Asia-Pacific Economic Cooperation

APEC MENTAL HEALTH INITIATIVE

Report on Strategic Needs in Mental Health | July 2016

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EXECUTIVE SUMMARY

Joining the global movement to strengthen mental health, APEC economies are committed to combatting a long-neglected issue. They have done so through agreement on a Roadmap to Promote Mental Wellness in a Healthy Asia-Pacific, the launch of the APEC Digital Hub for Mental Health, and serving as a strategic partner during the April World Bank/High-Level Meeting *Out of the Shadows: Making Mental Health a Global Development Priority* in Washington, D.C. This report documents the submitted needs, areas of commonality, and variation in resources/approaches to improving mental health. It is important to note that the effects of mental health within populations are felt across an economy. As such, the Strategic Needs Assessments (SNAs) only provide part of the total landscape. There is scope to extend these SNAs to an assessment of economic impact and thus returns on investment for certain interventions. Because of the widespread economic and societal impact of mental illness in an economy, bringing together a variety of stakeholders in multi-sectoral collaborations to address the challenges in individual economies is a top priority. APEC's convening power is an important first step to successfully limit the economic and societal consequences of mental health challenges.

In advance of the 2015 APEC Roundtable on Mental Health in Manila, interested member economies were invited to submit SNAs to identify common focus areas that will inform the launch of pilot collaborations under the *APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific* and operationalized through the APEC Digital Hub. Roundtable participants were asked to evaluate responses to the SNAs. Submissions have been received from 15 economies[1]. This report represents a comprehensive review of those assessments. Other APEC economies are encouraged to submit an SNA for inclusion in this report. The report examines the priorities, challenges, and potential areas of regional and multi-stakeholder cooperation and identifies seven common focus areas on which APEC economies could focus their collaborative efforts. In addition to those common focus areas, this report offers several recommendations for APEC economies to address the common concerns noted by member economies in their SNA submissions.

The seven common focus areas for expanded mental health collaborations are:

1. Vulnerable communities and children;
2. Indigenous communities;
3. Integration with primary care and community-based settings;
4. Workplace wellness and resilience;
5. Advocacy and enhancing public awareness;
6. Disaster resilience and trauma; and
7. Data collection and standardization.

The report proposes five recommendations based on an assessment of the SNA submissions:

1. Advance an APEC-wide strategy to advocate for mental health, including with legislative bodies, as well as to enhance public awareness to reduce social stigma;
2. Establish expert working committees and novel partnerships through the *APEC Digital Hub for Mental Health: Best Practices and Innovative Partnerships* to address each of the common focus areas;
3. Build stronger linkages with the APEC Business Advisory Council (ABAC) and expert organizations, particularly in the promotion and strengthening of workplace mental health;
4. Build linkages with the APEC Emergency Preparedness Working Group (EPWG) in disaster resilience and trauma activities; and
5. Consider the development of APEC resources that center on linkage between mental health and economic growth/sustainability.

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[1] Submissions were received from Australia; Canada; Chile; Hong Kong, China; Indonesia; Japan; Korea; Malaysia; Mexico; New Zealand; Peru; The Philippines; Thailand; the United States; and Viet Nam

COMMON FOCUS AREAS / RECOMMENDATIONS

The Strategic Needs Assessments (SNAs) submitted by interested APEC member economies reveal seven common, priority focus areas for projects to advance innovative, multi-stakeholder partnerships in mental health. These common focus areas are:

1. **Vulnerable communities and children**: Several economies have expressed interest in focusing on vulnerable communities which include children, the disabled, women, and elder populations.
2. **Indigenous communities**: In economies with large indigenous populations, a common thread is the inadequacy of mental health services. Collaboration on indigenous mental health should seek to foster more equitable access to services and higher quality/"culturally safe" delivery of such services.
3. **Integration of primary care and community-based settings**: Nearly every economy that submitted an SNA prioritized the integration of mental health services into primary care or emphasized the importance of community support networks for mental health.
4. **Workplace wellness and resilience**: In emphasizing the important links between economic productivity, development, and mental health, several economies expressed an urgent interest in taking part in collaborations to address workplace stress and interventions to produce mentally healthy work environments.
5. **Advocacy and enhancing public awareness**: Stigma reduction persists as an underlying theme in every SNA as one of the largest challenges in strengthening mental health. During the 2015 APEC Roundtable, there was widespread agreement that mental health advocates in both government and the community should learn how to better advocate with leaders.
6. **Disaster resilience and trauma**: Natural disasters are having an increasing impact on the APEC region's populations. Several APEC economies share heightened risks for natural and man-made disasters. These commonalities are borne out in a common push for improved mental health responses to natural disasters and traumatic events.
7. **Data collection and standardization**: As mental health emerges as an important economic and social issue, more data and sound research, standardized through best practices, is necessary to design strong interventions that will support mentally healthy societies.

APEC economies may consider undertaking the following recommended actions:

1. Advance an APEC-wide strategy to advocate for mental health, including with legislative bodies, as well as to enhance public awareness to reduce social stigma;
2. Establish expert working committees and novel partnerships through the *APEC Digital Hub for Mental Health: Best Practices and Innovative Partnerships* to address each of the common focus areas. Based on the SNA submissions, organizations from the following economies, among other stakeholders from across the region, may wish to serve on these committees and collaborate on projects in these focus areas:
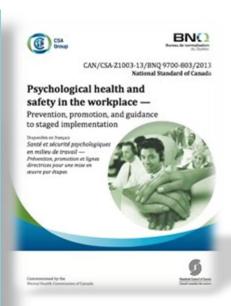
Vulnerable Communities and Children	Chile; Hong Kong, China; Indonesia; Peru; Thailand; Viet Nam
Indigenous Communities	Australia; Canada; Mexico
Integration into Primary Care and Community-Based Settings	Australia; Chile; Indonesia; Mexico; New Zealand; Peru; The Philippines; Thailand; Hong Kong, Japan
Workplace Wellness and Resilience	Australia; Canada; Malaysia; Viet Nam
Advocacy and Public Awareness	Canada; Indonesia; Korea; Malaysia; Peru; Thailand, United States
Disaster Resilience and Trauma	Indonesia; Japan; Korea; Malaysia; The Philippines
Data Collection and Standardization	Canada; Malaysia; Mexico, United States

3. Build stronger linkages with the APEC Business Advisory Council (ABAC) and expert organizations, particularly in the promotion and strengthening of workplace mental health;
4. Build linkages with the APEC Emergency Preparedness Working Group (EPWG) in disaster resilience and trauma activities
5. Consider the development of APEC resources that center on linkage between mental health and economic growth/sustainability. Such research should ensure that monitoring and surveillance efforts are aligned with agreed data collection methods, standardized decision-making procedures, and work is based on international best practices.
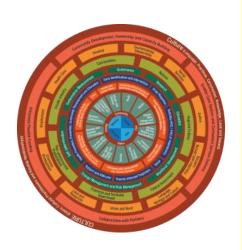
HIGHLIGHTED CASES OF INNOVATIVE MULTI-STAKEHOLDER COLLABORATIONS

National Standard of Canada for Psychological Health and Safety in the Workplace

Public and private sector organizations have elevated workplace mental health to a top priority. Developed in 2013, the National Standard of Canada for Psychological Health and Safety in the Workplace(National Standard), championed by the Mental Health Commission of Canada (MHCC), provides a voluntary set of guidelines, tools, and other resources to improve workplace mental health. The National Standard emphasizes the prevention of harm, the promotion of health, and the resolution of workplace conflicts, incidents, and concerns as fundamental to the development of a mentally healthy workplace. Its guiding principles also point to the importance of the active participation of all workplace stakeholders in fostering a mentally healthy workplace, based on mutually respectful relationships throughout the organization. Collaboration is key in the adoption of the National Standard as it continues to undergo implementation by numerous organizations across the economy.

The First Nations Mental Wellness Continuum Framework (Canada)

In response to the disproportionate incidence of mental illnesses among Indigenous communities in Canada, Health Canada and the Assembly of First Nations (AFN) collaborated to create *The First Nations Mental Wellness Continuum Framework*. The drafting of the framework in 2012 involved over 1,000 partners at the community, regional, national, and government levels to map existing mental health and addiction programs. This collaborative process informs improvements to existing and new mental wellness services for First Nations communities. The Framework describes a new vision for First Nations mental wellness, placing Indigenous culture and First Nations' strengths as central guidelines for improving the accessibility of mental health services as well as advising policy and program changes. While the outcomes of the Framework are under evaluation, this collaborative process may serve as a potential model for other economies who see Indigenous mental wellness as a shared priority.

Chile Crece Contigo (Chile)

Chile Crece Contigo (ChCC) is a program enacted through law that follows the development of young children in detecting social risk conditions, developmental delays or other health issues, implementing early interventions as mental health challenges arise. The program's success relies on collaborations between the Chilean Ministries of Social Development and Health and community stakeholders. The program comprises one element of Chile's Integral Protection to Childhood Initiative which prioritizes childhood mental health. ChCC promotes the biological, physical, psychological, and social conditions necessary for the development of mentally healthy children. This involves interventions and capacity-building within the community network of mother, fathers, primary healthcare providers, and hospital providers. The program receives political and financial support, better ensuring health benefits to vulnerable populations. Other economies seeking to prioritize early interventions, particularly for children, may view this program as a model.

Mapping Health Care in Violence against vulnerable communities (Indonesia)

To better understand the drivers of violence against children and women as well as human trafficking, Indonesia launched an innovative, multi-stakeholder collaborative effort to map such incidences across three provinces. Partnering with the UN Population Fund (UNFPA), local primary health care providers, the Integrated Service Center of Women and Children Empowerment (P2TP2A), Firm Family Planning, local police, and local NGOs, the initiative is backed by a reserve of human resources. The project collects data from service recipients (those reporting violence), service providers (local hospitals and P2TP2A), as well as stakeholders involved in violence reporting in other sectors. Despite its small scale and limited capacity to handle an increasing caseload, the project has been successful in providing a clearer overview of the mental health and violence problems it is facing. As this report recommends the development of partnerships that support the mental health needs of vulnerable communities, Indonesia's collaborative work serves as a powerful example.

Healthy Mind Summit (The Philippines)

Striving to achieve the economy's first mental health legislation, hundreds of stakeholders, mobilized by the Philippine Psychiatric Association and the National Program Management Committee of the Department of Health, came together to advocate for a mental health bill presented to the Philippine Congress in 2014. A pre-summit for the legislation was held in July 2014, gathering patient and family groups, mental health professionals, academics, legislators, local and international NGOs, and other stakeholders. These stakeholders reached consensus on four primary issues in need of legislative action for strengthen mental health: family-level mental health, financing, advocacy, and research. The work at the pre-summit resulted in the Manila Declaration of Support for a Mental Health Act. At the October 2014 Healthy Mind Summit, draft legislation was agreed upon and submitted to members of Congress for sponsors and revisions. The movement to adopt the bill has support from local universities as well as charitable foundations. According to the Philippines, the vast scale of this movement suggests the "power of partnership" by numerous stakeholders can serve as a template for future collaborations in mental health advocacy.

Philippine Health Information System on Mental Health (The Philippines)

Launched in 2013 at the University of the Philippines, the Philippine Health Information System (PHIS-MH) is a model for multi-stakeholder support in mental health data collection. Serving as a collaboration between multiple private and public sector entities, including the Philippines National Center for Mental Health, the Philippines Department of Health, the Institute for Clinical Epidemiology, the Philippine Psychiatric Association, Johnson & Johnson, and psychiatric facilities. PHIS-MH was officially launched in July 2014 and showcased in August 2014 at Peking University during the APEC Workshop for Innovative Collaborations in Mental Health. The platform serves two primary objectives: (1) to improve mental health reporting and patient monitoring, and (2) to generate consistent and reliable information to bolster knowledge of mental health issues. PHIS-MH has over 5,000 clients enrolled in the program and its widespread support among key government agencies and private partners helps ensure system's growth and sustainability.

Mentari Program (Malaysia)

MENTARI are Community Mental Health Centers which provide screening, diagnosis, treatment and rehabilitation services for any person suffering from a mental disorder. There are twenty centers nationwide: funded by the Ministry of Health Malaysia (MOH) and managed by the MOH's Psychiatry and Mental Health Services. As Malaysia has prioritized improving outcomes for individuals with mental illness, supported employment has become a core activity of MENTARIs. Guidelines and training modules are being prepared to standardize the implementation process. MENTARI teams include a lead psychiatrist, medical officers, occupational therapists, nurses and health attendants, as well as volunteers from the local community. The program partners with local NGOs and the Malaysian Psychiatric Association in outreach with potential employers and the community. The program has improved employment opportunities for patients while reducing stigma and discrimination. In sharing stories about the successes of participants, the program further reduces stigma within society and among employers.

SUMMARIES OF APEC ECONOMY STRATEGIC NEEDS ASSESSMENT SUBMISSIONS

Australia

*Priorities***:** In November 2014, Australia launched the Report of the National Review of Mental Health Programmes and Services, which outlined an ambitious new plan to re-configure the mental health infrastructure, recognizing that the government was not equipped to meet rising demand. That report informed Australia's SNA which focused on community-based services, primary health care, prevention and early intervention, advocating a people-first approach to mental health treatment strategies, and a renewed emphasis on the unique and heightened mental health challenges facing Aboriginal and Torres Strait Islander peoples.

Challenges: The 2014 review revealed that there was a need to develop a strategy upon which to base resource allocations. In some areas there was duplication of effort and in others there were considerable unmet needs. As a result, Australia has sought to invest in collaborations and partnerships that are needs-based and prioritize early intervention, so as to reduce access gaps. Australia's SNA notes that it has experienced several successful public-private collaborations on mental health in efforts to integrate primary care services with specialist providers, but that such partnerships are often vulnerable to "structural, cultural, and practice barriers" which may lead to "system inefficiencies" and unsatisfactory mental health outcomes for individuals.

*Collaboration***:** As the Australian Department of Health embarks on its new strategy to rectify system inefficiencies and to foster a unified national approach, it has expressed interest in multi-stakeholder collaborations in several areas. The government is interested in pilots and partnerships relating to indigenous mental health services, employment opportunities for those with mental illness, and e-mental health technology.
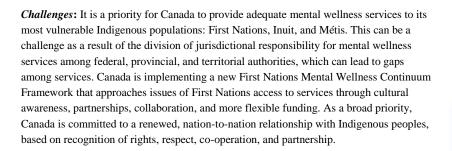
SNA Submission Highlights

Submitted by: Department of Health
Top Priority Areas
- Workplace wellness
- Indigenous communities
- Community-based prevention and promotion strategies

Canada

*Priorities***:** The priorities outlined in Canada's SNA were informed, in part, by the nation's first Mental Health Strategy, which was launched in 2012 by the Mental Health Commission of Canada (MHCC). First, Canada seeks to continue work in areas such as stigma reduction, implementation of the recommendations of the Mental Health Strategy for Canada, and knowledge exchange. Second, Canada seeks to increase accessibility and to develop more "culturally safe" methods for mental wellness services. Indigenous peoples experience some of the highest rates of depression, suicide, and substance abuse issues, and experience high rates of other relevant socio-economic challenges that can have an impact on mental wellness, including high unemployment, poverty, poor housing, displacement, and marginalization. Third, the government has also prioritized promoting workplace wellness and supporting the mental health needs of veterans and first responders. Canada is also making significant research investments each year to build evidence on mental health and inform decisions and policies on how to improve mental health services for patients.

*Challenges***:** It is a priority for Canada to provide adequate mental wellness services to its most vulnerable Indigenous populations: First Nations, Inuit, and Métis. This can be a challenge as a result of the division of jurisdictional responsibility for mental wellness services among federal, provincial, and territorial authorities, which can lead to gaps among services. Canada is implementing a new First Nations Mental Wellness Continuum Framework that approaches issues of First Nations access to services through cultural awareness, partnerships, collaboration, and more flexible funding. As a broad priority, Canada is committed to a renewed, nation-to-nation relationship with Indigenous peoples, based on recognition of rights, respect, co-operation, and partnership.

*Collaboration***:** Canada's SNA indicates interest in regional pilot collaborations on workplace wellness initiatives and in partnerships for addressing mental health solutions for Indigenous peoples. In particular, Canada proposes collaborations that will share best practices, raise awareness, and create new measurable indicators for developing healthy workplace environments. For Indigenous mental wellness, Canada seeks to engage Indigenous partners in community-driven and culturally safe responses that will help achieve a new vision for mental wellness among Indigenous peoples.

SNA Submission Highlights

Submitted by: Public Health Agency of Canada
Top Priority Areas
- Workplace wellness research
- Indigenous communities
- Community-based prevention and mental health promotion strategies

Chile

Priorities: Chile's SNA identifies four primary areas of need
First, Chile seeks a broad structural reform agenda addressing taxes, education, and labor that will reduce societal inequities and enhance general well-being. Second, Chile desires increased cross-sectoral involvement for mental health promotion and prevention. Following from this priority, Chile seeks improved integration of primary health care with specialist services and improved financial coverage within private and public insurance programs. Finally, Chile emphasizes intersectoral efforts for social inclusion collaboration with the NGO sector to advance the well-being of persons with mental disabilities.

Challenges: Chile's submission indicated that the current percentage of the health budget devoted to mental health is inadequate to carry out the goals of Chile's National Mental Health Plan. An increase in the budget devoted to mental health would help address Chile's greatest mental health burdens, which arise from "common mental health disorders, mainly depression and substance abuse, which are known to affect mostly the poor, women, children, and other vulnerable groups." Increased funding would also address the existing inadequate support structure for people with more serious mental disorders and disabilities. Chile also believes that larger social inequities are contributing to the increasing mental health burden in Chilean society – recognition that mental health is linked to the overall economy.

Collaboration: Building on the outcomes from its innovative "Chile Crece Contigo" program, which follows the development of children from prenatal to the age of 4 to detect social risk conditions and potential developmental delays, Chile seeks further cross-sectoral and potentially regional collaborations on early intervention and mental health promotion programs. Chile has partnered with Peru on mental health in the past and expresses interest in future collaboration with Peru to inform structural mental health reforms in Chile. The SNA also indicates interest in piloting regional cooperation on issues of social inclusion for persons with mental disabilities.

SNA Submission Highlights

Submitted by: Ministry of Health
Top Priority Areas
- Integration of primary care and mental health services
- Social inclusion approaches for the mentally disabled
- Promotion and prevention
- Structural reforms to reduce inequalities and enhance overall wellbeing

Hong Kong, China

Priorities: At the time of Hong Kong's submission, the government was undertaking a mental health review under the Secretary for Food and Health. The review identified several priority areas: dementia care, support for adults with mental health problems, adolescent mental health, mental health promotion, and the proposed introduction of community treatment centers. The enhancement of dementia care and adolescent mental health services were viewed as the primary areas of emphasis. The SNA noted that the mode of delivery of such services is an area in need of improvement to address to these mental health challenges. Therefore the SNA prioritizes the development of community-based responses emphasizing family and community support structures for both dementia patients and adolescents dealing with mental health problems. According to the SNA, these responses must be bolstered by cross-sectoral and functional collaborations between government agencies, the Hospital Authority (HA), and other community stakeholders.

