care and community settings; advocacy and public awareness; mental wellness for indigenous communities, vulnerable communities and children; data collection and standardisation; and disaster resilience and trauma. Within these areas, the Digital Hub will facilitate interactive training modules, map mental health stakeholders, and showcase novel research on the effects of mental health, as well as the cost–benefit analysis of investment for interventions. Based on the strategic needs assessments, five recommendations are proposed (APEC, 2016b):

1. to advance an APEC-wide strategy that includes legislative bodies to advocate for mental health, as well as to enhance public awareness to reduce social stigma;
2. to establish expert working committees and novel partnerships through the APEC Digital Hub for Mental Health to address each of the common priority areas;
3. to strengthen linkages with the APEC Business Advisory Council and expert organisations, particularly in the promotion and strengthening of workplace mental health;
4. to build linkages with the APEC Emergency Preparedness Working Group in disaster resilience and trauma activities; and
5. to develop APEC resources centred on the linkage between mental health and economic growth/sustainability.

Implementation of the APEC Roadmap and Digital Hub will heighten exchange and dissemination of best practices and innovations in Asia-Pacific mental health partnerships. The Hub provides an unprecedented opportunity to enhance recognition among the highest government leaders, health and non-health officials, institutions and organisations, as well as the public, of the importance of strengthened and strategic investment in mental health to support economic growth. APEC has an aspirational vision to strengthen mental health and reduce the economic effects of mental illness in the Asia Pacific region. Success of the venture will become an exemplar of the positive influence that multi-stakeholder collaboration and public–private partnerships can have to improve mental wellness for millions across a wide diversity of settings and cultures.

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THEMATIC PAPER

Mental health and integration in Asia Pacific

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Acknowledgements. The report 'Provision for supporting people with mental illness: A comparison of 15 Asia-Pacific countries' (2016) was prepared and written by The Economist Intelligence Unit (EIU) and sponsored by Janssen Asia Pacific.

This brief report examines the extent to which community-based treatment and integration support are provided for people living with mental illness across 15 selected Asia-Pacific economies. Some of the key findings are discussed in light of the diversity of economies and cultural contexts.

Background

The 2010 Global Burden of Disease Study estimated that mental and substance use disorders accounted for 7.4% of all disability-adjusted life years (DALYs) globally, an increase of 37.6% over the preceding 20 years (Whiteford *et al*, 2013). Mental and substance use disorders were the leading cause of years lost due to disability (YLDs) worldwide. Asia Pacific is a region characterised by rapid changes in economic and technological

Conflicts of interest. None.

doi:10.1192/bji.2017.28

development, population growth, migration and demographics. Across this region, it is alarming that fewer than half of those affected by mental illness receive any treatment. This is despite increasing attempts by policy makers and governments to develop national mental health reforms, particularly in community mental health (Ng *et al*, 2009). Consequently, there have been significant multilateral and global ratifications to prioritise mental health, including by the Commonwealth of Nations (54 economies) (Ng, 2013), the Asia-Pacific Economic Cooperation (21 economies) (Ng *et al*, 2017) and the World Health Organization (WHO, 2013).

Recently, the Economist Intelligence Unit (EIU) released the results of a regional mental health research initiative (EIU, 2016), on which this paper is based. The Asia-Pacific Mental Health Integration Index, which measures performance across a range of areas relative to integration, was devised and constructed by the EIU research team. The EIU had previously created a Europe Mental Health Integration Index in 2014 which included 30 countries. The Asia-Pacific report also drew on inputs from 20 local and international experts in mental healthcare and substantial desk research. Using quantitative and qualitative data, the study examined the extent to which community-based treatment and integration support are provided for people living with mental illness across 15 selected Asia Pacific economies. The 'integration index' applied a range of indicators to assess the ability of people with mental illness to lead fulfilling lives in the community. Indicators are grouped into four categories: environment (the extent to which policy supports the ability of people with mental illness to have a stable home and family life); access to treatment (the availability of mental health services and human resources); opportunities (the degree to which policy encourages those with mental illness to engage in employment); and governance (efforts to reduce stigma, increase awareness and promote the human rights of mental health patients). The aim of the index was not to provide a competitive ranking system, but to promote discourse among economies about current performance and how they can improve, and to share best practices.

