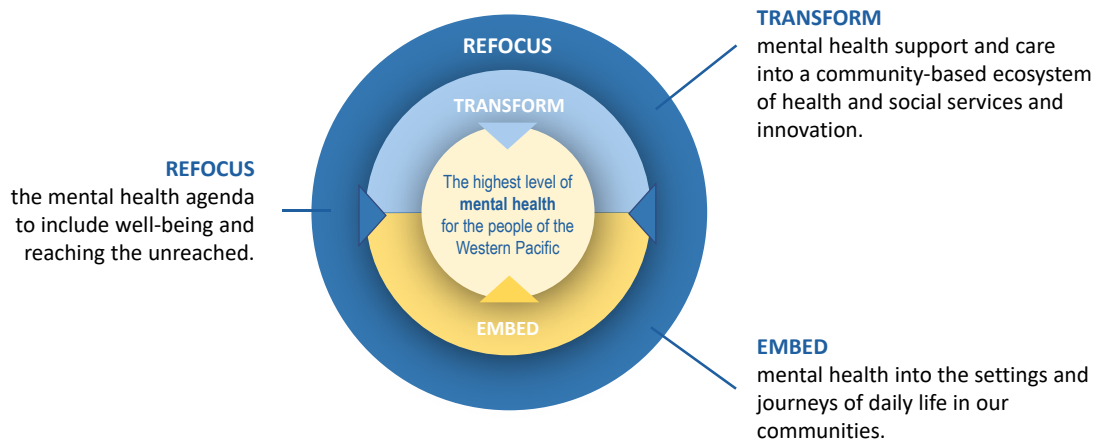
The future of mental health must place the community at the centre, with the full range of community assets mobilized within an integrated mental health ecosystem that empowers individuals and communities to take control of their mental health. Partnerships will be key to making this happen. Building the capacity of communities, civil society (for example, faith-based organizations, media and communicators, volunteers, women's groups and young people) and other key sectors (for example, education, social welfare, justice and labour) to effectively implement interventions and collect and use data will lead to partnerships that are mutually beneficial.

Harnessing the insight of people with lived experience ensures inclusive approaches to service delivery that are safe, recovery-oriented and culturally appropriate and protect human rights. Channelling the dynamism of young people will also help spur the creativity and innovation needed for the future. Many breakthroughs in mental health have originated from people with lived experience themselves. However, too often, they are excluded, leading to missed opportunities to build bridges and reduce stigma in wider communities. Providing opportunities for everyday citizens to participate meaningfully in mental health initiatives will be critical for developing solidarity around challenges faced by people with mental health difficulties and their families. Young people are naturally inclined to explore beyond conventional approaches and have a vested interest in shaping the future. Families also have a major role in fostering positive values towards mental health. Mobilizing these segments of society and creating spaces for dialogue and participation can help build the necessary social capital for the future of mental health.

Finally, innovation has the potential to revolutionize all aspects of mental health – from promotion to prevention, management and recovery. This includes the development and scale-up of digital mental health tools, platforms and approaches – such as mobile technology, artificial intelligence, social media, data science, etc. – to enhance and transform mental health. Innovation also refers to social innovations that are grounded in local contexts, wisdom and insights, such as indigenous models of care that are more acceptable to the community.

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Fig. 6. A systems approach to mental health



### 3.2 Stepping into the future together

Guided by directional strategies and enabling strategies, the corresponding actions, as outlined below, are recommended for Member States, with support from WHO and other partners, to secure the future of mental health. They were developed through consultation and consensus, representing key steps towards achieving the vision of a transformative environment for mental health in the Region.

These actions also supplement, or complement, the actions and options for implementation under Appendix II of the global *Mental Health Action Plan*. Member States are encouraged to refer to the directional strategies when setting priorities and identifying actions appropriate for their national context and available resources. These strategic objectives and actions are described below.

**Objective 1:** Refocusing the mental health agenda to include well-being and reaching the unreached through leadership that champions mental health in all policies, and strategies generated from the grounds up that match solutions to the voiced needs of communities, supported by strategic communication and advocacy.

- Reorient mental health laws, policies, plans and strategies towards promoting well-being and reducing mental health inequities (Boxes 5 and 6). Mainstream mental health and the rights of people with mental health conditions into national development strategies, emergency preparedness, and relevant sectoral laws, policies and strategies (for example, education, social welfare, justice and labour). Identify political champions to drive this change and mobilize resources at all levels of government and across sectors to support its implementation.
- Through research, proactively identify vulnerable and marginalized groups in society, including the newly marginalized as a consequence of the COVID-19 pandemic, in order to significantly reduce mental health inequities.
- Meaningfully engage service users, young people, wider communities and the next generation of mental health professionals in identifying service needs and barriers through dialogue and community engagement.

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- Mainstream mental health promotion by: integrating approaches from indigenous models of healing, understanding and valuing of mental health; describing the underlying drivers of stigma; and applying a settings approach to mental health, targeting homes, communities, schools, workplaces, online communities and other virtual settings.
- Enhance population mental health literacy by: promoting self-care, positive psychology and resilience through digital mental health software applications; providing platforms for collective action; and developing a new narrative for mental health grounded on individual and societal well-being brought to life through storytelling and amplified across all forms of media (Box 7).
- Reduce stigma around mental health with responsible journalism, guidelines on the proper reporting or coverage of mental health issues, well-informed content creation, and social and behaviour change communication interventions.
- Advocate for progressive and multisectoral legislation, social policies, strategies and plans that address the full range of mental health determinants and promote well-being.

**Box 5. Promoting a comprehensive approach to mental health**

Endorsed in December 2021, Mongolia's *National Action Plan on Healthy and Active Life 2021–2024* aims to establish a supportive social environment that nurtures the mental health and well-being of all people. Under the objective on mental health, the plan calls for comprehensive population-based measures and actions to support mental health.

Achieving the aim of the new plan involves enhancing access to mental health services and psychosocial support by developing community-based programmes and strengthening capacity among non-specialists to deliver basic mental health interventions. The Ministry of Health and the National Center for Mental Health are championing these initiatives and have started rolling out programmes in Ulaanbaatar and the province of Khentii. Education is another key intervention, with the new plan calling for further integration of mental health into the primary and secondary school curriculum. It also aims to empower young people by enhancing their mental health literacy and facilitating access to early intervention through digital applications. Building capacity among schoolteachers, administrators and social workers is also crucial to engaging the education sector more broadly.

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### Box 6. A commitment to promoting well-being for the future of mental health

In 2019, the Government of New Zealand unveiled an ambitious budget of NZ\$ 1.9 billion over four years to support the well-being of its citizens as part of a long-term vision and strategy to transform its approach to mental well-being.

*Kia Manawanui Aotearoa: Long-term pathway to mental wellbeing* is the Government's strategy and action plan for promoting, protecting and strengthening mental well-being. The plan is anchored in the longer-term vision of *Pae ora* (healthy futures) and seeks to expand on narrow definitions of mental health and services by taking into consideration the daily realities of people's lives – that is, the way “people live, grow and develop as individuals and as members of families, whānau, communities and their wider environments”.

Underpinning the plan are five interconnected focus areas that cover the continuum of mental well-being, spanning promotion and prevention, as well as mental well-being support and services:

- Building the social, cultural, environmental and economic foundations for mental well-being
- Equipping communities, families and individuals to look after their mental well-being
- Fostering community-led solutions
- Expanding primary mental well-being support in communities
- Strengthening specialist services.

Kia Manawanui applies a population-based approach in order to strengthen the focus on promoting the wider determinants of mental well-being and addressing inequities that lead to disparities in outcomes for specific population groups, alongside strengthening mental health and addiction services for those who need them. It is a whole-of-government plan that acknowledges the need for a collective approach – across government; communities; *whānau* (families), *hapū* (extended kin groups) and *iwi* (tribal kin groups); and individuals themselves – to improve mental well-being.

### Box 7. Harnessing digital media for mental health promotion

A robust digital infrastructure enabled the Government of Hong Kong SAR (China) to reach the public with key messages and various other initiatives to enhance mental health literacy and encourage appropriate health-seeking behaviour. Investments in social marketing and the development of digital resources, combined with the involvement of public personalities (artists, influencers, etc.) and civil society organizations in campaign implementation, contributed to the wide reach and impact of mental health promotion activities. For example, taking its name from a famous song, the mental health initiative “Shall We Talk” encourages the public – especially young people – to spend 15 minutes checking in on the mental health of their friends. The original singer of the song serves as a mental health ambassador and openly shares his own struggles, thus helping to reduce stigma. The campaign utilizes a variety of settings and channels, and new innovations are being explored, including a chatbot and a website/information hub that are currently being developed to provide information on mental health to all who seek it.