Challenges: Hong Kong's SNA reveals that the economy is facing increased demand for mental health services across all age groups. Without modifications to the current mode of mental health service delivery, the rising caseload may strain the healthcare and social system to its limits. Collaboration and communication is emphasized in Hong Kong's Case Management Program. Through three-tiered collaboration initiatives between central, district, and local service delivery levels, the government seeks to improve collaboration and communication within the program so as to eliminate existing service gaps and improve mental health responses from service providers.

Collaboration: Hong Kong's mental health services infrastructure exhibits improving cross-sectoral collaboration between its primary providers, the Hospital Authority and the Social Welfare Department, and secondary providers such as NGOs. The government is keen to continue facilitating these relationships in order to improve the mental health infrastructure. Because the SNA was completed in parallel with the government's mental health review, Hong Kong's submission expressed a need to wait for the results of that review before joining any regional pilot collaboration. However, based on the report's assessment of the priority areas and collaborative efforts indicated in the review, initial indications are that Hong Kong could benefit from the regional exchange of best practices in community-based responses to mental health challenges.

SNA Submission Highlights

Submitted by: Department of Health
Top Priority Areas
- Enhancement of dementia care
- Enhancement of adolescent mental health services

Indonesia

Priorities: Indonesia's SNA asserted increasing access to mental health services as the top priority. Indonesia has proposed several interrelated strategies towards this end, such as integrating primary care and mental health services, improving community-based responses, and strengthening human resources. In developing these solutions, Indonesia hopes to reduce the treatment gap, destigmatize mental health issues, reduce discrimination, free those with severe mental disorders from restraint and violence, and lessen the burden on families and individuals. The SNA also prioritizes the development of mental health promotion and prevention for vulnerable populations defined as pregnant women, infants, children, the elderly, disaster victims, stocks and illegal laborers.

Challenges: Indonesia's submission suggests that there exist gaps in access and in the quality of mental health services as well as a lack of general community awareness about mental health. Therefore, Indonesia has piloted Community Mental Health Cadre Training for Community Mental Health Care to empower communities to gain more knowledge about mental health issues that may foster a better support system for individuals suffering from mental health challenges or disorders. In addition, the SNA indicates challenges with regards to increasing community violence, including against women, children, and with respect to human trafficking. The economy is also prone to natural disasters and has recognized a need to develop appropriate mental health solutions for disaster victims.

> *SNA Submission Highlights*
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> **Submitted by**: Directorate Prevention and Control of Mental Health Problems and Substance Abuse, Ministry of Health
> **Top Priority Areas**
> - Increased mental healthcare access and availability
> - Community-based responses to mental health care
> - Mental health promotion and prevention for at-risk populations

Collaboration: Indonesia has participated in multi-stakeholder collaborations on community mental health through the Community Mental Health Cadre Training program and on violence and disaster mental health through a disaster mapping project in 3 provinces in partnership with the UN Population Fund (UNFPA). Due to the limited budget and small scale of the UNFPA project, Indonesia has expressed interest in regional pilot collaborations with regards to mental health for disaster victims and on community-based mental health programs in accordance with its identified priority areas.

Japan

Priorities: Japan's national mental health policy currently emphasizes promoting acute inpatient care and discharging long-stay patients, providing community-based responses for those with and at-risk for mental health disorders, and facilitating the integration of primary and mental health services through the exchange of knowledge among various health care professionals. The SNA focuses largely on the theme of integration of services and disaster mental health, as a result of Japan's experience.

Challenges: Japan has an increased need for disaster mental health services due to the frequency of natural disasters in the last few decades. The SNA suggests that Japan's mental health infrastructure has steadily improved to cope with disasters after major earthquakes in 1995, 2011, and 2016. Natural disaster recovery poses the compound dilemma of requiring affected individuals to recover both economically and mentally. As is well known, Japan displays the highest rate of aging (26%, 2015) among all economies in the world. As elderly patients very often suffer from physical complications of mental illness, the integration of primary care and mental health services is in urgent need in Japan.

Collaboration: As Japan seeks to build capacity for the integration of primary and mental health services, it has focused early efforts on the need to increase the awareness of mental health problems among various stakeholders. The National Institute of Mental Health has brought together the National Cancer Center, the National Cerebral and Cardiovascular Center, the National Center for Global Health and Medicine, the National Center for Child Health and Development, and the National Center for Geriatrics and Gerontology to increase knowledge of mental health issues. In the effort to improve integration of services, Japan has expressed willingness to collaborate and share knowledge with other APEC economies, as it has already engaged in collaboration on best practices in primary care and mental health services with agencies in Singapore and Korea. In disaster mental health, various government ministries collaborate with NGOs, private mental health facilities, health care professionals, school teachers, and journalists. It has leveraged these cross-sectoral relationships to build an informative website for guidelines and basic principles for post-disaster mental health. The Japanese government is also collaborating with the WHO's Western Pacific operations to establish standard practices and information on psychological first aid across Asia Pacific economies. Japan's SNA expresses willingness to expand such collaboration throughout APEC so as to enhance cost-efficiency, education, training, and communication.

SNA Submission Highlights

Submitted by:
National Institute of Mental Health,
National Center of Neurology and Psychiatry
Top Priority Areas
- Integration of primary care and mental health services
- Disaster mental health

Republic of Korea

Priorities: Korea's SNA submission prioritizes best practice collaborations for Suicide prevention. Suicide prevention is a key focus in Korea's 2016 National Plan of Mental Health, in addition to mental health promotion, strengthening community care for severe mental disorders, and developing a social system to prevent substance abuse. In order to combat high national suicide rates, the Plan proposes three main strategies: creating a social environment that actively seeks to prevent suicides, providing customized community suicide prevention services, and implementing the national suicide prevention policy over five years. The government is focusing on education and awareness campaigns aiming to educate 5% of the population by 2020 to decrease the suicide rate and encourage those with higher risks towards committing suicide to find help. The plan particularly targets suicide reduction and prevention among the elderly living in rural areas as a key area in need of improvement. The submission also notes a recent realization of the need to improve disaster mental health services.

Challenges: According to the submission, Korea has the highest suicide rate among OECD countries at 28.7 per 100,000 people as of 2013, which is more than double the OECD average. In addition, the SNA notes that the suicide burden, measured in direct and indirect economic costs such as lost productivity, is extremely high. The SNA also suggests that suicide reporting in the media is affecting the potential of high-risk groups to commit suicide. Therefore the government is hoping to increase media compliance with suicide reporting standards adopted by the government, Korea Suicide Prevention Association, and Korea Press Association to 30% by 2020. Compliance between 2011 and 2015 was just 9% according to the SNA submission. Another challenge has been the prevalence of insecticides, used in suicides-by-poison, within rural homes.

SNA Submission Highlights

Submitted by:
National Center for Mental Health
Top Priority Areas
- Suicide prevention and awareness
- Disaster mental health

Collaboration: Korea has attempted to address these challenges through collaborative efforts. The guidelines developed for suicide reporting were jointly developed by the government, national suicide prevention association and the Korea Press Association. To create more suicide-resilient communities, the Central Government and Life Insurance Philanthropy Foundation partnered to fund a gatekeeper education program that promotes suicide awareness and prevention strategies among the office workers, soldiers, healthcare providers, civil servants, the elderly and adolescents. The program draws on partnerships with corporations, schools, primary health care facilities, and public institutions to accomplish its goals. Similarly, the Korea Suicide Prevention Association and the Life Insurance Philanthropy Foundation have partnered on a campaign to prevent the distribution of "insecticide safety boxes" in rural areas and to end the production of fatal insecticides such as Gramoxone to reduce suicides in rural areas. Between 2012 and 2014, these efforts helped reduced poisoning suicides by 60%. Korea's SNA submission also seeks regional collaboration for providing psychological support in disaster situations.

Malaysia

Priorities: Malaysia's SNA indicated several mental health priorities within a wide array of issues. The SNA prioritized increased collaboration between primary health care services and specialist services; improved mental health research, data collection, and evidenced-based interventions; increasing community-based services while decreasing admissions to psychiatric institutions; and increasing human capital within the mental healthcare field. Malaysia's SNA also focused heavily on increasing employment opportunities and inclusion for those with mental disabilities; developing research for detecting workplace stressors; and a heightened need to respond to the psychological traumas of natural disasters.

Challenges: According to Malaysia's SNA, 20% of Malaysian hospitals provide psychiatric services. There is an imbalance in Malaysia between the resourcing of mental health services for mental institutions – which have over 80% of psychiatric beds – and general hospitals. Furthermore, Malaysia needs to build up a cadre of psychiatrists and mental health professionals. One implication of this mental health landscape is that Malaysia has often approached mental health with a "curative" (hospital-based) approach with less attention to preventive and rehabilitative methods. The SNA's priorities and proposed mental health strategies also reflect an intention to strengthen the mental health infrastructure towards prevention, promotion, and rehabilitation programs. Malaysia's SNA also discusses a "vicious cycle" in which employers refuse to employ people with mental disabilities, leaving them isolated. The prevalence of man-made and natural disasters also are contributing to growing mental health challenges.

Collaboration: Despite growing challenges, Malaysia's SNA demonstrates a robust program of innovative strategies that have been employed to improve mental health. Mentari Malaysia, a program seeking to improve employment opportunities for the mentally disabled through job training and volunteering, has piloted numerous collaborations with government agencies and NGOs. The Malaysian Psychiatric Association has sponsored mental health advocacy programs and rehabilitative mental health approaches. As Malaysia continues to improve these existing services and programs, it seeks regional collaboration on many of these issues such as employment for the mentally disabled, mental health promotion, and the improvement of the mental health infrastructure. Lastly, Malaysia seeks regional collaboration on psychological responses to natural disasters and work-stress research.
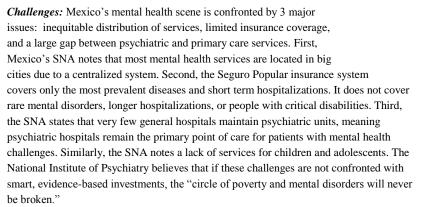
> *SNA Submission Highlights*
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> **Submitted by**: Ministry of Health
> **Top Priority Areas**
> - Integration of primary care and mental health services
> - Increased human capital within mental health
> - Mental illness prevention and mental health promotion
> - Employment opportunities for the mentally disabled
> - Workplace mental health research

Mexico

Priorities: Mexico's SNA emphasizes two main priorities: (1) the need to invest in a more equitable distribution of mental health resources to different regions of the economy, especially outside of the major urban centers, and (2) prioritizing the integration of primary health services with specialist mental health services. Mexico also identifies the need to support projects directed at translating scientific knowledge of mental health into technology and innovation that supports mental wellness. Mexico hopes that such research investment will yield better information systems and a system of evaluating mental health outcomes with specific focus on treatment, local characteristics, and patient diversity

Challenges: Mexico's mental health scene is confronted by 3 major issues: inequitable distribution of services, limited insurance coverage, and a large gap between psychiatric and primary care services. First, Mexico's SNA notes that most mental health services are located in big cities due to a centralized system. Second, the Seguro Popular insurance system covers only the most prevalent diseases and short term hospitalizations. It does not cover rare mental disorders, longer hospitalizations, or people with critical disabilities. Third, the SNA states that very few general hospitals maintain psychiatric units, meaning psychiatric hospitals remain the primary point of care for patients with mental health challenges. Similarly, the SNA notes a lack of services for children and adolescents. The National Institute of Psychiatry believes that if these challenges are not confronted with smart, evidence-based investments, the "circle of poverty and mental disorders will never be broken."

SNA Submission Highlights

Submitted by: National Institute of Psychiatry
Top Priority Areas
- Integration of primary care and mental health services
- Mental health research

Collaboration: Mexico has worked on a number of collaborative projects with the WHO, the National Institutes of Health in the U.S., and foreign universities on diverse projects such as the World Mental Health Survey to determine the epidemiology of different mental disorders, mental health services utilization, substance abuse interventions, depression in women, and stress among others. The SNA expresses interest in regional pilot collaborations on analytical research into the economic costs of mental health issues, genetics and mental health, and the role of environmental factors in mental health. Mexico also is open to the sharing of best practices on innovative and successful intervention and treatment strategies with regards to depression, suicide, and teenage drug use.

New Zealand

Priorities: New Zealand's SNA focuses largely on the dynamic between mental health and economic participation. This perspective informs New Zealand's prioritization of early intervention and prevention programs for mental health. New Zealand plans to build on its strong service delivery for those with the highest needs by improving investments in primary care options. The SNA consistently emphasizes the development of a new "social bonds[2]" financing mechanism to fund programs that enable the employment of people facing mental health difficulties.

Challenges: The SNA submission notes the development of increased mental health service delivery by private and not-for-profit organizations (NGO's). While this is a positive development in terms of increasing the variety of service provider options between public and private providers, New Zealand suggests this can pose a regulatory challenge. According to New Zealand, each service provider must be large enough "to maintain critical capability, capacity, and to manage the governance of the services that they deliver." With this concern in mind, many NGO providers have begun merging to ensure quality coverage and governance.

Collaboration: New Zealand has been an active funding donor for mental health services in Pacific Island Nations through the WHO's Pacific Island Mental Health Network. New Zealand has also been a direct donor of health services for clinical and logistics services in Samoa. Although New Zealand's SNA does not indicate any specific proposals for regional pilot collaborations, New Zealand may find potential regional collaborations to share best practices on innovative funding in mental health or new projects to ensure quality mental health service delivery in fragmented provider environments as areas of fruitful regional cooperation.

SNA Submission Highlights

Submitted by: Ministry of Health
Top Priority Areas
- Early intervention and prevention programs
- Employment for individuals with mental health challenges

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[2] Though New Zealand's "social bonds" program remains developmental, its main function is to encourage private investment in the employment of people with mental health problems with the aim of achieving effective long term outcomes for these individuals.

Peru

Priorities: In Peru's SNA, early prevention among youth, integration of primary care and specialized mental health services, and the establishment of residential protections for people with mental disabilities are the key priority areas. Early prevention strategies are aimed primarily at pre-school and school children and require resources and coordination from schools, local authorities, the Ministry of Health, and the Ministry of Education. Improving the level of integration between general health services and specialized mental health care will require improved community-based resources for mental health responses, including increased training of mental health professionals. With a large population of individuals with mental disabilities who have been "abandoned" by their families in hospitals, Peru hopes that a new residential protection provision will help reduce stigma and discrimination against such groups.

Challenges: Each of Peru's stated mental health priorities responds to existing challenges in the mental health landscape. 85% of Peru's health spending goes towards services in the capital city, where only 30% of the population lives. This leaves a large population of Peruvians without access to quality mental health services. Peru's treatment model also leans towards a curative approach focused on psychiatric hospitals. There is not a community network of mental health services. The SNA describes this system as an "inefficient model" producing treatment gaps "ranging from 84% in Lima to 90% in the rest of the country." Finally, the SNA notes the existence of 500 patients with mental disabilities who have been "abandoned" by their families in Peruvian hospitals.

Collaboration: In addressing the issue of housing for the mentally disabled, several Peruvian authorities – the National Institute of Mental Health and NGO partners – with Chilean cooperation, developed the first protected home for people with mental disabilities in Lima. Peru is open to regional collaboration on how to supplement and improve its residential protection programs. Peru also seeks regional collaboration and consultation on how best to implement integration of primary and mental health services. Lastly, Peru's experiences implementing interventions for physical, emotional, and sexual domestic violence against children may serve as a useful template for collaboration with other APEC economies.

SNA Submission Highlights

Submitted by: Ministry of Health
Top Priority Areas
- Integration of primary care and mental health services
- Early prevention programs
- Residential protection programs for individuals with mental disabilities

The Philippines

Priorities: The SNA submission from The Philippines identified 3 primary areas of strategic need. First, The Philippines is committed to enhancing its infrastructure around disaster related mental health. The Philippines wants to improve mental health knowledge among disaster responders as well as provide mechanisms to protect the mental health of first responders. Second, The Philippines seeks to institutionalize community mental health services. This priority includes the deployment of a human resource development plan to establish realistic indicators for what community mental health networks – hospitals, specialists, provincial governments, and other authorities – should achieve. Third, the Philippines has prioritized the establishment of an efficient and sustainable drug supply chain, involving increased access for mental health medicines and improved regulatory and clinical guidance for mental health treatments.

Challenges: Each of The Philippines priority areas corresponds directly with existing challenges within its mental health landscape. The push for enhanced disaster related mental health responds to the heightened disaster risks in The Philippines – its geographic location, political and socioeconomic situation, and the adverse effects of global climate change. The Philippines specifically notes the inadequate responses to recent natural disasters, such as Typhoon Haiyan in 2013. A desire to improve community mental health networks results from increasing incidences of suicide, drug use, neurological diseases, and mental health complications from infectious diseases. In terms of the drug supply chain, the SNA notes bottlenecks, pricing, and lack of clinical coordination as contributors to unstable access to drugs and treatments for patients.

Collaboration: The SNA calls for increased public-private collaboration to standardize mental health care delivery and to create a more unified information system. The provider network is extremely fragmented, causing inefficiencies, gaps, and inequities in service delivery. After standardization, The Philippines hopes that multi-stakeholder investment in a Mental Health Information IT system can rectify some of these dilemmas. Despite these challenges, The Philippines has launched innovative multi-stakeholder collaborations, such as the National Framework for Action on Mental Health and The Healthy Mind Summit, which presented Congress with the first ever draft of a national mental health policy bill.

SNA Submission Highlights

Submitted by: National Center for Mental Health, Department of Health
Top Priority Areas
- Disaster resilience
- Institutionalization of community-based responses to mental health challenges
- Establishment of a sustainable drug supply chain

Thailand

Priorities: Thailand's SNA suggests prioritization of community-based and person-first responses to mental health problems. It identifies as a goal the integration of mental health into primary care services with strong links to specialist services, as well as informal community support structures. Another area of priority is supported employment for psychiatric patients and people with disabilities. Thailand seeks the development of evidence-based supported employment schemes that produces competitive employment for individuals based on preferences, includes integrated work settings, and provides continuous mental health support between jobs.

Challenges: In order to develop the job placement schemes it desires, Thailand needs to engage and sustain interest from a number of public agencies and private sector groups. These include the Ministry of Labor, the Ministry of Social Development and Human Security, as well as employers. The largest obstacles to these efforts are ensuring that employers receive relevant information about mental disorders to deal effectively with mentally disabled employees and reducing the stigma associated with mental health both within society and among employers.

Collaboration: Thailand's SNA expresses interest in regional collaboration to deepen supported employment programs. Thailand has piloted its own program with the job placement activities through Srithunya Psychiatric Hospital. The program involves multiple stakeholders to conduct training on job skills, independent living, and work habits. Thailand may benefit from regional pilot collaborations on the integration of primary care and mental health services.

SNA Submission Highlights

Submitted by: Ministry of Public Health
Top Priority Areas
- Supported employment for the mentally disabled
- Integration of primary care and mental health services

The United States

Priorities: Two broad priorities indicated in the United States SNA are to increase public understanding of the costs of untreated mental illness and to work towards the integration of mental health services with primary care. With these overarching objectives, the SNA identifies more specific priorities within mental health research and mental health services. Under research, the United States is focusing on growing the BRAIN Initiative, a national brain research project; understanding mental health disparities across sex, gender, age, race, ethnicity, and geography through studying diverse populations; engaging in globally oriented mental health research; and harnessing big data for research collaboration. In terms of services, the United States seeks to prioritize recovery support, integration of health solutions and increased access to care, childhood mental health and early prevention, trauma mental health, and suicide prevention.

