Compendium of Best Practices on Mental Health Resilience of Healthcare Workers in the New Normal

APEC Health Working Group

July 2024

Asia-Pacific Economic Cooperation

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INTRODUCTION

Definition of Concepts

Wellbeing

Wellbeing in the context of health can be defined as a state of optimal physical, mental, and social functioning that goes beyond the absence of disease or infirmity. It encompasses a holistic view of health that takes into account not only the individual's physical health but also their mental and social well-being (Gall et al., 2021).

Resiliency

Resiliency is "an ability to recover from or adjust easily to adversity or change" ("Definition of Resiliency," 2023). The American Psychological Association (n.d.) also defines psychological resilience as a process or outcome of overcoming complex challenges in life through "mental, emotional, and behavioral flexibility," as well as "adjustment to external and internal demands."

Healthcare workers

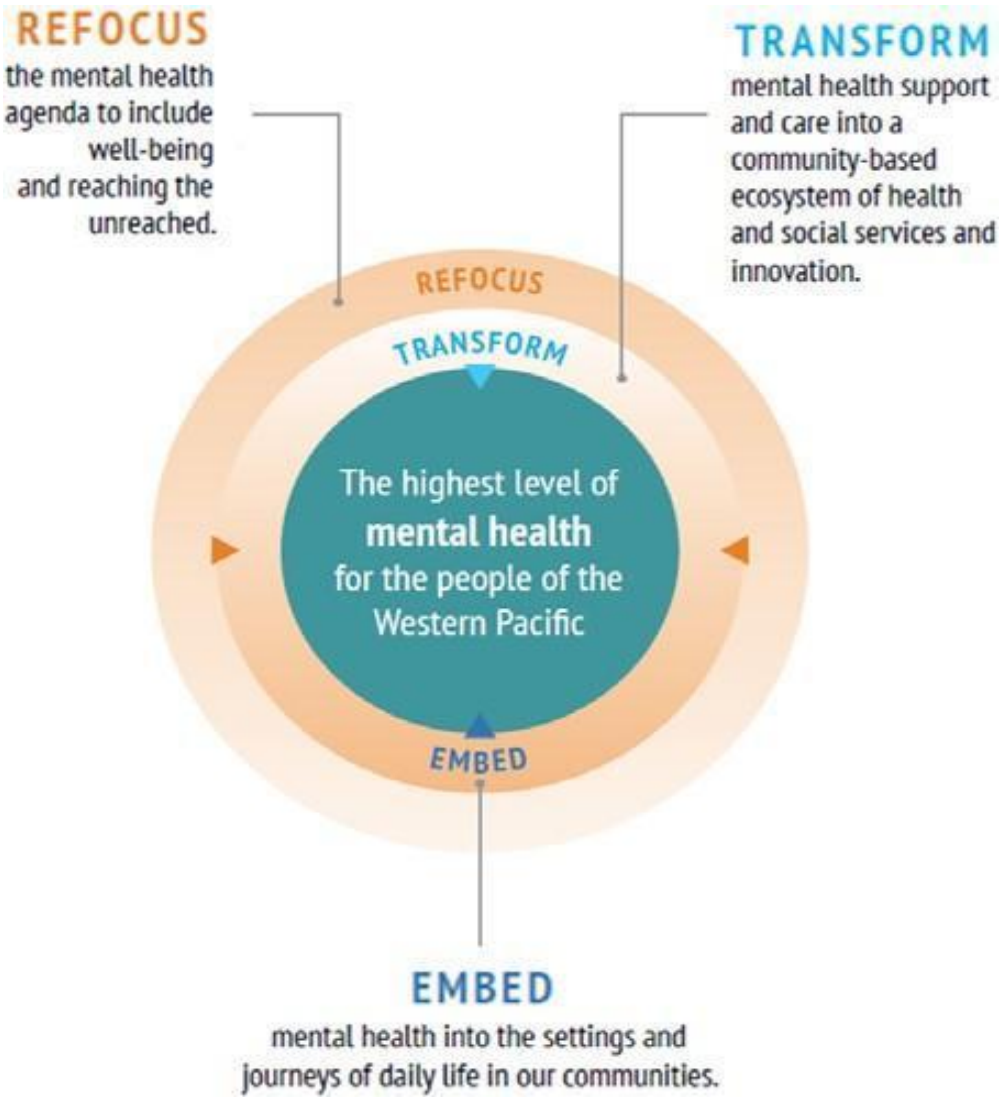
Healthcare workers (HCWs) deliver direct or indirect care and services to the sick and ailing. They are doctors, nurses, aides, helpers, nutritionists, and laboratory technicians, among others. (Joseph and Joseph, 2016)

FRAMEWORKS USED

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

The Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030 by the World Health Organization outlines a comprehensive approach that promotes mental well-being, prevents mental health problems, and ensures access to quality care and support for those who need it. It includes a systems approach to mental health that enumerates (1) refocusing the mental health agenda to include well-being and reaching the unreached, (2) transforming the mental health support and care into a community-based ecosystem of health and social services and innovation, and (3) embedding of mental health into the settings and journeys of daily life in communities as directional strategies to the way forward: achieving the highest level of mental health for the people of the Western Pacific region.

Figure 1: Regional Framework for the Future of Mental Health in the Western Pacific 2023–2030



Mental Health Rehabilitation (MHR) Intervention Challenge Framework (Sigua, 2023)

In the dynamic landscape of mental health, the need for innovative and effective interventions has never been more pronounced. Acknowledging the multifaceted nature of mental health challenges, the Mental Health Rehabilitation (MHR) Intervention Challenge Framework (Figure 2) emerges as a pivotal framework. Rooted in the principles of Innovate, Interface, Integrate, Intensify, and Invest, this framework represents a comprehensive approach to addressing the complexities of mental health rehabilitation. The mentioned components of the MHR Intervention Challenge Framework, explores how each element contributes to a comprehensive and adaptive strategy for mental health rehabilitation.

Figure 2: Mental Health Rehabilitation (MHR) Intervention Challenge Framework (Sigua, 2023)

1. Innovating

This scoping review found diverse approach frameworks, including the pyramidal framework of Mental Health Psychosocial Support Framework, the Hazard & Vulnerability Framework of Disaster Response and Climate Change, and Harvard's Multi-Systems Public Health Framework, and Theory of Social Change (Dwyer & Minnegal, 2010; Harvard School of Public Health, 2016; Robielos et al., 2020; IFRC Research Centre, 2021). Each setting or locality can find its most suitable theoretical framework to scaffold in, using the scientific rigor of mixed methods to arrive at innovative designs. It is important that principles of co-design and co- production be used to come up with sensible and evidence-based innovation that can be subjected to pre-set indicator measurements or scoring. Innovations are not worth having if they cannot be shared through common language. Data sharing is most needed and trans-government and organization research, and innovation should be allocated enough funding and resources for mental health programs for HCWs. This includes funding for research, mental health services, training, and infrastructure. There is a need to prioritize mental health policy-informing research. This can include policies that promote mental health awareness, reduce stigma, and improve access to mental health services for HCWs.

To address uptake or utilization — research on what works may be culture- specific. Confidentiality, sensitive communication of motives, open culture on mental health (MH) may be important in analyzing the dynamics. Team based and peer-based support should be subjected to operational research, and likewise the delicate balance between systems and personal self-care. Virtual access tipping point states the need for intentional integration of virtual care into the future and the role of innovation in the ecosystem. The rise of virtual care has provided a new era of accessible and on-demand services offered by a range of public and private players. As the system goes virtual — experts debate how to integrate virtual care with the current service delivery model. Gaining traction over the past years, virtual care has gone through a catalytic acceleration due to COVID-19 and the shift to remote and online care. Now, many services that were providing in-person support have shifted to virtual or phone alternatives, including sessions with psychiatrist, addiction support and physician appointments. The number of tech and startup players in the virtual mental health space has risen dramatically, increasing the awareness and investment in mental health, while supporting a rise in on-demand text and phone support. Many experts consider the rise of virtual care to be positive, while confirming that text, phone or video care cannot replicate the role of in-person care (Li et al., 2021). As we move through the coming years and transition out of COVID-19 response, the mental health system will need to intentionally integrate in-person and virtual care services that center the needs of the individual. The potential lies in bringing stakeholders together to bridge the two service approaches and redefining mental health services and access to support through a collaborative and needs-focused approach.

2. Interfacing

Removing siloes so we can diminish each other's blind spots and establish synergy in outcomes is critical. The scoping review revealed that in areas of collaboration and communication, there are several gaps faced by APEC economies in promoting mental health resilience among healthcare workers (HCWs) in the area of research, policy benchmarks and adoption, and implementation (Murphy et al., 2021). Interfacing may lead to reframing and knowledge building across multiple perspectives, paradigms, models — recognizing common grounds provides a model for systems linking, especially involving funding models.

COVID-19 offers a potential to finally break down silos and collaborate across sectors to address the growing mental health needs of APEC economies. The "silo" is one of the most pervasive metaphors in mental health care, with organizations, specialty practices, governments and private companies operating largely in isolation. As a result, the system lacks effective oversight and accountability, there is no coordinated collection, monitoring, evaluation, and sharing of mental health data, and accessing and navigating services becomes complicated and challenging (Greiner & Knebel, 2003). With a major increase in awareness of the mental health crisis exacerbated by COVID-19, it is clear that we need more collaboration between stakeholders, working together to deliver a system of care matched to each individual's needs. Individual member economies and global investments in mental health over the past year point to this potential for change.

The World Health Organization recognized mental health, especially among HCWs, as a core issue of the pandemic, and the governments has made large investments in help lines and suicide prevention services accessible to all in the member economy. We have an opportunity to build on this momentum and collectively restructure the system in a way that improves holistic mental health outcomes for all APEC economies.

Intervention points can be constructed through developing a common language and definition of mental health ; developing shared outcomes and accountability; incentivizing collaboration through funding that requires partnerships ; bringing service delivery networks together and maximize collective resources; creating spaces where governments, policy-makers, care providers, families, schools, private companies, community support groups, and people seeking support can collaborate ; building on inherent potential within local systems.

Supporting trends include greater awareness of mental health among the young; increased conversations in public discourse around mental health; global and member economies' investments in mental health programs and strategies; research-based innovation, dialogical communication, equitable and integrated framework, past and future-based sustainability; and technological support to enable greater access to self-help tools.

Intervention points include proactively seeking out community, peer to peer and informal support networks to identify successful practices, understanding and learning from them; bringing the system to the community; actively learning from and supporting, through applied and action research methods, effective approaches and practices, and speeding up knowledge to action cycles.

Supporting trends include publicly funded programs; spiking demand from the young HCWs; building optimistic resilience; prioritizing community care and prevention.

There is a need to bridge the solitude of spotlights between public and private institutions to work together for the greater good. The next few years will require the best efforts of both public and private mental health services and resources. It is time to work through an integrative approach for the common good. The significant and as yet unknown impacts on the mental health and wellbeing of HCWs of all APEC economies and its corollary catalyzing effects are still under assessed, but likely to be unprecedented. We are already seeing alarming rises in anxiety and depression, a 'shadow pandemic' of domestic violence, and worrying uncertainties in global and individual member economies, predicted to disproportionately impact the financially insecure and equity seeking groups. It is going to take integrative and innovative approaches from both the health systems and private actors, such as employers and health insurance companies, to best ensure that all economies are able to access support and care where and when required (Kruk et al., 2018). There is great opportunity, and urgent need, to find and implement ways to best utilize the relative strengths and capacities of public and private mental health services and capacities. This will require as yet undeveloped capacity for person-centered care, and a new willingness to cooperate and coordinate.

Taking a ground up approach centers the invaluable community and peer-to- peer support systems. The pandemic has catalyzed innovation across many areas of mental health support. Much of this innovation has been at the community level. As the pandemic disrupted all facets of life, including the health system and community mental health, innovative approaches to outreach, support and care were created and implemented at the community level (Rajkumar, 2020). Many of these initiatives have been and continue to be successful, created at little or no cost and utilizing capacities and resources available to all. As we move forward, facing an unprecedented scale of system disruption and unprecedented need for mental health support, we should actively seek out, learn from and support local successes, identify valuable innovations, and find ways to build on and more broadly implement the 'wisdom of the community'. This will require a change in paradigm in both custom and attitude. The traditional approach to developing new practice in the health system is deliberate, top down and, often appropriately, slow moving. We have an opportunity to harvest community level insight, innovation, capacity and knowledge which, if we are not careful, might otherwise be lost.

Promote collaboration and communication: Collaboration and communication between healthcare providers, researchers, policymakers, and other stakeholders is essential for promoting mental health among HCWs. Governments and organizations should promote collaboration and communication through forums, conferences, and other initiatives.

3. Integrating

There is a need for Integrating not only service but models, perspectives, lenses, principles and essential tools to see and administer fixes together — harmonization. The learning curve becomes less steep, and resources are less wasted. This includes learning a common language for monitoring and evaluation of outcomes. Increase awareness and education: Governments and organizations should upend advocacy and literacy on mental health rehabilitation (MHR) not only among HCWs but the general public as well.

When models and perspectives are integrated, service and action can follow. Even cultural sensitivity can be improved as acceptance and tolerance of diversity increases. Mental health services may not be culturally sensitive or appropriate for all HCWs, which can hinder their ability to access support and resources for mental health resilience (Bhui et al., 2007). Stigma and discrimination around mental health can also be a barrier to promoting HCW mental health resilience. Healthcare workers may feel ashamed or afraid to seek support, fearing that it may impact their job security or reputation (Knaak et al., 2017).

4. Intensifying

In the area of attaining sustainability of programs, there are several gaps, barriers, and challenges faced by APEC economies in promoting mental health resilience among healthcare workers (HCWs).

The survey revealed only limited policy support: Policy support is essential for sustaining mental health programs. Limited policy support for mental health programs can make it difficult to sustain these programs over time (Wainberg et al., 2018). We need to know how to identify and prioritize the most vulnerable ones. We need to intensify strategies at the organizational level.

Build a healthy work culture

Be intentional about how you design your team's work and your workplace culture, so you can create an environment that supports mental well-being. Examples include the following: Provide employees the flexibility in how they structure their day or where they get their work done, encourage employees to approach their supervisors if expectations or workloads become difficult to manage and commit to finding solutions together.

Other examples include the following: model healthy behaviors by using paid time off (PTO) and talking about how you make time for self-care, accommodate PTO to focus on improving mental, not just physical, health; adopt company policies that reflect employee mental health needs; provide outlets for expressing concerns and asking for support; foster a culture of connection by implementing support groups, employee resource groups, and informal opportunities for socializing, while respecting the need for personality-based desire for more intimate and private self-help.

Proactively promote well-being and putting the measure of positive protective factors

Employers play an important role in destigmatizing mental illness. Some of the steps you can take may include: encouraging managers and company leaders to talk openly about their mental health, which helps others feel more comfortable opening up as well on all-company call; doing regular check-ins and surveys and following through with meaningful action based on the findings; developing anti-stigma campaigns; and forming a team of "mental health champions" who build awareness and act as non-judgmental sources of support.

Provide training for managers & healthcare systems leaders

Many employees assume their managers are receiving training on identifying mental health issues and providing referrals to helpful resources. However, surveys suggest that managers have actually not received this type of education, so that providing such training should be considered.

In the systems level, this may require policy development. For instance, lack of motivation of employees to change and do something for their mental health could be due to the lack of buy-in from senior leaders regarding the importance of employees' well-being. This lack of commitment has a cascading effect, as leaders were also unaware of the impact they had on their employees' overall experience within the organization. Another issue revolved around the accessibility of well-being programs during work hours. Employees were often unclear about when they could access and utilize these programs, thus creating confusion and reducing their effectiveness. Furthermore, due to family responsibilities, there was no dedicated time available after work hours to leverage these programs, limiting participation. Adherence to well-being programs also proved to be a challenge, as employees struggled to turn newly acquired knowledge and skills into lasting habits. The workforce's literacy was not considered, making it difficult for some employees to fully engage with these programs. One-and-done programs were another problem area, as they failed to account for the impact of the forgetting curve on habit development, undermining the long-term effectiveness of our well-being initiatives. Additionally, employees expressed concerns about their privacy, which needed to be addressed to build trust and ensure their comfort.