**Objective 2:** Transforming mental health support and care into a community-based ecosystem of health and social services and innovations, enabled by an expanded and well-trained mental health workforce comprising specialists, non-specialists and social networks, delivering the full range of interventions, and underpinned by a responsive information system that drives impact.

- Co-design with different stakeholders and people with lived experience a comprehensive community mental health ecosystem that integrates mental health into all care touchpoints and organizes health services (for example, self-care, informal care, community care, low-intensity



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interventions and specialized care) and social services (for example, housing, employment, food security, access to education, and specific services for women, indigenous people, migrants and other minorities) around the particular needs and context of the service user (Fig. 7).

- Accelerate deinstitutionalization, implement alternatives to coercive practices in different settings, and promote care pathways to rehabilitation and recovery through: legislation and other policy actions, expansion of access to community-based care, promotion of early intervention, simultaneous quality improvement of inpatient and residential mental health care while moving away from custodial care in psychiatric hospitals, and social and behaviour change communication interventions.
- Integrate mental health into UHC reform by passing appropriate legislation, incorporating recovery-oriented and rights-based concepts and approaches in the design and delivery of person-centred and human-rights-based care, and providing equitable and sustainable financial protection for people living with mental health conditions (for example, through inclusion of mental health in social insurance schemes or essential packages of health care).
- Build the capacity of the next-generation mental health workforce, comprising specialists, non-specialists and social networks within and outside the health sector, to engage in multisectoral action for mental health by mobilizing family and community assets and the full use of digital mental health to deliver services, screen for mental health issues, provide psychosocial support and respond to health emergencies.
- Organize community-based service delivery networks around a people-centred model of care, moving away from approaches grounded exclusively on clinical presentation and outcomes towards a fuller consideration of a person's rights, needs, perspectives and priorities. Mobilize and strengthen the capacity of an expanded mental health workforce, comprising people with lived experience (peer support), community workers, faith-based workers, the private sector, volunteers, family members and other mental health stakeholders, to deliver a range of mental health and psychosocial interventions (Boxes 8 and 9).
- Improve clinical and public health decision-making by developing information systems that are fit for purpose, adhere to the principles of data ethics, and facilitate accountability and impact (Box 10).
- Improve basic, applied and implementation research on mental health through inclusive and participatory agenda setting, resource allocation or mobilization, and capacity-building.

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**Box 8. Providing comprehensive care at the community level**

Efforts are currently underway in Japan to strengthen the capacity of its public health nurses to deliver community-based care and support, while mobilizing the wider community of mental health supporters or *Cocoro* around a people-centred approach to mental health support and care. Applying lessons from initiatives to ensure healthy ageing, Japan is moving towards a comprehensive community-based model of care that integrates health and social services. Under this model, social services such as employment, housing, education and social welfare are viewed as part of a comprehensive approach to addressing mental distress. Close collaboration across different public sectors – health, education, social welfare, labour and justice – and with the local government has been key to breaking down silos, closing existing gaps, and bringing the focus back to people and their communities. This approach is envisioned to help address common issues involving mental health in Japan, for example, stigma around mental health conditions, lack of access to early intervention, lack of coordination among service providers, long-term hospitalization and the upstream determinants of mental health. Promoting mental health first aid and enhancing mental health literacy are key actions to enable self-care and informal mental health care that have the potential of reaching the widest segment of the population.

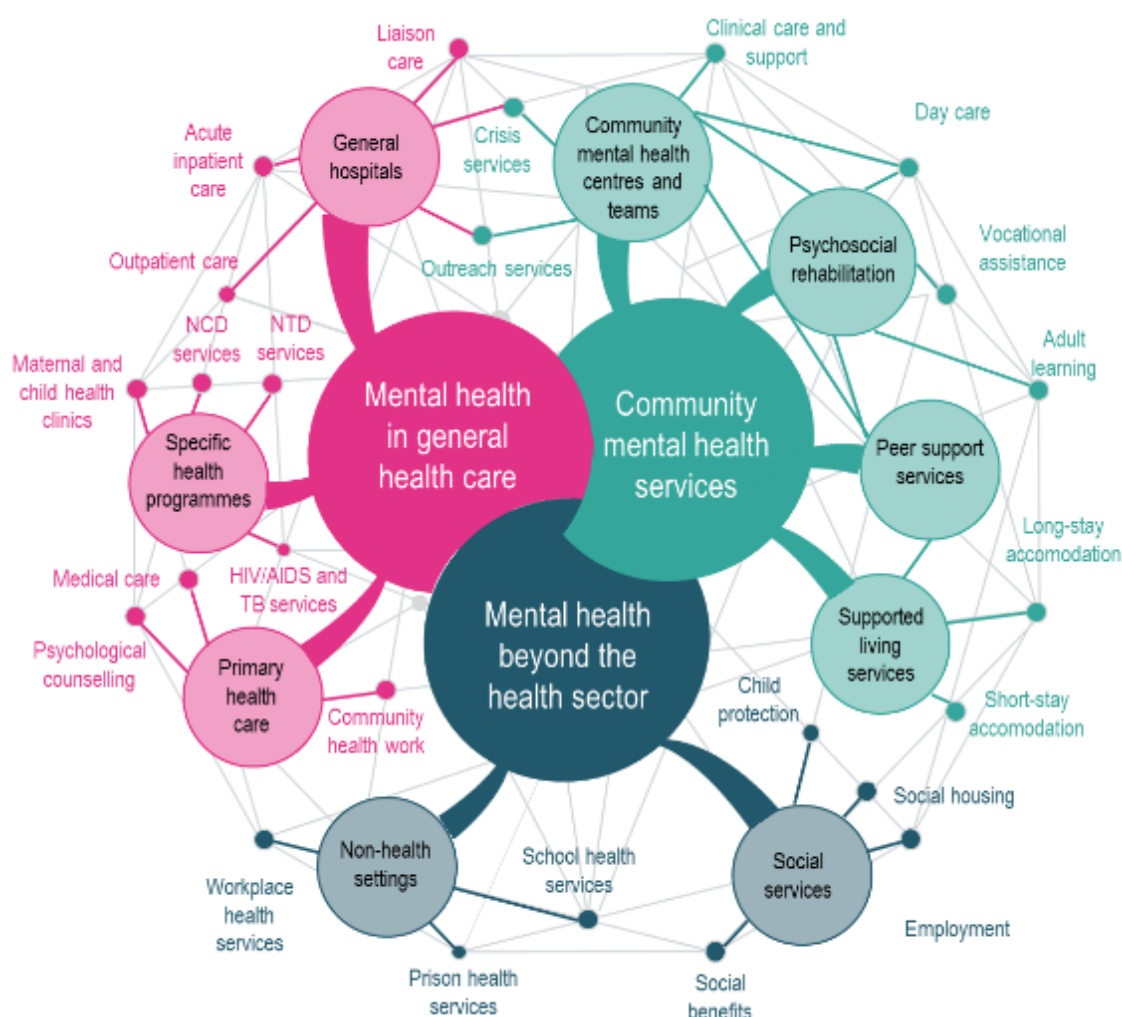
**Box 9. Mental health nurses lead in the provision of services in low-resource settings**

Fiji, which belongs to the LMIC group, faces many of the challenges to scaling up treatment for mental health conditions that characterize similar countries. In particular, there are significant gaps in resources and treatment coverage, relatively low expenditure on mental health, a concentration of treatment in designated tertiary facilities, and a significant lack of training and resources for non-specialist health-care providers. The vast geographical area of Fiji and the remoteness of much of its population complicate the provision of services. Lack of transportation for the limited number of mental health staff exacerbates the problem. The priorities for improving delivery of mental health care include increasing the number and capacity of the health workforce in facilities.

The Fijian Ministry of Health and Medical Services, with support from WHO and district health managers, has sought to enhance mental health services by decentralization. More than 500 non-specialist health-care providers have been trained in the WHO Mental Health Gap Action Programme (mhGAP), including general practitioners and nurses, to assess and manage priority mental health conditions in health-care facilities. In the absence of specialists, mental health nurses in some districts have been trained as mhGAP trainers, and, with the support of mental health specialists, they train, support and supervise non-specialist health-care providers and manage cases in coordination with general practitioners in facilities for pharmacological treatment and with nurses for non-pharmacological psychosocial support. The stress management units at three provincial hospitals receive people with moderate-to-severe mental health conditions referred by trained non-specialist health-care providers.