General common findings

Across the Asia Pacific region, mental illness causes a significant health and socioeconomic burden, which on average accounts for more than 20% of total YLDs and 9.3% of DALYs among the economies included in this report. Moreover, the absolute age-standardised DALYs attributable to mental illness have remained virtually unchanged relative to other diseases; together with rapid population growth, this has resulted in a rising disease burden and public health and economic effects (Charlson *et al*, 2016). Even such advanced economies as Australia and New Zealand have gross domestic product deficits of 3.5 and 5%, respectively, linked to mental illness (The Royal Australian and New Zealand College of Psychiatrists, 2016). In the next 15 years, it is estimated that mental illness will result in a loss of $11 trillion in economic growth for India and China alone.

According to a WHO survey of 50 low- and middle-income countries, the median treatment gap was 69%; that for low-income countries (89%) was greater than for lower-middle-income and upper-middle-income countries (69 and 63%, respectively) (Demyttenaere *et al*, 2004). In another study, the treatment gap was 35 to 50% in high-income countries, compared with 76–85% in lower-income countries (Lora *et al*, 2012). The EIU report cited similar figures of around 90% for those not receiving mental health treatment in middle-income countries such as China and India, whereas in higher-income countries such as Singapore and Australia, the treatment gap was above 50%. More importantly, where services are provided, most are neither patient-focused nor integrated to support those with mental illness to live a meaningful life in the community. The recovery model is gradually emerging as the standard of best practice in treatment worldwide. However, in reality, most services in the region are hospital-based and not oriented towards a recovery-focused approach that is integrated with social, housing, employment and community services.

There are also common challenges, although these may take different shapes in the different economies studied. Good epidemiological data on mental disorders are generally lacking, especially in lower-income economies where even basic data are often absent. Without an adequate mental health information system, effective service planning and resource allocation are seldom achieved. Notably, across the region, the stigma of mental illness – especially serious mental disorders – remains prevalent and a significant barrier to treatment access. This has given rise to various forms of prejudice and discrimination faced by people living with mental illness, ranging from social distance, limited employment prospects and inadequate insurance coverage to excessive use of physical restraints and human rights abuses.

The discrepancy between treatment in urban and rural areas is glaring in both high-income and low- to middle-income economies. Rural mental health services are typically under-resourced, often resulting in a disproportionately wide treatment gap and higher suicide rates. This highlights considerable nationwide variations not measured by the integration index, such as variability of services and coordination across city and rural areas, policy implementation by individual provinces or states, provisions for different sub-populations or cultural groups, and capacities of various local service providers. Therefore, having an overall country index score may not provide meaningful information about the degree of integration at the local level.

Comparison between income groups

The report found a diverse range of performance scores in all indicators across the economies, especially in terms of measures that help people with mental illness to find and sustain meaningful work, and the provision of training and vocational support programmes. Compared with a similar study in European countries conducted in 2014, the range of index scores was substantially greater (about 35%) in this Asia Pacific study, reflecting a more economically and culturally diverse region. Overall, the features of countries and territories included in this survey fall within four groups of mental health integration that are closely linked with economic development levels.

(a) High-income oceanic countries (New Zealand and Australia). Similar to leading European countries (e.g. the UK), both countries started mental health reform very early in the 1990s and began addressing the transition from institutional to community-based, recovery-focused care. Substantial investment in policy, resources, infrastructure and workforce (including non-governmental organisations (NGOs)) has led to a decrease in stigma against those living with mental illness.

(b) High-income Asian countries (Taiwan, Singapore, South Korea, Japan and Hong Kong). Backed by advanced health and social service systems, these economies have begun implementing community-based services for those with mental illness. The key challenges include lack of human resources, cross-sectoral coordination, funding incentives for community treatment and patient advocacy.

(c) Upper-middle-income countries (Malaysia, China and Thailand). Recent increases in national policy commitment to community-based care have been established. However, development of appropriate mental healthcare facilities and personnel remains in progress. Major issues still need to be addressed, including huge treatment gaps, inadequate mental and allied health professionals, and little coordination between healthcare providers.

(d) Lower-middle-income countries (India, the Philippines, Vietnam, Indonesia and Pakistan). All the above mental health challenges are huge in these countries, where treatment, resources and workforce are scarce. Resources, where available, are frequently tied up in outdated institutional facilities and treatment modalities. Health systems have an insufficient budget or lack the technical capacity to fully execute mental health expenditure. On the other hand, early signs of improvement in recent legislation, policy and programmes are encouraging.