Challenges: According to the SNA, mental health challenges cause excessive suicide rates and nearly $300 billion in costs annually in the United States. Moreover, people suffering from substance abuse issues tend to be excluded from mental health services and are forced to rely on "public safety net" programs. 11.8 million Americans report unmet mental health needs in addition to the 20 million Americans with untreated substance abuse issues. This service gap is reflected in the SNA's prioritization of reducing stigma, increasing mental health care access, and integrating services at the primary care level. Another challenge is that many mental health treatments may not meet the evidence-based standards required under recent health insurance legislation, even though such legislation federally mandates that insurers provide access to mental health services. The American mental health landscape is also confronting the disruptive power of technology as well as increasingly divergent mental health outcomes in illness prevalence and service delivery across sex, gender, age, race, ethnicity, and geography.

SNA Submission Highlights

Submitted by: National Institute of Mental Health
Top Priority Areas
- Integration of primary care and mental health services
- Stigma reduction
- Mental health prevention and early intervention
- Research

Collaboration: The United States submission suggests an eagerness to partake in regional collaborations on mental and substance use disorders as well as research capacity building efforts. The Substance Abuse and Mental Health Services Administration (SAMHSA) has already begun these efforts by providing expertise to Asia Pacific countries on substance abuse, while the National Institute of Mental Health (NIMH) has launched two international collaborative research efforts between researchers, governments, and NGOs. Both SAMHSA and NIMH are committed to public/private partnerships to achieve a variety of mental health outcomes, including stigma reduction, social inclusion, mental illness related to incarceration, integration of services, psychological trauma, and developing a behavioral health workforce. Mental health agencies in the United States have been active in collaborative initiatives such as the National Action Alliance for Suicide Prevention, and "The Children's Mental Health Initiative," while SAMHSA's Strategic Prevention Framework engages multisector stakeholders in building coalitions to strengthen community mental health prevention strategies.

Viet Nam

Priorities: A heavy focus on the links between economic and agricultural and industrial development is persistent in Viet Nam's SNA. This focus informs Viet Nam's prioritization of "providing good primary mental health care services for labor forces in factories," as well as building positive mental health environments in schools and rural communities. Viet Nam wishes to refocus the national mental health strategy to hone in more on the economic links between mental health and sustainable development. The SNA also notes attention towards improving informal mental health networks and early prevention strategies to promote mental health in schools.

Challenges: Viet Nam's SNA states that more 90% of the national health budget is spent on mental health within hospitals. Another issue cited is the lack of access to treatment for individuals facing more common problems, such as depression, anxiety, or childhood mental disorders. Free public treatment is only available for mental health patients with more serious problems, such as schizophrenia. The SNA also notes the weakness of childhood mental health structures and the lack of clarity and guidance within the national mental health plan as challenges within Viet Nam's mental health landscape.

Collaboration: In alignment with its identified strategic needs, Viet Nam has engaged in recent studies to improve household prevention and care of prenatal mental disorders. Viet Nam seeks APEC collaboration for further interventions for mental disorders among children 0-18 years old as well as the exchange of best practice models for improving the quality of the informal and community-based mental health care system. Viet Nam has engaged in collaboration with the Research and Training Venter for Community Development and the MOLISA Department of Child Care and Protection to put mental health on the national policy agenda. Furthermore, Viet Nam has expressed interest in leading international cooperation on sharing experiences with partnerships between public, civil society, and private organizations for mental well-being among women and children.

> *SNA Submission Highlights*
>
> **Submitted by**: General Administration of Preventive Medicine, Ministry of Health
> **Top Priority Areas**
> - Early prevention programs in childhood mental health
> - Workplace mental health
> - Community-based responses to mental health challenges

BACKGROUND ON THE
APEC MENTAL HEALTH INITIATIVE

Mental health is crucial to social and economic health, worker productivity and sustainable economic growth. Mental disorders serve as a leading cause of disability and are magnified by the effects of swift economic change and ageing populations. The impact of mental disorders on APEC economies is widespread, resulting in costs that impede the achievement of economic development goals and threaten the wellness of communities and workplaces.

The World Economic Forum noted in 2011 that chronic disease will cost the global economy more than US$47 trillion between 2010 and 2030. More than a third (US$16 trillion) is attributed to mental disorders. The World Health Organization advises that mental disorders serve as the world's leading cause of disability-adjusted life years (DALYs) and account for 37% of all healthy life years lost from chronic disease. Furthermore, 25% of all patients using a health service suffer from at least one mental disorder. Despite this burden, annual spending worldwide on mental health is less than US$2 per person.

Obstacles to care and recovery from mental disorders drive the impact on APEC economies. These obstacles include social stigmatization, shortages of specialists, limited access to initial/continued care and effective medicines, and treatment compliance. APEC economies acknowledge obstacles should be addressed through resources that support awareness building, effective mental healthcare interventions, enhanced information sharing on lifestyle choices, and engagement on community-based care.

The World Health Organization has called for the integration of mental health into development efforts since 2010. The World Health Organization Comprehensive Mental Health Action Plan 2013-2020[3], adopted by the World Health Assembly in May 2013, and the ongoing efforts of the WHO Mental Health Gap Action Programme (mhGAP), call for a comprehensive and multi-sectoral approach to address mental disorders worldwide. The Commonwealth Health Ministers called for expanded economic and social inclusion to address mental disorders in May 2013 in Geneva, Switzerland.[4]

Success by APEC economies to reduce obstacles to care and recovery from mental disorders is enhanced through heightened collaboration among all stakeholders, including the private, academic, community, health and non-health public sectors. Multi-sectoral, multi-lateral collaborations and model public-private partnerships – built on best and innovative practices and appropriate to the local situation – support the translation of global mental health policy recommendations and local economy mental health plans into concrete, measurable results. The elaboration of effective collaborations and partnerships also provide evidence within APEC economies to communicate the benefits of expanded public and private resources.

In July 2013, the APEC Life Sciences Innovation Forum (LSIF) and APEC Health Working Group (HWG) convened in Medan, Indonesia for their first roundtable dialogue to share experiences and develop a path forward for APEC to support mental health. Both fora subsequently adopted the APEC HWG-LSIF Joint Work Plan on Mental Health[5], launching an effort to address mental health challenges in the region through the promotion of innovative, multi-sectoral collaborations. The work plan was endorsed by APEC Ministers in October 2013, who also issued their first call to action:

> *"We recognized that health plays an important role as a driver of economic development. We also recognized the role that innovation and innovative approaches, multi-sectoral and multi-stakeholder collaboration, and public-private partnerships in APEC in ensuring the physical and **mental health** of our citizens."[6] APEC Ministers also acknowledge "the need to address including through public-private partnerships the significant burden of **mental illness**."[7]*

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[3] World Health Organization Comprehensive Mental Health Action Plan 2013-2020: http://www.who.int/mental_health/action_plan_2013/en/
[4] Commonwealth Health Partnerships: Mental Health ~ Towards Economic & Social Inclusion: http://www.commonwealthhealth.org/wp-content/uploads/2013/07/Mental-Health-Overview_CHP13.pdf
[5] APEC HWG-LSIF Joint Work Plan on Mental Health (See Pages 12-13): http://mddb.apec.org/Documents/2013/MM/AMM/13_amm_011.pdf
[6] 2013 APEC Ministerial Meeting (AMM) – Joint Ministerial Statement:
http://www.apec.org/Meeting-Papers/Ministerial-Statements/Annual/2013/2013_amm.aspx
[7] 2013 APEC Joint Ministerial Statement – Sustainable Healthcare System in the Asia-Pacific: http://www.apec.org/Meeting-Papers/Ministerial-Statements/Annual/2013/2013_amm/annexe.aspx

In April 2014, the APEC Task Force on Mental Health was launched to support implementation of the APEC LSIF-HWG Joint Work Plan on Mental Health. This included preparations for the *APEC Workshop to Promote Innovative Collaborations in Mental Health* held at Peking University in Beijing, China on 20-21 August 2014. The workshop convened regional experts and thought leaders across sectors to exchange best and innovative practices in multi-lateral, multi-sectoral collaborations and model public-private partnerships. Participants also prepared a draft of an APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific through 2020 (APEC Roadmap) which was endorsed by APEC Ministers in November 2014. This endorsement was followed by APEC Economic Leaders (Heads of State) recognition of the importance of mental health for the first time in the Forum's 25 year history.[8]

As the lead forum supporting sustainable economic growth and prosperity in the Asia-Pacific region, APEC has an opportunity to continue to lead in the promotion of innovative collaborations in mental health that provide tangible benefits for economic growth and the wellness of our communities and workplaces. APEC has a unique advantage to convene key stakeholders, to raise awareness at both the highest and grassroots level, and to support region-wide and local capacity building efforts. In 2015-2016, in accordance with APEC Ministers and Leaders mandate, the APEC Mental Health Initiative has initiated implementation of the APEC Roadmap.

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[8] 2014 APEC Economic Leaders (Heads of State) Declaration: http://www.apec.org/Meeting-Papers/Leaders-Declarations/2014/2014_aelm.aspx

APEC DIGITAL HUB FOR MENTAL HEALTH:
BEST PRACTICES AND INNOVATIVE PARTNERSHIPS

The Asia-Pacific Economic Cooperation (APEC) forum – an inter-governmental organization of 21 member economies[9] with 2.8 billion people that constitute a majority of global GDP – has prioritized strengthening mental health through the elaboration of multi-stakeholder collaborations and public-private partnerships based on international best practices. As a central component of the *APEC Roadmap to Promote Mental Wellness in a Healthy Asia-Pacific*, endorsed by APEC Ministers in 2014, the organization has launched an interactive *APEC Digital Hub for Mental Health: Best Practices and Innovative Partnerships* (the Digital Hub) in 2015-2016.

The Digital Hub serves as an opportunity to address obstacles to early intervention, care and recovery from mental disorders through the identification and implementation of evidence and practice-based models in multi-stakeholder collaboration and public-private partnership that (A) strengthen mental wellness in support of sustainable economic growth and (B) best meet the needs of individual economies, in alignment with established international best practices. APEC economies have acknowledged that such obstacles should be addressed through innovative efforts aligned with seven common focus areas as identified by APEC member economies during the Strategic Needs Assessment (SNA). Through its novel approach, the Hub will serve as a regional incubator of new ideas and practices as well as augment existing platforms and networks.

The Digital Hub is uniquely positioned for success. As an inter-governmental organization built on collaboration and public-private partnership, APEC has extraordinary convening power, a reporting structure directly to political leadership and a dedicated focus on capacity-building, particularly for developing member economies.

The Digital Hub will operate under the guidance of the APEC Life Sciences Innovation Forum (LSIF) in consultation with the APEC Health Working Group (HWG) of senior health officials. Academicians, practitioners, community partners, policy officials, and the private sector will serve as key stakeholders and partners in the Hub. Projected activities and outcomes over the next 5 years are needs based and include web based and on site advocacy training with the development of curricula; an interactive compendium of best practice collaborations and partnerships in specific topic areas based on the needs of member economies; stakeholder collaboration and mapping, and research on the regional economic impacts of mental disorders.

The Digital Hub's Executive Director will be based at the University of British Columbia. The Hub host institutions will develop a network of partner institutions across the APEC region to provide training and/or expertise that best fits an economy's unique situation. The Digital Hub will also serve as the administrative and secretariat center to support implementation of the APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific.

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[9] APEC Member Economies: Australia; Brunei Darussalam; Canada; Chile; China; Hong Kong, China; Indonesia; Japan, Korea; Malaysia; Mexico; Papua New Guinea; Peru; Philippines; Russia; Singapore; Chinese Taipei; Thailand; United States; Viet Nam.

ACKNOWLEDGEMENTS

Australia	University of Melbourne	**Peru**	Ministry of Health
Australia	Monash University	**Peru**	National Institute of Mental Health
Australia	Victoria University	**Peru**	Ministry of Tourism and Trade
Australia	James Cook University	**The Philippines**	Department of Health
Australia	Department of Health	**The Philippines**	National Center for Mental Health
Australia	Asia-Australia Mental Health	**The Philippines**	University of the Philippines-Manila
Brunei Darussalam	Ministry of Health	**The Philippines**	Philippine Psychiatric Association
Canada	Public Health Agency of Canada	**Singapore**	Ministry of Health
Canada	Mental Health Commission of Canada	**Singapore**	Institute of Mental Health
Canada	University of British Columbia	**Singapore**	Agency for Integrated Care
Canada	University of Alberta	**Chinese Taipei**	Ministry of Health and Welfare
Canada	Mood Disorders Society of Canada	**Thailand**	Ministry of Public Health
Canada	Ontario Brain Institute	**Thailand**	Center of Excellence for Life Sciences
Canada	Grand Challenges Canada	**Thailand**	Alzheimer's Foundation
Chile	Ministry of Health	**The United States**	Department of State
People's Republic of China	National Health and Family Planning Commission	**The United States**	Substance Abuse and Mental Health Services Administration
People's Republic of China	Peking University	**The United States**	Department of Health and Human Services
People's Republic of China	Shanghai Mental Health Center	**The United States**	National Institute of Mental Health
Hong Kong, China	Janssen Asia-Pacific	**The United States**	Medical College of Wisconsin
Indonesia	Ministry of Health	**The United States**	Johnson & Johnson / Janssen Scientific Affairs
Japan	National Institute of Mental Health	**The United States**	C&M International
Republic of Korea	National Center for Mental Health	**Viet Nam**	Ministry of Health
Malaysia	Ministry of Health	**Viet Nam**	Research and Training Center for Community Development
Mexico	Secretariat of Health	**WHO**	Department of Mental Health and Substance Abuse
Mexico	Ramón de la Fuente Muñiz, National Institute of Psychiatry	**WHO**	Western Pacific Regional Office
New Zealand	Ministry of Health	**WHO**	Pan-American Health Organization
New Zealand	Health Quality and Safety Commission	**United Kingdom**	Mental Health Innovation Network
Papua New Guinea	National Department of Health	**United Kingdom**	London School of Hygiene and Trop. Med.

APPENDIX: APEC ECONOMY STRATEGIC NEEDS ASSESSMENT SUBMISSIONS

AUSTRALIA
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Department of Health
Previous Needs Assessment or Strategy Policy	The Executive Summary of the Final Report of the Review of Mental Health Programmes and Services is <u>attached</u> with this strategic needs assessment. A copy of the Final Report can be accessed via the Commission's website at www.mentalhealthcommission.gov.au/.

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

The Australian Government tasked the National Mental Health Commission with conducting a national Review of Mental Health Programmes and Services (the Review). The Final Report of the Review, *'Contributing Lives, Thriving Communities'*, provides 25 recommendations across nine strategic directions which guide a detailed implementation framework of activity over the next decade.

The Commission has recommended a shift in focus towards community based services, primary health care, prevention and early intervention; and to better focus on services supporting individuals and families. It also proposes actions to improve the social and emotional wellbeing of Aboriginal and Torres Strait Islander people and the mental health and wellbeing of people living in regional, rural and remote Australia.

The Australian Government recognises that improving outcomes for people with mental illness requires long term effort and commitment. The Government is examining the Review's substantial content to develop a considered strategy and to ensure that the next steps taken deliver a genuine and unified national approach to reform.

Details of funding arrangements for mental health services in Australia are outlined in the Final Report.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

The Final Report of the Review makes numerous references to partnerships, including strong links and partnerships between the Commonwealth, states and territories*, and opportunities for partnerships across agencies on a local or regional level to improve access to services. It notes examples of developing partnerships with Indigenous primary health care organisations to ensure better mental health outcomes for Aboriginal and Torres Strait Islander people, and developing partnerships between governments and businesses to ensure that meaningful employment is equally accessible for people experiencing mental ill-health. The Review also recommends a national collaborative approach, supported by public-private partnerships to integrate the mental health system with the use of e-mental health technologies. *Note that Australia is a Federation, with powers distributed between a national government (the Commonwealth) and nine state and territory governments.*

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

Successful examples of multi-stakeholder collaborations or public-private partnerships include the National Mental Health Strategy, which is a commitment by Australian governments to improve the lives of people with a mental illness. The strategy was endorsed in April 1992, and the concept has grown to encompass the range of national policy and planning documents regarding mental health reform that have been agreed by all governments. The strategy has been reaffirmed by the health ministers a number of times since 1992. In 1998, the Second *mental health plan* was developed, and in 2003 the *National mental health plan 2003-2008* was endorsed. Most recently, the 1992 *National mental health policy* was revised in 2008 and the *Fourth national mental health plan* was released in November 2009. The *Mental health statement of rights and responsibilities* was revised in 2012.

Factors that have made the National Mental Health Strategy successful include shared commitment across both the State and Commonwealth levels. The Strategy has fostered important public-private partnerships, between specialist services and primary care providers, and more broadly, between the health sector and sectors outside health that influence people's lives.

The Review notes examples of gaps or barriers to successful collaborations and partnerships, with structural, cultural and practice barriers to integrated supports leading to system inefficiencies and poorer mental and physical health outcomes for individuals.

Other examples of multi-stakeholder collaborations or public-private partnerships include National Partnership Agreements, which are agreements between the Commonwealth of Australia and the states and territories. Specific funds for mental health services are provided by the Commonwealth to states and territories under the National Partnership Agreements on Mental Health, to help improve state services, particularly in the priority areas of accommodation support and presentation, admission and discharge planning in emergency departments.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?

Australia's capacity to collaborate with other APEC member economies on a regional pilot collaboration will need to be considered within the context of the Australian Government response to the Review.

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CANADA
STRATEGIC NEEDS ASSESSMENT

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RESPONDENT INFORMATION

Organization	Public Health Agency of Canada
Other Organizations	Health Canada Canadian Institutes of Health Research Department of Employment and Social Development

STRATEGIC NEEDS ASSESSMENT

> ***APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.***

Canadian Context

In Canada, provinces and territories (P/Ts) have jurisdiction for the delivery of primary healthcare and social services delivery (including physician and hospital services, mental health psychiatric hospitals, mental health counselling, addiction treatment and crisis response services) to all residents, including First Nations living off reserve, Inuit and Métis. The federal government provides funds to the provinces and territories through the Canada Health Transfer and supports the mental health of Canadians through initiatives and activities that complement those of the P/Ts.

While the provision of primary healthcare services is under the jurisdiction of the P/Ts, certain populations fall under the jurisdiction of the federal government, such as the military and veterans; federal offenders; the Royal Canadian Mounted Police (RCMP); immigrants and refugees; and federal public servants through the Employee Assistance Services. This includes the provision of access to health services for First Nations people who are residing on reserve where access to a P/T health system can be a challenge, such as in isolated or remote communities. These supports are provided through a range of community-based health programs, including mental health promotion; addictions and suicide prevention; counseling and other crisis response services; and treatment and after-care services.