**Box 10. A data-driven approach to community mental health**

Technology and information systems provide the backbone for an innovative approach to community mental health in Malaysia. In pilot sites across the country, real-time data support clinical decision-making, programme design and monitoring, trend analysis, and linkages between health and social services. *Mentari* programmes serve to connect local communities with health clinics, nongovernmental organizations and volunteers to provide mental health screening, consultation, referral, support and information to people in need of mental health care. There are now 35 *Mentaris* throughout the country, and the number is growing due to their success in achieving this goal. One example of a much-needed service provided by *Mentaris* is employment support for people with lived experience of mental ill health. An innovation that arose during the development of the programme was the creation of its own information technology system to capture data in a way that can be aligned with that of the Ministry of Health.

**Fig. 7. Community-based mental health care**

NCD: noncommunicable disease; NTD: neglected tropical disease; TB: tuberculosis.

Source: World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022.

**Objective 3:** Embedding mental health into the settings and journeys of daily life by engaging and empowering communities with tools and platforms that enhance protective factors and reduce risk

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factors across the life course, and by fostering social interventions and partnerships with co-benefits for mental health and other social sectors.

- Institutionalize and fund mental health promotion and protection programmes and services across the life course – including those that cover early childhood interventions, life skills and youth development, school and workplace mental health, improved access to education and microcredit for women, housing and labour, violence prevention, healthy ageing, community development and support for minorities.
- Guided by the SDGs, integrate mental health into other sectoral priorities and implement initiatives with co-benefits for mental health and other social sectors – for example, education, social welfare, justice, labour, gender, peace, poverty reduction and human development. Examples include conditional cash transfers, housing programmes, violence prevention programmes, fair wage campaigns and other social protection schemes.
- Build community competencies by increasing knowledge and understanding of mental health, harnessing local insight and wisdom for mental health promotion, creating safe spaces for dialogue and participation across many types of communities, and forming partnerships to facilitate priority setting, diffusion of innovation and resource mobilization (Boxes 11 and 12).
- Promote social cohesion and help people overcome loneliness and social isolation by creating urban spaces and built environments that support mental health and well-being, and by activating the Healthy Cities movement for mental health.
- Facilitate the rapid deployment of psychosocial support during health emergencies and complex humanitarian crises by investing in systems, capacities, equipment and other assets across different sectors and settings.
- Establish national, multisectoral mental health coalitions, comprising health and other public sectors, civil society, nongovernmental organizations, development organizations, communities, champions and other people of influence, and other stakeholders, to provide a platform for high-level political commitment, community engagement, social mobilization, whole-of-society action and sustained advocacy.

### **Box 11. Applying social prescribing to address the socio-structural determinants of mental health in later life**

Social prescribing represents an innovative type of intervention addressing the social/structural determinants of mental health. It is a means for health workers to connect people to a range of non-clinical services in the community to improve health and well-being. It can help to address the underlying causes of a patient's health and well-being issues, as opposed to simply treating the symptoms. It can take various forms, but all involve connecting patients to resources in their communities based on individual needs, often relying on link workers as intermediaries.

Various initiatives on social prescribing have been implemented by the WHO Regional Office for the Western Pacific to address loneliness in later life – an important mental health concern.<sup>a</sup> For instance, the WHO Healthy Ageing Unit and Peking University Institute of Mental Health piloted a social prescribing scheme in the city of Shangrao in 2021. This project aimed at testing an intervention that could support older people experiencing loneliness, anxiety and depression by connecting them with relevant community resources. It relied on mental health-care workers in the community to organize social prescribing activities with older people.

Overall, social prescribing proposes an integrated approach to both mental health and ageing. It is aligned with the ground-up and community-based approach advocated by the vision contained in *For the Future: Towards*

*the Healthiest and Safest Region* and the new *Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030*. It emphasizes the important role that communities play in supporting well-being.

<sup>a</sup> Advocacy brief: social isolation and loneliness among older people. Geneva: World Health Organization: 2021.

#### **Box 12. Preventing suicide across the “LifeSpan”**

As one of the leading mental health research institutions in the world, Australia’s Black Dog Institute has developed an integrated framework – LifeSpan – to help communities develop evidence-based, targeted and responsive suicide prevention initiatives at the local level. The LifeSpan approach takes a holistic, systems approach to suicide prevention; it comprises the simultaneous implementation of nine evidence-based strategies adaptable to local contexts and the needs of priority populations.

Rather than applying a “one-size-fits-all” strategy, the LifeSpan approach recognizes the complex and multifactorial nature of suicide and the importance of addressing its various social determinants, which vary from person to person and from one community to the next. The approach provides a coordinating framework that spans from public health interventions to prevention and aftercare, and involves various stakeholders such as schools, workplaces, community organizations, emergency departments and police, all of which play a role in strengthening the protective factors and reducing the risk factors of suicide. Enabling and facilitating the establishment of regional alliances and cross-sectoral partnerships is crucial to actively engaging stakeholders within communities.

Involving people with lived experiences in ways that are genuine and comprehensive has proven to be invaluable in shaping the right interventions for specific priority populations. Similarly, effective planning for implementation should include identification of barriers and facilitators within local communities that take into account specific historical, cultural, economic and social contexts.

### **3.3 Enabling synergy and innovation for the future of mental health: priorities for WHO**

WHO works with national health authorities and a network of partners, including mental health experts and collaborating centres, and other non-state stakeholders:

- to develop norms, standards and guidance;
- to adapt global goods and initiatives to the specific needs and context of the Region;
- to shape a multisectoral health agenda through advocacy and communication;
- to strengthen capacity to achieve better health outcomes by providing technical support to governments; and
- to establish strategic partnerships and mobilize resources for implementation and monitoring.

Guided by this new *Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030*, WHO is committed to advancing the mental health agenda in the Region and working collaboratively to support Member States in achieving this bold new vision for the future.

#### **Establishing a regional knowledge hub for the future of mental health**

Feedback from the summative assessment of the previous mental health plan, the *Regional Agenda for Implementing the Mental Health Action Plan 2013–2020 in the Western Pacific*, and the series of consultations convened to develop the new Regional Framework indicates strong demand for greater

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levels of cooperation and coordination among Member States and other mental health actors. Frequently requested priorities for future support include facilitating the use of technical resources, knowledge transfer and capacity-building, and the dissemination of country experiences and lessons in a dynamic and inclusive manner.

WHO proposes to establish a regional knowledge hub for the future of mental health. The hub is envisioned to provide a platform for: identifying strategic areas of cooperation; generating momentum to expand existing partnerships; and monitoring, evaluating and communicating progress towards the shared vision behind the new Regional Framework. As a coordination mechanism, the hub will assist in matching country needs with regional and global expertise, and in co-creating projects and initiatives that will move the agenda forward. The hub's structure will remain agile, supported by a core secretariat at the WHO Regional Office, but responsive to the evolving mental health landscape and priorities or opportunities that may arise in the future.

Grounded by operational shifts that enable WHO to deliver more strategic support to Member States, the following priority actions were identified during the development of the Regional Framework and will guide the work of the Secretariat through the knowledge hub moving forward:

- Provide a platform to establish and enhance partnerships by convening various mental health stakeholders and actors, such as government representatives, WHO collaborating centres, development organizations, mental health experts, academic centres and groups representing people with lived experience.
- Sustain and strengthen regional collaborative networks for mental health such as the PIMHNet and other networks among Member States, mental health professionals, mental health organizations, young people, media professionals, academia, cultural groups and faith-based organizations, among others.
- Develop an implementation toolkit for the Regional Framework containing technical tools and resources for national mental health programme managers, policy-makers, development partners, civil society leaders and advocates.
- Foster the development, implementation, expansion and evaluation of digital mental health interventions.
- Provide technical support for regional, national and subnational capacity-strengthening programmes and initiatives focused on the next-generation mental health workforce.
- Cultivate and strengthen the capacity of the next generation of mental health leaders.
- Collaboratively adapt and implement global goods and other knowledge products.
- Lead high-level advocacy and public awareness campaigns, including a regional communication campaign on mental health and well-being.
- Collate and disseminate best practices on refocusing, transforming and embedding for the future of mental health.

### **3.4 A manifesto for the future of mental health**

Good mental health is integral to the well-being of all people.

It is essential to unlocking the full expression of human potential, enabling individuals and societies to thrive and flourish. It is also critical to the health and future of children and young people, as well as the quality and length of life of older people and the productivity of all sectors of society. The vision of this

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new Regional Framework is nothing less than the highest level of mental health and well-being for all people in the Western Pacific. Working towards this vision today is critical to addressing the unprecedented and complex mental health challenges of tomorrow. In a region that is rapidly and constantly evolving – bringing forth new threats and opportunities – fostering a transformative environment for mental health by refocusing, transforming and embedding will bring this shared vision to life.