5. Investing

The survey also revealed the lack of funds for programs towards MHR among HCW from mental health research to implementation and evaluation. The already- overwhelmed and under-resourced services in the health and mental health systems, especially among the most disadvantaged and vulnerable, are frequently in crisis due to lack of resources and capacity (Fegert et al., 2020). Our current formal funding structures are (often appropriately), but slow to change; however, they tend to privilege established organizational structures and institutions, regardless of changes in the nature, scale and urgency of emerging and growing need. Many of the gaps in funding have been filled in partly by charitable giving, fundraising and philanthropy. Although this will continue, it cannot be relied upon to meet the significant and new emerging mental health needs exacerbated by the pandemic in all areas of society. There needs to be an integrated, agile, proactive and responsive process of identifying and understanding immediate need and allocating and delivering funding and resource support at all levels of provision from the central government, and local government in a circular fashion.

Institutionalized mental health programs require resources such as trained personnel, infrastructure, and technology (Rathod et al., 2017). However, many healthcare facilities are resource-scarce. We need to talk about funding models that highlight a need to reimagine system-wide resourcing and funding. Although investing in mental health reaps hugely, return of investment may take a long. Mental health is an economic concern. Current health (and mental health) funding structures disproportionately privilege large healthcare players, create unnecessary competition among smaller organizations, and reinforce silos and duplications. The pandemic has highlighted and stressed pre- existing inadequacies across many health sectors, including mental health.

Intervention points include these: strengthen and increase access to funding support for applied and action centric research; directly fund inclusive knowledge translation activities; situate and expand research activity and funding in community mental health settings develop appropriate and applicable measures for evaluating situated mental health activity and context.

Supporting trends include capitalizing on government central and local mental health support created during the pandemic: hospitals moving into community care space; integrate community players with hospital resource support; investing for organizational/ institutional leaders by putting your pocket where the heart is; funds, extra money, time, resources, strategic inputs like leaders, and echoing the right mindsets, role model passion. We need to see and observe the strategic points, the socio-ecological units or layers that envelop the HCWs. In today's workplace, a baseline investment in an employee assistance programs (EAP), health plan, or mental health app is not enough. With these approaches, low utilization, long wait times, and other barriers keep people from accessing mental health services. Instead, companies are choosing more comprehensive mental health solutions. Investing in mental health pays off. Most employees say that when considering a new job, it's at least somewhat important that the prospective employer offer mental health benefits. When employees feel their companies do not support their mental health, they are to experience symptoms of mental illness, miss work, or underperform. On the other hand, if supported, they are also more likely to talk about mental health concerns, feel satisfied with their job, and feel proud to work and provide care and service to patients. (American

Psychological Association, 2022).

We need to understand that before we can convince ourselves and others to invest, we need to understand the why's and how's of the four other I's: innovating, interfacing, integrating, and intensifying. This wheel of challenges can ensure moving forward and moving forward in synchrony, in synergy and in order.

CRITERIA FOR BEST PRACTICE

Level of Data

One of the key criteria in selecting the best practices for mental health initiatives is the level of data supporting a particular approach. This involves assessing whether there is substantial empirical evidence, research, and data indicating the effectiveness of a specific mental health intervention. Data considered results from studies, surveys, real-world case examples, and forum presentations that demonstrate the positive impact of the initiative on individual's mental health. The more robust and comprehensive the data, the more likely it is that the initiative will be considered a best practice. Decision-makers can prioritize initiatives with a strong evidence base to ensure that their efforts are based on sound scientific principles and have a higher likelihood of achieving positive outcomes.

Evidence-Based Approach

An evidence-based approach is crucial in selecting the best mental health practices. This criterion emphasizes the importance of choosing strategies, interventions, or programs that have been rigorously tested and validated through scientific research. Evidence-based practices are more likely to deliver consistent and measurable results. These practices are typically well-documented, have clear guidelines for implementation, and are supported by peer-reviewed studies.

Certified Outcomes

When evaluating mental health initiatives, it's essential to consider whether they have certified outcomes. Certified outcomes add credibility and assurance that the initiative is effective and aligns with recognized standards for mental health support.

Covers Priority Areas

The chosen initiatives have a targeted approach that aligns with the priority areas from the roadmap of the Future of Mental Health in the Western Pacific 2023– 2030. These can cover areas such as:

(1) Leadership and governance for mental health: This involves strengthening policies, systems, and governance structures to support mental health.

(2) Mental health promotion and prevention: This involves promoting mental wellbeing and preventing mental illness through public health campaigns, education, and community-based interventions.

(3) Access to mental health services: This involves improving access to evidence-based mental health services, including primary care, specialized care, and community- based services.

(4) Quality of mental health services: This involves ensuring that mental health services are of high quality, effective, and person-centered.

(5) Human resources for mental health: This involves building a competent and diverse mental health workforce that is capable of delivering quality services.

(6) Research, monitoring, and evaluation.

APEC ECONOMIES MENTAL HEALTH INITIATIVES

AUSTRALIA

Introduction of the member economy's healthcare delivery

Australia has a mixed healthcare system, with a public system and a private system (Verhoeven et al., 2016). The government funds the public system and is available to all Australian citizens and permanent residents. It covers a wide range of services that include inpatient and outpatient services, as well as prescription drugs. However, there are some out-of-pocket costs, such as specialist visits and ambulance services. The private system comprises private hospitals, doctors, and other healthcare providers. People who choose to use the private system usually pay for their care upfront, but they can claim a rebate from the government. The private system offers a broader range of services than the public system, and patients can usually get faster access to treatment. About 60% of Australians use the public system, while about 40% use the private system.

Australia's healthcare delivery system has changed significantly over the past three years. The government has taken several initiatives to improve the quality of care and ensure that all citizens have access to quality healthcare services. One of the most notable changes in the healthcare delivery system is the increased focus on preventive care (Department of Health Australia, 2021). The government has introduced several programs to promote healthy lifestyles and prevent chronic diseases. For example, the "Diabetes Services Scheme" in Australia provides subsidized access to diabetes-related products and services (Olson et al., 2022). In contrast, its Bowel Cancer Screening Program offers free bowel cancer screening to eligible Australians aged 50-74 (Dasgupta et al., 2023). Another significant change in the healthcare delivery system is the increased use of telehealth services. The COVID-19 pandemic has accelerated the adoption of telehealth services, allowing patients to access medical care from the comfort of their homes. The government has also expanded the range of telehealth services covered by Medicare to include mental health services, which has improved access to mental health care for many Australians (Matthew et al., 2023).

The government has also taken steps to improve the quality of healthcare services. The Australian Commission on Safety and Quality in Health Care has developed several standards and guidelines to improve the safety and quality of care (Greenfield, 2015). The government has also invested in training healthcare professionals to ensure they have the necessary skills and knowledge to provide quality care. In addition, the government has increased funding for hospitals and healthcare services (Australian Government Department of Health and Aged Care, 2022).

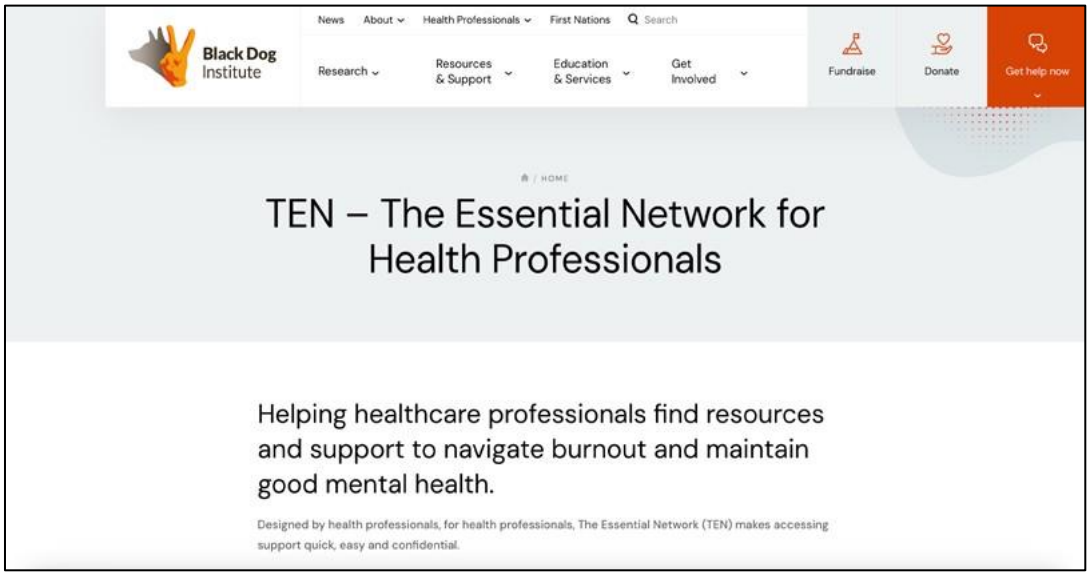
Despite these improvements, there are still challenges facing the Australian healthcare delivery system, including aging population, rising healthcare costs, and inequity (Callander, 2023). The Australian government is working to address these challenges. The government is investing in the public system, and it is also working to improve the efficiency of the system. The government is also considering introducing reforms to the private system to make it more affordable (Australian Government Department of Health and Aged Care, 2023).

Australia's healthcare delivery system is well-functioning and provides high- quality care to all citizens. However, there are some challenges that the government needs to address to ensure that the system remains sustainable in the future.

Discussion of the good practices and facilitating factors

Best Practice: The Essential Network (TEN)

The Essential Network (TEN) was introduced by the Black Dog Institute in 2020, with funding support from the Australian Government Department of Health and Aged Care as part of the Australian Government's response to the COVID-19 pandemic. The network was designed by healthcare experts for the benefit of healthcare professionals. Even after the pandemic, TEN's demand continues to increase. Initially intended to establish a link between healthcare professionals and essential mental health and well-being services, TEN continues to provide specialized, personalized mental health guidance and prioritized support to connect healthcare workers with the assistance they need for mental health concerns. The initial purpose of TEN was to connect them with mental health guidance and well-being services so that they could effectively manage the stress caused by the COVID-19 pandemic. Even after the pandemic, there is still a need for TEN, and the service remains committed to promoting the mental health of Australian healthcare workers.



TEN – The Essential Network for Health Professionals page.

Photo from the Black Dog Institute website

TEN was conceived by and designed for Australian healthcare professionals who are interested in taking care of their health, whether at work or outside of it. Through the website and online program, eligible Australian healthcare professionals can gain insight from step-by-step guides and receive guidance from individuals who have personally experienced burnout at any time. In addition, eligible Australian healthcare professionals (those registered with Australian Health Practitioner Regulation Agency (AHPRA) or a recognized professional body) can use the TEN clinical consultation service. This service includes up to five complimentary consultations with a psychiatrist or clinical psychologist. The TEN clinic connects healthcare professionals with Black Dog Institute mental health specialists. They cater to eligible Australian healthcare professionals with the intention of providing assistance and guidance in a private and compassionate environment (Black Dog Institute, 2023).

The program is equipped to assist healthcare workers with various challenges, both in their professional and personal life, which may encompass the following issues: managing stress and work-related concerns, balancing the demands of work and home life, addressing burnout and compassion fatigue, coping with trauma, anxiety, and periods of low mood, tackling sleep-related issues, and handling stress effectively.

TEN is progressing mental health support for healthcare professionals. Leaders and managers in the fields of mental health, public health, clinical peer support,

and technology have united efforts to streamline the process of accessing mental healthcare for essential workers. TEN was possible because of the collaboration of various organizations and institutions such as the University of New South Wales, University of Melbourne, This Way Up, The Royal Australian and New Zealand College of Psychiatrists, Australian Psychological Society, Hand-N-Hand, and SAS Viya.

TEN provides discreet and convenient access to support, serving as a digital gateway that opens up access to a network of resources which include:

(1) TEN Digital Mental Health Check-up: A self-guided mental health evaluation offering a variety of prioritized support alternatives. The TEN Digital Mental Health Check-up has been created to assist in recognizing and addressing challenges to healthcare workers' emotional well-being while connecting them with evidence-based support. It works by completion of a check-up where afterwards respondents receive an assessment report pinpointing any signs of depression, anxiety, post-traumatic stress, or burnout one may be encountering. This report serves to help comprehend symptoms and provides a variety of adaptable, evidence-supported avenues for treatment and assistance, including. Another is the option to have up to five confidential telehealth consultations with an expert clinical team within the TEN clinic. Next are links to an array of professional support alternatives tailored to one's specific needs. Furthermore, healthcare professionals can utilize the insights from this report to engage in discussions about their emotional well-being with a general practitioner or a mental health professional.

(2) Connection to one-on-one clinical care through Black Dog Institute's TEN Clinic. This feature includes up to five complimentary telehealth sessions with a clinical psychologist or psychiatrist.

(3) Evidence-based tools and resources customized to meet the requirements of healthcare professionals given an assortment of valuable mental health materials, evidence-supported instruments, and guidance tailored to the needs of healthcare professionals.

(4) Peer support through TEN's partner, Hand-n-Hand, providing one-on- one or group peer assistance to healthcare professionals by pairing them with experienced mental health volunteers who are committed to helping healthcare workers seeking support. This organization which receives funding support from the Australian Government Department of Health and Aged Care, comprises of psychiatrists, general practitioners, nurses, and allied health professionals with expertise in mental health, working to establish a strong peer support system for all healthcare workers during the pandemic and even after. Hand-n-Hand is a cost-free non-clinical service and does not encompass any medical or psychiatric interventions. Instead, it revolves around peer support and mentorship.

(5) Digital mental health programs are available free of charge, including the This Way Up platform and the TEN Navigating Burnout program. Within TEN is the Navigating Burnout program which was crafted with a specific focus on the needs of healthcare professionals, aiming to alleviate the effects of burnout in a manner that recognizes the unique challenges they encounter. This program, accessible around the clock online, empowers healthcare professionals with step-by-step guidance and insights from peers who have personally experienced burnout. It encompasses pragmatic, evidence-based techniques and exercises rooted in the most recent cognitive behavioral therapies, all aimed at preventing and mitigating the impact of burnout on healthcare professionals. For leaders seeking strategies to cultivate mentally healthy work environments such as in healthcare settings, there is a dedicated section offering the latest research-driven approaches to support teams and enhance workplace culture.

Insights and Lessons

Maximizing Technology for the Service Delivery of Mental Health Programs

The field of mental health is experiencing a profound transformation, given the rapid advancements in technology. Mental health programs are leveraging technological tools to enhance service delivery, expand outreach, and ensure the accessibility of support to a broader population. As such, TEN has demonstrated the vital importance of maximizing technology for the service delivery of mental health programs, with benefits such as effectiveness, reach, cost-efficiency, and destigmatization.

TEN has demonstrated that the use of technology in mental health service delivery can transcend geographical boundaries. Telehealth, for instance, enables individuals in remote or underserved areas to access mental health services without the need to travel long distances. The use of video conferencing, online platforms, and mobile applications has democratized and personalized access to mental health support. Moreover, platforms such as TEN allows for greater reach into communities where the stigma associated with mental health issues may deter individuals from seeking help in traditional settings.

TEN has shown how technology can enable mental health programs to offer timely and efficient services. Referral to crisis hotlines, chat services, and artificial intelligence-driven features available on the e-hub of TEN can provide immediate responses to individuals in distress. This fast response can prevent the escalation of mental health crises, improving overall outcomes for those in need. Furthermore, the use of technology such as in TEN allows for streamlined administrative processes, reducing wait times for appointments and ensuring that individuals receive the support they require without unnecessary delays.

Technology in mental health programs allows for the collection and analysis of vast amounts of data. These data can be harnessed to understand trends, measure the effectiveness of interventions, and identify areas where mental health services may need improvement. It aids in evidence-based decision-making and continuous quality improvement, enhancing the overall effectiveness of mental health programs such as those that can specifically cater to the pluralistic needs of healthcare professionals.

Maximizing technology in service delivery leads to cost-efficiency. Telehealth, for instance, reduces overhead costs associated with maintaining physical infrastructure. Online platforms and applications such as TEN can significantly cut the expenses related to printed materials and in-person counseling sessions. This cost-effectiveness ensures that limited resources can be allocated more efficiently, extending the reach of mental health programs to help more individuals in need.

Another insight from TEN is the reduction of stigma through maximizing such platforms. Stigma remains a significant barrier to mental health support. Many individuals are hesitant to seek help due to societal misconceptions and prejudices. Technology, by allowing individuals to access services discreetly from the privacy of their own homes or workplaces, diminishes the stigma associated with mental health issues. It can foster a sense of safety and comfort in seeking support, encouraging more people to address their mental health concerns.