Canadian Priorities and Needs

First Nations, Inuit, and Métis Populations

Mental health and addictions issues are consistently identified as high priority by First Nations and Inuit in Canada. Some First Nations and Inuit face major challenges such as high unemployment, poverty, poor access to education, poor housing, remote location from health services, the displacement of traditional language and culture, and social and economic marginalization; all of which continue to impact their health and well-being. In this context, mental health and substance use issues continue to be some of the more visible and dramatic symptoms of these underlying challenges, and may intensify underlying challenges or health determinants. This can include: higher rates of depression and suicide, higher incidences of substance use issues (including prescription drug abuse), and increased rates of sexual, physical and emotional abuse.

While federal, provincial, and territorial mental wellness programs and services seek to address the mental wellness challenges faced by many First Nations communities, there can be gaps between and among these services; they could be better coordinated, and are not always delivered in a culturally safe manner. Canada's priority is to strengthen federal mental wellness programming and support integration between federal, provincial and territorial programs so that programming and supports are easily accessible, comprehensive and culturally safe for First Nations communities.

Access to the full basket of mental wellness services through a continuum of care should be applied across a broad range of policy areas and programs to create connections. For example:

- Partnerships, collaboration, aggregation, alternative service delivery models, flexible funding, elimination of program silos, and quality improvement.
- Team-based approaches, linking with primary care and public health approaches, including communicable and chronic disease.
- Focus on individuals, families, and communities, across the lifespan.

Health Canada, in partnership with First Nations, is implementing a comprehensive Mental Wellness Continuum (MWC) Framework aimed at strengthening current programming to make sure it meets the needs of First Nations individuals, families and communities. The Framework outlines access to mental wellness services along a continuum through partnerships, collaboration, flexible funding, elimination of program silos, etc. The Government has also committed to a new relationship with Indigenous peoples, and to working with them on the issues that they have identified as their greatest priority.

Other federal populations

The Government has committed to supporting the mental health of Canada's veterans, by enhancing mental health service delivery, and to public safety officers, by developing a coordinated national action plan on post-traumatic stress disorder.

Workplace Wellness

The Government of Canada has also identified a number of priorities to reduce the impact of mental illness on the economy. These include raising awareness of psychological health and safety issues in the workplace, and making tools and promoting best practices by making tools and resources available to workplace parties that help to address psychological health and safety issues in the workplace. The federal government has also identified the need for measurement, evaluation and research, including research that demonstrates the benefit of proactively addressing workplace psychological health and safety and the associated economic impacts of not doing so, as well as research on leading indicators that identify workplaces at higher-risk of psychological health and safety issues.

Mental Health Research

Through the Canadian Institutes of Health Research, the Government of Canada has invested more than $280 million since 2010-11 to support research performed in universities and research institutions in areas related to mental health. This includes an investment of $54 million in 2014-15 alone.

CIHR has launched a number of research initiatives tailored to address mental health challenges faced by vulnerable populations, such as children and youth and Indigenous peoples. Examples of CIHR-initiatives in this area include:

• The Pathways to Health Equity for Aboriginal Peoples Initiative launched in 2012 represents an investment of over $25M over ten years. This initiative aims to achieve a better understanding on how to implement and scale up interventions and programs that will address First Nations, Inuit and Métis health inequities in four priority areas, one of which is suicide prevention.

•Through Pathways, CIHR has also provided $500,000 in funding to two international research teams to assess the outcomes of community-based interventions in circumpolar regions in order to identify and share best practices in promoting mental wellness in youth and preventing suicide in later years. The work of these two funded research teams was an integral component of an Arctic Council initiative on suicide prevention led by Canada under its chairmanship of the Arctic Council. Initiated by CIHR, this work is now being continued under the US chairmanship through the RISING SUN project. In support of this US-led project, Canada will host a meeting in March 2017 which will bring together the work from the two year project and expand Artic States' capacity to evaluate suicide prevention interventions.

• CIHR, in collaboration with the Graham Boeckh Foundation, is supporting Access Open Minds – a research network dedicated to improving the care provided to young Canadians with mental illness by translating promising research findings into practice. This initiative represents an investment of $25 million over five years, split evenly between CIHR and the Graham Boeckh Foundation. It represents the first research network supported through Canada's Strategy for Patient-Oriented Research (SPOR) – a national coalition led by CIHR dedicated to integrating research evidence into care.

• In November 2015, CIHR and its partners announced an investment of $9.9 million to support eight research projects dedicated towards early identification of, and intervention for youth and adolescents (11-25 years of age) with mental health conditions. These projects are funded as part of CIHR's eHealth Innovations Initiative, which aims to identify patient-oriented eHealth solutions that will improve health outcomes, patient experience, and lower the cost of care in priority areas.

• In 2015, CIHR, in collaboration with the Social Sciences and Humanities Research Council, launched an initiative called Healthy and Productive Work. This initiative aims to bring key stakeholders together to help create the conditions for healthy work – more specifically, on the interventions (accommodations, tools, policies) necessary to foster the labour force participation of people with health issues, including mental health challenges.

•As part of the National Anti-Drug Strategy, CIHR also established the Canadian Research Initiative in Substance Misuse (CRISM), a national research network aimed to improve the health of Canadians living with prescription drug abuse, addiction and substance misuse. This network, which represents a federal investment of $7.2 million over five years, is unique for substance misuse research in Canada, as it focuses on translation and implementation of results across many sectors.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

Canada's Successes in Stakeholder Collaborations

Two areas in which Canada has made significant strides in terms of multi-stakeholder collaborations are in addressing stigma associated with mental illness and in addressing mental health and homelessness (detail is provided in the next section). Canada has also invested in developing a pan-Canadian network of researchers specializing in depression via the Canadian Depression Research and Intervention Network (CDRIN) – a network of academics across Canada collaborating on post-traumatic stress disorder and depression research, clinical care, education and training.

Beneficial Priority Areas

Areas that could benefit from stakeholder collaborations and/or public-private partnerships, identified in the *Mental Health Strategy for Canada* (Mental Health Commission of Canada, 2012), include promoting and preventing mental illness and suicide, and mobilizing leadership, improving knowledge and fostering collaboration at all levels , including strengthening data collection.

Mental Health in the Workplace

Supporting the uptake of the *National Standard of Canada for Psychological Health and Safety in the Workplace* is an ongoing area of activity. The National Standard is a voluntary set of guidelines, tools and resources focused on promoting employees' psychological health and preventing psychological harm due to workplace factors. The Mental Health Commission of Canada, an arm's length organization funded by the Government of Canada, has developed a toolkit and other materials to support awareness and encourage uptake of the standard by organizations and companies.

Additionally, Canada would benefit from multi-stakeholder collaborations and/or public-private partnerships in the following priority areas:

Sharing best practices and innovative approaches (both regulatory and non-regulatory) to addressing psychological health and safety in workplaces.

Developing activities which serve to raise awareness of the importance of creating a psychologically healthy and safe workplace (including stigma reduction), and demonstrating to employers the organizational benefits of maintaining a psychologically healthy workplace.

Developing metrics to help employers better evaluate psychological health and safety in the workplace and the impacts of proactive policies and programs addressing workplace psychological health and safety.

First Nations, Inuit, and Métis Populations

Achieving the envisioned mental wellness continuum for Canada's First Nations communities will require sustained commitment, collaboration, and partnerships, supported by effective leadership across the system. "Change leaders", whether individuals or collectives (e.g. governments, partners, teams, institutions, agencies, individuals, or communities) Indigenous or non-Indigenous, must play a key role in achieving this vision, wherein First Nations individuals, families, and communities across Canada are supported to enjoy high levels of mental wellness.

The First Nations Mental Wellness Continuum (FNMWC) Framework is rooted firmly in culture. Culture must not only guide Canada's work, it must be understood as an important social determinant of health. Culture, as a foundation, implies that all health services and programs related to First Nations go above and beyond creating culturally relevant programs and safe practices. The cultural values, sacred knowledge, language, and practices of First Nations are essential determinants of individual, family, and community health and wellness. A strength of the Framework process has been its connection to regional and national First Nations health and wellness networks, which have guided the process, shaped the Framework's vision, and supported engagement with First Nations communities. As a result, building culture as the foundation for Canada's mental health programming and supports must remain a priority.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

First Nations, Inuit, and Métis Populations

The processes for the development of the *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* (http://nnadaprenewal.ca/) and the *First Nations Mental Wellness Continuum Framework* (http://health.afn.ca/uploads/files/24-14-1273-fn-mental-wellness-framework-en05_low.pdf) are both considered best practices for partnership and collaboration in Canada.

Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada:

From 2007 to 2011, Health Canada worked in partnership with the Assembly of First Nations (AFN) and the National Native Addictions Partnership Foundation (NNAPF) to carry out a comprehensive, community-driven review of substance use-related services and supports for First Nations. This review included a wide range of knowledge-gathering and consensus-building activities, including regional addiction needs assessments; a national forum; a series of research papers; regional workshops; and an Indigenous knowledge forum. In 2011, this review resulted in the development of a national framework to address substance use issues among First Nations people in Canada. *Honouring Our Strengths: A Renewed Framework to Address Substance Use Issues Among First Nations People in Canada* outlines a continuum of care in order to guide the design, coordination, and delivery of services at community, regional and national levels.

The First Nations Mental Wellness Continuum (FNMWC) Framework:

Initiated in 2012, the Framework was developed with extensive engagement from First Nations across the country. The process, guided by an Advisory Committee co-chaired by Health Canada's First Nations and Inuit Health Branch (FNIHB) and the AFN, involved a comprehensive mapping of existing mental health and addictions programming with the support of community mental health leaders from across the country. Collectively, regional, national and federal engagement sessions engaged more than 1,000 contributors.

The Framework describes the vision for First Nations mental wellness, with culture as the foundation. It outlines a continuum of mental wellness services all First Nations communities can access and emphasizes First Nations strengths and capacities and provides advice on policy and program changes that can improve First Nations mental wellness outcomes.

<u>*Mental Health Commission of Canada (MHCC)*</u>

The MHCC has created effective cross-sectoral partnerships which have allowed the organization to benefit from a variety of perspectives on mental health and to develop relevant and inclusive recommendations for governments, service providers and community leaders. Examples include collaborative work on the National Voluntary Standard on Workplace Psychological Health and Safety; the *Opening Minds* (OM anti-stigma and anti-discrimination initiative; and the *At Home/Chez Soi* research demonstration project on homelessness and mental illness. *At Home/Chez Soi* tested the effectiveness of a "Housing First" approach, which emphasizes stable housing as a priority for vulnerable individuals, and then offers recovery-oriented services and supports for underlying issues. The project involved a high degree of collaboration among health/housing/social services and other community-based support services with non-profit / private sector partners. http://www.mentalhealthcommission.ca/English/initiatives-and-projects/home

<u>Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?</u>

Canada is interested in regional pilot collaboration including sharing best practices and information.

CHILE
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Ministry of Health of Chile, MINSAL

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

Chile, as most countries in the world, has a great burden due to mental health problems. Since 1990 a gradual shift has been made from traditional mental hospital based to community and general health insertion of mental health and psychiatry programs. The main funding for mental health programs comes from Government (e.g. national or sub-national public health insurance / reimbursement schemes), Households (e.g. direct out-of-pocket payments and private insurance), Employers (e.g. social health insurance schemes), in that order. In Chile, about 2% of the health budget is dedicated to mental health, and estimations show that to fulfil our National Mental Health Plan this percentage should rise to a minimum 5%. People with diseases like Depression, Schizophrenia from the first episode, Bipolar Disorder and Substance Abuse in adolescents with low psicosocial repercussion have a legally guaranteed treatment. Our greatest burden is based on common mental health disorders, mainly depression and substance abuse, which are known to affect mostly the poor, women, children and other vulnerable groups. Inequity and personal indebtedness is an important factor that may be fuelling mental health burden in our society. On the other side, persons with disabilities due to serious mental disorders don´t receive enough support to guarantee social inclusion, mainly because of a lack of cross-sectoral involvement.

From a priorities point of view, Chile´s main needs for strengthening mental health are:

1. Structural reforms such as taxes, education and labour regulations between others may have an important role in reducing inequities and enhancing human development and wellbeing;

2. Cross-sectoral involvement in promotion and prevention in mental health;

3. Strengthening of mental health services with a strong integration in general health, primary health and community insertion; and improvement of mental health financial coverage in private health and insurance programs.

4. Cross-sectoral involvement in social inclusion of persons with mental disabilities.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

The main multi stake holder collaborations and partnerships needed in Chile are:

- Cross sectoral involvement, mainly of education, work, housing and social development sectors for promotional, prevention and inclusion programs.

- Agreements with Universities so as to form mental health professionals aligned with the needs of the population and mental health attention system.

- Solid grounded Public - NGOs partnership for the development of community inclusion programs such as rehabilitation, anti-stigma, inclusive work, and participation programs.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

Programa "Chile Crece Contigo" ("Chile Grows with You" Program): is a program of Integral Protection to childhood that is implemented mainly by Ministries of Social Development and Health, with many components in the community. It follows the development of children from pregnancy till they are 4 years old, detecting social risk conditions, development delay and other health conditions, implementing actions for each of these, in order to assure a healthy development on the first critical years.

It is a program created by law, relies mainly on a strong Primary Health Network, and has a strong political support and public approval.

Chile Crece Contigo (ChCC) is a subsystem of the System of Social Protection named Subsystem of Integral Protection to Childhood. Its purpose is to attend the needs and support the development of childhood on every stage of early infancy (from pregnancy to 4 years old) promoting the necessary basic conditions, considering that childhood development is multidimensional and therefore simultaneously influenced by biological, physical, psychic and social aspects of the child and his milieu. The subsystem expects to impact in the early child development, in the caring and raising behaviors of mothers, fathers and carers, and in the quality of attention they receive in the health system and other local services for childhood. The subsystem organizes in 4 main lines:

1. Educational program for all the citizens.

2. An accompaniment system for the child since the first pregnancy control till they enter the school system (prekinder).

3. Guaranteed benefits for the 60% most vulnerable segment of the population: Technical aid for children with disabilities, free access for day nursery, free access for kinder garden, guaranteed access for the benefits of "Chile Solidario" Program ("Solidary Chile", another subsystem of the System of Social Protection).

4. Preferential access for the benefits for the 40% most vulnerable population.

This program has a good evaluation and acceptance. A problem that has been addressed and is being evaluated, is the convenience of extending it to a greater age, for example till 8 years old.

www.crececontigo.gob.cl/

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?

Yes, as a country we are interested in developing regional pilot collaboration to strengthen mental health. This could be done with Perú, country with which we have a story of mutual collaboration on mental health issues, mainly in the reform of the mental health system, through PAHO. It would be interesting to focus on cross sectoral involvement for the promotion of positive mental health, prevention of mental health problems and social inclusion of persons with mental disabilities.

HONG KONG, CHINA
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Department of Health
Other Organizations	Food and Health Bureau

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

The Hong Kong Government attaches great importance to the mental well-being of our population. The Government has been adopting a multi-disciplinary approach with cross-sectoral participation in the promotion of mental health, as well as prevention and treatment of mental problems. Despite continuous Government investment on strengthening mental health, we see a rising demand for mental health services across all age groups. To ensure a sustainable provision of mental health services and to further strengthen support for persons with mental problems, the Government is undertaking a mental health review under the leadership of the Secretary for Food and Health. The review seeks to map out the future directions for development of mental health services in Hong Kong.

The review has identified a few priority areas for actions. Among others are the need to enhance dementia care in view of a rapidly ageing population, and the need to enhance child and adolescent mental health services in view of rising occurrence of mental health problems in children and adolescents. If the problem is not addressed promptly and the caseload not relieved, the huge volume of cases will stress our healthcare and social systems. We therefore need to enhance our readiness by refining the mode of service delivery and the review is going along this direction.

In the public sector, mental health services are provided mainly by the Department of Health, Hospital Authority (HA) and the Social Welfare Department (SWD) (which provides subvention to non-governmental organisations to provide rehabilitation services and organise mental health promotion campaigns). The services are funded through the annual budget of the respective departments/authority.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

Cross-sectoral collaboration is essential in the delivery of mental health services. We seek to provide comprehensive, multi-disciplinary and cross-sectoral services to persons with mental health problems through a number of policy bureaux and departments, and in partnership with the HA, non-governmental organisations and other stakeholders in the community.

The mental well-being of the population hinges on a whole host of complicated factors and addressing mental health issues requires a collective response of the community involving not only the government, but also the individual, the family, other social units and so forth. An effective partnership among different sectors of the community is crucial to ensure the provision of holistic care and quality mental health services to the public. It also calls for the collaborative efforts of the community to provide a caring and accommodating environment where members of the public recognise the importance of mental health, take care to manage their mental health, and support the social inclusion of persons with mental illness.

In Hong Kong, cross-sectoral collaboration is seen in the delivery of various mental health services, including the delivery of dementia care, as well as in child and adolescent mental health services.

As far as the provision of dementia care is concerned, persons with dementia require continuous medical and social care support and services. Social care services that support the persons with dementia and their carers to facilitate the former to stay in the community for as long as possible play an equally important role as clinical diagnosis and medical treatment. Having strong social and community support will avoid premature admission to long-term care facilities. We are also refining a care model that seeks to enhance primary health and social care in the provision of services for persons with uncomplicated dementia. These persons will get medical and social support in the community by primary care personnel. This will allow specialists more time to focus on cases requiring intensive care.

The provision of child and adolescent mental health services call for medical-social-education collaboration. Supporting children and adolescents with mental health problems is the joint responsibility of parents, teachers, healthcare and social care professionals, as well as other caring players in the community. As the case in the provision of dementia care, prevention and intervention provided at the primary care setting will allow specialists more time to handle complicated cases. To prevent emotional distress and mental problems in children, it is much more effective to build a caring and enabling family, school and community environment than to try to repair a damage at a later stage. It is therefore important to involve all stakeholders in various sectors and to construct an effective communication platform in the school setting in the formulation of care approaches and to coordinate the necessary services for those in need of child and adolescent mental health services.

The mental health review is examining ways to enhance cross-sectoral collaboration with a view to enhancing the cost-effectiveness of prevention and intervention strategies, and hence the mental well-being of the targeted groups.

__Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?__

It is the international trend to gradually focus on community and ambulatory services in the treatment of mental illness, and to allow the early discharge of mental patients when their conditions are stabilised for treatment in the community. Patients with mental illness living in the community are supported by a wide range of medical and social services to facilitate their rehabilitation. The effective operation of community mental health services calls for close collaboration among stakeholders from the medical and social care sectors. To provide intensive, continuous and personalised community support for discharged patients with severe mental illness, the HA launched a Case Management Programme since 2010 where an experienced healthcare professional or a social worker will provide support to help the person recovering from mental illness to re-integrate into society.

Following the implementation of the Case Management Programme, a three-tier collaboration platform was instituted by HA and SWD in 2010 to facilitate cross-sectoral communication at the central, district and service delivery levels. At the central level, the HA head office and SWD headquarters as well as non-governmental organisations meet regularly to discuss service strategies and explore models of collaboration. At the district level, the HA's chiefs of psychiatry services and SWD's District Social Welfare Officers liaise regularly with service providers in the district and relevant government agencies to coordinate community support services, and to consider any necessary adjustment to service models having regard to district-specific demographics and service demand. At the service delivery level, HA's case managers maintain close contact with other service providers, including SWD's Integrated Community Centres for Mental Wellness, for discussion and coordination on matters such as case referral and arrangements for rehabilitation services.