Such a transformative environment calls for the engagement of all members and sectors of society. Promoting and protecting mental health must be a shared responsibility within and outside the health sector – mental health is everyone’s business. Social solidarity around the right to health and the values of social justice, inclusion and fairness provides the impetus to act on this ambitious agenda and reach the unreached.

This vision of the future of mental health also calls for collaboration on a much wider scale than ever before, especially as the Region builds back better and fairer and moves forward from the impact of the COVID-19 pandemic. New paradigms, narratives and ways of working must be embraced, alongside the mobilization and empowerment of communities. In this way, intergenerational patterns can be broken, as well as unfair social structures that perpetuate stigma and stand in the way of people achieving the highest level of mental health.

There is no health without mental health. The time is now for social solidarity behind mental health and well-being for all.

Annex

References

1. Urban health. In: World Health Organization [website]. 29 October 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/fact-sheets/detail/urban-health>, accessed 31 May 2022).
2. Regional framework for urban health in the Western Pacific 2016–2020: healthy and resilient cities. Manila: WHO Regional Office for the Western Pacific; 2016.
3. Yang J, Siri JG, Remais JV, Cheng Q, Zhang H, Chan KKY, et al. The Tsinghua–Lancet Commission on Healthy Cities in China: unlocking the power of cities for a healthy China. *Lancet*. 2018;391(10135):2140–84. doi:10.1016/S0140-6736(18)30486-0.
4. Gruebner O, Rapp MA, Adli M, Kluge U, Galea S, Heinz A. Cities and mental health. *Dtsch Arztebl Int*. 2017;114(8):121–7. doi:10.3238/arztebl.2017.0121.
5. Kasai T. Preparing for population ageing in the Western Pacific Region. *Lancet Reg Health West Pac*. 2020;6:100069. doi:10.1016/j.lanwpc.2020.100069.
6. Prince M, Wimo A, Guerchet M, Ali G-C, Wu Y-T, Prina M. World Alzheimer Report 2015: the global impact of dementia – an analysis of prevalence, incidence, cost and trends. London: Alzheimer’s Disease International; 2015.
7. Wu B. Social isolation and loneliness among older adults in the context of COVID-19: a global challenge. *Glob Health Res Policy*. 2020;5:27. doi:10.1186/s41256-020-00154-3.
8. Regional action plan on healthy ageing in the Western Pacific. Manila: WHO Regional Office for the Western Pacific; 2020.
9. Spanakis P, Peckham E, Mathers A, Shiers D, Gilbody S. The digital divide: amplifying health inequalities for people with severe mental illness in the time of COVID-19. *Br J Psychiatry*. 2021;219(4):529–31. doi:10.1192/bjp.2021.56.
10. Philbin MM, Parish C, Pereyra M, Feaster DJ, Cohen M, Wingood G, et al. Health disparities and the digital divide: the relationship between communication inequalities and quality of life among women in a nationwide prospective cohort study in the United States. *J Health Commun*. 2019;24(4):405–12. doi:10.1080/10810730.2019.1630524.
11. Nixon CL. Current perspectives: the impact of cyberbullying on adolescent health. *Adolesc Health Med Ther*. 2014;5:143–58. doi:10.2147/AHMT.S36456.
12. Su Z, McDonnell D, Wen J, Kozak M, Abbas J, Šegalo S, et al. Mental health consequences of COVID-19 media coverage: the need for effective crisis communication practices. *Global Health*. 2021;17(1):4. doi:10.1186/s12992-020-00654-4.
13. Lund C. Poverty and mental health: a review of practice and policies. *Neuropsychiatry*. 2012;2(3):213–9.
14. Banerjee S, Ng P. Why can’t dynamic Asia-Pacific beat poverty? In: United Nations Economic and Social Commission for Asia and the Pacific [website]. 5 July 2019. Bangkok: ESCAP; 2019 (<https://www.unescap.org/blog/why-cant-dynamic-asia-pacific-beat-poverty>, accessed 31 May 2022).
15. Patel V, Kleinman A. Poverty and common mental disorders in developing countries. *Bull World Health Organ*. 2003;81(8):609–15.
16. World drug report 2019. New York (NY): United Nations Office on Drugs and Crime; 2019.
17. Opioid overdose. In: World Health Organization [website]. 4 August 2021. Geneva: World Health Organization; 2021 (<https://www.who.int/news-room/fact-sheets/detail/opioid-overdose>, accessed 31 May 2022).
18. Why is there comorbidity between substance use disorders and mental illnesses? In: Common comorbidities with substance use disorders research report. Bethesda: National Institute on Drug Abuse; 2020 (<https://nida.nih.gov/publications/research-reports/common-comorbidities-substance-use-disorders/why-there-comorbidity-between-substance-use-disorders-mental-illnesses>, accessed 31 May 2022).
19. Baskin-Sommers A, Sommers I. The co-occurrence of substance use and high-risk behaviors. *J Adolesc Health*. 2006;38(5):609–11. doi:10.1016/j.jadohealth.2005.07.010.



20. Western Pacific regional framework for action on health and environment on a changing planet. Manila: WHO Regional Office for the Western Pacific; 2017.
21. Hayes K, Blashki G, Wiseman J, Burke S, Reifels L. Climate change and mental health: risks, impacts and priority actions. *Int J Ment Health Sys.* 2018;12:28. doi:10.1186/s13033-018-0210-6.
22. Gibson KE, Barnett J, Haslam N, Kaplan I. The mental health impacts of climate change: findings from a Pacific Island atoll nation. *J Anxiety Disord.* 2020;73:102237. doi:10.1016/j.janxdis.2020.102237.
23. GBD 2019 Risk Factors Collaborators. Global burden of 87 risk factors in 204 countries and territories, 1990–2019: a systematic analysis for the Global Burden of Disease Study 2019. *Lancet.* 2020;396(10258):1223–49. doi:10.1016/S0140-6736(20)30752-2.
24. McGorry PD, Mei C, Chanen A, Hodges C, Alvarez-Jimenez M, Killackey E. Designing and scaling up integrated youth mental health care. *World Psychiatry.* 2022;21(1):61–76. doi:10.1002/wps.20938.
25. Kieling C, Salum GA, Pan PM, Bressan RA. Youth mental health services: the right time for a global reach. *World Psychiatry.* 2022 Feb;21(1):86–7. doi:10.1002/wps.20933.
26. Kølves K, Mathieu S, Fleischmann A. Suicide and self-harm surveillance across the Western Pacific: a call for action. *Lancet Reg Health West Pac.* 2022;19:100367. doi:10.1016/j.lanwpc.2021.100367.
27. De Leo D, Milner A, Xiangdong W. Suicidal behavior in the Western Pacific region: characteristics and trends. *Suicide Life Threat Behav.* 2009;39(1):72–81. doi:10.1521/suli.2009.39.1.72.
28. Ayhan CHB, Bilgin H, Uluman OT, Sukut O, Yilmaz S, Buzlu S. A systematic review of the discrimination against sexual and gender minority in health care settings. *Int J Health Serv.* 2020;50(1):44–61. doi:10.1177/0020731419885093.
29. White Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: a critical review of stigma determinants, mechanisms, and interventions. *Soc Sci Med.* 2015;147:222–31. doi:10.1016/j.socscimed.2015.11.010.
30. Reisner SL, Poteat T, Keatley J, Cabral M, Mothopeng T, Dunham E, et al. Global health burden and needs of transgender populations: a review. *Lancet.* 2016;388(10042):412–36. doi:10.1016/S0140-6736(16)00684-X.
31. COVID-19 Mental Health Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic. *Lancet.* 2021;398(10312):1700–12. doi:10.1016/S0140-6736(21)02143-7.
32. Mental health and COVID-19: early evidence of the pandemic's impact: scientific brief, 2 March 2022. Geneva: World Health Organization; 2022.
33. Loades ME, Chatburn E, Higson-Sweeney N, Reynolds S, Shafran R, Brigden A, et al. Rapid systematic review: the impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19. *J Am Acad Child Adolesc Psychiatry.* 2020;59(11):1218–39.e3. doi:10.1016/j.jaac.2020.05.009.
34. The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment. Geneva: World Health Organization; 2020.
35. Mental health atlas 2020. Geneva: World Health Organization; 2021.
36. For the future: towards the healthiest and safest region: a vision for the WHO work with Member States and partners in the Western Pacific. Manila: WHO Regional Office for the Western Pacific; 2020.
37. Mental health: fact sheet on Sustainable Development Goals (SDGs): health targets. Copenhagen: WHO Regional Office for Europe; 2018.
38. Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. *Lancet.* 2018;392(10157):1553–98. doi:10.1016/S0140-6736(18)31612-X.
39. Comprehensive mental health action plan 2013–2030. Geneva: World Health Organization; 2021.
40. Sartorius N. Fighting for mental health: a personal view. Cambridge: Cambridge University Press; 2002.