Individualized mindfulness techniques incorporated into digital technology, and subsequently offered through applications in organizational and workplace settings, have gained increasing attention in recent years. These innovative approaches to mindfulness training are effective for a variety of reasons, offering numerous benefits for individuals and the organizations they work for. For one, digital technology makes individualized mindfulness techniques more accessible to a broader audience. Employees can access these tools on their smartphones, tablets, or computers, allowing them to engage in mindfulness practices at their own convenience. This accessibility eliminates barriers like geographical limitations, scheduling conflicts, and the need for physical materials. Next, digital mindfulness applications are highly scalable. Organizations can offer these resources to several employees simultaneously without a significant increase in cost.

This scalability allows for a more widespread implementation of mindfulness programs within the workplace. Individualized mindfulness applications allow employees to learn at their own pace such as in the case of the modules provided on TEN. This self-directed approach empowers individuals to explore and deepen their mindfulness practice gradually, without feeling rushed or overwhelmed. It accommodates varying levels of experience and comfort with mindfulness techniques. Such digital mindfulness applications also offer flexibility in terms of when and where employees can practice mindfulness. This means that individuals can integrate mindfulness into their daily routines and address stress and challenges as they arise, improving their overall well-being and productivity. Digital applications to employees are also often more cost-effective. Organizations can deliver high-quality mindfulness training without the need for in-person instructors or printed materials. Individualized mindfulness techniques delivered through digital technology in organizational/workplace settings similar to TEN may be effective for these reasons. These benefits not only improve individual well-being but can also lead to a healthier, more productive, and more harmonious workplace environment.

Strengthening Mental Health Service Delivery through Collaboration

TEN has exhibited that mental health service delivery is a complex and multi- faceted endeavor that demands a collaborative effort from a range of institutions and organizations. The importance of collaboration among academic institutions, non-government organizations (NGOs), civic society organizations, and community- based organizations in enhancing mental health service delivery is therefore crucial. Through collaboration of such relevant stakeholders, a more comprehensive and effective support system for individuals with mental health issues can be possible.

Collaboration among academic institutions and NGOs can bridge the gap between research and innovations such as demonstrated by TEN. Academic institutions serve as hubs of knowledge generation, offering the latest research findings, evidence-based interventions, and the training of future mental health professionals. NGOs, on the other hand, can operate on the front lines, providing services and assistance to those in need. By working in concert, academic institutions can ensure their research is directly applicable and effective, while implementing NGOs can benefit from the most up-to-date knowledge and methods, ultimately improving the quality of mental health service delivery. This was the case in TEN, where the program has partnered with such organizations to make the program possible.

The combined efforts of NGOs, civic society organizations, and community- based organizations can be effective in mobilizing resources for mental health initiatives. These organizations often have extensive networks, connections with donors, and experience in fundraising. By collaborating, pooled resources can increase the financial and human capital available for mental health service delivery. This, in turn, allows for more comprehensive and sustainable support systems. TEN has exhibited this through partnering with peer support group networks that can provide counselling and mentorship.

CANADA

Introduction of the member economy's healthcare delivery

Canada is an advanced industrialized member economy, making it a member of the influential G20 that impacts the global economy. It is also a member of the Commonwealth of Nations, which it joined as an independent state in 1931. By 1982, the patriation of Canada's Charter of Rights and Freedoms ensured the state's full sovereignty with respect to its relationship with the United Kingdom and the rest of the Commonwealth. This impacts the powers of Canada's parliament, and the policies created for all residents.

Canada's population was estimated to be at 39,566,248 as of 2023, representing a record population growth of 2.7% between 2022 to 2023. This population figure includes permanent and non-permanent residents, as well as Indigenous Peoples (Statisque Canada, 2023). This population is distributed across 10 semi-autonomous provinces and three other territories with less autonomy in Canada's governance system. Ontario, where the capital is located, is the most populated province with an estimated population of over 14 million. This is in contrast to the province of Prince Edward Island, with a population of over 154,000. Among the territories, the Northwest Territories are the most populated with over 41,000 individuals, while the least populated is Nunavut with just over 36,000 persons. Official languages in the provinces and territories include English, French, Inuktitut, Inuinnaqtun, and other "First Nations" languages (World Population Review, 2023).

The principal legislation for the structure and financing of Canada's healthcare is the Canada Health Act, which operates on these five principles: public administration, comprehensiveness, universality, accessibility, and portability. These principles ensure that the public health system is run on a non-profit basis and can provide a wide variety of health services regardless of location within Canada's territory. The Canadian federal government's roles in health care include setting and administering domestic principles for the system under the Canada Health Act; financial support to the provinces and territories; and several other functions, including funding and/or delivery of primary and supplementary services to certain groups of people. These groups include: "First Nations" people living on reserves; Inuit; serving members of the Canadian Armed Forces; eligible veterans; inmates in federal penitentiaries; and some groups of refugee claimants. The public health system is funded through general taxation, although provinces may charge residents an additional premium for local/provincial health programs such as supplemental services not covered in the Canada Health Act. These include but are not limited to drugs prescribed outside hospitals, ambulance costs, and hearing, as well as vision and dental care.

Some services such as long-term care for the elderly or persons with disabilities, must be funded through out-of-pocket payments or private insurance plans (Health Canada, 2019).

Local primary health clinics, be they under the public health system or private practices, are usually the first point of contact for residents in Canada. Primary care services include preventive care and health promotion, management of common diseases, injuries, and emergencies, maternity care, child development care, palliative and end-of-life care, and primary mental health care. Primary health facilities also coordinate and refer patients to other facilities for more specialized care. As much as possible, specialized care is given in the community setting through secondary level facilities or through home and community care arrangements (Health Canada, 2019).

Undermining the capacity of Canada's healthcare system for service delivery over such a wide jurisdiction is an ongoing shortage in human resources for health. In 2021, there were 93,998 physicians registered in Canada, coming up to a ratio of 246 physicians per 100,000 population.

In 2022, there were 255,165 registered nurses involved in direct patient care throughout Canada's healthcare system, with only 64% employed on a full-time basis (Canadian Institute for Health Information, 2022). This also represents a 5.8% vacancy rate for jobs and positions in healthcare, with the biggest gap being in nursing and residential care facilities. Family physician positions make up about 51% of unfilled opportunities in the healthcare system. This short supply compared to the continuous demand for healthcare threatens to undermine

Canada's healthcare system, especially on the primary care level (C.D. Howe Institute, 2022). To address this crisis, the Canadian government has updated policies to provide better protection to healthcare workers and has scaled up migration programs to encourage an influx of medical and allied health professionals from other areas. Platforms to directly address mental health issues have also been rolled out to address post-traumatic stress disorder for workers in healthcare and other essential services (Health Canada, 2023).

Equity in health service delivery and access also continues to be a struggle for healthcare systems in Canada. In particular, Indigenous Peoples such as Inuit, Métis, and "First Nations" still contend with socioeconomic inequality rooted in impacts from colonial policies such as forced removal from ancestral lands, or separation from their communities through the residential school's system. The intergenerational consequences of these policies are still apparent in systemic issues including but not limited to racism and discrimination even in government services and health facilities. As a result of colonial legacies, Indigenous Peoples have lower average income, shorter life expectancies, and higher disease burdens from non- communicable illnesses, compared to non-indigenous Canadians (Durand-Moreau, et al, 2022).

The 2017 Commonwealth Fund report on 11 members' healthcare systems placed Canada, France, and the United States as among the bottom three members for equity in the healthcare system. Social determinants influencing health equity in these economies include disparities in post-tax income as well as structural racism against the Indigenous Peoples. Ways to resolve these health service inequities include multi-sectoral solutions such as cash transfers to alleviate household poverty, as well as training and sensitization on cultural safety and Indigenous Peoples' health (Nickel et al., 2018).

Other initiatives to improve healthcare service delivery in Canada include decentralization for local health decision making, development of eHealth services such as electronic records and telehealth, and studies on patient safety and reduced patient waiting time. These will not only improve the efficiency of the healthcare system, but also help close some gaps in underserved areas and improve patient satisfaction with public health services (Health Canada, 2019).

Backgrounder or situation before the introduction of the best practice

Mental health services are offered on different levels of care in Canada's public health system. The first public health strategy for mental health, "Changing Directions, Changing Lives", was published in 2012. This document outlined six main directions for Canada's mental health care agenda:

1. Promote mental health across the lifespan in homes, schools, and workplaces, and prevent mental illness and suicide wherever possible.
2. Foster recovery and well-being for people of all ages living with mental health problems and illnesses and uphold their rights.
3. Provide access to the right combination of services, treatments and supports, when and where people need them.
4. Reduce disparities in risk factors and access to mental health services and strengthen the response to the needs of diverse communities and Northerners.
5. Work with "First Nations", as well as Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures.
6. Mobilize leadership, improve knowledge, and foster collaboration at all levels.

This strategy emphasizes broadening mental health service access, while collaborating with vulnerable communities to reduce health inequities (Mental Health Commission of Canada, 2012). This policy has been further operationalized in subsequent documents such as the Federal Public Service Workplace Mental Health Strategy, which aims to uphold psychological safety in the occupational setting. This plan focuses on changing workplace cultures within the federal public service, capacity building for employees at all levels, and monitoring and evaluation (Government of Canada, 2016).

Another important related policy is the Federal Framework for Suicide Prevention Act, which was also legislated in 2012. This law's framework focuses on raising public awareness about the impact of suicide, connecting Canadian residents to resources for mental health and suicide prevention, and accelerating research and prevention towards suicide prevention. The framework also seeks to specifically address the needs of vulnerable population groups such as farmers, veterans, Indigenous Peoples, and the LGBTQI+ community. Activities under this suicide prevention framework include awareness campaigns such as Operation Lifesaver, the rollout of hotlines made accessible to the aforementioned population groups, a suicide prevention platform with resources about mental health, suicide, and substance abuse for the general public, and providing funding and support for suicide prevention research on the community level (Government of Canada, 2023). 9-8-8 Suicide Crisis Helpline, a domestic three-digit number for suicide prevention and emotional distress became available across Canada since November 2023.

Even with these policies and frameworks, mental health continues to be a significant health burden on the health of the Canadian population. The percentage of Canadians aged 15 years and older who met diagnostic criteria for generalized anxiety disorder in the 12 months before the survey doubled from 2.6% to 5.2% between 2012 and 2022. Similar increases were observed for the 12-month prevalence of major depressive episodes, from 4.7% in 2012 to 7.6% in 2022. Other mental health problems of concern include substance use disorders, bipolar mood disorder, eating disorders, and schizophrenia. In 2019, there were approximately 4,500 deaths by suicide in Canada, with a disproportionate rate among Indigenous Peoples. Suicide is also the second leading cause of death for adolescents and young adults from ages 15-34 years (Canadian Mental Health Association, 2021).

Thus, the demand for mental health services in Canada continues to grow and further taxing mechanisms for service delivery. During the fall of 2020, almost one in five Canadians (18.1%) aged 12 and older reported that they needed some help with their mental health in the past year (Statistics Canada, 2021). Among those who perceived a need, slightly more than half (55.0%) felt their needs were fully met (i.e., they received some form of care or help and did not report needing additional care).

The remaining (45.0%) felt that their needs were either unmet (i.e., some care was needed but none was received) (22.5%), or only partially met (i.e., some care was received but was not sufficient) (22.5%). This perception of unmet needs stems from barriers to care such as long wait times for psychiatric services, and the lack of integration of community resources with mainstream health services. Other hindrances to health-seeking behavior for mental health include the cost of mental health services not covered by insurance plans, not having knowledge on how to connect to mental health resources, cultural and language barriers, and persistent stigma regarding mental health conditions. In some cases, the difficulty of seeking outpatient care for mental health leads to patients desperately going for care at emergency rooms and departments, thus further taxing resources at these facilities (Moroz et al., 2020).

Of particular concern in Canada are the numerous barriers to care and inequities that worsen the mental health status and overall health status of Indigenous Peoples. It has been estimated that 25% of the indigenous population in Canada experience substance use disorders, compared to 17% of the general population. Suicide rates among indigenous youth are also about six times higher than that of their non-indigenous counterparts. Moreover, Indigenous Peoples are found to have a life expectancy of 14 years less than most other Canadians. These adverse outcomes are rooted in intergenerational trauma and inequities from colonial policies, as well as non-inclusive policies that fail to address the socioeconomic determinants of health for indigenous groups. These determinants include poverty, unemployment, housing, and food insecurity due to lack of access or outright destruction of traditional food sources (Toth, 2022). Other factors that impact Indigenous Peoples' mental health and overall health status include increased exposure to occupational hazards, reduced opportunities for safe and economically rewarding employment, and Indigenous youth's limited access to education and skills training.

Racism and discrimination in the workplace has also been shown to negatively impact Indigenous Peoples, and thus contribute to mental health problems (Durand-Moreau et al., 2022).

Efforts to address these inequities and injustices against indigenous peoples with regard to health service delivery and access include the development of culturally safe models, tools, and approaches to healthcare. This entails collaborating with leaders and representatives from indigenous groups to working in partnership with provinces and territories, health system partners and educational institutions to further integrate learning on cultural safety in training for health professions, to integrate cultural and patient safety within the health system, and to advance anti- racism and cultural safety for all Indigenous People accessing health care services across systems. Access to mental health services, or other health services as a whole can be increased through urban clinics, and remote interventions for Indigenous Peoples living outside the cities (Toth, 2022). However, these interventions have faced limitations such as funding gaps as well as upheavals in the healthcare system during the COVID-19 pandemic. As a result, more Indigenous Peoples reported worse mental health outcomes and physical wellbeing during the pandemic, compared to non-Indigenous patients.

Communities off-reserve were less able to seek care, contributing to worsening chronic conditions and non-communicable diseases, as well as mental health conditions including but not limited to depression and anxiety. Fewer Indigenous patients were able to schedule mental health consults, while others experienced delays and cancellations in their appointments during the COVID-19 pandemic (Hahmann & Kumar, 2022).

Canada documented its first case of COVID-19 in January 2020, and community transmission was confirmed by 5 March 2020. The government adopted a decentralized approach to addressing the COVID-19 pandemic, in keeping with its federal political system and the semi- autonomy of its provinces. While this decentralization facilitated local participation in decision making for healthcare, there was a noted failure to implement efficient data sharing practices across jurisdictions, thus adversely affecting the agility of the health sector's response. Variations in local policies for quarantine and isolation led to failure to curb local transmission, thus necessitating most areas declaring a state of emergency by March 2020. Some provinces had limited access to tocilizumab, remdesivir, and ritonavir-nirmatrelvir and other key commodities, thus leading to rationing in the public health system and hospitals. As the pandemic evolved, failure to properly coordinate general vaccine guidelines led to each province or territory making its own vaccine eligibility plans, allocation, and mandates. Moreover, an ongoing shortage of healthcare workers has further limited the healthcare system's capacity to address the pandemic and led to poorer health outcomes in vulnerable populations such as nursing and long-term care facility residents (Bubela et al., 2023).

The COVID-19 pandemic resulted in operational shifts within the healthcare system, specifically in nursing and long-term care facilities which saw higher mortality rates compared to the general population. More of these facilities made changes to air purification and ventilation systems or converted areas to semi- private and private rooms. Administrative and procedural changes included regular testing of staff, screening of visitors, implementing strict hand hygiene protocols, and eventually ensuring that staff in these facilities received the COVID-19 vaccine. However, staffing shortages persisted, representing a gap for healthcare in this sector (Graham and Hosseini, 2022).

Outside of the healthcare sector, COVID-19 also impacted workplace patterns, specifically through the use of e-commerce in business transactions and operations. More businesses shifted to online platforms for the first time, while others reworked their business processes such as the ordering and shipping of goods. Despite initial setbacks such as the need for large capital to set up online platforms, many businesses opted for online operations as means of coping with health and economic restrictions arising from the pandemic (Asselin and Bilodeau, 2022). The shift to online modalities provides a promising venue for some workplace interventions, but also poses a challenge for fostering safe spaces and open communication in other workplace situations.