Concluding remarks

Although guidelines are inappropriate for a highly diverse region, some lessons can be learned from this study to assist progress towards community integration. Various economies are at markedly different stages of reform in the provision of the care, services and environment necessary for integration of people with mental illness into the community. While there is a growing trend across the region in policy and plans to shift from hospital-centric treatments to community-based care, integration for people with mental illness remains slow. Overcoming the regional gap to deliver community-based care requires strong mental health policy implementation, sufficient timeframe, consistent efforts and sustainable integration of all health and non-health sectors to meet the diverse needs of people living with mental illness.

More important than funding is the question of how funds are used and applied according to policy goals. Greater emphasis is needed on developing and integrating a range of system resources, especially to build capacity among NGOs, non-health sectors and non-professionals to deliver community mental healthcare. It is obvious that more reliable data on prevalence, best practices and cost-effective treatments are required. There is a critical need across the Asia Pacific region to strengthen information systems and improve evidence and research in mental health; fundamental goals of the WHO Global Comprehensive Mental Health Action Plan (WHO, 2013).

Finally, integration depends to a large extent on the cultural acceptance of those living with mental illness. Explanatory models of mental illness and their treatments are often shaped by different cultures in the Asia Pacific region. For instance, family and societal attitudes towards mental illness are heavily influenced by cultural values, and the concept of recovery may have different meanings in Asian contexts. Along with the development of community-based infrastructure, efforts towards anti-stigma education, human rights campaigns and patient advocacy should also consider local cultural appropriateness.

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THEMATIC PAPER

Resilience in Haiti: is it culturally pathological?

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Conflicts of interest. None.

doi:10.1192/bji.2017.25

Not for the first time in recent history, the people of Haiti have been obliged to fall back on their resilience strategies in the aftermath of Hurricane Matthew. Following the powerful earthquake that struck the country on 12 January 2010, the entire population had to find the resources to survive in the face of extensive material damage and loss of life: over 222 000 dead, more than 300 000 injured and between 4000 and 7000 amputees (UNDP, 2010).

Paradoxical resilience

Several post-disaster studies (Cénat & Derivois, 2014a, 2014b; Derivois *et al*, 2014b) found that there was a marked prevalence (varying between 30 and 50%) of post-traumatic stress disorder and depression symptoms in the population. These studies show that these traumas are complex and not just related to natural disasters (Derivois *et al*, 2014a). Furthermore, the research showed that the resilience levels of survivors in Haiti were superior to those of other countries with experience of similar natural disasters such as China, Armenia, Japan, Italy and Taiwan (Cénat & Derivois, 2014b; Derivois *et al*, 2014a, 2014b). The same studies also highlight a paradox: the most vulnerable populations in Haiti have the highest resilience scores. Children living in the street with no schooling have higher resilience levels than children who go to school and have a house in which to live. A more recent study (Cadichon & Derivois, 2016) conducted 6 years after the seismic event has revealed that resilience levels are higher among: (a) children and adolescents whose parents do not work (compared with those of working parents), and (b) people with disabilities following the earthquake (compared with those with no disability). Although a high level of resilience does not imply an absence of trauma (as emphasised by Almedom & Glandon, 2007), it is surprising that children and adolescents who live in the street, do not go to school, have a disability or whose parents are unemployed have more resources to cope with adversity.

Halfway resiliency or a pathological resilience?

How can we make sense of these findings, is resilience the central issue? Various studies (Cénat & Derivois, 2014a, 2014b) have postulated that resilience goes beyond dealing with and adapting to traumatic experiences, i.e. being able to absorb or resist them. Resilience is, above all, the capacity to bounce back and develop in a positive way following traumatic events and adversities. But does this definition remain valid in light of the outcomes of sociological studies that reported day-to-day life in post-earthquake Haiti (Farmer, 2012)? Although these studies reported that people were able to cope with the quake's aftermath, they have not experienced a 'positive development'. Indeed, they did not collapse psychologically, but they did not rebound either. The data from studies cited above indicate that the more difficult the conditions are, the more likely people are to invent paradoxical coping strategies. They were not more ready, however, for new natural disasters.

Hurricane Matthew, which left hundreds dead in Haiti, has recently shown that although the population was completely unprepared to tackle