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41. Herrman H, Saxena S, Moodie R. Promoting mental health: concepts, emerging evidence, practice. Geneva: World Health Organization; 2004.
42. Pathare S, Burgess RA, Collins PY. World Mental Health Day: prioritise social justice, not only access to care. *Lancet*. 2021;398(10314):1859–60. doi:10.1016/S0140-6736(21)02232-7.
43. Nishtar S, Niinistö S, Sirisena M, Vázquez T, Skvortsova V, Rubinstein A, et al. Time to deliver: report of the WHO Independent High-Level Commission on NCDs. *Lancet*. 2018;392(10143):245–52. doi:10.1016/S0140-6736(18)31258-3.
44. Woelbert E, Lundell-Smith K, White R, Kemmer D. Accounting for mental health research funding: developing a quantitative baseline of global investments. *Lancet Psychiatry*. 2021;8(3):250–8. doi:10.1016/S2215-0366(20)30469-7.
45. Kola L, Kohrt BA, Hanlon C, Naslund JA, Sikander S, Balaji M, et al. COVID-19 mental health impact and responses in low-income and middle-income countries: reimagining global mental health. *Lancet Psychiatry*. 2021;8(6):535–50. doi:10.1016/S2215-0366(21)00025-0.
46. Lund C, Brooke-Sumner C, Baingana F, Baron EC, Breuer E, et al. Social determinants of mental disorders and the Sustainable Development Goals: a systematic review of reviews. *Lancet Psychiatry*. 2018;5(4):357–69. doi:10.1016/S2215-0366(18)30060-9.
47. Herrman H, Jané-Llopis E. The status of mental health promotion. *Public Health Rev*. 2012;34(2):1–21.
48. Burgess RA, Jain S, Petersen I, Lund C. Social interventions: a new era for global mental health? *Lancet Psychiatry*. 2020;7(2):118–9. doi:10.1016/S2215-0366(19)30397-9.
49. Rose N, Manning N, Bentall R, Bhui K, Burgess R, Carr S, et al. The social underpinnings of mental distress in the time of COVID-19 – time for urgent action. *Wellcome Open Res*. 2020;5:166. doi:10.12688/wellcomeopenres.16123.1.
50. Burgess RA, Ní Chobhthaigh S, Lee S, Pathare S, Iemmi V, Lund C. Scoping review protocol: establishing a socio-political economy of global mental health. Charlottesville (VA): OSF Registries - Center for Open Science; 2022. <https://osf.io/cgjqh>.
51. Burgess RA, Fonseca L. Re-thinking recovery in post-conflict settings: supporting the mental well-being of communities in Colombia. *Glob Public Health*. 2020;15(2):200–19. doi:10.1080/17441692.2019.1663547.
52. Vaillant GE. Positive mental health: is there a cross-cultural definition? *World Psychiatry*. 2012;11(2):93–9. doi:10.1016/j.wpsyc.2012.05.006.
53. Policy brief: COVID-19 and the need for action on mental health. New York (NY): United Nations; 2020.
54. Mishra C, Rath N. Social solidarity during a pandemic: through and beyond Durkheimian lens. *SSHO*. 2020;2(1):100079.
55. Bowe M, Wakefield JRH, Kellezi B, Stevenson C, McNamara N, Jones BA, et al. The mental health benefits of community helping during crisis: Coordinated helping, community identification and sense of unity during the COVID-19 pandemic. *J Community Appl Soc Psychol*. 2022 May-Jun;32(3):521–35. doi:10.1002/casp.2520.

## Appendices

### Appendix 1. Mental health in the Sustainable Development Goals (SDGs)

The United Nations SDGs directly related to mental health:

<b>SDG 3: Ensure healthy lives and well-being for all at all ages</b>	
<b>Target 3.4:</b> Countries should “reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being” by 2030.	<ul style="list-style-type: none"> <li>• <b>Indicator 3.4.2:</b> Suicide mortality rate</li> </ul>
<b>Target 3.5:</b> Countries should “strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol”.	<ul style="list-style-type: none"> <li>• <b>Indicator 3.5.1:</b> Coverage of treatment interventions for substance use disorders</li> <li>• <b>Indicator 3.5.2:</b> Harmful use of alcohol (per capita consumption)</li> </ul>
<b>Target 3.8:</b> Countries should “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all”.	<ul style="list-style-type: none"> <li>• <b>Indicator 3.8.1:</b> Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn, and child health, infectious disease, noncommunicable diseases, and service capacity and access, among the general and the most disadvantaged populations)</li> <li>• <b>Indicator 3.8.2:</b> Proportion of population with large household expenditures on health as a share of total household expenditure or income</li> </ul>

Actions to protect mental health and well-being across relevant SDGs:

<b>SDG 1:</b> End poverty in all its forms everywhere.	<ul style="list-style-type: none"> <li>• Directing poverty alleviation interventions to people with mental disorders</li> <li>• Providing welfare payments (basic income grant) for people in extreme poverty</li> <li>• Providing financial protection to people and families living with mental disorders</li> </ul>
<b>SDG 2:</b> End hunger, achieve food security and improved nutrition, and promote sustainable agriculture.	<ul style="list-style-type: none"> <li>• Ensuring adequate nutrition to all children and pregnant women for optimum brain development</li> <li>• Reducing prevalence of depression and anxiety through improved food security</li> </ul>

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<p><b>SDG 3:</b> Ensure healthy lives and promote well-being for all at all ages.</p>	<ul style="list-style-type: none"> <li>• Integrating mental health promotion, prevention and care across the life course within the context of national efforts to achieve universal health coverage</li> <li>• Shifting mental health care from institutions to community platforms</li> <li>• Developing and implementing a suicide prevention strategy</li> <li>• Decreasing harmful use of alcohol and psychoactive substances</li> <li>• Identifying and treating substance use disorders</li> </ul>
<p><b>SDG 4:</b> Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all.</p>	<ul style="list-style-type: none"> <li>• Providing early child stimulation and school readiness programmes</li> <li>• Integrating life skills into school curricula</li> <li>• Identifying and assisting education of children with developmental disabilities early</li> <li>• Tailoring education to the abilities and interests of children</li> <li>• Providing lifelong learning to people with mental disorders to assist recovery</li> <li>• Providing cognitive stimulation and learning to older adults to prevent and manage dementia</li> </ul>
<p><b>SDG 5:</b> Achieve gender equality and empower all women and girls.</p>	<ul style="list-style-type: none"> <li>• Preventing violence against women and children</li> <li>• Ensuring that mental health services are gender sensitive and specifically geared to address mental health problems in women, such as maternal depression and the consequences of violence</li> <li>• Increasing support for caregivers, who are frequently women</li> </ul>
<p><b>SDG 8:</b> Promote sustained, inclusive and sustainable economic growth, full and productive employment and decent work for all.</p>	<ul style="list-style-type: none"> <li>• Implementing mental health in the workplace programmes</li> <li>• Providing social and occupational interventions and support for people with mental disorders and their families</li> <li>• Assisting workforces affected by changing needs of industries – for example, due to the growing role of technology</li> </ul>

<b>SDG 10:</b> Reduce inequality within and among countries.	<ul style="list-style-type: none"> <li>• Providing welfare payments (basic income grant) for those in extreme poverty</li> <li>• Reducing stigma and discrimination for people and families with mental disorders</li> <li>• Promoting and increasing opportunities for social inclusion for people with mental disorders</li> </ul>
<b>SDG 11:</b> Make cities and human settlements inclusive, safe, resilient and sustainable.	<ul style="list-style-type: none"> <li>• Creating built environments that minimize the social determinants of poor mental health</li> <li>• Ensuring safe use of chemicals, including pesticides, to prevent neurotoxicity, self-harm and suicides</li> </ul>
<b>SDG 13:</b> Take urgent action to combat climate change and its impacts.	<ul style="list-style-type: none"> <li>• Integrating psychosocial support in all humanitarian assistance related to natural disasters and other consequences of climate change</li> <li>• Adding the voice of the mental health community to highlight the importance of climate change action, because of its effect on mental health</li> </ul>
<b>SDG 16:</b> Promote peaceful and inclusive societies for sustainable development, provide access to justice for all, and build effective, accountable, and inclusive institutions at all levels.	<ul style="list-style-type: none"> <li>• Developing and implementing progressive laws related to mental health and human rights</li> <li>• Preventing the incarceration of people with mental disorders in institutions (for example, prisons and institutions for the care of children)</li> <li>• Implementing mental health programmes in prisons</li> </ul>
<b>SDG 17:</b> Strengthen the means of implementation and revitalize the Global Partnership for Sustainable Development.	<ul style="list-style-type: none"> <li>• Showing the effect of mental health interventions on work in other sectors related to the SDGs</li> <li>• Developing and sustaining a partnership to transform mental health globally.</li> </ul>

Source: Patel V, Saxena S, Lund C, Thornicroft G, Baingana F, Bolton P, et al. The Lancet Commission on global mental health and sustainable development. Lancet. 2018 Oct 27;392(10157):1553–98. doi:10.1016/S0140-6736(18)31612-X.