As Canada recovers from the COVID-19 pandemic, an important assessment for the restructuring of mental health service delivery was conducted to identify drivers of change and mental health scenarios. The "Future of Mental Health" report emphasizes the need to balance the following needs:

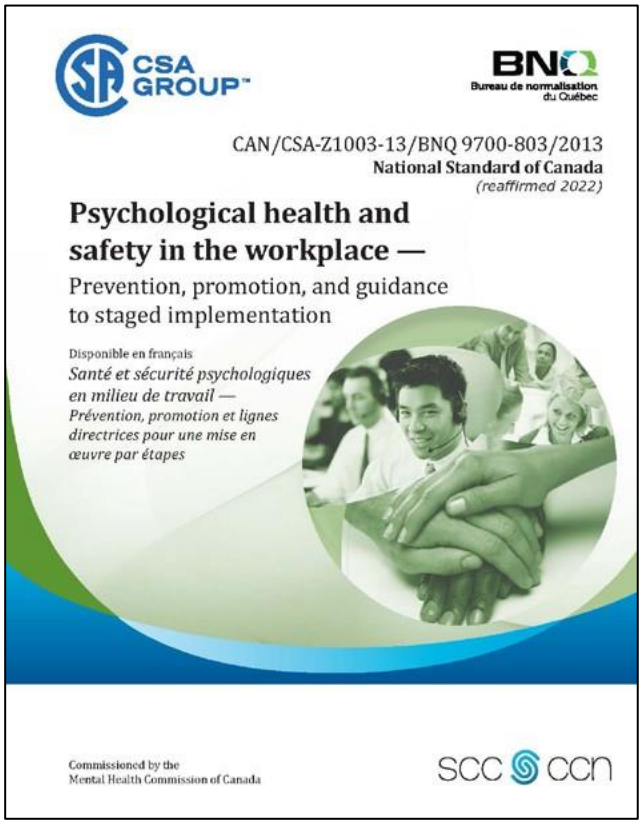
- A sliding scale between ongoing clinical emphasis/diagnosis-based healthcare and addressing social determinants of mental health
- Combining recovery from the pandemic with combating emerging variants
- Thus several scenarios should be considered by Canadian mental health system
- A return to the "access squeeze" of mental health services prior to the pandemic
- Increase in the models of the social delivery of healthcare in the context of continued recovery from the pandemic.
- Increased privatization of mental health services in the context of ongoing pandemic disruption due to new variants
- Increase in the models of the social delivery of healthcare in the context of persistent pandemic disruption.

These scenarios, or a situation set somewhere in between these, should take into account the capacity of healthcare workers to mentally cope with the evolution of the pandemic as well as sudden spikes and resurgences (Institute for Advancements in Mental Health, 2021).

Discussion of the good practices and facilitating factors

Best Practice: National Standard for Psychological Health and Safety — Psychological Health and Safety in the Workplace

The "National Standard of Canada for Psychological Health and Safety" was first published in 2013, with its latest reaffirmation in 2022. This voluntary standard is a guide to systematically develop a psychologically healthy and safe workplace, with the collaboration of employees and workplace leadership. It was developed by the Mental Health Commission of Canada with the participation of representatives from other public health agencies, worker organizations, and the academe.



Cover image of the National Standard for Psychological Health and Safety - Psychological Health and Safety in the Workplace.
Photo from the Mental Health Commission of Canada website

This standard is grounded on these guiding principles:

1. Legal requirements associated with psychologically healthy and safe workplaces applicable to the organization to be identified and complied with as a minimum standard of practice.
2. Psychological health and safety is a shared responsibility among all workplace stakeholders and commensurate with the authority of the stakeholder;
3. The workplace is based on mutually respectful relationships among the organization, its management, its workers, and worker representatives, which includes maintaining the confidentiality of sensitive information; Individuals have a responsibility towards their own health and behavior.
4. A demonstrated and visible commitment by senior management for the development and sustainability of a psychologically healthy and safe workplace.
5. Active participation with all workplace stakeholders.
6. Organizational decision making incorporating psychological health and safety in the processes.
7. A primary focus on psychological health, safety, awareness, and promotion as well as the development of knowledge and skills for those persons managing work arrangements, organization, processes, and/or people.

Psychological safety in this framework is defined as: *"the absence of harm and/or threat of harm to mental well-being that a worker might experience"*. A psychologically healthy and safe workplace is defined as: *"a workplace that promotes workers' psychological well-being and actively works to prevent harm to worker psychological health including in negligent, reckless, or intentional ways."*

This standard uses the following pillars to outline the functions of a psychological health and safety system:

- Prevention of harm (the psychological safety of employees),
- Promotion of health (maintaining and promoting psychological health),
- Resolution of incidents or concerns.

From a managerial perspective, adopting a paradigm oriented towards psychological health and safety in the workplace would facilitate risk mitigation, cost effectiveness, improved recruitment and retention of workers, and ultimately organizational excellence and sustainability. These factors would incentivize employers, human resource departments, and other leadership to adopt this standard.

From an occupational health or public health perspective, psychological safety in the workplace is considered a key foundation to ensure the success of health promotion endeavors and should become a norm in different industries. To ensure this psychological safety, basic factors such as human needs for security and physiological safety, belonging, social justice, self-worth, self-esteem, self-efficacy, accomplishment, and autonomy should be provided for in the environment.

Organizations and workplaces adopting this standard must come up with a psychological health and safety management system that is composed of the following elements: commitment, leadership, and participation.

(a) planning
(b) implementation
(c) evaluation and corrective action
(d) management review

As part of the planning component, workplaces must also undertake a risk assessment and mitigation process that considers psychological hazards in the environment. The risk mitigation process should include the following components:

(a) hazard identification;
(b) elimination of those hazards that can be eliminated;
(c) assessment for level of risk for hazards that cannot be eliminated;
(d) preventive and protective measures used to eliminate identified hazards and control risks; and

(e) a priority process reflecting the size, nature, and complexity of the hazard and risk, and, where possible, respecting the traditional hierarchy of risk control.

Assessment of hazards considers the following 14 factors (Canada Labour Congress, 2022), as seen in Table1.

Table 1: Factors for Hazard Assessment (Canada Labor Congress, 2022)

FACTOR	DESCRIPTION
Psychological support	A workplace where co-workers and supervisors are responsive and supportive of employees' psychological and mental health concerns.
Organizational culture	A workplace characterized by trust, honesty and fairness.
Clear leadership and expectations	A workplace with effective leadership and support that helps define roles of employees, appreciates their value, and appraises them of changes.
Civility and respect	A workplace where employees are respectful of human dignity and considerate in their interactions within the workplace and externally with customers/the public.
Psychological job demands	A workplace where the psychological demands of work or tasks are documented and assessed in conjunction with the physical demands of the job, as part of risk assessment and hazard reduction.
Growth and development	A workplace where employees receive encouragement and support in the development of their interpersonal, emotional and job skills.
Recognition and reward	A workplace where there is appropriate acknowledgement and appreciation of employees' efforts in a fair and timely manner.
Involvement and influence	A workplace where employees are included in discussions about how their work is done and how important decisions are made.
Workload management	A workplace where tasks and responsibilities can be accomplished successfully within the time available.
Engagement	A workplace where employees enjoy and feel connected to their work and where they feel motivated to do their job well.
Work/life balance	A workplace where there is recognition of the need for balance between the demands of work, family and personal life.
Psychological protection from violence, bullying, and harassment;	A workplace where employees feel able to put themselves on the line, ask questions, seek feedback, report mistakes and problems, or propose a new idea without fearing negative consequences to themselves, their job or their career.
Protection of physical safety	A workplace in which employees' psychological, as well as physical safety is protected from hazards and risks related to the worker's physical environment.
Other chronic stressors	These may be identified by workers or workers' unions.

Other important processes and activities outlined in this standard include:

- Preventive and protective measures to address the identified work-related hazards and risks. These include eliminating hazards altogether, putting in place engineering or administrative controls, use of personal protective equipment where applicable, response plans to hazard exposures, and resources for

workers experiencing mental health difficulties.

- Data collection and management systems for qualitative, quantitative, and mixed methods data including but not limited to the following: organizational policies, laws and other public directives, job descriptions, employee absenteeism and turnover, audit results, industry established best practices, and research.
- Plans to promote diversity and inclusion in the workplace, and to address workplace factors related to the psychological needs of different groups.
- Education, training, and competency building activities. These should also address critical event preparedness on both individual and organizational levels.
- Evaluation and corrective action that protects the privacy and confidentiality of affected employees and addresses non-conformance to this standard.
- Internal governance structures for implementing organizations.
- Setting objectives and targets for monitoring and evaluation
- Management review processes

This standard also presents models and schemes for implementation in workplaces of different scales/sizes. These workplace scenarios provide steps including problem recognition, policy statement and commitment, enlisting participation of employees/staff, planning and needs assessment with inputs from employees and stakeholders, implementation, evaluation and corrective actions, and finalizing with management review.

A staged implementation approach is advocated for workplaces with multiple locations, limited resources, and other practical considerations for psychological safety. This incremental approach has four main levels:

- Awareness/readiness/preparedness (in strategic plan)
- Needs/current state assessment
- Setting goals and objectives to develop the implementation plan.
- Plan implementation

This is separate from securing leadership commitment, which also takes place over four steps:

- Leveraging existing resources for planning and implementation
- Engaging leadership from labor and management
- Embedding across the organization through action items across stages such as recruiting and hiring, orientation and training, performance management, promotion, and termination.
- Closing the accountability loop by developing processes for monitoring relevant outcomes, and continually improving processes

These four steps are meant to concretize leaders' commitment to creating psychologically healthy and safe workplaces, without them seeing this task as overly onerous or a drain on extant resources. This standard is presented not only as a public or occupational health necessity, but as a best practice to promote productivity and develop the capacities and skills of employees and leaders.

A chief facilitating factor for this standard is the overarching commitment to mental health in different settings, as shown by the Canada Health Act and related policies more specifically for mental health such as "Changing Directions, Changing Lives". The recognition and reaffirmation of the workplace as a venue and determinant for psychological health and safety shows the importance of this standard for occupational health promotion and mental health as a whole, and provide legal footing for such workplace interventions. Canada's standard for psychological safety in the workplace complements other directives such as the Federal Public Service Workplace Mental Health Strategy and The Federal Framework for Suicide Prevention Act by setting the stage for mental health promotion efforts and providing blueprints for organizations to operationalize the tenets of public strategies for mental health. Furthermore, this public sector commitment to mental health in the workplace also incentivizes private workplaces to voluntarily adapt this standard.

A second facilitating factor is the presence of public and private resources that may be tapped for employees' mental health. Companies and organizations may provide information to their employees about availing mental health care in the public system or collaborate with private providers to cover employees' mental health needs as part of workplace benefits. Organizations may also expand employees' healthcare insurance coverage to

accommodate preventive mental health services as well as interventions for critical events. Partnerships with private providers for healthcare or insurance coverage would help increase employees' opportunities to seek timely mental health care, and further reduce barriers to health-seeking behavior by reducing out of pocket spending, eliminating or reducing the need for long waitlists to see providers, and directly providing information on mental health resources. Ultimately, these partnerships would also help reduce the burden on the public mental health system, especially for emergency mental health care and outpatient services on the primary care level.

A third facilitating factor is the presence of community and government-wide commitments and mechanisms to rectify racial and socioeconomic inequities on different levels. This would facilitate plans for diversity in workplaces and support the mental health of vulnerable groups such as Indigenous Peoples.

These mechanisms would also form the basis for preventive and corrective actions, education and capacity building measures, and enlisting the active participation of employees for mental health.

A fourth facilitating factor is the emphasis on building a workplace culture based on respect and civility, as opposed to outlining specific behaviors to achieve this standard. This factor allows for the standard to be adapted by a wide range of workplaces, and for leaders to set benchmarks that are more appropriate for their employees. This thrust of culture building also allows for the sustainability of the psychologically healthy and safe workplace, since this would allow for the organic growth and ownership of workplace practices, and for newer employees to imbibe this positive culture as they are integrated into their teams and company hierarchies.

A fifth facilitating factor is the shift of some business processes in Canada to e-business or digital platforms, representing the increased acceptance and usage of technology by employees in business set ups. These virtual office set-ups can also be used to cascade psychological health and safety communications to teams and build a positive company culture even over distances.

A sixth facilitating factor, internal to the standard itself, is its emphasis on monitoring and evaluation, as well as managerial review. These practices are vital in pinpointing areas for further improvement in implementing this standard and developing plans for correction. Furthermore, review of best practices can also highlight possible innovations that can be shared to other workplaces or for future reaffirmations of the standard. Monitoring and evaluation also helps employees with benchmarking, and thus to have a more concrete grasp as to how to better align their behaviors and office practices to achieve the goal of psychological health and safety in the workplace.

Relationship to Healthcare Workers and Providers

The "National Standard for Psychological Health and Safety in the Workplace" will have a big effect on the workplaces of people who work in healthcare. Healthcare settings can be very stressful and demanding, and putting this standard into place can make a difference in the wellbeing of healthcare workers. This initiative relates to the workplaces of healthcare workers given that the nature of their jobs, people who work in health care are often under a lot of stress and emotional strain. The focus of the standard on promoting mental health helps healthcare workers directly by addressing things that can lead to burnout, compassion fatigue, and other mental health problems that are common in the field.

The initiative stresses how important it is for employees and those in charge of the workplace to work together. It is important for patient care that different healthcare professionals can talk to each other and work together well. Implementing the standard can lead to better teamwork and communication, less conflict at work, and better outcomes for patients.

People who work in healthcare are exposed to many psychological risks, such as traumatic events and high-stress situations. The risk assessment and mitigation process outlined in the initiative can help healthcare organizations find and deal with these risks so that they have less of an effect on the mental health of healthcare workers.

Education and training: Healthcare workers need ongoing education and training to stay up to date on best practices and deal with the demands of their jobs. The standard encourages activities that help with education, training, and building skills, which are all important for the development of healthcare professionals over time.

Healthcare organizations can work with mental health providers to make sure their employees can get mental health care. The fact that partnerships with private providers are mentioned in the standard is in line with efforts to give healthcare workers full mental health support.

The "National Standard for Psychological Health and Safety in the Workplace" gives a framework that is very useful in healthcare settings. Implementing this standard can improve the mental health of healthcare workers, improve how well patients are cared for, and make healthcare organizations more supportive and welcoming places to work.

Insights and Lessons

For Government Agencies

- Expand platforms and venues for mental health promotion and prevention in the community setting, including schools and workplaces.
- Invest in training and support of healthcare workers for mental health, especially in rural areas.
- Explore recruitment, deployment, and retention programs for the mental health workforce in underserved provinces.
- Strengthen referral systems and networks for mental health services between the public and private sectors.
- Enhance public messaging on normalizing mental health seeking behavior, suicide prevention and management of substance abuse disorders.
- Create and implement policies to improve delivery of essential services for health, education, livelihood, and food security to indigenous peoples and other outlying communities.

For Healthcare Providers and Institutions

- Provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services.
- Strengthen referral systems and networks for mental health services between the public and private sectors.
- Engage in mental health outreach or community engagement programs for underserved communities such as indigenous peoples.
- Provide mandatory training in cultural sensitivity and communication to healthcare workers.
- Promote diversity in healthcare teams by training and engaging healthcare practitioners from indigenous groups.

For Workplaces

- Engage with public and private practitioners to readily provide mental health services to employees, as well as broaden health insurance coverage.
- Promote diversity in the workplace by training and engaging employees from indigenous groups.
- Provide mandatory training in cultural sensitivity and communication to employees and leadership for a psychologically healthy and safe workplace.
- Cascade/disseminate important mental health information to employees, especially messaging to reduce stigma and promote health seeking behavior.

For Private Sector Organizations

- Engage with the healthcare sector to provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services.
- Conduct mental health outreach or community engagement and advocacy programs in the community setting, especially to indigenous peoples.

CHILE

Introduction of the member economy's healthcare delivery

Chile is a South American member economy found to be closest to Antarctica. Its population is estimated to be approximately 18.5 million as of 2023, 88.9% of which are white and non-indigenous, 9.1% Mapuche, 0.7% Aymara, and 1.3% are either unspecified or from other indigenous groups. (Chile — the World Factbook, 2023). It is now governed by a presidential republic, following a 16-year military dictatorship until 1990.

Chile has a dual healthcare system, with a public system known as the *Fondo Nacional de Salud* (FONASA) and a private system known as *Instituciones de Salud Previsional* (ISAPREs) (Oliveira, 2021). A 7% payroll tax funds FONASA and covers about 70% of the population. It offers a basic package of benefits, including preventive, inpatient, and outpatient care. Patients can choose their healthcare providers but may have to wait longer for appointments and treatment in public hospitals.