In response to rising expectation for seamless collaboration between the medical and social sectors, HA and SWD have set up a task group to revisit the existing service model and develop a service framework for enhancing collaboration and communication between the two sectors. The service framework seeks to articulate a clear delineation of roles of different service providers, which would help eliminate service gaps and enable service providers to better respond to the needs of patients and families.

__Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?__

The review on mental health is underway. We expect that there will be some recommendations in enhancing mental health services coming out from the review. Given that mental health service needs are disease-, age- and clientele-specific, we prefer to wait for the conclusion of the review before considering any forms of regional collaboration.

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INDONESIA
STRATEGIC NEEDS ASSESSMENT

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RESPONDENT INFORMATION

Organization	Directorate Prevention and Control of Mental Health Problems and Substance Abuse, Ministry of Health
Other Organizations	World Health Organization

STRATEGIC NEEDS ASSESSMENT

> *What are your economy's top priorities for strengthening mental health as well as the areas of greatest strategic need to strengthen mental health outcomes? Please describe how your economy funds mental health services.:*
>
> **Our top priority on Mental Health is increasing access to mental health services. Some strategies are**:
>
> 1. Integrating mental health into primary care, general hospital and community to facilitate access and the availability of mental health services.
> 2. To improve and strengthen the role of primary health care and general hospitals in order to implement the mental health services so that will increase the mental health services coverage, which will reduce the treatment gap, withdrawal, discrimination, stigmatization, disability, suffering, and burden of the disease.
> 3. To strengthen the availability of human resources in the field of mental health workers by: (a) Mental health education and training in order to increase knowledge and skills; and, (b) Equitable distribution of mental health professionals and workers in the province, regency/city.
>
> **Outcome:**
> Reduce the treatment gap, stigma, discrimination, severe mental disorder free from restrain and the burden of costs and family. Mental health budget is obtained from: (1) National Health Insurance administered by the Social Security Agency (BPJS) to achieve Universal Health Coverage (UHC) in 2019; (2) Local insurance; and, (3) Out of pocket.

> *Please identify and describe 2 or 3 priority areas that your economy would benefit from through the piloting of multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health.*
>
> 1. Promotion and prevention especially population at risk, for examples: pregnant woman, infants, population of children and adolescents, elderly population, disaster victims, and Indonesian illegal labor.
> 2. Increase human resources capacity, such as: education and training of general practitioners, nurses and mental health professionals, etc.

> *Please list and describe examples of multi-stakeholder collaborations or public-private partnerships (at a local or economy-wide level) that are currently underway or have recently taken place? What are the critical factors that have made them successful or what factors may still be missing? Suggest 500 words or less and please include website links, if available:*
>
> 1. **Community Mental Health Cadre Training for Community Mental Health Care** *(Komunitas Peduli Kesehatan Jiwa)* **in collaboration with World Health Organization:** Cadres could give support to people with severe mental disorder and their family. It is important to improve cadres knowledge and skills on mental health as part of community empowerment. Workshop of Training of Community Mental Health Cadres was held on 13-15 November 2014. It took 2 months preparation of materials by consultants. The objective of the workshop was to improve community's awareness, specifically caregivers of persons with mental disorders through community empowerment activities. The other aim was to improve knowledge of community mental health cadres and caregivers of mental disorders patients as a basic mental health knowledge, as well as to support their treatment. The participants of the workshop were 32 cadres of Indonesia Schizophrenia Community Care *(Komunitas Peduli Skizofrenia Indonesia/KPSI)* from 10 districts in 7 provinces. This program practiced in small area or a small pilot project, and will be followed by training cadres in other districts and not yet followed by monitoring and evaluation.
>
> 2. **Mapping Health Care in Violence against children and women, including the crime of human trafficking (TPPO) in 3 provinces in collaboration with UNFPA:** Violence in the community has increased and cases of violence have not been exposed or handled properly in accordance with applicable regulations. Victims of violence and health workers are rarely reported to Integrated Service Center of Women and Children Empowerment *(Pusat Pelayanan Terpadu Pemberdayaan Perempuan dan Anak/P2TP2A)*. The objective of the program is to collect data from the service recipient, service providers and across relevant sectors in three (3) provinces. Each province has chosen two (2) primary health care to overview the problem of violence, health care and referral systems to violence against children and women, including the crime of human trafficking, and to collect data from the service recipient, service providers and across relevant sectors. Partnerships within this program are Primary health care, General Hospital in districts, P2TP2A, Firm Family Planning, Police, and NGOs. This program is good in response, it has the facility and enough human resources but lack capacity to handle the cases of violence. This program practiced in small area or a small pilot project with limited budget and human resources. There are no violence regulations governing child and women in the area.

> *Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in cross-border cooperation?*
>
> Yes
> - Community mental health programs
> - Disaster victims

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JAPAN
STRATEGIC NEEDS ASSESSMENT

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RESPONDENT INFORMATION

Organization	National Institute of Mental Health, National Center of Neurology and Psychiatry

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

National mental health policy has been revised every 5 years since 2004. Top priorities for the mental health policy include: (1) promoting acute inpatient care and discharging long stay patients, (2) providing community care for people with mental disorders as well as for high risk youth, and (3) facilitating exchanges of knowledge with various health professionals to integrate mental health care into primary care settings. The policy will result in more successful treatments of mental disorders that will reduce indirect costs of social burden of mental disorders especially in their workplace. In Japan, the mental costs of depression amount to $11 billion per year, 63% lost in the workplace. The promotion of mental health care including the prevention countermeasure in the field is urgent in Japan.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

Regarding the APEC digital Hub's Mental Health Focus Areas, the National Institute of Mental Health in Japan currently focus on "Disaster mental health" and "Integration of primary care and mental health services."

Disaster mental health

Japan has experienced a number of devastating natural disasters such as Hanshin-Awaji quake in 1995, Great East Japan Earthquake in 2011, and Kumamoto's great earthquake in 2016. It is crucially important to facilitate the mental health recovery of the victims and community so as to promote the recovery and build-back process of economic growth. Examples of multi-stakeholder collaborations are as follows:

- *Collaboration of various ministries of the government including that of health labour and welfare, education, police, and self-defence force.*

- *Collaboration of the official/governmental sectors and private mental health facilities, as well as NGOs.*

- *Collaboration of the mental health and mental health professionals, school teachers, journalists.*

Integration of primary care and mental health services

Considering the high comorbidity of physical illnesses and psychiatric diseases, the integration of mental health services into primary care is essential. However, the awareness of mental health problems in primary physicians is extremely low. The National Institute of Mental Health has been collaborating with the other national specialized care and research centers. These centers include National Cancer Center, National Cerebral and Cardiovascular Center, National Center for Global Health and Medicine, National Center for Child Health and Development, and National Center for Geriatrics and Gerontology

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

Disaster mental health: The National Institute of Mental Health provided comprehensive guidelines and information website, which served as the basic principles for all the post-disaster mental health countermeasure by Japanese official and affiliated private sectors. This helped to establish unanimous and effective post-disaster mental health promotion.

Integration of primary care and mental health services: As the first phase of the project, a cohort study is designed to assess the impact of medication adherence on renal function in comorbid patients with type 2 diabetes and depression. To our knowledge, this will be the first study to assess how adherence to hypoglycemic medication relates to the decline of renal function in comorbid patients with type 2 diabetes and depression. As adherence to hypoglycemic medication is a major concern of the physicians who are in charge with the treatment of diabetes, the influence of comorbid depression that might decrease the adherence level has become of interest. The diagnostic skill of depression may be a gap that needs to be filled.

> ***Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?***
>
> **Disaster mental health:** We are collaborating with WHO Regional Office for the Western Pacific (WPRO) to establish and disseminate the common material of the psychological first aids in Japan and Asian countries. We could benefit from expanding the region to APEC member economies that would certainly lead to a higher level of activity. To have the common material enhances cost-effectiveness in preparation, education, training and communication across different countries.
>
> **Integration of primary care and mental health services:** The National Institute of Mental Health in Japan shares the knowledge and experiences in primary care and mental health services with the Institute of Mental Health in Singapore and National Center for Mental Health in South Korea. We surely welcome other countries to join the party.

REPUBLIC OF KOREA
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	National Center for Mental Health

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

Suicide Prevention
The suicide rate of Korea is very high, at 28.7 per 100,000 persons in 2013, which is approximately 2-folds higher than OECD average (12.1 per 100,000 persons), and Korea has been ranked the first among the OECD countries.

Considering direct cost to be put into mental illness such as depression and indirect costs due to further deterioration of productivity, the economic burden is enormous. In particular, Socio-economic cost of 6.5 trillion won due to suicide has become a drag on national economic growth. Mental health problem due to suicide is a matter of national majority, and it has been required national intervention because of individual and familial distress.

In Korea, the policy of suicide prevention was put into high priority according to National Comprehensive Plan of Mental Health announced in 2016.

The nationwide 4 major strategies for suicide prevention are, 1) To make suicide preventing environment across the society 2) To provide the customized suicide prevention services in the communities 3) To implement the suicide prevention policy for the next five years.
Other major areas of the Korean Government to improve mental health are: 1) Mental health promotion of the general population, esp. early diagnosis and management of mild and moderate mental disorders, 2) strengthening community care for the severe mental disorders, and 3) developing social system to prevent substance and behavioral addiction.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

1. Gatekeeper Education for Suicide Prevention

In 2012, with the support from the Central Government and Life Insurance Philanthropy Foundation, the gatekeeper education program (**Seeing, Listening and Speaking**) was developed. The gatekeeper program has been spread by the partnership with corporations, schools, primary health care facilities, public institutions. So far, 15 million people including the elderly, adolescents, office workers, soldiers, healthcare providers, and civil servants completed the education from 2013 to 2015. And the goal is to educate 5% of the total population by 2020. Through this program, the final goal is 1) to decrease the suicide rate, 2) to find a high-risk group and encourage them to consult with experts in order to change their knowledge and attitudes towards suicide.

2. Development of Media guideline for Suicide Report

Suicide report is affecting the potential suicide high-risk group among general population. Therefore, in 2004, government, the Korea Suicide Prevention Association and Korea Press Association announced standard recommendation of suicide report to decrease the suicide rate by decreasing the flow of suicide risk information and managing suicide harmful information with creating life respecting culture.

On September 2013, standard recommendation of suicide report was amended and it was presented a clear frame of reference about newspaper, broadcasting as well as internet, SNS. Furthermore, harmful information about suicide has been monitored. Monitoring guide has produced with collaboration of many stakeholders such as information providing company, the relevant intelligence agencies and private organizations.

Compliance rate of media for keeping guideline for suicide report from 2011 to 2015 is 9 percent and the goal by 2020 is up to 30%.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

Suicide Prevention Program for the Elderly in Rural Area

Decreasing the suicide rate of Korean elderly was followed by the policy of private-public collaboration to prevent dissemination of "insecticide safety box" in the rural area (Life Insurance Philanthropy Foundation & Korea Suicide Prevention Association), and production & sales discontinuation of fatal insecticide (Gramoxone). The regular monitoring was conducted on a regional basis. And if the elderly high-risk group for depression occurred, they were sent to professional services. Until 2016, "insecticide safety box" has been placed in 4,353 households and it is about 0.38% of the whole of the

National Agricultural households. In addition, Production has been stopped about 11 kinds of fatal insecticide, Gramoxone and the access to the means of suicide was blocked by prohibiting the use. As a result of these efforts, the number of poisoning suicide deaths was decreased more than 60% from 2,719 people in 2010 to 1,072 people in 2014.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?:

Disaster Mental Health

After experiencing insufficient initial management of psychological support in disaster situations such as Sewol ferry accident in 2014, the need to provide systematic and standardized disaster mental health program to respond to various types of disasters has been increased. Recently we have witnessed so many natural and man maid disasters in the Asia pacific Region and very effective intervention programs developed by many countries.

The National Center for Mental Health developed diverse disaster mental health interventions and training programs for the psychological recovery of the victims. We'd like to share our experiences with other Asian countries and learn from them. For this purpose, there should be collaboration for disaster mental health in our region.

MALAYSIA
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Psychiatric and Mental Health Services, Ministry of Health
Other Organizations	Malaysian Psychiatric Association (MPA)
Previous Needs Assessment	National Health and Morbidity Survey 2011, executive summary in PDF attached
	National Healthcare Establishment & Workforce Statistics (NHEWS) 2011; available via http://www.moh.gov.my/index.php/pages/view/115

STRATEGIC NEEDS ASSESSMENT

__What are your economy's top priorities for strengthening mental health as well as the areas of greatest strategic need to strengthen mental health outcomes? Please describe how your economy funds mental health services.__

Malaysia has a population of 28.25 million (Department of Statistics 2011); it consists of 13 states and 3 federated territory (330,290 sq km). Seventy percent of its population resides in urban areas. It has a five-year development agenda: the 11th Malaysia Plan will be implemented in 2016-2020.

There are 443 hospitals in Malaysia, and only 20% of them provides psychiatric services. The majority of patients are managed by public hospitals run by the Ministry of Health Malaysia (MOH); which provides psychiatric services via 4 mental institutions and 45 general hospitals. The number of psychiatric beds is 4,707: of these 80.1% (n=3,772) are in mental institutions and 19.9% (n=935) are in general hospitals. In addition, there are 3 teaching hospitals run by the Universities (under the purview of the Ministry of Education) and 1 private sector hospital with a psychiatric ward. The ratio of psychiatrists is 0.08 per 10,000 population (n=319). Health clinics provide continuing care for stable patients. There is a traditional dichotomy which separates the Public Health Division which handles policies and primary care services; from the Medical Division which handles hospitals and specialist services – thus there might be occasional overlaps and miscommunications during referrals. In the long run, mental health services might benefit from a joint National Institute/ Committee on Mental Health with representatives from both divisions and other major stakeholders.

To strengthen mental health outcomes, areas of greatest strategic needs are:

1) Service re-organization: to create a balanced mix of services by increasing community-based services and facilities; increasing acute beds in general hospitals; and decreasing number of beds in psychiatric institutions. It also involves shifting from "curative" services to preventive and rehabilitative psychiatry; and enhancing collaboration between primary healthcare services and specialist services.

2) Enhance Information and evidence-based practices: developing mental health databases and capturing the trends; and making best efforts to provide evidence-based treatment based on local needs and resources; and creating a governance mechanism to oversee this.

3) Human capital: to increase the numbers of psychiatrists, nurses, occupational therapist, counsellors/ clinical psychologists and medical social workers; and providing ongoing training so that they have the necessary skill levels to handle the changing landscape.

Funding:

There is a two-tier system of funding: i.e. a government-run universal healthcare system and a co-existing private healthcare system. According to Health Expenditure Report 1997-2013 Preliminary Data (Malaysia National Health Accounts), total health expenditure in 2013 is RM 44,948 million: the biggest source of funding is   Ministry of Health (43%) and "Out-of-pocket" sources (39%) Please refer Appendix 1 for summary of the report.

__Please identify and describe 2 or 3 priority areas that your economy would benefit from through the piloting of   multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health.__

From our past experiences, collaborations need to be anchored to specific projects on common areas of concern. Especially so in delightfully multicultural Malaysia: without specific projects, it might be difficult for collaborations to provide adequate attention to the complexities of multiple stakeholders, multiple agendas and politics of change. Thus, the priority areas that we are proposing are technically project management endeavours. These are new-ish scopes for our services, and we welcome collaborations and partnership to enhance its implementation. The priority areas are:

Supported Employment for People with Mental Disability (PWMD):

Employment data for people with disability consistently showed that those with mental disability are those with the lowest rates of employment. There seem to be a vicious cycle of professionals who say that PWMD are unlikely to be able to work; and PWMDs believing that they cannot work and gave up trying; resulting in very few PWMD in employment; and ending with employers believing that PWMD cannot work – thus did not employ them. To remedy this, the psychiatric fraternity is attempting to target the first chain of that cycle and had made the **Supported Employment – Individual Placement and Support (SE-IPS)** project as the core activity for Community Mental Health Centres (CMHCs) or the "Mentari" Program. [Collectively, we call ourselves "Mentari Malaysia"]. This priority area is further sub-divided into several activities:

- Develop a training module for SE-IPS**:** To ensure good standards for this new service scope, training modules need to be developed for the different types/ skill levels of health professionals. This is done in collaboration with the People with Disability (PWD) Services Development Unit, Public Health Division MOH.

- Getting trained volunteers to work with us: Mentari does not have dedicated staff. One of our strategies is to reach out to volunteers from among retired nurses, psychologists etc.

- Publicity and Outreach: one of the best ways to address stigma against mental illness is by sharing the success stories of patients who had begun working; and by making Mentaris more accessible. At the moment, Mentari Malaysia is planning for a national newsletter; and we hope to explore other modes of sharing.

- Mentari IT System (MITS): With 12 centres receiving funding simultaneously, the Psychiatric fraternity had decided to use part of the funding to acquire a nationwide IT system with a built-in data warehouse. This will enable data on services and outcomes to be collected during routine clinical activities.

Other priority areas, which is still in early development phase:

- **Early Detection – with focus on Work Stress**: Policy makers had recently expressed concern regarding the increasing numbers of working adults who are suffering from mental illness. There is no official database to capture this trend, nor clear pathways to care.

- **Psychosocial Response to Disasters**: In 2013-2014 several man-made and natural disasters (military invasion in Lahad Datu, disappearance of MH370, shooting down of MH17, and massive floods in Kelantan) had highlighted the need for good psychological first aid services.

Please list and describe examples of multi-stakeholder collaborations or public-private partnerships (at a local or economy-wide level) that are currently underway or have recently taken place? What are the critical factors that have made them successful or what factors may still be missing?

Examples of collaborations:

- Each Mentari had initiated various kinds of partnerships with local agencies, NGOs and local healers to improve outreach and employment opportunities patients.
- Mentari Malaysia had organized a joint symposium in May 2015 which engaged other agencies involved in employment services: the Human Resource Ministry, Welfare Department, and the Job Coach Network. Venue for that event was acquired via a public-NGO-private collaboration.
- MPA via the 'Circle of Care' Program: MPA is a strong advocate of mental health promotion in Malaysia and provides grants to implement programs for public education or rehabilitation - Mentaris greatly benefited from this. MPA had also sponsored the airfare for an additional representative from Malaysia for the coming APEC roundtable
- Training for volunteers-cum-Job Coaches: The Social Welfare Department (SWD) and the Job Coach Network Malaysia had agreed to work with Mentari Malaysia to prepare a training module for our volunteers who are keen to be job coaches for PWMD. Job Coaches registered with the SWD will gain access to regular refresher training, networking and transport allowances.
- Working with volunteers: volunteers regularly contribute to Mentari's rehabilitation activities. Mentari Selayang has got a volunteer trained in medical social work from Japanese International Cooperation Agency (for 2015-2016) which is a great help in implementing SE-IPS.

Note: The Mentari Program is a landmark achievement for MOH Psychiatric Services during the 10th Malaysia Plan. The government finally approved dedicated funding for twelve centres all over the country in 2014 – four years after the initial proposal. Scope of services: early detection, prevention, rehabilitation and integration.