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**Appendix 2. Indicators for measuring progress in the Western Pacific Region towards defined targets of the WHO Comprehensive Mental Health Action Plan 2013–2030**

- **Objective 1.** To strengthen effective leadership and governance for mental health.
  - Global target 1.1: 80% of countries will have developed or updated their policy or plan for mental health in line with international and regional human rights instruments, by 2030 (Western Pacific Region as of 2020: 51%).
  - Global target 1.2: 80% of countries will have developed or updated their law for mental health in line with international and regional human rights instruments, by 2030 (Western Pacific Region as of 2020: 33%).
- **Objective 2.** To provide comprehensive, integrated and responsive mental health and social care services in community-based settings.
  - Global target 2.1: Service coverage for mental health conditions will have increased at least by half, by 2030 (Western Pacific Region as of 2020: 28%).
  - Global target 2.2: 80% of countries will have doubled the number of community-based facilities, by 2030 (Western Pacific Region as of 2020: N/A).
  - Global target 2.3: 80% of countries will have integrated mental health into primary health care, by 2030 (Western Pacific Region as of 2020: 75.9%).
- **Objective 3.** To implement strategies for promotion and prevention in mental health.
  - Global target 3.1: 80% of countries will have at least two functioning national, multisectoral mental health promotion and prevention programmes, by 2030 (Western Pacific Region as of 2020: 59%).
  - Global target 3.2: The rate of suicide will be reduced by one third, by 2030 (Western Pacific Region as of 2019: 7.2 per 100 000 population. The value is based on an age-standardized global estimate and represents a 15% reduction from the age-standardized suicide rate of 8.4 per 100 000 population in 2013).\*
  - Global target 3.3: 80% of countries will have a system in place for mental health and psychosocial preparedness for emergencies and/or disasters, by 2030 (Western Pacific Region as of 2020: 51%).
- **Objective 4.** To strengthen information systems, evidence and research for mental health.
  - Global target 4.1: 80% of countries will be routinely collecting and reporting at least one core set of mental health indicators every two years through their national and social information systems, by 2030 (Western Pacific Region as of 2020: 26% of responding countries reported compiling mental health specific data at least in the public sector; additionally, 52% of responding countries reported compiling mental health data as part of general health statistics only).
  - Global target 4.2: The output of global research on mental health doubles, by 2030 (Western Pacific Region as of 2020: N/A).

\* From WHO Global Health Estimates [online database]. Geneva: World Health Organization (<https://www.who.int/data/global-health-estimates>, accessed 17 June 2022).

*Note:* Proportions were computed based on the number of responding countries to the *Mental Health Atlas 2020* survey.

*Source:* Mental health atlas 2020. Geneva: World Health Organization; 2021.

### Appendix 3. Options for the implementation of the WHO Comprehensive Mental Health Action Plan 2013–2030

#### **OBJECTIVE 1.** To strengthen effective leadership and governance for mental health

*Develop, strengthen, keep up to date, and implement national policies, strategies, programmes, laws and regulations relating to mental health within all relevant sectors, including protective monitoring mechanisms and codes of practice, in line with evidence, best practice, the Convention on the Rights of Persons with Disabilities and other international and regional human rights instruments.*

#### **Options for implementation:**

- Develop and implement a comprehensive mental health policy and plan that complies with international human rights instruments, includes allocated human and financial resources, and undergoes regular monitoring against indicators or targets for implementation.
- Decriminalize suicide, suicide attempts and other acts of self-harm.
- Set up a functional mental health unit or coordination mechanism(s) in the health ministry, with an allocated budget and responsibility for strategic planning, coordination, needs assessment, inter-ministerial and multisectoral collaboration and service evaluation for mental health across the life course.
- Ensure coordination of mental health and social care activities at all relevant subnational levels (for example, district, municipality and community levels).
- Sensitize policy-makers to mental health and human rights issues through the preparation of policy briefs and scientific publications and the provision of leadership courses and other learning and knowledge exchange opportunities in mental health.
- Undertake capacity-building among stakeholders, including policy-makers, regarding strategies to promote respect for people's will and preference in mental health and related services.
- Mainstream mental health and the rights of persons with mental disorders and psychosocial disabilities into all sectoral policies, laws and strategies (for example, health, social affairs, education, justice and labour/employment), including emergency preparedness and response, poverty reduction and development.
- Improve accountability by setting up mechanisms, using independent bodies, to monitor, prevent and respond to torture or cruel, inhuman and degrading treatment and other forms of ill treatment and abuse; collect data on restraint and seclusion and involuntary treatments; and involve appropriate stakeholder groups in these mechanisms – for example, lawyers and people with mental disorders and psychosocial disabilities, in a manner consistent with international human rights instruments.
- Amend or repeal legislation that perpetuates stigmatization, discrimination and human rights violations against people with mental disorders and psychosocial disabilities.
- Monitor and evaluate the implementation of policies and legislation to ensure compliance with international human rights conventions, including the Convention on the Rights of Persons with Disabilities and the Convention on the Rights of the Child, as appropriate, and feed this information into the reporting mechanism of these conventions.
- Establish supported decision-making mechanisms; help people to develop advance plans that state their will and preference should they experience a crisis in the future; and ensure that people have all the support they require in order to make a decision, including access to trusted persons and advocates and provision of valid information about all matters relevant to their decision.

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*Plan according to measured or systematically estimated need and allocate a budget, across all relevant sectors, that is commensurate with identified human and other resources required to implement agreed-upon, evidence-based mental health plans and actions.*

**Options for implementation:**

- Include mental health services, such as psychosocial and psychological interventions and basic medicines for mental disorders, in universal health coverage and financial protection schemes, and offer financial protection for socioeconomically disadvantaged groups.
- Use – and if indicated, collect – data on epidemiology and resource needs in order to inform the development and implementation of mental health plans, budgets and programmes.
- Set up mechanisms for tracking expenditures for different types of mental health services in health and other relevant sectors such as education, employment, criminal justice and social services.
- Identify available funds at the planning stage for specific community-based, culturally appropriate, cost-effective activities so that implementation can be assured.
- Join with other stakeholders to effectively advocate for increased resource allocation for mental health, including through investment cases for mental health.

*Engage stakeholders from all relevant sectors, including persons with mental disorders, carers and family members, in the development and implementation of policies, laws and services relating to mental health, through a formalized structure and/or mechanism.*

**Options for implementation:**

- Convene, engage with, and solicit consensus from all relevant sectors and stakeholders when planning, developing and implementing policies, laws and services relating to health, including sharing knowledge about effective mechanisms to improve coordinated policy and care across formal and informal sectors.
- Build local capacity and raise awareness among relevant stakeholder groups about mental health, laws and human rights, including their responsibilities in relation to the implementation of policy, laws and regulations.

*Ensure that people with mental disorders and psychosocial disabilities are given a formal role and authority to influence the process of designing, planning and implementing policy, law and services.*

**Options for implementation:**

- Provide logistical, technical and financial support to build the capacity of people with mental disorders and psychosocial disabilities and their organizations, including youth and carers, in understanding and advocating the realization of human rights conventions, policy, law and services, based on their needs and preferences.
- Encourage and support the formation of independent national and local organizations of people with mental disorders and psychosocial disabilities, and establish formal mechanisms to ensure their full and effective participation in the development and implementation of mental health policies, laws and services, as well as their monitoring and evaluation.
- Involve people with mental disorders and psychosocial disabilities in the assessment and monitoring of all public and private mental health services, including psychiatric hospitals and social care homes.



- Include people with mental disorders and psychosocial disabilities and their organizations in capacity-building of stakeholders, including policy-makers and health workers delivering mental health care.