In contrast, ISAPREs are private health insurance companies offering more comprehensive benefits than FONASA. Premiums paid by individuals and employers fund them. Patients who join an ISAPRE can usually get faster access to appointments and treatment, but they may have to pay higher premiums.

The Chilean government has been working to improve the quality and accessibility of healthcare in recent years. Its healthcare has undergone reforms since 2000 and has since implemented universal health coverage for its citizens as defined by their Regime of Explicit Guarantees in Health Law or Garantías Explicitas en Salud (GES) in 2005, (Caneo and Calderon, 2017). The GES program has successfully reduced waiting times for specific procedures and improved the quality of care for some diseases, supported by other laws such as the Health Authority and Management, Private Health, and Financing Government Expenditure Laws (Bastias et al., 2008).

Recently, the Chilean government has increased investment in its public system, including constructing new hospitals and clinics, reducing waiting times for some procedures, and improving the quality of its public system. The public system now has a new payment system designed to reward hospitals and clinics for providing high-quality care (Results for Development Institute, 2014). They have also expanded the GES program to cover more diseases and procedures, ensuring all citizens have access to essential health services.

Other key changes in Chilean healthcare is the increased focus on prevention, with the implementation of programs to promote healthy lifestyles and prevent chronic diseases, and improved access to mental health care (Cabieses et al., 2022).

These changes have helped to improve the quality and accessibility of healthcare in Chile. However, there are still challenges facing the system. One challenge is the high cost of healthcare. The Chilean government spends about 9% of its GDP on healthcare, one of Latin America's highest rates (Cerda et al., 2022). Another challenge is the growing inequality in access to healthcare. People who are members of ISAPREs tend to have better access to healthcare than people whom FONASA covers (Roman-Urrestarazu et al., 2018).

The Chilean government is continuing to work to improve the healthcare system. The government is investing in new hospitals and clinics and working to improve the quality of care in the public system. The government is also considering introducing a single-payer healthcare system, which would provide universal coverage and reduce the cost of healthcare (Bossert and Dintrans, 2020).

Chile's healthcare delivery system is a work in progress but has made noteworthy progress recently. The government is committed to improving the system and providing universal coverage to all citizens.

Backgrounder or situation before the introduction of the best practice

Since the end of the military dictatorship in the Republic of Chile in 1990, there have been cases of civil unrest. The first case of COVID-19 in Chile was identified in March 2020, a few months after what was considered one of the biggest episodes of civil unrest, in the form of massive protests due to the widening social inequalities faced by its citizens (Caqueo-Urizar, 2021). There was increasing distrust, affecting the credibility of key governmental institutions, law enforcement and the military, including the Catholic Church.

To address the COVID-19 pandemic, Chile mainly employed large scale COVID-19 testing, and quarantine measures to active COVID-19 cases, complemented by the swift implementation of vaccinations programs on December 2020 backed by their already strong public immunization program, and little anti-vaccine sentiment from its people (Farzan, 2021). Although no government-wide lockdown measures were implemented like in Argentina and Peru (Nessi, 2020), it employed dynamic quarantine in Santiago, its capital, that was adjusted accordingly as the situation progressed; and local lockdowns in other cities and neighborhoods.

The implementation of mental health services in Chile can be traced back to the Caracas Declaration in the 1950's (Minoletti et al., 2012). Their health system included at least 4 mental hospitals as of late 1960s. From the 1950s and 1960s, early attempts in implementing community-based mental health services and formulation of a member economy-wide mental health program occurred.

Though this may be the case, it was in 1990 where psychiatric service modernization started in Latin America, marked by another Declaration of Caracas (Mundt et al., 2022). Since then, several government-wide mental health plans (NMHPs) were implemented, guided by principles of rehabilitation and community care for those with psychiatric disabilities, decentralized health services networks, as well as deinstitutionalization through resource reallocation from psychiatric hospitals to general hospitals. Over time, a decrease in the rate of long- stay and short-stay beds in psychiatric hospitals was reduced by 90% and 26%, respectively, with an increase in psychiatric beds by 122% (Mundt et al., 2022) associates these changes in the rates of mental health services with the NMHPs implemented in 1993 and 2000, with the 2000 plan focusing on the following priority areas:

- Promotion and Prevention in Mental Health
- Attention Deficit Hyperactivity Disorder (ADHD) in Children and Adolescents
- Mental Conditions Associated with Violence
- Depression
- Schizophrenia
- Drug and Alcohol Abuse and Dependence
- Alzheimer's Disease and other dementias

To implement these plans, the following strategies were implemented (Minoletti et al., 2005):

- Public Sector Fund Allocation for Mental Health
- Comprehensive Network of Community-based services
- Stakeholder participation in the Planning and Evaluation of Mental Health Services
- Augmentation of Mental Health Expertise in Primary Care
- Comprehensive Program for the Treatment of Depression
- Decentralized Ambulatory Secondary Care System
- Transformation in the Inpatient Care Structure
- Human Rights Protection for Persons with Mental Disorders
- Specification of Needed Inputs to Calculate Average Intervention Costs for each Priority Area

This reduction of psychiatric beds is coupled with other factors, such as the shift towards community-based mental health services, as observed for Europe and the Americas (Razzouk et al., 2012; Semrau et al., 2011). From all these, the strong public network of health facilities, along with the commitment to narrow the gap in treating mental disorders, strong advocacy, and conduct of epidemiological and services research in collaboration with the academe are nominated as key factors that have contributed to improving their mental health services. As for health service providers, it has been observed that there was a reduction in sick leaves due to depression, anxiety, or acute stress reaction, possibly alluding to either their resilience, or so as to not compromise of frontline health service providers (Olivares-Tirado and Zanga-Pizzaro, 2023). In any case, the mental health care of children, adolescents, and native peoples, as well as the promotion and prevention of mental health, and the inclusion of persons with mental disability to society still have unmet needs (Minoletti et al., 2012).

Discussion of the good practices and facilitating factors

Best Practice: Mental Health and Psychosocial Support in Disaster Risk Management that references GMIH, UN Convention on Rights of Persons with Disabilities, and WHO Roadmap for National Mental Health Reform 2012-2022.

Chile's initiative called Saludable Mente or A Healthy Mind, a comprehensive wellness and mental health plan by their Ministry of Health, includes a section on the "General Considerations for the Care of the Mental Health of Workers and Workers of the Health Sector in the Context of COVID-19" as an evidence-based guideline for medical institutions such as hospitals, and family health centers among others to help face the challenges brought about by COVID-19 in terms of the mental wellbeing of health workers. The document enumerates the following goals:

- To provide considerations and recommendations for the development and updating of plans aimed at mental health care for workers in the health sector in the context the COVID-19 pandemic
- To publicize actions, experiences and intervention models so that health establishments develop and update an action plan for the promotion of mental health and the protection of the wellbeing of workers; and
- To provide tools to provide the sustainability and deepening of the actions proposed in the plans in course

The document is intended for managers in the health sector, as well as team leaders and those involved in human resources. The said considerations apply to health workers of both public and private health facilities in multiple contexts.

Saludable Mente contact page.
Photo from the Gobierno de Chile website

Starting off with a systematic review of available literature on the COVID-19 and its impact on the mental health of healthcare workers, their findings suggest that approximately 62.5% of health workers exposed to COVID-19 reported symptoms such as fear, insomnia, anxiety, and burnout (De Pablo et al., 2020). To add, their findings suggest that although this is the case, health workers were less likely to experience post-traumatic stress symptoms (20.7%) compared to the general population (32.5%) that often appear only a few months after a traumatic event. The systematic review also enumerated risk factors that affect the mental health of healthcare workers during the pandemic such as:

- **Factors related to working conditions**
  - Lack of experience
  - Increased contact with patients
  - Part-time work
- **Organizational and Social Factors**
  - Inadequate training
  - Lack of organizational support
  - Lack of compensation
  - Social Stigma
  - Socioeconomic Status
  - Spending time watching news related to COVID-19
- **Factors related to sociodemographic characteristics**
  - Sex (Women are more vulnerable)
  - Age (Younger people are more vulnerable)
  - Parents
  - Social isolation due to prolonged quarantine
  - Fear of infecting the family
  - Having a family member with COVID
  - Pre-existing psychological or physical illness

They have also enumerated protective factors that healthcare workers may have such as clinical experience, having frequent short breaks between tasks, adequate rest, support from family and working environment, communication with other staff, as well as access to psychological interventions. Aside from these, other factors such as adequate training, trust in the preventive measures, and access to personal protective equipment (PPE) were also mentioned.

Of the six interventions evaluated in their systematic review, only two were evaluated to be effective, which were the Battle Buddies Intervention (Albott et al., 2020) and Homerton Covid Psychological Support (Cole et al., 2020), both of which involved supporting the basic needs at the individual level, as well as support at the organizational level.

The second part of the document provides guidelines for developing a mental health program with the following enabling conditions/guiding principles:

- Active participation of all the workers in the institution
- Clarity of duties of each member of the organization
- Consideration of specific needs of the different groups
- Constant monitoring and evaluation, and change management
- Need for education, awareness, and communication

Aside from these, they have also enumerated the following key drivers for the success of the program:

- Creation of an Institutional Committee composed of professionals, experts in occupational health and safety, and external advisors
- Strategic alliance with Non-Government Organizations and the Academe

- Participation of stakeholders in identifying needs and proposing solutions
- Sustainability perspective aimed at monitoring, evaluating, and improving, and institutionalizing best practices

A dynamic and circular process is proposed, composed of the following startegies:

- **Communication Strategy**
  - Providing the key message that protecting the mental health of the workers is priority
  - Keeping multidirectional channels
- **Intervention Strategy**
  - Inclusion of stakeholders in the process
  - Relevance to the context and objectives proposed
- **Institutionalization of Change**
  - Integration to existing information systems
  - Inclusion of resolutions, guidelines, and ordinances
  - Monitoring & Evaluation
  - Continuous Quality Improvement
- **Sustaining Change**
  - Change Management
  - Shift to Preventive Mental Health Care

The document has also included findings from their qualitative, empirical, preliminary analysis on the mental health of healthcare workers between April and June 2020, carried out by the Accion Salud UDP of the Universidad Diego Portales, which described the negative effects in mental health they have experienced during the pandemic, such as emotional psychological effects (e.g., anguish, physical and emotional exhaustion), fear of infection, and fear of death and grief. They have also raised concerns on the changes in working conditions, feelings of hopelessness, and identity crisis as they brought about sudden change in the way they work, and the way they interact with their families and co-workers. To address these, they have emphasized the need for rest, recognition, and being heard and welcomed. They have also enumerated the following as key aspects for the protection of mental health:

- Recognition of the dimensions of work organization
- Recognition of the emotional impact brought about by emergencies
- The need to address specific needs of certain groups or departments
- Central role of leadership
- Destigmatization of suffering due to work
- Organizational justice
- Training of the youth

They have also recommended a set of minimum requirements to address the protection of the psychological health of healthcare workers during the pandemic. These basic recommendations emphasize personal care, and the following central elements in developing an action plan for the management of psychosocial risks in the workplace, especially in health facilities during the COVID-19 pandemic:

- **Health work and its specifics in situations of catastrophes, emergencies and pandemics (with emphasis on the satisfaction of an individual's basic needs)**
  - Emotionally draining nature of the job
  - Psychosocial occupational risks
  - Emotional labor and ethical suffering at work
  - Having to perform multiple jobs or tasks due to lack of resources or understaffing
  - Availability of PPE
  - The culture of "sacrifice", the "war" metaphor and "hero" figure
  - Promotion healthy coping strategies

- Addressing the dynamics of recognition
- The relevant role of the leadership
- Gender perspective

In addition, Elements of Collective Protection (EPC), or the group of elements and strategies to promote the mental wellbeing of teams were suggested:

(1) Recognition

- Recognizing that fear and uncertainty is real and normal
- Recognizing that failure is possible
- Appreciating efforts
- Respecting dedicated work hours and breaks

(2) Social Support

- Accepting emotions of the self and others without guilt or shame
- Preparing for intense emotions and sharing of fears
- Creating safe spaces and keeping in touch with families

(3) Role of leadership

- Maintaining clear and widely communicated work plan
- Communicate organizational measures to the team
- Accept that it is normal to commit mistakes even in emergency situations, and that recognizing and tackling them as a team is a responsible and constructive way to do it

(4) Meaning of work

- Vocation and commitment are not synonymous with working beyond capabilities
- It is okay to say "no", especially when experiencing burnout from demanding work
- "Heroes" must also set limits to take care of their own health

(5) Communication

- To not be afraid to put into words how they feel
- To keep in touch with loved ones
- To show concern and support to colleagues who may feel overwhelmed
- The uncertainty that can arise in a health alert situation can lead to anxiety and despair about the future. In these situations, it is helpful to identify the things we are certain about
  - "I know I can make mistakes"
  - "I know we will go through strong emotions"
  - "I know I am not solely responsible for another's life–it's a collective effort"
  - "I know that beneath the hero's facade, I am also a human being"
  - "I know I have my partner"
  - "I know my concerns can also be concerns of the team."

(6) Participatory Management by Various Working Groups

- Establish forums for the participation of all workers or their representatives in designing, implementing, and monitoring of actions related to their mental health
- Allow workers to also participate in the evaluation of these action, enabling their revision and improvement

(7) Institutional Communication and Education

- Institutional communication should always aim to reduce uncertainty and reinforce those institutional messages that are a priority. In this context, it is essential to effectively communicate the protocols and actions taken to prevent infection to help provide more certainty and reduce fear.
- Institutional communication gradually builds an "us" that allows employees to strengthen their collective identity, and in the current context, it is an opportunity to create a "discourse of care and protection of individuals".
- Communication is a two-way street, meaning it is crucial to constantly "listen to and address" the

institution's response. Is the message reaching the employees? Who is it reaching?

Diversifying communication strategies and channels is undoubtedly a necessary challenge today, requiring us to be creative.

- Not all institutional communication educates; often, we think that simply informing is enough to create a culture of safety and protection within the workplace. When the goal is education, such as proper use of personal protective equipment, the strategy should consider individual, team, and organizational elements. It may be relevant to focus communication strategies on specific groups based on their level of exposure risk.
- The communication should involve the top management of the healthcare establishment, so that employees feel the organization's support.
- Communication should be delivered through defined and regular channels that provide clear and timely information.

(8) Coordination of institutional actors

- In the current context, it is protective to create spaces for participation that involve all institutional actors, working together in a coordinated and regular manner with trade associations, leaders, and other key stakeholders.
- Empowering relevant social actors will be a strategy that allows for decision-making "while listening to the organization".

Some recommendations for those who support healthcare workers:

- Don't forget that you are also a healthcare worker and will be emotionally affected by your work. Therefore, seek the necessary support and emotional care for yourself as well.
- Remember that your role is primarily to develop strategies that help minimize the impact of the current context on the mental health of healthcare workers. However, this impact is not solely your responsibility, and it cannot be reduced to zero; it will have significant consequences.

The last two sections of the document narrate the initiatives and experiences for healthcare workers developed by the Health Services, and with collaborating with academic institutions. These initiatives they've implemented were divided into the following themes:

(1) Prevention and Mental Health Care

- Design, implement, and monitor stress and burnout prevention and management activities for employees of healthcare teams in health facilities
- Workshops for emotional expression and support in the field, primarily for clinical teams on the frontlines
- Psychological first aid consultations and psychosocial counseling for employees who need it through video conferencing.