- Work Stress: we are exploring whether Mentaris can be used as an entry point for working adults who are facing work-related stress. Coupled with the built-in MITS – we can generate data on demographic and diagnostic trends for this phenomenon; and subsequently identify appropriate intervention programs.
- Psychosocial Response Team for disasters: the psychiatric fraternity had collaborated with other MOH agencies and NGOs so deploy teams and provide simple triage and rapid treatment of survivors and rescue workers.

Critical factors available are:

- Achieving consensus: This basically means a lot communications, mainly person to person and occasionally via organisations that Mentari Malaysia had to carry out to engage relevant stakeholders.
- Maximise funding: The government funding definitely escalated the implementation of activities. Working across agencies had enabled us to pool our resources and identify other sources of funding.
- Aligning ourselves to the policy-makers' philosophy: e.g. in the case of the Mentari Program – we leveraged on the policy makers' efforts on decongestion of general hospitals and meaningful outcome for patients (work). We also drew their attention to the major global documents e.g. the WHO's Mental Health Action Plan.
- Leadership: Competencies in managing stakeholder relationships; project planning and tracking; managing product acceptance and transitioning; and evaluate/ track project performance is important. For Mentari Malaysia, leadership occurs on two levels i.e. the authorizing level and the project team. The authorizing level is an advisory committee comprising of senior colleagues, policy makers and other stakeholders; while the project team consists of young Psychiatrists in charge of the respective Mentaris.

Critical factors which needs to be improved

- Organisational structure and communications – clear timelines and platforms for regular meetings and feedback sessions is still being drafted; and how MOH can interface with universities and professional associations.
- Ongoing training: we have a strong Conjoint Committee comprising of senior psychiatrists from universities and MOH to oversee Masters and subspecialty training in Psychiatry. However, we need to develop more structured training programs for other areas of interest e.g. disaster psychiatry; and training for SE-IPS integrated teams.
- Making time commitment for service development: due to our scarcity, mental health professionals tend to hold functional tasks in various levels and locations. Man-hours might be compromised.
- Track progress and outcome: Partly due to the limited man-hours, efforts are mainly concentrated on service delivery and not as much on tracking progress and outcome. Might be remedied via MITS.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in cross-border cooperation?

Implementation of SE-IPS: the originators of the SE-IPS method are from the USA i.e. the Dartmouth Johnson & Johnson Group. We hope that it will be possible for the member economies to have joint workshops to draw from the experience of these 'gurus' and from each other, so that we can establish our own training modules, fidelity scales and outcome measures.

Publicity and Outreach: we hope to participate in the global mental health hub so that we can share our efforts to a wider audience and also learn from others.

National Institute of Mental Health for Malaysia: we have an ongoing registry on schizophrenia and soon service/ outcome data from Mentari via MITS. In the future, plan to have our own National Institute of Mental Health which can facilitate better data management, researches and publications – whether locally or as cross-border project. We welcome inputs/ tips from other member economies on how we can navigate this.

Work Stress Survey/ Research: If APEC is going to conduct a survey on work stress in the member economies, we would certainly like to participate. This will require collaboration at a higher level, most probably via the Institute of Health Behaviour Research, MOH and MPA.

Joint efforts on Psychosocial Response to Disasters: provide awareness and training so that member economies can contribute to international disaster databases e.g. the EMDAT. We also look forward to the formation of a simple-triage-rapid-treatment information system so that better data can be collected, and we can respond better to disasters in the future.

MEXICO
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	National Institute of Psychiatry Ramón de la Fuente Muñiz

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

The axis of attention of mental health continues to be the psychiatric hospital with its outpatient and inpatient services with very few units of psychiatric hospitalization in existence in general hospitals. Residential establishments and specific services for kids and adolescents are also lacking. Furthermore, access to mental health services is limited due to the centralization of the attention system since most of the establishments are located in big cities. Only 30% of primary care services have protocols for the evaluation and treatment of mental disorders and the personnel who is trained to deal with these disorders is very limited.

In Mexico, the Seguro Popular (Popular Insurance) covers the main diseases, but the funding is not sufficient for the most part of the people who are sick. The ambulatory attention is covered in primary care, but there is not enough coverage for the population who is in need. The sick people who receive ambulatory services in psychiatric hospitals are not covered and they do not have access to medication; the short length of hospitalization that is covered is not sufficient for many patients and those who require a longer hospitalization are not covered. As a result, there are no options for people who have critical disabilities and/or state of neglect.

It is paramount that financial resources for mental health are an integral component of the funding allocated to health in general with specific allocations for mental health associated with other health initiatives. This will allow a more efficient use of resources rather than competing for the budget; for example the programs focused on mental health could be part of broader programs of reproductive health.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

Within areas of priority, two main groups can be mentioned, the ones associated with the improvement of health services and the ones related to research.

a) In terms of attention services, it is necessary to accomplish an equal distribution of resources in the different regions of the country, and the availability of basic psychotropic medication. We should also continue with efforts to accomplish the integration of mental health services to general health services. If we do not invest mental health, the circle of poverty and mental disorders will never be broken, which will prevent a good development.

b) In terms of research, it would be really useful to support projects directed at translating scientific knowledge into technology and innovation. Funding models that make the effective transference of institutional knowledge through research into the community; develop better systems of information and evaluation of the results while transferring knowledge by taking into account the structure of the systems of treatment, local needs, and patient diversity as provided by people delivering treatment within different institutions.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

In the field of research, they have carried different projects in collaboration with private institutions as Rio Arronte Foundation, with other public institutions such as the World Health Organization (WHO); the National Institutes of Health in the United States. There also collaborative projects with national and foreign Universities.

Examples of this collaborative work are: (1) Various models of mental health care, on issues such as stress and mental health, depression in women, adolescents and mental health, brief interventions for attention for substance abuse problems, among others. Link: www.inpsiquiatria.edu.mx/moodle/ ; and, (2) "Programa de Ayuda para el Abuso de Drogas y Depresión" (Assistance Program for Drug Abuse and Depression) (PAADD). Link http://www.paadd.mx/

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation? Suggest 250 words or less:

Some of the areas for opportunity of collaboration between Mexico and other economies that belong to APEC are: a) Economic analysis of the costs of mental disorders, addictions, and violence. b) Intervention and treatment strategies that have been successful in other countries, which focus on leading problems such as depression, suicide, or drug consumption among teenagers. c) Genetic studies associated with health and mental disorders. d) Studies pertaining to environmental factors and social determinants that influence the development of mental disorders and addictions. e) Strategies to evaluate the advances in public politics in terms of mental health and drugs

NEW ZEALAND
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Ministry of Health

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

The New Zealand Government has developed an increasing investment approach across the social sector within which mental health services are an important component in assisting Government to reach its overall social sector goals of improving employment and ensuring people are active participants in the economy. Therefore there is a focus on intervening early and preventing the development of long term problems and long term conditions. Government's policy is to increase delivery of care closer to home with earlier intervention and encouraging people to remain active participants in the economy and the community. This requires augmenting the focus of the mental health services from the current strong delivery to those of highest need, to investment in primary care options.

Mental health services are funded largely directly through Vote: Health (tax based funding) but a new approach of "social bonds" is encouraging private investment in the employment of people with mental health problems and is aiming to achieve more effective long term outcomes. This is still at a developmental stage.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

A new approach to the investment in the social sector in terms of "social bonds" is underway this year. The first area of focus is mental health. This involves a joint non-government organisation(NGO) and Bank partnership to deliver programmes that enable people with mental health problems to gain employment. This is in the process of commencing now.

The delivery of mental health services in New Zealand has significant private or not for profit organisations participation from NGOs and Primary Health Organisations (PHOs), thus there is diversification across both publically and privately provided services, although all are predominated publically funded. One of the features of the delivery of mental health services is the significant involvement of private or not for profit providers.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

One of the features of the development of New Zealand's mental health services has been the development of a broad range of NGO providers which has given diversity in terms of service provider options. One of the learnings out of this has been the importance of ensuring organisations are of a sufficient size to maintain critical capability, capacity and to manage the governance of the services that they deliver.

With an increased focus on quality and delivering outcomes, a number of the NGO providers have commenced merging or amalgamating to give critical mass and coverage as well as good governance. This suggests that the sector as a whole has identified that strategic alliances or partnerships are imperative for optimal service delivery options.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?

Under the scheme for New Zealand Aid to other countries, significant funding has been given to support the development of mental health services and mental health delivery within the Pacific Island nations. This is done in two ways. Firstly, by funding the Pacific Island Mental Health Network which is currently under the auspices of the World Health Organisation (WHO), and secondly, by directly funding service delivery from a NZ health service, such as the Counties Manukau district health board, by providing clinical and logistic assistance to the development of services in Samoa.

PERU
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Ministry of Health

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

Peru has a similar reality to many of the countries in the region, with 17% of the burden of disease attributable to mental disorders. Among them, alcohol abuse and dependence, as well as Major Depression are the more significant, in special among young people and adults from 15 to 44 years old. At this range of age, 7 out of the 13 highest contributions to the burden or disease are coming from mental disorders.

This data are associated to the normally high prevalence of mental disorders. In Peru about 5 million 12 years and older people and 1 million children out of a total population of 30 million people for the country present mental disorders. It is important to take into account that Peruvian health system is fragmented in three: open public services, private services and insurance related services.

Peruvian government inversion hardly reaches $ 3.5 per person per year. 85% of this amount is spent just on the capital city, inhabited by 30% of the population of the country. Peru keeps up a curative model, mainly focused on 3 psychiatric hospitals without either a community network of mental health services, or a social protection system going beyond diagnosis and hospitalization or outpatient psychiatric drug treatments and some psychotherapeutic treatments.

Both inefficient model and underinvestment produce treatment gaps ranging from 84% in Lima to 90% in the rest of the country. In theory, starting 2011 public health insurance should benefit the treatment of Mayor Depression, Anxiety, Alcoholism and Schizophrenia. Despite of it, except the three psychiatric hospitals, no new services have been implemented to deal with them.

In 2015, the Peru has begun the process of implementation of outpatient specialized services based on community, and units of psychiatric hospitalization in general hospitals, under cover of the Law 29889, law that modifies the General Law of Health, and protects the rights of people with mental health problem.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

1. Primary and secondary prevention of mental health in preschool and school children. This need requires the participation of the Ministry of health and the Ministry of education, local authorities and the authorities of private and public educational institutions, as well as the cooperation of economies that have successfully developed primary and secondary prevention strategies in this population.

2. Strengthening of the link between the general health services and outpatient specialized mental health services based on community. Requires trained specialists for the work based on community and non-specialist health professionals trained to the attention of mental health problems, and process strength of bonding between both. This need requires of the cooperation of de academic Institutions.

3. Residential protection for people with mental disabilities in family abandonment. At the moment we have about 500 patients abandoned in psychiatric hospitals and psychiatric hospitalization in general hospitals services. The public residential protection system does not include this type of population. This problem demands the involvement of other sectors, civil society and public-private partnerships to implement residential protection services and strategies in the fight against stigma and discrimination. The cooperation of economies in the region that have developed successful strategies of residential protection for this population, is required to strengthen the advocacy in related sectors and the implementation of these services.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

The first protected home for people with mental disabilities, in Lima, was organized with the participation of the National Institute of Mental health, the NGO Partners in Health and the Municipality of the District of Carabayllo. The success of this initiative is at the call of civil society and the municipality, as well as the existence of the Mental Health Law and the cooperation of Chile that helped demonstrate to stakeholders the benefits of this service for people with mental disabilities. One of the most important barriers to the sustainability of this service and the implementation of further services of this kind is the lack of exclusive funding for its operation.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?

Peru can collaborate by sharing experiences in the intervention in physical, emotional and sexual domestic violence against children. It is a policy making experience based on the Modules for Child Abuse in Health (MAMIS) and Municipal Defenders of Children and Adolescents (DEMUNAS).

THE PHILIPPINES
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Department of Health – National Center for Mental Health
Other Organizations	Philippine Psychiatric Association

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

It is deemed that the top priorities of the Philippines for strengthening mental health that would support sustainable economic growth are the following:

1. Enhancing Disaster Mental Health

On 8 November 2013, Typhoon Haiyan (locally known as 'Yolanda') swept across our economy, the Philipiines. Over 14 million people were affected, 6,300 died, and more than 28,000 were injured. Families lost homes, livelihoods, and loved ones. The typhoon now ranks as the worst natural disaster to ever strike the country and one of the strongest typhoons to hit land on record globally.

WHO estimates that in humanitarian emergencies, the number of people with common mental disorders such as depression or anxiety disorders can double from a baseline of 10% to 20%. The number of persons with severe mental disorder (e.g. psychosis and severely disabling depression and anxiety) can increase by up to half, from a baseline of 2–3% on an average. In the case of Typhoon Haiyan, this meant a large number of people affected could suffer from common or serious mental health problems with a significant proportion requiring different interventions.

In a recent assessment, the following challenges were noted in the implementation of MHPSS locally: (1) lack of awareness of IASC Guidelines especially among faith-based groups; (2) lack of awareness of the MHPSS programs and services; (3) lack of mental health programs that address the seriously mentally ill; (4) lack of coordination among service providers; (5) lack of standards by which to evaluate services being offered; and (6) weak referral system (IASC 2014; PST-CRRC-UNICEF, 2015).

The Third UN World Conference on Disaster Risk Reduction in March 2015 approved the Sendai Framework for Disaster Risk Reduction 2015-2030 that recognized the need to enhance recovery schemes to provide psychosocial support and mental health services for all people in need. The Philippines is a disaster-prone area because of its geographic location, political and socio-economic situations and the global effects of climate change. It would benefit from enhancing disaster mental health capacity that includes supporting and empowering mental health workers with a range of mental health and psychosocial interventions, arming disaster responders with adequate knowledge to be mindful of the role of mental health and psychosocial support when providing services, as well as ensuring a mechanism to protect the mental health and psychosocial well-being of first responders. Mental health and psychosocial support in disaster preparedness and planning also needs to be strengthened and institutionalized.

There are current initiatives to draft a National Guideline on MHPSS in Emergencies (PST-CRRC, UNICEF), review the implementing guidelines of the National Disaster Risk Reduction and Management Council (Office of the Civil Defense, NRDMMC), develop modules on psychosocial care in emergency settings particularly addressing the needs of persons with disabilities (Handicap International, Center for Disaster Preparedness Foundation, Inc.), and enhance the National Mental Health Program (DOH) to name a few. In the recent year, Civil Engineering 10, a class on disaster mitigation, adaptation and preparedness that resulted from a Biodiversity and Resilience Project, was offered in a University (Commission on Higher Education).

It is our view that now is a good time to sync the different initiatives by varied groups to a clear goal and direction for enhancing disaster mental health in the Philippines.

2. Institutionalizing Community Mental Health Services

It is estimated that 2-3 million suffer from serious mental illness and one million suffer from epilepsy in the Philippines. The Global School Based Health Survey (WHO 2011) has shown that 16% of students between 13-15 years old have ever seriously considered attempting suicide during the past year while 13% have actually attempted suicide one or more times during the past year. The incidence of suicide increased from 0.23 to 3.59 per 100,000 for males and 0.12 to 1.09 per 100,000 in females between 1984 and 2005 (Redaniel, Dalida and Gunnell, 2011). In 2012, 2.1% of Filipinos aged 16 to 64 were using shabu, and "domestic consumption of methamphetamine and marijuana continued to be the main drug" (Inquirer 2012). Recent hospital data (PGH 2014) show that epilepsy accounts for 33.44% of adult and 66.20% of pediatric neurologic out-patient visits annually. Mental health conditions are also correlated with infectious diseases like HIV and tuberculosis, conditions that continue to plague our public health.

At the global level, urgent attention to mental, neurological, and substance use (MNS) disorders have been called. The Global Strategy to Reduce Harmful Use of Alcohol, Global Mental Health Action Plan 2013-2020, and the Resolution on the Global Burden of Epilepsy were adopted during the World Health Assembly 2010, 2013, and 2015 respectively.
In 2014, the Department of Health defined its breakthrough goals for mental health: (1) increase the number of provinces that have integrated mental health services and programs starting at the community level and in their primary and secondary health care systems with referral to tertiary health care system from 0 to 10 by 2016; and (2) increase the percentage of tertiary hospitals with an out-patient psychiatric clinic and/or Acute Psychiatric Unit (APU) to 100% by 2016. Work on this has been started in partnership with the WHO and other NGOs with the mhgAP training as one of the tools, with the targets pretty much attained.

In spite of steady efforts, addressing the mental health needs of the population places a great toll on the Department of Health in terms of its current organizational structure, infrastructure, resources, and support mechanisms. This is the backdrop for the need to institutionalize the integration of mental health, neurological health and substance use services down to the barangay through the development of health professionals (at all levels) to enhance service delivery. It is equally important to incentivize provinces and hospitals that are models of integrated mental health care as expressed in the National Breakthrough Goals. Institutionalization of a human resource development plan for community mental health service provider and establishing realistic indicators of a model province and a model hospital have the potential to help institutionalize community mental health services. In the long run, institutionalizing services at the community level can generate information of health service utilization as well as expenditures that can serve as basis for health financing and equitable access to mental health care.

The evidence of the value of investing on community mental health is well-established. Problems with a person's mental well-being can adversely compromise creativity, productivity, and contribution to family and society. Nine out of the 20 leading causes of years lived with disability worldwide (more than a quarter of all measured disability) and 10% of the global burden of disease (which includes deaths as well as disability). The World Economic Forum estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16 trillion over the next 20 years. (WHO 2013)

3. Establishing an efficient and sustainable drug supply chain

In 2012, the Department of Health issued the Guidelines on the sub-allotment and disbursement of funds for the implementation of the Medicine Access program for Mental Health (DOH Order 2012-0045). The Medicine Access Program for mental health is a government program that ensures the availability and accessibility of free mental health medicines to persons with mental health needs across the country. Subsequent DOH issuances have supported the increase in the budget of medicines with the growing number of facilities becoming access points for medicines as well as more persons with mental and neurological illness availing it.

In spite of great progress in the distribution coverage, there are still systemic weaknesses preventing reliable access to psychotropic drugs at the primary health care level. A review of the psychotropic supply chain identified some bottlenecks that need to be addressed to ensure that appropriate medicines will be available in areas where they are needed in a timely manner. The review highlighted the importance of instituting a need-based supply system that caters to demand for medicines that is generated from the local level.

It is known that the provision of essential medicines, in this case psychotropics and anticonvulsants, is a building block of the health system. By essential, they must be available and affordable, of assured quality, and properly used by providers and patients. They should also be available in adequate amounts, in appropriate dosages and preparations, at a price that individuals and systems can afford. Studies show that strengthening particular aspects of the mental health system would improve psychotropic access, address the treatment gap, and improve mental health care. Thus, overall development of an economy is associated with the availability and affordability of mental health medicines. In our economy, the cost of treating a person with psychosis on an out-patient basis, depending on the kind of medication allowed in the Philippine National Drug Formulary ranges from 150.00 (USD3.28) to 1,500 (USD328.00) a month. The transportation cost of bringing one patient to a psychiatric hospital would be 10-20 times this cost.