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

*Systematically shift the locus of care away from long-stay mental hospitals towards non-specialized health settings with increasing coverage of evidence-based interventions (including the use of stepped-care principles, as appropriate) for priority conditions and using a network of linked community-based mental health services, including short-stay inpatient and outpatient care in general hospitals, primary care, comprehensive mental health centres, day-care centres, support of people with mental disorders living with their families, and supported housing.*

**Options for implementation:**

- Develop a phased and budgeted plan for scaling down and closing long-stay psychiatric institutions and replacing them with support for discharged residents to live in the community.
- Work towards a gradual shift of financial resources and staff towards community-based care, closing long-stay institutions once there are adequate community alternatives.
- Accompany the process of scaling down long-stay psychiatric institutions with (a) human rights protection and improvements in quality of life in institutions and (b) ensuring continuity of care and welfare provision for discharged long-stay residents (for example, livelihood and housing support, including places in small-group homes).
- Provide outpatient mental health services and an inpatient mental health unit in general hospitals.
- Build up interdisciplinary community-based mental health services for people across the life course through, for instance, outreach services, home care and support, primary health care, emergency care, community-based rehabilitation and supported housing.
- Integrate mental health and social care into disease-specific programmes and services, such as those for HIV/AIDS, tuberculosis, noncommunicable diseases and neglected tropical diseases, and into population-specific programmes and services, such as maternal, sexual and reproductive health; child and adolescent health; gender-based violence; and family health and well-being programmes and services.
- Engage service users and family members and/or carers with practical experience as peer-support workers.
- Support the establishment and implementation of community mental health services run by nongovernmental organizations, faith-based organizations and other community groups, including self-help and family support groups, which protect, respect and promote human rights and are subject to monitoring by government agencies.
- Consider the use of evidence-based innovative approaches to provide psychological support at scale (for example, guided self-help, digital self-help, collaborative and stepped-care approaches).
- Develop and implement tools or strategies for self-help and care for people with mental disorders, including strengthening the use of electronic and mobile technologies, potentially as part of a stepped-care system.

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- Develop capacity, policies and operational procedures for remote delivery of services (for example, telehealth) and use digital health solutions to support practitioners in providing care, where feasible.
- Provide in-home and other community support services for carers of children and of adults with psychosocial disabilities, including carer skills training and other multidisciplinary services (for example, physical and occupational therapy, nutritional support, housing, education support and early childhood development).

*Integrate and coordinate holistic prevention, promotion, rehabilitation, care and support that aims at meeting both mental and physical health-care needs and facilitates the recovery of people of all ages with mental disorders within and across general health and social services (including the promotion of the right to employment, housing and education) through service-user-driven treatment and recovery plans and, where appropriate, with the input of families and carers.*

### **Options for implementation:**

- Encourage health workers to initiate and support recovery plans and link people with services and resources based on their needs and preferences, including education, work, health care and livelihood opportunities.
- Develop the planning and delivery of services jointly with people with mental health conditions and psychosocial disabilities.
- Implement guidelines for the management of physical health in people with severe mental health conditions.
- Advocate with other sectors (for example, livelihood support, housing, education, vocational training, employment, social welfare and legal support) for the inclusion and support of people with mental disorders and psychosocial disabilities in their services and programmes.
- Cultivate recovery-oriented and culturally appropriate care and support through awareness-building opportunities and training for health and social service providers.
- Provide information to people with mental disorders, their families and carers on causes and potential impacts of disorders, treatment and recovery options, as well as on healthy lifestyle behaviours in order to improve overall health and well-being.
- Foster the empowerment and involvement of people with mental disorders, their families and caregivers in mental health care.
- Procure and ensure the availability of basic medicines for mental disorders included in the WHO Model List of Essential Medicines at all health system levels, ensure their rational use and enable non-specialist health workers with adequate training to prescribe such medicines.
- Build competencies of health professionals to provide accurate information about a range of feasible evidence-based psychosocial and pharmacological interventions and to discuss benefits and risks, including possible side and withdrawal effects of interventions.
- Address the mental well-being of children and carers when a family member with severe illness (including mental disorders) presents for treatment at health services.
- Provide services and programmes to children and adults who have experienced adverse life events – including ongoing domestic violence, civil unrest, conflict or disaster – that meet people's mental health needs, promote recovery and resilience, and prevent further distress for those who seek support.

- Implement interventions to manage family crises and provide care and support to families and carers in primary care and other service levels.
- Provide early interventions for children and adolescents with mental health conditions through family-centred and child- and adolescent-responsive health care, at the primary health care, school and community levels.
- Implement the use of WHO QualityRights standards to assess and improve quality and human rights conditions in inpatient and outpatient mental health and social care facilities, including policies and procedures to stop the use of coercive practices in services.

*Work with national emergency committees to include mental health and psychosocial support needs in emergency preparedness, and enable access to safe and supportive services, including services that address psychological trauma and promote recovery and resilience, for people with (pre-existing as well as emergency-induced) mental disorders or psychosocial problems, including for health and humanitarian workers, during and following emergencies, with due attention to the longer-term funding required to build or rebuild a community-based mental health system after the emergency.*

**Options for implementation:**

- Work across sectors with national and subnational actors on integrating mental health and psychosocial support (MHPSS) in all national and local emergency preparedness and response policies, plans, procedures and actions as outlined in *The Sphere Handbook* minimum standards and the Inter-Agency Standing Committee *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*.
- Prepare for emergencies by training health and community workers in basic psychosocial support, such as psychological first aid.
- During emergencies, ensure coordination with partners across health, protection, nutrition and education sectors on the application of the relevant minimum standards detailed in *The Sphere Handbook* and the *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* issued by the Inter-Agency Standing Committee.
- Include MHPSS as an integral, cross-cutting component in public health emergency responses (for example, to COVID-19 and Ebola virus disease) as part of a range of pillars or domains, such as case management, risk communication and community engagement, continuation of services, response coordination, and operations (for instance, staff support).
- Use emergencies as an opportunity to build or rebuild sustainable community-based mental health and social care systems and to demonstrate the feasibility and effectiveness of community models of care that address the long-term increase in mental disorders in emergency-affected populations.

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*Build the knowledge and skills of general and specialized health workers to deliver evidence-based, culturally appropriate and human-rights-oriented mental health and social care services, for children and adolescents, among other things, by introducing mental health into undergraduate and graduate curricula and through training and mentoring health workers in the field, particularly in non-specialized settings, to identify and offer treatment and support to people with mental disorders, as well as to refer people, as appropriate, to other levels of care.*

**Options for implementation:**

- Develop and implement a strategy for building and retaining human resource capacity to deliver mental health and social care services across the life course in health, social and educational settings, such as primary health care, general hospitals and schools.
- Support pre-service and in-service training of health workers in the WHO Mental Health Gap Action Programme's *Intervention Guide* for the identification and management of mental, neurological and substance use disorders in non-specialized settings, evidence-based psychological interventions, and associated training and supervision materials for prioritized expanded care.
- Ensure that health and social care workers have access to a cadre of supervisors with experience in evidence-based interventions who can provide continued mentoring and support.
- Collaborate with universities, colleges, other relevant educational entities and professional associations to define and incorporate a mental health component in undergraduate and postgraduate curricula, to offer continued education and knowledge exchange on mental health, and to ensure accreditation and oversight of mental health professionals.
- Ensure an enabling service context for training health, education and social care workers that focuses on the ongoing development, monitoring and evaluation of competencies, and that includes clear task definitions, referral structures, supervision and mentoring.
- Improve the capacity of health, education and social care workers in all areas of their work (for example, covering clinical, human rights and public health domains), including e-learning methods where appropriate.
- Ensure inclusion of human rights and people-centred, recovery-oriented approaches in the curricula of undergraduate and graduate courses, continuing professional development opportunities and professional accreditation mechanisms, and offer internships and learning placements in services that promote such approaches.
- Establish or strengthen supervised clinical training for prospective mental health professionals, including psychologists, social workers, psychiatric nurses and psychiatrists. Improve working conditions, financial remuneration and career progression opportunities for mental health professionals and others, including lay workers, in order to attract and retain the mental health workforce.
- Collaborate with educational institutions and places of employment to improve recruitment and retention of people from various backgrounds (including people with lived experience of mental health conditions and psychosocial disabilities) to amplify their voices and diversify the mental health workforce and leadership.