(2) Accompaniment and Support for Confirmed and Quarantined Employees

- Keep information on confirmed cases, recoveries, hospitalizations, and preventive quarantines of employees updated.
- Contact employees via phone, WhatsApp, home visits, or other means to gather information about specific health status, diagnosis, progress, and recovery, among other aspects.
- Carry out support on a daily basis and through phone calls to understand the health status of affected individuals.
- Timely referral of employees in quarantine and preventive quarantine to a psychologist or psychiatrist based on the identified need.
- Support and monitor situation of former or retired employees.
- Economic support actions by providing benefits to employees affected by the pandemic such as gift cards.
- Provide reassurance and financial support to the family or beneficiaries in the event of death of an employee due to COVID-19

(3) Strengthening a good working environment

- Conduct specific interventions for work teams that request support in the context of COVID-19
- Launch digital campaigns promoting Good Labor Relations and preventing workplace violence during the pandemic
- Provide telephone coaching to leadership teams that require guidance in resolving issues arising in the workplace due to COVID-19

(4) Reconciliation of family, personal, and work life

- Gather data about reconciliation tensions arising in the context of COVID-19 and implement psychosocial interview to identify them
- Monitor the need for employees to use childcare facilities
- Conduct virtual interviews to provide support and guidance to families
- Design activities for emotional support and containment for children and their families
- Provide wards for employees who have tested positive and those who care for the confirmed cases

(5) Remote work measures

- Provide basic protective equipment such as gloves, masks, and hand sanitizers to employees who need them
- Provide employees with knowledge about the proper use of personal protective equipment (PPE) and the necessary measures to prevent infection through campaigns and training activities

(6) Employee Health

- Send videos on ergonomics in the workplace
- Coordinate and execute virtual health breaks and distance learning courses in leadership and mental health crisis management
- Provide campaigns, educational and informative audiovisual materials on self-care and mutual care recommendations, healthy coping styles, and protocols for treating employees with COVID-19 symptoms and subsequent referral for Polymerase Chain Reaction (PCR) testing

As for those developed with academic institutions, the following two protocols were for promoting and protecting the mental health of healthcare workers in the context of the COVID-19 pandemic, which are:

(1) "Safe Place": A protocol for operational continuity in caring for personnel during a crisis, Pontificia Universidad Catolica Chile

- Based on ISO 22303, WHO Recommendations, and a psychological support model by Figueroa et al. (2010)
- Organizational and institutional guidelines for group and individual care, through incremental phases of complexity depending on the mental health status of the staff
- Provision of physical space for emotional support, with video guide on practicing diaphragmatic breathing, psychoeducation on emotional reactions and crises, as well as online interventions with audiovisual materials for relaxation exercises and psychoeducational content

(2) "Acción Salud UDP": Intervention devices for protecting the psychological health of healthcare workers during the COVID-19 pandemic, Universidad Diego Portales

- Five specific actions
  - Communication Campaign for the promotion of mental health among healthcare workers
  - Crisis Intervention through support and containment devices for healthcare workers facing critical situations
  - Psychosocial Work Clinics that facilitate collective discussions about work in healthcare, release of emotional stress, sharing of daily experiences, and seeking of ethical and technical agreements regarding the work organization
  - Workshops with Middle Management

- Support and accompaniment spaces for the directors and deputy of the health institution

Insights and Lessons

All these developed protocols, guidelines, and initial analyses are suggested for implementing a program to support the wellbeing of healthcare workers in medical institutions as what they did for Chile. Not all items may apply and can be modified depending on the needs of the institution. These guidelines can also be adapted and modified in preparation for other disasters. It is still recommended that a mental healthcare program is complemented by strong leadership, open communication, timely education, and supportive work settings.

JAPAN

Introduction of the member economy's healthcare delivery

Japan is a prosperous archipelagic member economy situated in East Asia. It is also a member of the economically and geopolitically powerful G20. As of 2022, Japan had a population of about 124.49 million, representing a decrease by over half a million individuals from the previous year. Japan has among the lowest birth rates worldwide, combined with high life expectancies. Thus a major concern for Japan's economy and social services is the rapidly aging population, which lacks a sustainable younger workforce to sustain it (Yeung and Karasawa, 2023). Japan has been run by a parliament with a constitutional monarchy since 1947, with frequent elections for the upper and lower houses (Japan Health Policy Now, n.d.).

Japan's first iteration of its Health Insurance Act was implemented in 1922, in response to the labor sector's reforms toward protection of workers in case of occupation-related injury. The present public health insurance program utilizes three schemes: an employment-based health insurance system, a residence-based "National Health Insurance" system, and a specific medical insurance system for all residents aged 75 and over. These publicly funded programs have helped facilitate Coverage, further supported by legislation such as the "National Insurance Law" of 1958 and the 1982 "Public Aid for the Aged Act". This coverage allows residents to avail of care in public as well as private facilities, with the latter accounting for 70% of all hospitals in the member economy (Japan Health Policy Now, n.d.).

To some degree there is decentralization in Japan's healthcare system, since each prefecture has the mandate to make its own healthcare "vision", as well as exercise regulatory powers such as hospital inspections and handling concerns related to patient safety. Furthermore, patients have the freedom to choose their own primary health physicians and specialists. They are not assigned to practitioners based on area of residence. A fee-for-service schedule is used for primary care services as well as for specialist care. A particular challenge in Japan is providing long- term care for the elderly in different settings such as home care and respite care, as well as in long term care facilities and hospice. Most of this care is provided by private organizations, including for-profit practitioners and non-profit organizations (The Commonwealth Fund, 2023).

Much of Japan's disease burden is related to NCDs, which account for half of mortalities across all age groups. The top NCDs of concern in Japan are diabetes mellitus, hypertension, ischemic heart disease, heart failure, and cerebral infarction (Okada and Yasunaga, 2022). Government strategies for NCD prevention and control include the provision of a free healthcare service package including screening services for all individuals over the age of 40.

The following services are covered in this package: body height, weight, waist circumference, blood pressure, liver function tests (AST, ALT, γ-GTP), blood lipids and glucose, and urine markers. Information on medication use, smoking history, and self- reported symptoms are also included in this annual risk assessment. Patients are then classified into one of three risk categories, which will dictate the type of intervention and health guidance to be provided (Wu et al, 2017). Further efforts to address the problem of NCDs are integrated in the Health Japan 21 (HJ21) public health promotion program, which is set to begin its 3rd term in 2024. The HJ21 program has 79 targets in the following areas: nutrition and diet, physical activity and exercise, promotion of rest and mental health, smoking, alcohol use, dental and oral health, diabetes, cardiovascular disease, and cancer. HJ21's third term seeks to step up accomplishments in these target areas, while addressing changes brought about by the COVID- 19 pandemic. A notable facet of HJ21 is its inclusion of interventions to address the following infections associated with higher cancer risks: hepatitis B virus, hepatitis C virus, Helicobacter pylori, human papillomavirus (HPV), and human T-cell leukemia virus type 1 (HTLV-1). Addressing these, in addition to preventable metabolic and lifestyle factors, is seen as a key step to reducing the burden of NCDs in this member economy (Nomura, et al, 2022).

Specific successful health promotion interventions seen by the mid-term evaluation of HJ21's second term include the following:

- Increase in number of corporations in food industry that supply food product low in salt and fat.
- Increase in the number of food service facilities that plan, cook, and improve menus based on clients' nutritional needs.
- Reduction in the number of employees who work 60 hours or more per week.
- Eradication of under-aged drinking
- Eradication of alcohol consumption among pregnant women
- Reduction in percentage of adult smoking rate
- Reduction in overall suicide rate
- Increase in percentage of occupational settings where interventions for mental health are available.

However, there are still challenges in evaluating elderly with difficulties in cognitive function, as well as addressing specific mental health needs such as anxiety and mood disorders. These pose priority areas to be addressed in HJ21's next phase as well as in other health promotion initiatives (Tetsuji, 2020).

Backgrounder or situation before the introduction of the best practice

Mental health disorders have posed a significant public health problem in Japan even prior to the COVID-19 pandemic. It was estimated in 2017 that over 4.1 million people in Japan were living with mental health disorders, with over 3.8 million receiving outpatient treatment. In this same year, Japan also reported the highest number of persons hospitalized for mental health reasons per capita worldwide. About 302,000 in- patient admissions for mental health concerns were recorded, with patients averaging about 265.8 days staying in facilities (Japan Health Policy Now, n.d.). Mental disorders represent a loss of 1,333.3 disability adjusted life-years per 100,000 population. The age-standardized suicide rate in Japan for 2019 at 12.24 per 100,000 persons, showing a downward trend from 16.69 in 2013 and 13.75 in 2016 (World Health Organization, 2022).

Substance use disorders, particularly alcohol abuse and dependence, were the most prevalent mental health problems for both men and women in Japan, as seen in the World Mental Health Japan Survey Second conducted from 2010 to 2015. Mood disorders such as major depressive disorder were the second-most prevalent group of mental disorders in this study, followed by anxiety disorders. However, the true prevalence of some disorders such as bipolar mood disorders may actually be underreported due to difficulties in gathering data from respondents to help come to a diagnosis (Nishi et al, 2022). Japan also has documented mental health conditions such as hikikomori, which pertains to youth who become shut- ins at home in order to avoid social contact, and *karoshi*, which refers to deaths and suicides from overwork. These unique psychological phenomena show the complexity of Japanese psychology and sociology, and thus necessitate culturally specific mental health intervention and health promotion efforts (Statista Research Department, 2022).

Mental health in the workplace is a priority area for interventions in the Japanese healthcare system due to the impact of workplace stressors on productivity. It was estimated that 54.2% of workers surveyed had stress related to high workload. Other stressors included interpersonal troubles in the workplace as well as the content or nature of work. Long work hours alone were not found to be a strong predictor of workplace stress or poor mental health. Amotivation, or the lack of either intrinsic or extrinsic motivation in the workplace, was also associated with mental health problems (Kotera, 2022). Moreover, unhealthy behaviors such as working without breaks are reinforced as part of workplace culture and conformity. Economic instability, workplace culture, and stigma against mental health further complicate efforts to promote better mental health and wellbeing in the occupational setting (Pilla & Kuriansky, 2018).

Another particular concern in Japan is the mental health of children and adolescents. Despite doing well on physical health measures such as having a decreased prevalence of obesity, young people in Japan reported poorer mental well-being compared to youth in other prosperous economies. Out of 38 economies included in a 2018 report by UNICEF, Japanese children had the second worst-off rating in terms of mental wellbeing.

A notable finding was the suicide rate among adolescents, which was at an annual rate of 7.5 in 100,000 between 2013 to 2015. Other issues facing this age group included bullying, low self-esteem, and difficulty with family relationships and making friends. These factors and mental health stressors were expected to become more complicated during the COVID-19 pandemic, which will be discussed later in this report (Kyodo News, 2020).

Japan's aging population also necessitates that additional surveillance, prevention, and intervention be conducted to address the mental health concerns of the elderly. One concern is depression, especially among elderly adults who have become increasingly aware of their physical limitations, or who have a negative view towards aging. Other factors contributing to depression among the elderly include social isolation, living alone without spousal or family support, and life events such as the deaths of loved ones. Involvement in community and family activities has been found to help elderly adults adapt to the changes brought about by aging, and thus lead to a more positive view of the process (Okinaka, 2018).

To help address these mental health concerns on a policy level, Japan has implemented a law for mental health since 2013, with a distinct policy for suicide prevention implemented in 2017. A separate policy for child and adolescent mental health has also been in place since 2018. This has mandated significant government spending on mental health, which came up to 6.2% of total government health expenditure by 2020.

Yet even with this fiscal support, mental health services in Japan are short-staffed, with only 111.92 health workers to 100,000 population in 2020. This represents a downward trend from 117.08 in 2014, to 114.28 in 2017. The largest complement of these were social workers, numbering at 90,776 or at a ratio of 71.56 per 100,000 population. There was a total of 35,285 registered psychologists and 15,925 psychiatrists, resulting in ratios of 27.81 to 100,000 population and 12.55 per 100,000 population respectively. Human resources for mental health were distributed among 31,095 outpatient and 2,545 in-patient facilities. The great majority of outpatient facilities catered specifically to children and adolescents. Moreover, there were only 1,135 community-based facilities throughout Japan, leading to a ratio of 0.89 of these facilities per 100,000 population. This also represented a sharp decline from a ratio of 7.31 per 100,000 population in 2017, which was a marked improvement from 1.12 per 100,000 population in 2014 (World Health Organization, 2022).

Although there are limited community-based mental health facilities in Japan, health promotion and prevention for mental health are still conducted in different settings such as schools and workplaces. Examples of these include the "National Curriculum Standard" to be implemented in all government schools, the Stress Check Program in workplaces, and psychological first aid to be provided during times of disaster or calamity (World Health Organization, 2022). Drawing on culture- specific psychological concepts and protective factors such as *ikigai*, which can be broadly translated into "what makes life worth living", can also improve mental health outcomes. This has led Japanese policy for the elderly to align community and in-patient care to encourage older patients' *ikigai*, to help reduce psychological distress and improve subjective well-being (Okuzono et al, 2022).

Efforts to promote mental health through reducing social isolation and addressing factors specific to schools and workplaces were greatly challenged with the onset of the COVID-19 pandemic. Japan reported its first case of local transmission of the disease on 16 January 2020. Between this date and mid-2022, the healthcare system underwent seven waves of infections, and three declarations of a state of emergency. Although a massive vaccination campaign was undertaken by mid-2021, this was not sufficient to prevent later spikes in new infections with the Omicron variant. During states of emergency, the Japanese government emphasized non-compulsory mobility limitations, allocated additional resources to in-patient care of the severely ill, and stepped-up vaccination efforts for the elderly. Annual medical expenditure decreased in 2020, due to a drop in both in-patient and out- patient visits outside of patients seeking treatment for COVID-19. Hesitation to visit hospitals or seek medical care was seen in patients with other illnesses, thus delaying care and possibly worsening their conditions. Thus the healthcare system in Japan needs to find a way to manage or prevent future outbreaks of COVID-19, while ensuring continuous service delivery for other illnesses and conditions such as chronic conditions or NCDs. (Karako et al., 2022).

Loneliness was cited as one of the pressing mental health problems encountered in Japan during the COVID-19 pandemic. Over 41% of respondents in a survey were categorized as lonely during the first months of the pandemic. Loneliness was more evident in younger patients and those with socioeconomic disadvantages such as

low income or instability of finances or employment. It was also associated with poorer mental health outcomes such as anxiety or depressive symptoms. Thus it could be said that loneliness was a public health concern in Japan during the COVID-19 pandemic, and should continue to be addressed in mental health programs (Stickley & Ueda, 2022).

Schoolchildren and adolescents were among the hardest hit population groups in terms of mental health during the COVID-19 pandemic. A study showed an increase in manifestations of clinically significant behavioral problems such as emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, and a lack of prosocial behavior among children and adolescents during the pandemic. Young people already diagnosed with a neurodevelopmental disorder did not have a significantly higher incidence of emotional or behavioral problems, however it was acknowledged that the cumulative effect of neurodevelopmental disorders and the COVID-19 pandemic could be considered a risk factor for children and adolescent mental health. Interestingly, school closure alone was not a strong predictor of emotional or behavioral problems. It was suggested that other concurrent events such as child abuse, social deprivation, and other changes in lifestyle behaviors should also be considered as risk factors (Takahashi & Honda, 2021).

Among older people or the elderly, mental health problems were compounded with increased anxiety and fear surrounding COVID-19 due to their vulnerability to the virus. Elderly adults surveyed in the community setting had worsened depressed mood and apathy. More robust older adults were more impacted by the limitations on physical activity and mobility needed for disease control, and thus may have been more likely to feel depressed and apathetic. Moreover, the lack of screening systems for mental conditions in older adults may lead to underestimation of the continued effects of the pandemic such as post-traumatic stress disorder, and consequently delayed interventions for the mental health of the elderly population (Fujita, et al, 2021).

Discussion of the good practices and facilitating factors

Best Practice: Stress Check Program

Japan's Stress Check Program is an occupational health intervention that is part of operationalizing an amendment to the Industrial Safety and Health Law. This amendment was first implemented in 2015. One provision of this law mandates the use of the Stress Check Program at least once a year in all workplaces with 50 or more employees. This screening program has the following overarching strategy:

(1) Increasing employees' awareness of their own stress through periodic surveys and feedback as part of preventative measures against mental health problems.

(2) Analyzing pooled stress survey results to pinpoint areas for improvement in the workplace environment.

The Industrial Health and Safety Law was passed 2022 to oblige companies with more than 50 employees to have annual "status checks" for employees, which would cover more than 20 million employees domestically.

Photo by BLOOMBERG

(3) Screening employees who are at a high risk for mental health disorders, and subsequently referring them to a physician.

The Stress Check Program quantitatively measures the following domains: psychological stressors such as job demands, psychological and physiological stress reactions including but not limited to depression and anxiety, and social support in the workplace including support from colleagues and supervisors. Answers form the basis of individualized stress profiles for each employee, and these are used to determine which persons are "high stress". A rating of being "high stress" can be due to having a high level of stress reaction or having a moderate level of stress reaction but with high job stressors or low social support. Employees with these findings should be referred to a physician, who will then conduct further assessment to determine if these persons should be referred for further care under mental health practitioners.