While arrangements have been put in place whereby each Rural Health Unit (RHU) or medicine access point will prepare monthly medicine consumption reports that would form the basis for the medicine requests sent to the National Centre for Mental Health (NCMH), there is still a need to ensure that psychotropics and anticonvulsants will be included in the medicine supply that is regularly delivered to the RHUs, for example, antihypertensives and antibiotics. This mechanism is also one way of ensuring the integration of mental health as a regular health service provided at the RHU level. Such will entail a detailed analysis of correct diagnosis and appropriate prescriptions, review of available drug preparations as well as information relevant to the establishment of an efficient and sustainable drug supply chain. In this way we are able to ensure equity in access to medicines which is a human right.

Additionally there needs to be a unified and coordinated effort to review the Philippine National Drug Formulary that is based on evidence-based clinical protocols that are locally developed.

Anent the funding of mental health services in our economy, we still lack guidelines and policies that will define certain budget allocation for mental health programs. There is likewise a dearth of epidemiologic data to serve as basis in the allocation. Funding of mental health programs in the regional level of the Department of Health are subjected to the decisions of the regional directors while those of DOH-retained mental health facilities are defined by their bed capacity, current budget, a mark up of 4% inflation rate and their approved budget for some infrastructure improvements. To date, there is a health insurance policy (PhilHealth) provided by the Philippine economy that covers only patients with mental disorders that are categorized as being in "acute in-patient care" although discussions and public hearings to expand the insurance coverage for the mentally ill are currently being conducted by PhilHealth, an attached agency of the Department of Health.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

Our economy would most benefit from public-private partnerships in the following areas:

A.   Standardization of Mental Health Care Delivery:

Inequity in health status and access to services is the single most important health problem in the Philippines (Philippine Health System Delivery Profile 2012). Population surveys, special studies and routine data collection consistently show the following:

- Financial barriers, negative perceptions about quality of care (in public providers) and lack of awareness of services and available benefits packages.
- Life expectancy is more than ten years longer in richer provinces than in poorer ones.
- The prevalence of out-of-pocket payments as the main source of heath financing points to serious inequity in the health financing system since it forces the sick patient's family to find money to pay for care at the point of need, i.e., at the time when they are most vulnerable.

Reforms of the health sector beginning in 2000 have continued to have little or no impact on a hospital network dominated by high-end private institutions. As a consequence, poor health outcomes for the poorest income groups and geographic areas persist. The prolonged inequity of outcomes can be traced to a historical trend of poor basic health services at primary and secondary level of care.

Under the DOH, the National Mental Health Policy aims to integrate mental health within the total health system both at the central and regional level. Furthermore, it aims to ensure equity in the availability, accessibility, appropriateness and affordability of mental health and psychiatric services in the country. As to service delivery, the Department of Health (DOH) is responsible for developing health policies and programs, regulation, performance monitoring and standards for public and private sectors, as well as provision of specialized and tertiary level care. The DOH Centers for Health and Development (CHDs) are the implementing agencies in provinces, cities and municipalities, and link national programs to Local government units (LGUs). The CHDs are the DOH offices at the regional level.

Health service delivery has evolved into dual delivery systems of public and private provision, covering the entire range of interventions with varying degrees of emphasis at different health care levels. Public services are mostly used by the poor and near-poor, including communities in isolated and deprived areas.

Private services are used by approximately 30 % of the population that can afford fee-for-service payments. The service package supported by the government is outlined by PhilHealth (Government Insurance Agency attached to DOH). The dominant private sector is made up of large health corporations and smaller providers. Health maintenance organizations are also present.

The provider network:

In the public sector the Department of Health (DOH) delivers tertiary services, rehabilitative services and specialized healthcare, while the local government units (LGUs) deliver health promotion, disease prevention, primary, secondary, and long-term care. Primary health services are delivered in barangay (village) health stations, health centers, and at hospitals.

Formal well-defined referral mechanisms among the different parts of the health system are weak, despite a referral system being set by the DOH (Philippine Health System Delivery Profile 2012). Ideally, patients should enter health services at the barangay health centers and then be referred upwards. There is a district system of hospitals in each province to provide first level referral services for localities without hospitals, and to direct patients back to rural or barangay health services. Many cities and large municipalities also maintain their own system of referral hospitals. However, self-referrals at any level are common practice and there is no proper gate-keeping mechanism.

In private practice, patients may be referred by GPs or family physicians to specialists, then to subspecialists. Referrals are mostly done through referral letter. Both cost and access to services determine whether patients seek public or private sector care. Public providers may refer to the private sector when there is a need for specialized care or special facilities. There is very limited interaction between public and private sectors in mental health referrals.

Challenges in the provision of mental health care are the following (Philippine Health System Review 2011):
- Continuous overcrowding of mental hospitals despite efforts to integrate mental health within the general health services and the development of community-based programs;
- The inconsistent availability of psychiatric drugs
- The fact that hospital-based psychosocial rehabilitation of chronic patients remains the norm, and
- The reality that university and private hospitals with psychiatry departments are generally situated in urban areas.

Home-care services for chronic patients are increasing (in Manila), but the quality of care provided is largely unmonitored.

In general, the quality of health services as measured by outcomes, population coverage, effectiveness, and safety and other indicators is highly variable depending on geographic location and social and economic factors. Highly urbanized metropolitan areas with higher income levels tend to and are perceived to have better quality health service than the mainly rural impoverished and often isolated communities where licensing standards are absent, and accreditation rates are very low. Most hospitals and professional practitioners meet the quality standards set by licensing requirements and PhilHealth accreditation standards. The PhilHealth Benchbook (2009) outlines all standards of quality processes and outcomes for hospitals.

B. Unified Information System

Information is crucial for decision-making at all levels of the mental health system. Policy-makers need information to make the best use of scarce resources, planners for the design of more efficient and effective services, managers for the monitoring and evaluation of services, and clinicians to provide appropriate, good quality, evidence based care. In the context of limited resources, increasing decentralization and changes to the financing of mental health care, the quality of such data is becoming even more important.

The presence of an institutionalized and unified mental health information system can improve the effectiveness and efficiency of the mental health service and ensure more equitable delivery by enabling managers and service providers to make more informed decisions for improving the quality of care. According to WHO, MHIS (Mental Health Information System) is a system for action: it exists not simply for the purpose of gathering data, but also for enabling decision-making in all aspects of the mental health system.

The current state of mental health information system in our economy closely reflects the larger health information system. The national and local health information systems are poorly integrated and are weakly governed (Philippine Health System Review 2011). These conditions create information gaps at the national and local levels. The lack of health informatics standards -- which prevents any system from scaling at a faster rate or inter-operating with another system – is a key issue.

The Department of Health (DOH) has attempted to address this fragmentation by developing the Philippine Integrated Disease Surveillance and Response Project or PIDSR (Tan, 2007). The PIDSR aims to establish a surveillance system that enables early detection, reporting, investigation, assessment, and prompt response to emerging diseases, epidemics and other public health threats (Figure 2-2). This was followed by a DOH-led Philippine Health Information Network (PHIN) in 2008 which designed and now implements the Philippine Health Information System (PHIS). The PIDSR, PHIN and PHIS clearly document the health information strategy at the national and regional levels but the specifics and operational aspects at the field level (barangay) and among individual patients are vague at best. Likewise, private sector information, which forms a large bulk of actual transactions with family

physicians and general practitioners, is essentially absent in these DOH systems. This is partly due to weak enforcement of information-sharing regulations but also reflects a preference for proprietary software in private facilities, which limits the ability of the DOH to obtain assistance from other IT specialists in other sectors.

The lack of IT governance structures such as explicit standards and blueprints for health information, in addition to unclear considerations for the role of IT in primary health care, hinder the wide-scale deployment of reliable and operable information systems in the economy.

Because information systems require the participation of many stakeholders, consultation with these stakeholders is essential in the design and implementation of the information system. A variety of stakeholders have an interest in MHIS, and each stakeholder group has different information needs. Consultation with all stakeholders is necessary not only because of the ethical imperative to consult with all those involved, but also because those stakeholders could make useful suggestions about the way the information system should be designed and what information should be gathered.

It is through collaboration of all stakeholders that the Mental Health Information system of our economy will be able to gather the different types of information needed and that decision making/policy development can be possible for all levels of mental health care.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers? Suggest 500 words or less and please include website links, if available:

A.   The National Framework for Action on Mental Health:

Having no comprehensive mental health law in our economy, mental health has been one of the areas least prioritized in our health system. Budget allocation for mental health is 5% of the total health budget. It therefore receives the least budget from the total health budget. From the experts view, this is a far cry of what it should be. In the advent of the Universal Health Care Program, the need to mainstream mental health in everyday life was recognized. The need to review the mental health system became exigent. The review was guided by the following principles, namely: de-stigmatization, de-institutionalization, democracy, data on mental health, partnership and advocacy. In so doing, a consultative workshop of multi stakeholders from the academe, government organization and non-government organizations was organized where breakthrough goals and strategies were identified

The National Framework for Action on Mental Health is an initiative by the Department of Health through the National Program management on Mental Health, which has defined the roadmap to integrate mental health in the primary and secondary health care systems in the community level. Its breakthrough goals include initiating the integration of mental health to model provinces with referral system to tertiary health care system and for all the tertiary hospitals to have at least an outpatient psychiatric unit and/or acute psychiatric unit. It has also provided for the needed medicine supply to identified access sites that are providing mental health services. To implement its strategies, partnership with WHO, Philippine Psychiatric Association and other non-government organizations in capacitating the community with mhGAP as one of the tools were established. Though the targets were attained, nationwide coverage will still have to be pursued. There is still a need to establish a specific mechanism to create linkages and strengthen partnerships with the local government and non-government agencies of the locality to institutionalize the system.

B.   The Healthy Mind Summit: A Model of Public-Private Partnership for Policy Change

There is a dearth of laws in the Philippines that pertains to, or is incidentally related to mental health. In fact, the Philippines is within the few states in our region and the world that has still to legislate a mental health bill. To wit, based on the WHO in its World Report 2001 mapped out the regions of the world where there is mental health legislation

Regions	With legislation	No legislation
Africa	59%	41%
The Americas	73%	27%
Eastern Mediterranean	59%	41%
Europe	96%	4%
South-East Asia	67%	33%
Western Pacific	72%	28%

"There is no health without mental health" according to the World Health Organization. Yet, despite being a State Party to the UN Convention, voting for the UN General Assembly resolution 46/119 of December 17, 1991 which set "the principles for the protection of persons with mental illness and the improvement of mental health care, International Convention on Civil & Political Rights (ICCPR, 1966), International, Covenant on Economic, Social and Cultural Rights (ICESCR, 1966) Convention against Torture & Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT, 1984), the Philippines remains to be one of the remaining few countries in the world that remains without a mental health legislation.

Mindful of the APEC Roadmap to Promote Mental Wellness in a Healthy Asia Pacific (2014-2020) that highlights the significant economic benefits of a mentally healthy population and that prevention and recovery from mental disorders is possible through affordable and effective treatments and care. Further, that inaction by APEC member economies to prioritize and strengthen mental health will result in costs that impede the achievement of economic development goals while threatening the wellbeing of communities and workplaces.

The Healthy Mind Summit was organized by the Philippine Psychiatric Association through the support of the National Program Management Committee of the Department of Health to bring the Philippines to the ranks of other nations in recognizing and putting the importance of mental health in the national consciousness. The main objective was to gather key stakeholders in the mental health field in order to draft a Philippine mental health bill that would be proposed to legislators for enactment.

The main track on mental health legislation was supported by four sub-tracks: 1) Mental health of the Filipino and their families; 2) Mental health financing; 3) Mental health Advocacy; and 4) Research.

Towards drafting a mental health bill, the methodologies used included:

- Mental health policy research
- Development of Research Questionnaire for Stakeholder
- FGDs, Delphi Analysis, Key Informant Interviews
- Networking and Linkage Development
- Drafting of a Mental Health Act
- Writing Workshop

A Pre-summit was held on July 31, 2014: HEALTHY MIND SUMMIT PRE-SUMMIT at the SMX Aura Convention Center, Taguig City which drew in 100 key stakeholders from patient & family groups, mental health professional, academe, legislators, local & international NGOs, media and ad agencies, mental health and drug rehabilitation facility operators, health financial organizations and insurance, pharmaceutical groups, and key individuals, including former Sen. Leticia Ramos-Shahani. The main output was the "Manila Declaration of Support for A Mental Health Act". The succeeding weeks saw a series of working meetings by the respective sub-tracks to draft the mental health bill.

The Healthy Mind Summit was then convened on October 29, 2014 at the SMX Convention Center in Taguig city, which drew in 500 multisectoral & multi-disciplinary stakeholders in mental health. Sen. Pia Cayetano was the keynote speaker. The working draft was presented to the participants and the ad campaign for #mhactnow was launched online with a link to change.org.

With first draft in hand, the next task was to look for sponsors in both houses of Congress. All senators were sent copies of the draft. Within less than a month of the conclusion of the Healthy Mind summit, Sen. Loren Legarda filed the Mental Health Act of 2014 in the Senate. In the House, the Honorable Congresswoman Leni Robredo together with Cong. Miro Quimbo, Isagani Gutierrez, Walden Bello, and De Jesus filed House Bill 5347 also known as the Mental Health Act of 2015.

To date, various organizations and sectors have met to further improve the draft and is currently on the 21st version. Sen. Franklin Drilon, the senate president has committed to endorse the bill. Sen. Pia Cayetano is imminently going to file her version of the bill based on all the revisions.

On the advocacy front, there will be an information caravan, organized by the PPA, that will go nationwide involving universities as venues with local medical societies and other mental health groups in Luzon, Visayas, and Mindanao. PPA has also partnered with the Natasha Goulbourn Foundation/Hopeline to launch the video ads in support of #mhactnow in all Ayala Cinemas nationwide.

This has demonstrated the power of partnership of the Dept. of Health - providing financial, logistic, and technical support to the Philippine Psychiatric Association, which has provided expertise, organizational leadership and networking abilities. It provides a template for future collaborations toward convergent goals.

C. Philippine Health Information System on Mental Health

The Philippine Health Information System on Mental Health (PHIS-MH) was started last December 2013. This program was conceptualized by a Professor and Psychiatrist of the University of the Philippines (Dr Cynthia Leynes). Its structure and inter-operability mechanism was provided by the National Institute of the Philippines (Dr. Ma. Lourdes E. Amarillo) and was made possible through collaborations from different sectors like UP-NIH-ICE, Department of Health, Janssen-Face Inc., TWG, Philippine Psychiatric Association and 14 psychiatric facilities , both from the private and public sectors. These psychiatric facilities represent the major mental health providers across the economy. The main objectives of the program are the following:

(1) To strengthen case reporting and monitoring of the individual patients across participating health institutions, and

(2) Generate more consistent and reliable information to help better understand and address issues surrounding mental health.

The program was launched on July 22,2014 and its concept presented in Beijing in 2014. In its inception, there were 112 participants immediately trained from various participating institutions. Technical Working Group created a uniform Intake Forms, Progress Notes, and Inform Consent which were to be used in this project. This was encoded to the computer generated data base, and data were centrally stored at the National Institute of Health. There were more than 5000 clients enrolled in this project before July 31, 2015. Johnson & Johnson Pharmaceutical Companies had sponsored this project until July 31, 2015. The significance of this program to the Mental Health system of the economy was recognized by the Department of Health, PhilHealth, and Philippine Psychiatric Association (PPA) and upheld the concept of strengthening the collaboration by developing mechanism to sustain this syatem so as to further provide meaningful data for evidence-based policies and programs in the future.

THAILAND
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	Department of Mental Health, Ministry of Public Health

STRATEGIC NEEDS ASSESSMENT

What are your economy's top priorities for strengthening mental health as well as the areas of greatest strategic need to strengthen mental health outcomes? Please describe how your economy funds mental health services.

Economy funds mental Health service in term of providing comprehensive integrated community based mental health services. The goal should be to integrate mental health into primary care with string links to mental health specialist care and informal community-based services and self-care. 19, 20 There are specific evidence-based interventions that are cost effective, affordable and feasible for delivery in primary and secondary care. Depression, for example can be treated with antidepressants plus brief psychotherapy for less than US$1 per person. 21 National commitments to scaling up mental health innovations have been made in several countries, including low- and middle-income countries, and some successes have been documented. 22 But there is much more to be done. People with mental health problems and their carers must be empowered to advocate for the services that best meet their needs and should be involved in delivering solutions. There are many examples of empowerment initiatives across the world as this forms the value base of all family, survivor, and user-led mental health NGOs.

Please identify and describe 2 or 3 priority areas that your economy would benefit from through the piloting of   multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health.

Supported employment for psychiatric patients is the priority area that the economy could most benefit. Supported employment developed more than twenty-five years ago as an approach to help people with disabilities obtain competitive employment. This means that individuals are able to pursue employment of their choice in community settings of their preference earning wages that are at least equivalent to workers in the same or similar positions. As supported employment evolved, it became increasingly evident that it would represent a distinct alternative to facility-based programs such as adult training centers and sheltered workshops. One key distinction between sheltered employment and supported employment was the principle that "work readiness training" was no longer a pre-requisite for community employment. The great majority of people with severe mental illness desire competitive employment, and evidence-supported employment is currently the most effective way to help them achieve their goal. Evidence-supported employment emphasizes the following: competitive jobs that are based on a person's preferences for types and amount of work, integrated work settings, job-seeking when the unemployed person expresses interest, minimal prevocational preparation and assessment, and follow-along supports from mental health and vocational specialists to maintain the job transition to another one.

This area, we need to collaborate with multi stakeholder organization, such as Ministry of Labour, Ministry of Social Development and Human Security, and employers.

Please list and describe examples of multi-stakeholder collaborations or public-private partnerships (at a local or economy-wide level) that are currently underway or have recently taken place? What are the critical factors that have made them successful or what factors may still be missing?

The best practice examples of multi-stakeholder collaboration is the job placement program in Srithunya Psychiatric Hospital. This program has been success in training recovered mental illness for job as per their preferences and can be able to sustain in the job they get. The clients are being trained in the area of independent living skills and work habits before finding job and place in the job place. On the job training are being continued until they have their confidence to work on their own. However, the supervision is still provided periodically. The critical area of success is that clients should be trained to be readiness before working in the job place as well as continue support and supervision. At the same time employers should receive relevance knowledge about mental disorders so they can understand our clients. The obstacle is stigma which we have to put a lot of effort to get rid of this attitude. It is prevented the recovered person from getting jobs and integrate into normal society.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in cross-border cooperation?

The collaboration with other APEC member economies should be toward the development of recovery model within ASEAN context, especially, supported employment program.

THE UNITED STATES
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	U.S. National Institute of Mental Health
	Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

US Context

According to recent estimates, mental illnesses account for 21.3 percent of all years lived with disability in the United States.[1] An estimated 9.6 million American adults suffer from a serious mental illness (SMI) in which the ability to function in daily life is significantly impaired. Those with SMI die decades earlier than individuals in the general population, on average.[2] Furthermore, over 41,149 Americans die each year from suicide, more than twice the annual mortality from homicide or AIDS.[3] Beyond the morbidity and mortality, a conservative estimate places the direct and indirect financial costs associated with mental illnesses in the United States at well over $300 billion annually.[4] Mental illnesses rank as the third most costly medical conditions in terms of overall health care expenditure, behind heart conditions and traumatic injury.[5] This public health burden demands that we harness scientific knowledge and tools to achieve better understanding, treatment, and ultimately, prevention of these disabling conditions.