*Proactively identify and provide appropriate support for groups at particular risk of mental illness who have poor access to services.*

**Options for implementation:**

- Identify and assess the mental health needs and determinants of different sociodemographic groups in the community and also of vulnerable people who may not be using services – such as people living with homelessness; children; older people; people in the criminal justice system; people in detention; internally displaced people; asylum seekers; refugees; migrants; minority ethnic groups; people who identify as lesbian, gay, bisexual, transgender, questioning/queer or intersex (LGBTQIA+); indigenous populations; people with physical and intellectual disabilities; and people affected by emergency situations – and address the barriers that they face in accessing treatment, care and support.
- Develop a proactive strategy for targeting these people and groups, and provide services that meet their needs.
- Build competencies of health and social care workers to better understand the needs of vulnerable people and the social determinants of mental health, including poverty, inequality, discrimination and violence, and to respond adequately to these factors when providing care and support.

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

*Lead and coordinate a multisectoral strategy that combines universal and targeted interventions for promoting mental health and preventing mental disorders and for reducing stigmatization, discrimination and human rights violations, and which is responsive to specific vulnerable groups across the lifespan and integrated within the national mental health and health promotion strategies.*

**Options for implementation:**

- Develop and implement national, multisectoral mental health promotion and prevention programmes.
- Increase public knowledge and understanding about mental health, how to stop discrimination and how to access services, through media awareness campaigns and initiatives that involve people with lived experience of mental disorders and psychosocial disabilities.
- Include mental health care and support as part of home-based and health facility-based antenatal and postnatal care for new parents and/or carers, including skills training for carers.
- Provide early childhood programmes that address the cognitive, sensory-motor and psychosocial development of children as well as promote healthy child–caregiver relationships.
- Reduce the harmful use of alcohol by implementation of measures included in the WHO *Global Strategy to Reduce the Harmful Use of Alcohol*.
- Introduce brief interventions for hazardous and harmful substance use.
- Implement programmes to prevent and address domestic violence, including attention to violence related to alcohol use.
- Protect children and adults from abuse by introducing or strengthening community protection networks and systems.

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- Address the needs of children who have parents with chronic mental disorders within promotion and prevention programmes.
- Develop universal and indicated (targeted) school-based promotion and prevention programmes and activities to foster socioemotional life skills, counter bullying and violence, counter stigmatization and discrimination of people with mental disorders and psychosocial disabilities, and raise awareness of the benefits of a healthy lifestyle and the risks of substance use and early detection and intervention for children and adolescents with emotional or behavioural problems (including disordered eating) or neurodevelopmental disorders.
- Address discrimination in educational institutions and the workplace and promote full access to educational opportunities, work participation and return-to-work programmes for people with mental disorders and psychosocial disabilities.
- Promote safe, supportive and decent working conditions for all (including informal workers), with attention to organizational improvements in the workplace; implement evidence-based programmes to promote mental well-being and prevent mental health conditions, including training managers in order to benefit employees' mental well-being; introduce interventions for stress management and workplace well-being programmes; and address stigmatization and discrimination.
- Enhance self-help groups, social support, community networks and community participation opportunities for people with mental disorders and psychosocial disabilities and other vulnerable people, using digital interventions where possible.
- Encourage the use of evidence-based traditional and cultural practices for promotion and prevention in mental health (such as yoga and meditation).
- Enhance the use of social media in promotion and prevention strategies.
- Implement preventive and control strategies for neglected tropical diseases (for instance, taeniasis and cysticercosis) in order to prevent neurological and associated mental health consequences.
- Develop policies and measures to be implemented by relevant ministries (for example, finance, labour and social welfare) for the protection of vulnerable populations during financial and economic crises.

*Develop and implement comprehensive national strategies for the prevention of suicide, with special attention to groups identified as at increased risk of suicide, including lesbian, gay, bisexual and transgender people; youth; and other vulnerable groups of all ages based on the local context.*

**Options for implementation:**

- Develop, keep up to date, implement and evaluate national suicide prevention strategies that guide governments and stakeholders to implement effective preventive interventions, raise public awareness, increase help-seeking, and reduce stigmatization of suicidal thoughts and behaviours.
- Increase public, political and media awareness of the magnitude of the problem and the availability of evidence-based effective suicide prevention strategies.
- Ban highly hazardous pesticides and restrict access to other means of self-harm and suicide (for instance, high places, medicines and firearms).
- Promote responsible media reporting in relation to cases of suicide by training media professionals and others producing content for screen or stage on how to cover suicide.
- Implement universal and indicated school-based socioemotional learning programmes and other interventions to support adolescents in their problem-solving and coping skills.

- Promote workplace, school-based and other community-based initiatives for suicide prevention that are tailored to groups at risk, including adolescents and older people.
- Improve responses in the health system and other sectors to self-harm and suicide, including training of staff (for example, non-specialized health workers, social workers, teachers, police, people working in the criminal justice system, firefighters, other first responders and faith leaders) in the assessment, management and follow-up of self-harm and suicide.
- Engage communities in suicide prevention and optimize psychosocial support from available community resources for both those who self-harmed or who attempted suicide, and for families of people who died by suicide. Involve persons with lived experience of suicide or self-harm in the development of suicide prevention strategies where possible.
- Develop community-level strategies for suicide prevention, including access to formal and informal services, volunteer social support groups and other culturally appropriate programmes.
- Ensure financing of suicide prevention by allocating adequate resources.
- Ensure all relevant groups at risk of suicide, including indigenous people, are involved in developing suicide prevention strategies.
- Conduct a situation analysis (for instance, rates of suicide and self-harm, specific populations at risk, common methods of suicide, and existing suicide prevention activities and gaps) to inform the planning of suicide prevention activities.

**OBJECTIVE 4.** To strengthen information systems, evidence and research for mental health

*Integrate mental health into the routine health information system and identify, collate, routinely report and use core mental health data disaggregated by sex and age (including on completed and attempted suicides) to improve mental health service delivery, promotion and prevention strategies, and to feed into the Global Mental Health Observatory (as part of the WHO Global Health Observatory).*

**Options for implementation:**

- Establish a surveillance system for monitoring mental health and self-harm and/or suicide and suicide attempts, ensuring that records are disaggregated by facility, gender, age, disability, method and other relevant variables.
- Embed mental health and self-harm and/or suicide information needs and indicators, including risk factors and disabilities, within national population-based surveys and health information systems.
- Collect detailed data from secondary and tertiary services in addition to routine data collected through the national health information system.
- Include mental health indicators within information systems of other sectors.
- Analyse and publish data collected on the availability, financing and evaluation of mental health and social care services and programmes to improve services and population-based interventions.

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*Improve research capacity and academic collaboration on national priorities for research in mental health, particularly operational research with direct relevance to service development and implementation and the exercise of human rights by people with mental disorders, including the establishment of centres of excellence with clear standards, with the input of all relevant stakeholders, including people with mental disorders and psychosocial disabilities.*

**Options for implementation:**

- Develop and promote a prioritized and funded national research agenda in the area of mental health, based on consultation with all stakeholders.
- Improve research capacity to assess needs and to evaluate the effectiveness, implementation and scale-up of services and programmes, including human rights and recovery-oriented approaches.
- Enable strengthened cooperation among universities, institutes, health and social services, and other relevant settings, such as educational, in the field of mental health research.
- Conduct research, in different cultural contexts, on local understandings and expressions of mental distress, practices that are harmful (for instance, human rights violations and discrimination) or protective (for instance, social supports and traditional customs) and ways of help-seeking (for instance, through traditional healers), as well as the efficacy, acceptability and feasibility of interventions for treatment, recovery, prevention and promotion.
- Develop methods for characterizing mental health disparities that occur among diverse subpopulations in countries, including factors such as race and/or ethnicity, sex/gender, socioeconomic status and geography (for example, urban versus rural), and evaluate interventions that are responsive to the needs of specific groups and address social determinants.
- Strengthen collaboration among national, subnational and international research centres for mutual interdisciplinary exchange of research and resources among countries.
- Promote high ethical standards in mental health research, ensuring that research is conducted only with the free and informed consent of the person concerned; researchers do not receive any privileges, compensation or remuneration in exchange for encouraging or recruiting people to participate in the research; research is not undertaken if it is potentially harmful or dangerous; all research is approved by an independent ethics committee functioning according to national and international norms and standards; and research is carried out with meaningful involvement of local collaborators and stakeholders in the design, implementation and dissemination of research findings.
- Ensure that people with mental health conditions and psychosocial disabilities – and their organizations – contribute to mental health research, for instance, through setting the research agenda, advising on the research methods and design, and informing about their lived experience.
- Ensure the translation of results from research to practice and the transfer of knowledge from academic to service settings by training stakeholders, including policy-makers and mental health professionals, in the critical appraisal of evidence and providing open access to unbiased and easy-to-understand information.