Employers are also required to aggregate all employee stress profiles in batches of at least ten persons each in order to generate further analyses to pinpoint areas for workplace improvement. Provision of information on stress management is also a requirement of this program and should take into account recommendations from the physician who has been tasked to help with this program implementation (Kawakami and Tsutsumi, 2016).Although the government has provided long and short questionnaires for the Stress Check Program, employers may augment these forms with additional queries to better suit their work environment and circumstances, as may be the case in some high-stress workplaces. Such modifications or the use of completely new or customized tools are permitted provided that the aforementioned three domains are sufficiently covered. Employee participation in the program is voluntary, and employers cannot compel employees to answer questionnaires or to disclose the results of their stress profiles. Moreover, employees may choose to forego further psychological evaluation or referral based on the results of the Stress Check (Ogawa et al., n.d.).

The domains of this tool, particularly when using the recommended Brief Job Stress Questionnaire (BJSQ), correlate with other components and experiences surrounding employees' mental health. A strong correlation was found between the BJSQ and a self-assessment tool the Center for Epidemiological Studies- Depression scale (Spearman's rank correlation coefficient = 0.800, $p < 0.001$). BJSQ measurements of personal-level job satisfaction, workplace-level satisfaction and life satisfaction were also negatively correlated with voluntary retirement. BJSQ baseline assessment of physical burden, job satisfaction and support from superiors were also significantly related to deterioration in job adaptability within the next four years (Tsutsumi et al., 2020).

To assess the effectiveness of the Stress Check Program after two years of implementation, a retrospective cohort study in the form of a one-year follow up survey was conducted with 2,492 participants from various workplaces. Up to 82.9% of workplaces surveyed had implemented this Stress Check, with a participation rate of up to 78.0% of employees. About 78.3% of these workplaces conducted the team- based analysis or aggregation of the survey data. Participants who had previously participated in the Stress Check Program and who had also experienced positive changes in their workplaces had reduced psychological distress, but this effect size was small (Imamura et al., 2018).

Despite the mandated participation of all workplaces, another study found that employee engagement in this program varied across different industries. Employees in construction, transportation and postal services and those in small enterprises had higher participation rates compared to those in medical and welfare fields, or those employed in large enterprises of over 1,000 persons. Moreover, a higher engagement rate was reported for employees aged 30 years and above compared to their younger counterparts. Not all employees categorized as "high stress" followed through with the physician visit component of the program. Reasons for not requesting a physician interview included not receiving notice that this was a next step in the program, having no time for the visit, as well as employees' perception that they could handle their stress problems on their own (Tsutsumi et al., 2020). Furthermore, there were concerns raised by employees regarding the presence of a physician contracted by their workplaces, as well as the privacy of data being handled and transmitted from the Stress Check questionnaire itself (Kawakami and Tsutsumi, 2016).

The variability in reception of feedback in the form of stress profiles, as well as in participation and follow-through of participants weakens the strength of evidence showing that the survey and physician visit components

of the Stress Check program significantly reduce stress and improve employees' mental health. However, literature shows that improvement in workplace environments showed significant effects in stress reduction. Such improvements include providing stress management skills to employees at high risk, as well as education and training of managers (Kawakami and Tsutsumi, 2016).

Given these findings it is important to note that the Stress Check Program does not operate in a vacuum and should be combined with other occupational health interventions to provide the most benefit to workers' mental health. One measure related to the Stress Check Program is to decrease working hours, which is seen to most benefit female employees. This should be done in conjunction with identifying other factors that contribute to high stress (Ozawa et al., 2023). Even prior to the COVID-19 pandemic, Japan's Diet passed legislation to reform working hours, such as an overtime cap of 100 hours a month or 720 hours a year. Specific times for breaks or work intervals have also been set (Ito & Aruga, 2018). The reduction of working hours is important to reexamine and modify given the shifts in schedules and working patterns as a result of the COVID-19 pandemic.

Another measure related to the Stress Check Program is the implementation of policies to address bullying and harassment, which can erode workplace support and communication. Several types of these behaviors have been identified, such as:

- Power harassment involving higher status individuals bullying their subordinates.
- Sexual harassment
- Maternal harassment or pregnancy discrimination
- Moral harassment including mobbing or social exclusion.

Legislation has been put in place to help prevent these forms of harassment, particularly power harassment, in Japanese workplaces. In June 2020, the government enacted the Revised Labor Measures Comprehensive Promotion Act (The Power Harassment Prevention Law), which was immediately implemented for larger corporations and would extend to smaller corporations by 2022. This law mandates the implementation of help desks for employees, public call-outs for companies who do not improve their practices despite recommendations, and protection from professional repercussions for employees who report such abusive behavior. Moreover, sexual and maternity harassment are also forbidden under this law (Yuri, 2021).

Unfortunately, the onset of the COVID-19 pandemic poses additional challenges to the implementation and rollout of this legislation, due to the rise of COVID-19 related bullying in the workplace. A cohort study found that COVID-19 related bullying had a prevalence of about one in 15 workers. This bullying manifested as sarcastic comments, avoiding employees, accusing fellow employees of poor preparedness for the pandemic, being forced to self-isolate at home, and other forms of harassment. Particularly affected were manual workers and those with chronic illnesses or comorbidities who were deemed as more vulnerable to falling ill. However, employees with higher educational attainment were more sensitive to this type of bullying, possibly because of increased access to information about the pandemic. Healthcare workers were also targeted for COVID-19 bullying in the earlier phases of the pandemic (Iida et al., 2021).

The COVID-19 bullying experience shows some gaps in the Stress Check assessment, particularly the limitation of its contexts and domains. Another domain or area not considered in this intervention is ensuring physical safety in the workplace, which became a priority during the pandemic. A study showed that implementing workplace measures for infection control, accommodation of employees with more vulnerable health status, and temporary leave for infected individuals was related to reduction in psychological distress as well as improved work performance. However, the implementation of these measures and heightened awareness of COVID-19 infection was positively associated with increased fear about the pandemic, which may require another set of workplace mental health interventions to properly address (Sasaki et al, 2020).

Thus, it may be necessary to modify or update the Stress Check to consider the workplace evolution as a result of the COVID-19 pandemic, while taking into account newer legislation for workplaces and even the state of Japan's older workforce. The Stress Check may also need to be extended to account for workplaces and locations with less than 50 persons or employees, as part of capturing workplace modifications post pandemic as well as gathering occupational health data from micro-enterprises or even single proprietors.

Given the complexity of mental health problems in the Japanese context, a chief facilitating factor for the Stress Check Program and other related interventions would be the government's commitment to improving the mental health status of the citizens. This commitment is seen in successive legislation and policies for mental health, such as the stand-alone policies for suicide prevention and child/adolescent health. The presence of these policies shows the readiness of the government to pursue data-driven and culturally sensitive directives towards promoting mental health.

These policies also lend legal basis for mental health interventions in the workplace and community, empower practitioners who will be engaged in the Stress Check's physician interview component, and help facilitate referrals for employees needing specialist care for mental health concerns.

A second facilitating factor related to the government's commitment to mental health is the presence of other occupational health specific policies and strategies. These include but are not limited to the Revised Labor Measures Comprehensive Promotion Act and legislation to limit working hours. These policies support the domains being measured in the Stress Check Program and provide legal footing for psychosocial interventions to address workplace factors such as bullying and harassment. The Revised Labor Measures Comprehensive Promotion Act also may help increase employees' confidence in answering the Stress Check, since they may exercise candor in their replies without worrying about reprisals from employers if results turn out to be unfavorable. These occupational health policies go hand in hand with public directives to prevent adverse workplace outcomes such as *karoshi* or work related suicides.

A third facilitating factor for the Stress Check program and other mental health interventions is the coverage of universal healthcare in Japan. The presence of employment-based health insurance and residence-based health insurance helps ensure that employees will not fall in between the gaps or be missed in terms of financing of mental health services. The portability of health financing that allows individuals and even companies to select providers from the private sector provides additional flexibility and helps inspire confidence in the Stress Check program's assessments and interventions. The presence of primary health physicians to conduct the initial interviews and assessment in the workplace setting also supports the flexibility of the Stress Check's arrangements, and somewhat helps unload the mental healthcare system by reducing the number of patients who will undergo screening by specialists.

A fourth facilitating factor for the Stress Check and screening interventions in particular is Japan's comprehensive approach to NCDs. The mandatory provision of this NCD screening to employees aged over 40 presents an opportunity to administer the Stress Check or any other occupational health questionnaire and would also help facilitate individual physician follow-ups as a component of the Stress Check. Stress profiles and findings from physical examination and laboratory tests can be combined to provide more comprehensive individual recommendations for employees' mental and physical health. These data can also be used to come up with other recommendations for healthier workplaces to include factors such as diet, physical activity, and occupational hazard reduction, all of which would contribute to employees' psychological health as a whole.

A fifth facilitating factor that is particular to the Stress Check is its mandatory implementation in all workplaces while allowing for some measure of flexibility with screening and implementation of workplace interventions. While employees themselves may choose to avail of or opt out of screening, all employers are tasked to at least offer this option and act on any recommendations given as a result of analyzing the aggregated stress profiles. This mandatory administration of the Stress Check promotes widespread coverage of this intervention across most, if not all industries. Moreover, it compels employers to seek opportunities to improve their workplaces, or at least comply with occupational health standards. The flexibility given to employers to modify or even create a questionnaire also increases the acceptability of the Stress Check in various settings and gives employers the freedom to administer it at a preferred time and place, outsource the administration and screening to a third-party provider, and come up with solutions unique to their workplace's context.

A sixth facilitating factor related to the Stress Check itself is its high correlation with other measures of workplace wellness. Not only does this increase the Stress Check's actual utility in the workplace setting, it also allows for findings to be better triangulated with other tests should an employee choose to undergo further specialized psychological assessment. This factor can also help facilitate the employee referral process and allow for mental health practitioners to better address the concerns of patients being directed to them from workplaces.

A seventh facilitating factor for the Stress Check, especially its component for workplace improvement, is the strong emphasis in Japan on workplace dynamics and community support. Although workplace conformity and culture have been identified as factors for bullying and social exclusion, these can also be harnessed more positively to create and reinforce healthy changes in the workplace. Employers can draw upon employees' strong sense of camaraderie and connection to build a more supportive environment for high stress individuals and reduce the incidence of negative behaviors that contribute to stress and social isolation. Literature also shows that psychosocial interventions related to improving workplace dynamics through training for communication are among the most effective ways to reduce stressors and ensure better mental health outcomes, thus further strengthening the basis for workplaces to focus on these interventions in the Stress Check's third component.

An eighth facilitating factor for the Stress Check's component for workplace improvement is the concept of *ikigai*. *Ikigai* is not specific only to the elderly, but it can be applied to the economically productive sector. Using the Stress Check's recommendations to come up with solutions that also allow workers to nurture their respective *ikigai* may help reduce stress while increasing job satisfaction and productivity. This also presents an opportunity to build on employees' individual strengths and passions as part of capacity building, which could also boost leadership and innovation at work.

Although the Stress Check is in need of updating and has limited effectiveness especially from the employees' perspective, it remains to be a useful tool to help workplaces pinpoint areas for improvement of psychological health. It is a tried and tested means of gathering data that is unique to each workplace, and can be used to drive evidence-based recommendations.

Insights and Lessons

For Government Agencies

- Collaborate on the updating of the Stress Check and other mental health policies to account for societal changes due to the COVID-19 pandemic
- Integrate mental health screening, including the Stress Check, with screening for other conditions such as NCDs
- Invest in training and support of additional healthcare workers for mental health
- Enhance public messaging on normalizing mental health seeking behavior, suicide prevention and management of substance abuse disorders

For Healthcare Providers and Institutions

- Provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services
- Strengthen referral systems and networks for mental health services
- Engage in mental health outreach or community engagement programs for workplaces
- Collaborate with government agencies for the updating of the Stress Check and other screening tools and policies

For Workplaces

- Engage with public and private practitioners to readily provide mental health services to employees, as well as broaden health insurance coverage
- Normalize engagement with the Stress Check Program, including follow up with mental health professionals for employees categorized as "high stress"
- Cascade/disseminate important mental health information to employees, especially messaging to reduce stigma and promote health seeking behavior

For Private Sector Organizations

- Engage with the healthcare sector to provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services
- Collaborate with domestic agencies for the updating of the Stress Check and other screening tools and policies

MEXICO

Introduction of the member economy's healthcare delivery

Mexico, which is also officially known as the United Mexican States, is a federal republic in Latin America. The governance structure is divided into three levels: the member economy-wide federal government (Estado Federal), the intermediate or regional government (Estados Federales) that is composed of 31 states and the Federal District of Mexico City, and the local government (Municipios) that consists of 2,479 municipalities (Urban and Cities Platform, n.d).

Mexico's population is projected to be above 128.5 million as of 2023, making it the most populous Spanish-speaking APEC member economy. Most people are situated in urban areas such as Mexico City, Itzapalpa, and Ecatepec (United Nations, 2023). Mexico is also home to over 16 million indigenous persons from 68 ethnolinguistic groups, comprising over 15% of the total Mexican population. Many of these peoples face limited access to health and social services, as well as socioeconomic instability due to discrimination and marginalization (International Work Group for Indigenous Affairs, 2023).

Mexico's public health system coverage has two major components: employment-based social insurance coverage in the form of the The Mexican Social Insurance Institute (IMSS), and public health programs with financial protection for the uninsured and the informal sector. All Mexicans in the formal sector are enrolled in the IMSS, which is financed through employer contributions. A parallel system operates for federal government employees and those employed in the public oil company or the military. Various social welfare and protection schemes have been implemented for the informal sector and impoverished communities, such as Seguro Popular and its replacement the Institute for Health for Wellbeing (INSABI), the latter being a means of establishing a fully funded public health network. Mexico's public facilities, which cater to patients under the INSABI program, are under the purview of the Ministry of Health. The private sector also offers insurance coverage, covering around 8% of the population, many of whom are in the higher income brackets. Despite this variety of financial protection schemes, it has been estimated that close to 14% of the population were not enrolled in public insurance and were not likely to avail of private insurance (Block et al, 2020). Even in the portion of the population enrolled in public health insurance, effective access to services comes up only to 50%. This results in larger out-of-pocket payments, especially for medicine expenses. This highlights the need for better coordination across insurance providers to better ensure access and utilization of Mexico's public health services (Garcia-Diaz, 2022).

Primary care in Mexico is accessible through both the public and private sectors, through either fixed centers situated in the community, or through mobile brigades and other itinerant services. These facilities are points of access to preventive services such as vaccinations, as well as therapeutic services and consults. However, many of these units, especially those situated outside urban centers, do not have diagnostic services such as laboratory and imaging services. Emergency care capacity is also limited in most public health units.

Patients who are unable to regularly visit primary care clinics because of disability and debility may still access primary care services through the Physician in your Home Programme and other mobile services. The Physician in your Home Programme was initially piloted in Mexico City to provide care to elderly and patients with disabilities, but it has since been expanded to include pregnant women who are unable to avail of regular prenatal care, as well as terminally ill patients. In more recent years, telemedicine has also been utilized to provide outpatient services to remote communities.

Hospital care is also available from both the public and private sectors and is divided accordingly based on the levels of care being provided. Secondary hospitals offer general care, while more specialized care is available at tertiary hospitals. Public hospitals primarily cater to patients with fewer financial resources and to acute care cases. The public hospital system is complemented by the private system, which has more options for specialized and advanced care, which is more readily afforded by the well-off. Clinical research is also usually conducted in private tertiary hospitals (Block et al., 2020).

By 2020, Mexico's healthcare system had 13,495 outpatient clinics offering primary care services, as well as 1,510 public hospitals and 3,349 private hospitals. Despite the size and complexity of this network, there are still marked inequities in terms of distribution of facilities throughout Mexico. Urbanized areas such as Mexico City have a higher concentration of health facilities and specialized care, with Mexico City alone having 14.9% of available hospital beds in the member economy. Rural areas continue to remain underdeveloped due to limited government investment and lack of private sector regulation to ensure more equitable access to care (Singh & Venkateswaran, 2022).