A mix of private and public sector funding supports mental health services in the US. Among the priorities for strengthening mental health in the US are increasing the public's understanding of the costs of untreated mental illness and integrating mental health services with primary care. Prevention, treatment, and recovery support services for behavioral health are important parts of the health service systems for the community. The services work to improve our health and minimize costs to individuals, families, businesses, and governments. However, people experiencing either substance use and mental disorders, or both, because of their illness are often excluded from the current health care system and instead have to rely on "public safety net" programs. Last year alone, close to 20 million people in need of substance abuse treatment did not receive it. Further, an estimated 11.8 million people reported an unmet need for mental health care. The gap in service to this population unnecessarily jeopardizes the health and wellness of people and causes a ripple effect in costs to American communities.

Mental Health Research

The National Institute of Mental Health (NIMH) is the lead Federal agency for research on mental illnesses. The mission of the NIMH is to transform the understanding and treatment of mental illnesses through basic and clinical research, paving the way for prevention, recovery, and cure. To fulfill its mission, the NIMH supports and conducts research on mental illnesses and the underlying basic science of brain and behavior; supports the training of scientists to carry out basic and clinical mental health research; and communicates with scientists, patients, providers, and the general public about the science of mental illnesses.

NIMH has four high-level Strategic Objectives: 1) Define the mechanisms of complex behaviors; 2) chart mental illness trajectories to determine when, where, and how to intervene; 3) strive for prevention and cures; and 4) strengthen the public health impact of NIMH-supported research

Mental Health Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities by providing grants to States, localities and providers to provide behavioral health services. In order to achieve its mission, SAMHSA has identified strategic initiatives focused on leading change to better meet the behavioral health care needs of individuals, communities, and service providers. SAMHSA's current initiatives address prevention of substance abuse and mental illness; health care and health systems integration; trauma and justice; recovery support; health information technology; and workforce development.

US Priorities and Needs

Mental Health Research Priorities

The BRAIN Initiative

The BRAIN Initiative, announced by President Obama in April 2013 as the "next great American project," is supporting the creation of new tools for decoding the language of the brain. This initiative, which NIMH co-leads with the National Institute of Neurological Disorders and Stroke, supports teams of engineers, nanoscientists, computational scientists, and neuroscientists to find new, efficient ways to monitor and manipulate brain circuits.

The Changing Mental Health Care Landscape

The implementation of the Patient Protection and Affordable Care Act of 2010 (ACA) and the Mental Health Parity and Addiction Equity Act (MHPAEA) forecasts vast changes in mental health care. The MHPAEA requires insurance groups that offer coverage for mental health care to provide the same level of benefits that they offer for general medical treatment; the ACA defines mental health care as an "essential benefit" and extends the public reach of the requirements of the MHPAEA. However, the implementation of these laws may only apply to treatments that can meet evidence-based standards. While many evidence-based treatments exist, there is a need for valid metrics for measuring the quality and efficacy of care.

Technology

The rapidly evolving health technology sector has the potential to radically transform the way all people (i.e., patients, providers, researchers, payers) interact within the mental health care system. Mobile technologies are changing the world of mental health care in ways that could scarcely have been imagined before the social media revolution. This is evident in the use of mobile devices as sensors to detect subtle changes in activity, and by extension, emotional state; as online extenders of individual psychotherapy; or as tools to move evidence-based interventions into remote communities. There are still many unanswered questions about effectiveness, concerns about privacy, and challenges for regulation of these nascent technologies.

Mental Health Disparities

In U.S. mental health care, we see striking differences in illness prevalence, service delivery, and outcomes based on sex, gender, age, race, ethnicity, and geography. NIMH research needs to include adequate numbers of men and women and members of diverse racial/ethnic groups in studies—from genomics to services research—in order to detect and mitigate these disparities. In addition, studies of diverse populations can contribute to our understanding of risks for mental illness, responsiveness to prevention and treatment interventions, and access to and engagement in care. Specifically, research on sex, gender, age, racial, and ethnic differences related to mental disorders will provide information essential to the development of precision medicine and personalized interventions.

Global Mental Health

The challenges associated with mental illnesses are a global concern, and represent an opportunity to learn from, and with, other countries and other cultures. The rapidly increasing diversity of the U.S. population necessitates this global orientation. Worldwide, the distribution of morbidity associated with mental illnesses varies within and between countries. Within countries, disparities in mental health care and in the course and severity of illness occur along geographic and socioeconomic, as well as racial and ethnic, lines—as in the United States. Between countries, risk and protective factors, illness trajectories, and availability of quality care vary considerably. Addressing these shared challenges enriches the scientific enterprise overall, and will help us to advance U.S. research and to improve mental health care both domestically and globally.

Digital Enterprise

The success of many initiatives at NIMH requires a new culture of open science with broad and rapid data sharing. In this era of big data, revolutionary changes in data acquisition have created profound challenges, from storing massive quantities of data, to harmonizing and integrating data collections, to translating data into better knowledge, to addressing the impact on privacy and confidentiality. The National Database for Autism Research (NDAR) is an example of harnessing data sharing for collaborative science. Looking forward, the NDAR approach to collaborative data sharing will continue to grow, for example, through the National Database for Clinical Trials (NDCT), which will collect individual-level data from NIMH-supported clinical trials, and through the Research Domain Criteria Database, which will collect data from relevant clinical studies. NIMH is committed to working with the scientific community to identify common data elements that can support the integration of data across studies and to support the broad sharing of data and the resources necessary to accelerate scientific progress.

Mental Health Services Priorities

Recovery Support: SAMHSA funds a variety of programs designed to meet the needs of people in recovery from mental and substance use disorders. These include efforts to provide evidence-based services, from clinical treatment to help from peer providers and families with lived experience of recovery from mental and/or substance use disorders. Programs engage and respond to the self-identified needs and help find individual pathways to recovery. Specific initiatives and programs include:
- SAMHSA's **Recovery Support Strategic Initiative** to promote partnering with people in recovery from mental and substance use disorders and their family members to guide the behavioral health system and promote individual, program, and system-level approaches that foster health and resilience.
- **BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center Strategy)** - Offers policy guidance, technical assistance, training, materials, and subcontract awards to help states and providers, including peer providers, adopt and implement best and emerging practices in recovery supports, services, and systems.

Integration and increasing access to services: SAMHSA invests in programs designed to integrate primary care and physical health services into mental health care settings, provides coordinated and integrated care for people with mental and substance use disorders and HIV and/or viral hepatitis, and supports states and providers to adapt to a changing healthcare landscape. Numerous resources on integration are available from **the SAMHSA-HRSA Center for Integration Health Solutions** at www.integration.samhsa.gov.

Children and Youth

- **Project LAUNCH**: Project Linking Actions for Unmet Needs in Children's Health (LAUNCH) is a national initiative that has funded 55 sites, including states, tribes, territories, communities, and the District of Columbia. The purpose of the Project LAUNCH initiative is to promote the wellness of at-risk young children from birth to eight years of age by addressing the physical, social, emotional, cognitive, and behavioral aspects of their development.
- **Children's Mental Health Services:** It is estimated that over 7.4 million children and youth in the United States have a serious mental disorder. Unfortunately, only 50 percent of those in need of mental health services actually receive treatment. SAMHSA's Children's Mental Health Initiative (CMHI) addresses this gap by supporting "systems of care" (SOC) for children and youth with serious emotional disturbances and their families to increase their access to evidence-based treatment and supports.
- **AWARE grant programs**: With half of all mental health disorders showing first signs before a person turns 14 years old, and three quarters of mental health disorders beginning before age 24, to meaningfully affect the rates of mental disorders in our Nation, it is essential to begin screening, referring, and treating children and youth early. The AWARE grant programs provide critical funding to states and schools to not only train adults to understand the signs and symptoms of youth experiencing a mental health crisis or at risk of developing mental disorders, but also to support screening, early identification, referral, and receipt of care.
- **First Episode Psychosis**: SAMHSA is collaborating with NIMH to supports states' efforts to address the identification and referral of individuals experiencing first episode psychosis (FEP) in order to substantially reduce the duration of untreated psychosis. This includes assuring that states have access to information relating research-based early intervention programs to address serious mental illness

Trauma: SAMHSA invests in systems designed to improve trauma-informed care for children and youth, and efforts to promote care that recognize and respond to trauma. These programs and other SAMHSA efforts build on SAMHSA's publication "Concept of Trauma and Guidance for a Trauma-Informed Approach" offers a framework for how an organization, system, or service sector can become trauma-informed, including the following:.

- **National Child Traumatic Stress Network**: Child traumatic stress is a pervasive and potentially life changing experience that affects tens of thousands of children each year. Child traumatic stress occurs when children and adolescents are exposed to traumatic events or traumatic situations that overwhelm their ability to cope with what they have experienced. Child traumatic stress can interfere with a wide range of childhood developmental capabilities, including social and educational functioning. SAMHSA's National Child Traumatic Stress Initiative (NCTSI) provides funding for a national network of grantees to develop and promote effective community practices for children and adolescents exposed to a wide array of traumatic events.

Suicide prevention: SAMHSA supports the goals and objectives of the National Strategy for Suicide Prevention (NSSP) through the following:

- **Zero Suicide program**: SAMHSA provides these grants to embed the Zero Suicide model in State health care systems and to engage communities in a comprehensive effort to identify persons at risk for suicide and link them to needed services.
- **National Suicide Prevention Lifeline:** To prevent death and injury as the result of suicide attempts, individuals need rapid access to suicide prevention and crisis intervention services. In 2014, the National Suicide Prevention Lifeline, a network of 164 crisis centers across the US offering 24/7 suicide prevention and crisis intervention services for individuals, answered calls from over 1.3 million Americans. This helped provide rapid access at any time of the day or night to crisis intervention, and when needed, emergency response.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

Multistakeholder collaborations are important for US **mental health research** and **mental health services development**.

With respect to research, NIMH is committed to working with external stakeholders who are also committed to the prevention, recovery, and cure of mental illnesses. By utilizing existing partnerships with many stakeholders—whether they are patients, their families, service providers, advocacy groups, sister agencies in the U.S. Department of Health and Human Services, private partners (both domestic and international), or others—NIMH can efficiently leverage its collective investments and research infrastructure, as well as help evaluate and learn from stakeholders' experiences. In addition, rigorous collaboration, communication, and coordination between NIMH and its many stakeholders will lead to a quicker uptake of effective practices and programs. NIMH also seeks to develop new research partnerships, especially where there may be opportunities to harness developments in the fast-moving area of citizen-driven science. In all these ways, NIMH intends to maximize the impact of its research investments on the lives and outcomes of people with mental illnesses.

With respect to service delivery, SAMHSA prioritizes multi-stakeholder collaborations to address the following needs:

- Public-private partnerships to **reduce negative public attitudes** by increasing awareness/understanding of mental health and substance use disorders
- Public/private partnerships to **increase social inclusion**, including access to gainful employment, and ensure the rights of persons affected by these disorders
- Public/private partnerships to **address mental illness and incarceration**
- Public/private partnerships to **integrate behavioural health services into primary care**, based on the fact that the cost of treating common diseases is higher when a patient has untreated behavioral health problems.
- Public/private partnerships to **develop an adequate behavioral health workforce**, which in the US is aging and lacking in diversity
- Public/private partnerships to increase public understanding of the nature of **psychological trauma** and its link to mental and substance use disorders.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

Mental health agencies in the US Government lead/participate in many programs built on partnerships.

- **The National Action Alliance for Suicide Prevention** (i.e. Action Alliance), public-private partnership dedicated to advancing the National Strategy for Suicide Prevention (NSSP), has a 30-member Executive Committee composed of public (e.g., SAMHSA Administrator, NIMH Director) and private (Kaiser Permanente's Care Management Institute) representatives. The Alliance champions suicide prevention as a national priority, catalyses efforts to implement objectives of the NSSP, and cultivates the resources needed to sustain progress. Success factors: unwavering commitment to suicide prevention

- **Two partnerships aimed at primary prevention and children's mental health**

    o The **"Children's Mental Health Initiative"** is "a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families organized into a coordinated community network to build meaningful partnerships with families and youth and address their cultural and linguistic needs".

    o SAMHSA's **Strategic Prevention Framework** equips members from variety of sectors in a given community (e.g. schools, police, political leaders, parents) to build coalitions to identify and address their unique prevention needs, such as preventing underage drinking.

    In both cases, the success factor is the commitment of the community to healthy youth.

- NIMH supports two global research programs for which partnerships among researchers, government, and non-governmental organizations are central: the **Collaborative Hubs for International Research on Mental Health** and **Research Partnerships for Scaling Up Mental Health Interventions in Low- and Middle-Income Countries** (begins in 2016). The Collaborative Hubs (http://www.nimh.nih.gov/about/organization/gmh/globalhubs/index.shtml) support research aimed at reducing the mental health treatment gap in low resource settings and research capacity-building for regions of Latin America, South Asia, and sub-Saharan Africa. The Research Partnership Hubs integrate research into local and national mental health implementation initiatives while also strengthening research capacity for a region.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?

Given that SAMHSA is placing a special expert in substance abuse in Viet Nam to work with the SE Asia region as part of the President's Emergency Plan for AIDS Relief (PEPFAR) and that it provides support for mental and substance use disorders services for the 6 US-affiliated Pacific Jurisdictions, SAMHSA would be interested in a regional pilot to strengthen mental health in the region.

NIMH collaborative research and/or research capacity-building activities as of fiscal year 2015 have included several APEC economies (i.e. Australia, Canada, Chile, China, Japan, Peru, Singapore, Russia, Singapore, Thailand, Viet Nam). Research capacity-building activities that extend to Papua New Guinea will begin soon. NIMH is prioritizing global implementation science in diverse international contexts in order to build a stronger evidence base for reducing the mental health treatment gap among diverse settings and populations.

[1]*Analysis based on: US Burden of Disease Collaborators. (2013). The state of US health, 1990–2010: Burden of diseases, injuries, and risk factors. JAMA, 310(6), 591–608. (PubMed ID: 23842577)*

[2]*Walker, E. R., McGee, R. E., & Druss, B. G. (2015). Mortality in mental disorders and global disease burden implications: A systematic review and meta-analysis. JAMA Psychiatry, 72(4), 334–341. (PubMed ID: 25671328)*

[3] *Centers for Disease Control and Prevention (CDC). (2012). Web-based Injury Statistics Query and Reporting System (WISQARS™). Atlanta, GA: National Center for Injury Prevention and Control, CDC. (http://www.cdc.gov/injury/wisqars/)*

[4] *Insel, T. R. (2008). Assessing the economic cost of serious mental illness. American Journal of Psychiatry, 165(6), 663–665. (PubMed ID: 18519528)*

[5] *Soni, A. (2009). The five most costly conditions, 1996 and 2006: Estimates for the U.S. civilian noninstitutionalized population (Statistical Brief# 248). Rockville, MD: Agency for Healthcare Research and Quality. (http://meps.ahrq.gov/data_stats/Pub_ProdResults_Details.jsp?pt=Statistical+Brief&opt=2&id=910)*

VIET NAM
STRATEGIC NEEDS ASSESSMENT

RESPONDENT INFORMATION

Organization	General Administration of Preventive Medicine, Ministry of Health
Other Organizations	Research and Training Center for Community Development, Viet Nam (RTCCD); Viet Nam NCDs Alliance
Previous Needs Assessment or Strategy Policy	1. Assessment of mental health care models operated by NGOs in Viet Nam 2. Situation analysis of the Social Protection Center for People with severe mental disorders under the management of the Ministry of Labour, Invalids and Social Affairs 3. Evaluation of community mental health care project 4. WHO AIMS-REPORT on mental health system in Viet Nam (WHO, 2006)

STRATEGIC NEEDS ASSESSMENT

APEC has affirmed the importance of strengthening mental health among its member economies through improved services, promotion, heightened investment, and expanded cross-sectoral activities. What are your economy's greatest needs and top priorities for strengthening mental health that would support sustainable economic growth? Please describe how your economy funds mental health services.

Agriculture development for exporting agriculture-based products (especially organic food), tourism, and light industry (for producing consumers' ordinary goods) are the priorities in economic development in Viet Nam. Providing good primary mental health care services for labour forces in factories and building good mental health care environments at schools and community in rural areas would support sustainable growth. Currently, national strategic plan on primary mental health care at the school, factories or at community levels is not clear and doesn't built up from the link between economic and mental health. Funding the mental health services all came from the government. The government spends approximately two millions USD per year on mental health and more than 90% of this budget for hospital system. At the primary health care level, patients who discharged from mental health hospitals because of schizophrenia and epilepsy are freely distributed drugs for treatment at community level. However, other common diseases such as depression, anxiety, health disorders and all of the children mental disorders are out of public outreach medical care activities.

APEC seeks to facilitate multi-stakeholder collaborations and public-private partnerships that strengthen mental health to support sustainable economic growth. This includes partnerships between government agencies, academic institutions, private sector enterprises and other stakeholders (at the community, economy-wide, and regional levels) to address such obstacles as social stigma, shortages of specialists and poor treatment adherence (see APEC Roadmap for others). Please identify and describe 2 or 3 priority areas that your economy could most benefit from multi-stakeholder collaborations and/or public-private partnerships to strengthen mental health and support sustainable economic growth.

1/ At household and community level: We seek more collaborations between APEC members to help us to define strategies for improving quality of informal mental health care system (including self-care, family care, community informal care). A pilot intervention model of community-based NCDs control (including mental health) that MOH General Administration of Preventive Medicine is planning to launch 2015-2017.

2/ The school health system and mental health care: Child mental disorders prevention and care are among the weakest area in mental health care system in Viet Nam. Partnerships between APEC members for a pilot intervention on mental disorders prevention among children 0-18 year old using school based-wealthy environment (besides the community-based NCDs control above.

Please list and describe best practice examples of multi-stakeholder collaborations or public-private partnerships that are evident (at a local or economy-wide level)? What are the critical factors that have made them successful? What are the gaps or barriers?

We have launched a pilot study on informal mental health care for patients with schizophrenia in Hanam - a rural province. This study was conducted by the Research and Training Center for Community Development (RTCCD) in 2013-2014. In addition, we have launched an intervention to improve household prevention and care of perinatal mental disorders (chiefly depression and anxiety in pregnant women and new mothers) which contributed to prevent mental disorders among children and support child early development. This study was also initiated by RTCCD and expects to scale up to become a national strategy of prevention and care of child mental disorders before schooling. We have conducted several epidemiological studies of the burden of child mental disorders which reported from 10% to 15%. Collaboration between RTCCD and MOLISA Dept of Child care and Protection bring school mental health into public agenda. In 2015, RTCCD and its affiliation network, the Evidence-Based Health Policy Development Advocacy (EBHPD) network and the NCDs network (NCDs-VN) work together for a model of community-based NCDs control, and mental health (including perinatal and youth mental health) integrated into this model.

Is your economy interested in collaborating with other APEC member economies on a regional pilot collaboration to strengthen mental health? If so, in what areas would your economy benefit most in international cooperation?:

We propose an international cooperation to create an environment for exchanging and sharing experience on public-CSOs-private partnerships for mental well-being for women and children. This could be done through annual review meeting in order to exchange resource persons for case-study on success initiative, and training for capacity building of CSOs-Public-Private partnerships for mental health and well-being in 21 century.