Mexico's human resources for health are also hard pressed to meet the population's health needs. The physician to population ratio prior to the pandemic was at 2.4 per 1,000 persons, while for nurses and midwives it was at 2.8 per 1,000 persons (World Bank, 2019). This falls below the OECD recommendations for 3.8 physicians and 8.8 nurses per 1,000 population respectively.

The total number of health professionals in Mexico peaked to over 835,000 practitioners in 2020 due to additional personnel hired to support the COVID-19 control effort, but most of these were not retained throughout the pandemic. By the end of 2021, the total workforce for health had halved to over 407,000 practitioners, due to reasons such as the decreased need for personnel to handle COVID-19 related efforts, mortalities due to COVID-19 among healthcare workers, difficult working conditions during the pandemic, and decreased recertification especially among physicians (Statista Research Department, 2023).

Other social, economic, and historical factors beyond the capacity of Mexico's healthcare sector contribute to adverse health outcomes for the Mexican population. Youth situated in more marginalized urban centers have more years of life lost due to NCDs such as diabetes, ischemic heart disease, and cirrhosis, as well as due to violent causes such as homicide and vehicular accidents (González-Pérez & Vega- López, 2021). Access to healthcare is also negatively impacted by mistrust in the health system, which may stem from experiences with poor infrastructure and the quality of health service delivery. Thus, patients are more likely to turn to out-of-pocket expenditure and fundraising to cover catastrophic medical expenses. Alternatively, patients with adequate means are likely to turn to private health insurance with major service coverage (Martínez-Martínez & Rodríguez-Brito, 2020). A wider, multi-sectoral approach is needed to increase access and coverage of Mexico's healthcare, and to improve health outcomes for its most marginalized citizens.

Backgrounder or situation before the introduction of the best practice

Mexico has a significant disease burden from mental health, neurological, and substance abuse disorders (MNSS), which account for 34% of years lived in disability (PAHO, 2018). It is estimated that mental health disorders account for 1,653.5 disability adjusted life years per 100,000 population. The age-standardized suicide mortality rate was at 5.29 per 100,000 persons in 2019, representing a significant drop from 5.57 per 100,000 persons in 2016 (World Health Organization, 2022).

Developmental disorders such as autism make up 30% of the MNSS burden among children under 5, while conduct disorders and anxiety disorders become more prominent among older children and adolescents. Common disorders such as anxiety, depression, self-harm and somatic symptom disorder make up about 36% of the MNSS burden in adults over the age of 20, followed by substance use disorders, then more severe mental health disorders such as schizophrenia and bipolar mood disorders. Elderly adults have a significant burden from neurocognitive disorders such as Alzheimer's disease.

Among men, the top mental health concerns include alcohol use disorder, depressive disorders, self-harm, and suicide. Depressive disorders, Somatic symptom disorder with prominent pain, and anxiety disorders are among the top mental health concerns for women. On the whole, the burden of MNSS in Mexico outstrips the burden of communicable diseases, injuries, and some NCDs such as chronic respiratory diseases among adults (PAHO, 2018).

Mexico's unique and complex culture and history also shape the prevalence of mental health disorders as well as service delivery for mental health. Persons impacted by traumatic social events in Mexico, such as the family and relatives of individuals subject to enforced disappearances, have experienced severe emotional distress including suicidal thinking, anxiety, and role impairments. These bereaved persons articulated the need for psychosocial support while navigating legal processes and dealing with social fallout such as incrimination (Smid, et al, 2020). Other traumatic events such as the 2017 earthquake were also associated with a higher prevalence of post-traumatic stress disorder and depression among survivors in severely affected areas. A study showed the prevalence of severe PTSD to be at 11.9% and the prevalence of depression at 9.2% within the first 2 months following the earthquake that severely damaged Mexico City (Maya-Mondragón et al., 2019).

Increased levels of stress, anxiety, and depression have also been observed among some indigenous communities such as those in Oaxaca in southern Mexico. Language barriers and isolation pose significant barriers to providing timely assessment and treatment for mental health disorders, while other socioeconomic determinants such as poverty and low educational attainment negatively impact health seeking behavior. Cultural practices such as the reliance on traditional medicine make these communities vulnerable to health disparities but may also inform health promotion and mental health assessment practices (Pinzón-Pérez & Vásquez Santos, 2021).

Mexico's workforce for mental health is limited, with a total of 14.69 mental health workers per 100,000 population as of 2020. Psychologists make up the largest proportion of these, with a ratio of 5.86 per 100,000 population, followed by mental health nurses with a ratio of 4.86 per 100,000 population. There are significantly fewer psychiatrists, with a ratio of 1.56 per 100,000 population. Social workers are also few and far in between, with a ratio of 1.36 per 100,000 population. Few physicians specialize in child and adolescent psychiatry. The ratio of specialists per 100,000 population is only 0.39, while the total ratio of mental health workers specializing in the care of children and adolescents is 3.46 per 100,000 population (World Health Organization, 2022).

A total of 819 outpatient facilities for mental health were operational in Mexico, with 412 of them attached to a hospital. Around 785 facilities catered to children and adolescents' outpatient needs. In contrast, there were only 40 mental hospitals and 52 psychiatric units in general hospitals throughout Mexico. Only one of these was dedicated to children and adolescents. Mexico only had seven community residential facilities in the year 2020 (World Health Organization, 2022).

Mexico's responses to mental health problems involve several components such as policies, increasing access to care for communities, and programs for health promotion and prevention. Although no specific Mental Health Act or its equivalent has passed into law, the government has had a standalone mental health policy since 2019. Separate policies have also been articulated for child and adolescent mental health. A separate policy for suicide prevention was implemented in 2020 (World Health Organization, 2022).

Other policies include revisions to extant legislation, such as a proposed amendment to the Civil Code and Notary Public Act to end legal guardianship for people with disabilities and older persons. This proposal would uphold the autonomy and decision making of persons with disabilities, including mental health conditions, and provide access to supported decision making (Human Rights Watch, 2023).

An intervention to increase access to mental health care in Mexico is adapting a community health model to provide mental health services at three different levels. Comprehensive Mental Health Centers (CISAMEs) offer basic mental health in municipalities, while the next tier of care is available at community and general hospitals. More specialized care, including out-patient and in-patient services, is available at tertiary hospitals. However not all federal states have CISAMEs, or their equivalent, available at the community level. Even in localities with CISAMEs, access may be limited to residents due to transportation and distance constraints (Carmona-Huerta, 2021). As of 2020, there were a total of 414 community-based facilities, including CISAMEs, distributed throughout the territory. The ratio of these facilities to the population is only at 0.32 per 100,000 population (World Health Organization, 2022).

Community-based mental health services are also hindered by local financial constraints, including poor health insurance coverage on the part of patients, and unstable employee benefits for healthcare providers. Some

psychotropic medications were not covered by public funding, thus necessitating out of pocket payments. These expenses were difficult for the poorest patients to shoulder, thus compromising quality and continuity of care. Other hindrances to accessing community-based mental health services included limited operating hours of health facilities, inadequate time available for staff to properly assess patients due to high workload, language barriers, and limited knowledge about mental health resources. Stigma about mental health and seeking care also was prevalent, especially among male patients.

Some patients preferred to seek mental health care at hospitals, believing that the quality of services there would be better than those in the community setting (Martinez et al., 2017).

Mexico's health promotion programs for mental health included "*Lineamiento 2019 del componente vigilancia del desarrollo en la primera infancia*" geared towards early childhood development. Another program, "*Cuidar de Otros es cuidar de sí mismo. Herramientas de Soporte Socioemocional para la Educación en Contextos de Emergencia*", focused on providing psychosocial support in schools during emergencies. This was in line with the work of the Technical Working Group (*Grupo Técnico de Trabajo*) for mental health as part of disaster preparedness and response. Programs for reducing stigma or increasing mental health awareness were not being conducted on different levels of government as of 2020 (World Health Organization, 2022).

The COVID-19 pandemic put to test not only the strength of Mexico's program for mental health in disasters, but the capacity of the healthcare system as a whole. The first officially confirmed case of COVID-19 was documented in Mexico on 28 February 2020, although databases later recorded other individuals testing positive for the virus prior to this date. A widespread lockdown was implemented from 23 March to 20 May 2020. This was replaced by a system of alert levels to be applied to localities depending on case load. It was thought that the pandemic would peak early in Mexico; however, cases continued to rise to reach an initial peak by mid-July of 2020. The number of new cases slowly descended later in the year, but infections soon rose again by January 2021 to reach an incidence rate of 324 confirmed cases per 100,000 population. This devastating second peak was partially attributed to the late reinstatement of mobility restrictions and social distancing measures, thus allowing for massive transmission to occur during the holiday season (Sánchez-Talanquer, 2021).

Although Mexico had high compliance rates to personal protective measures such as mask wearing during the Influenza A AH1N1 pandemic, the same was not exhibited during the COVID-19 pandemic. During this pandemic, more people broke social isolation measures due to the need to remain employed, maintain routines, and provide for their families. Mask-wearing was still widespread, but a large segment of the population used homemade face masks or other alternatives providing less protection than a medically approved mask. These factors, combined with others such as overcrowding in the home or community setting, and the high prevalence of comorbidities, contributed to the disproportionately high mortality rate seen in Mexico (Ibarrola-Peña et al., 2022).

The member economy's epidemiological transition from one with high mortality rates due to infectious disease to one with a larger burden of disease from non-communicable diseases also accounted for the higher rates of severe or complicated COVID-19 disease. High body-mass index (BMI) and high fasting plasma glucose, two factors for death and disability in Mexico prior to the pandemic, were also associated with higher risks for mortality for COVID-19 in a study. (Sánchez-Talanquer, 2021).

The impact of COVID-19 on marginalized groups such as indigenous peoples was also devastating, with higher mortality observed in these groups. A study showed that the crude fatality rate per 1,000 person-weeks was 64.8% higher among indigenous than among non-indigenous people in Mexico, especially among individuals managed as out-patient. This disparity points to the significance of comorbidities, which are more prevalent among indigenous peoples, on COVID-19 patient outcomes, as well as the need to suggest or promote hospitalized management among patients with risk factors (Argoty-Pantoja et al., 2021).

Healthcare workers in Mexico were at high risk for contracting COVID-19, with increased mortality seen among those between 50 to 69 years of age. Although more nurses suffered from COVID-19 compared to other groups of healthcare workers, more mortalities were seen among physicians. Cases among healthcare workers eventually accounted for 10.1% of all COVID-19 cases in the member economy (Esquivel-Chirino, 2021). Mental health impacts on healthcare workers included depressive and anxiety symptoms and burnout. Stressors related

to these outcomes included fear of being infected and having family members infected. Resources to alleviate these stressors included the provisions of personal protective equipment, and support from family. Support from superiors was also a strong protective factor against the aforementioned stressors (Juárez-García et al, 2021). These findings show the need to provide psychosocial support for healthcare workers alongside provisions for their physical safety during events such as the COVID-19 pandemic.

Discussion of the good practices and facilitating factors

Best Practice: Governance Analytical Framework Study On Mexico's Policies

Addressing the threat of the COVID-19 pandemic in Mexico required strong leadership and governance in the public healthcare system. Although this system had been undergoing a program of reform to provide health services to residents without health insurance or social security, government efforts were rapidly diverted towards controlling the pandemic. Initial strategies included stopping the spread of local transmission through mobility restrictions and addressing the mental health impact on the general population as a result of these measures. This included issuing guidelines for mental health care and providing psychological first aid and crisis intervention.

The intended beneficiaries of these guidelines were the following:

- General population without COVID-19
- Patients with COVID-19 who are isolating at home
- Patients who have been hospitalized with COVID-19
- Relatives and caregivers of patients with COVID-19
- Healthcare workers and personnel

These guidelines for mental health care operated without a previously legislated Mental Health Act that would specifically pertain to the conduct of mental health services including the continuity of care for patients already diagnosed with mental health disorders prior to the pandemic. In the absence of such a legal framework, direction regarding strategies for mental health and other aspects of the COVID-19 response was provided by the following key actors (in no particular order):

- Federal Secretary of Health
- Secretary of Health (Northwest region)
- Secretary of Health (South Central region)
- Secretary of Health (Western region)
- Secretary of Health (North Central region)
- Institute of Security and Social Services of State Workers (Federal)
- Institute of Security and Social Services of State Workers (Northwest region)
- Institute of Security and Social Services of State Workers (Southeast region)

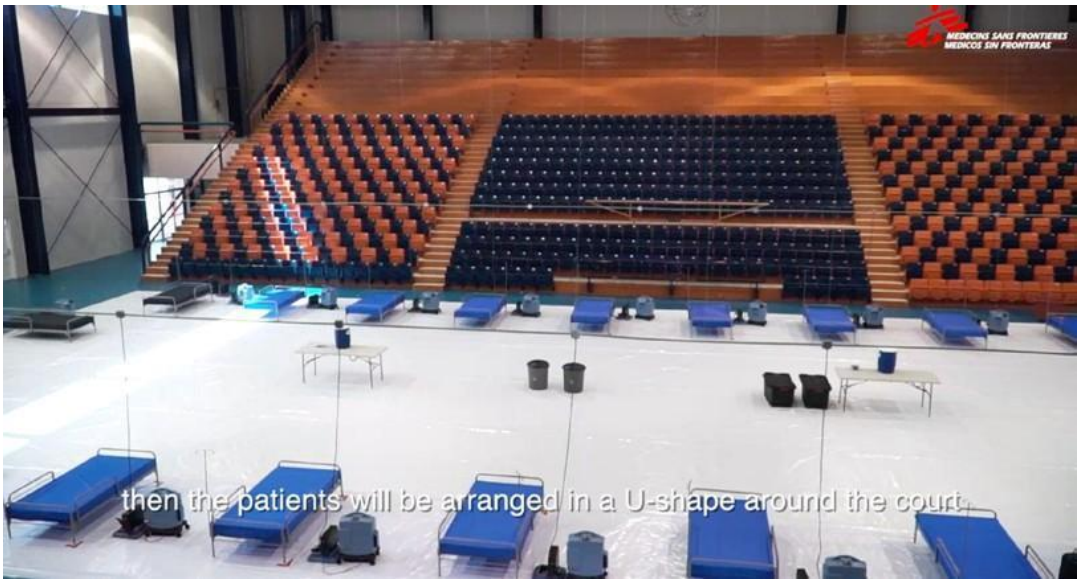
These aforementioned decision makers and health sector leaders had varying skills in management, administration, and governance. Most interactions and negotiations occurred in the virtual space, with few physical interactions due to the COVID-19 pandemic.

The following processes and qualities using the Governance Analytical Framework were also examined:

- Knowledge of the legal framework
- Capacity to modify the legal framework
- Level of involvement in the policy formulation
- Capacity to convene organizations

These leaders also had the power to create and guide policy and conduct of other governance interventions that may be categorized as follows:

- Allocating resources for policies
- Monitoring development and implementation policy
- Human resources training/capacity building
- Generate and disseminate information



Médecins Sans Frontières (MSF) has opened COVID-19 treatment centres in Reynosa and Matamoros, in far northeastern Mexico.
Photo from MSF Youtube / Sergio Ortiz

- Apply mechanisms of transparency
- Apply mechanisms of accountability

These leaders varied in their capacity to make monetary decisions, including the redistribution of resources. Most had limited power to generate and disseminate information. Although all the actors had knowledge of legal frameworks for mental health and care for vulnerable populations, only the secretaries of health had the capacity to modify these frameworks. The secretaries of health also had more power to convene organizations and apply mechanisms for transparency and accountability.

In the government-wide, direction-setting, and decision-making process described earlier, participation from the local or municipal levels were not included. Likewise, heads of hospitals or other health facilities directly caring for persons with mental health conditions were also not considered key policy makers during the pandemic. The private sector was also excluded despite its significant participation in Mexico's healthcare service delivery. However, many of the guidelines and directives from the key actors on higher levels were designed for implementation in the local level or scope, and would necessitate the cooperation of the private sector. Some of the policies and decisions created by these decision-makers included the following:

- Coordination for intersectoral action towards mental health policy formation
- Decreased admissions to 30% of hospital in-patient capacity
- Facility modifications to separate patients with COVID-19 from other patients
- Use of personal protective equipment in hospitals and healthcare facilities
- Consultations and follow-up of psychiatric patients via video call or other modalities

Despite the proactiveness of actors in the leadership and governance of Mexico's healthcare system, the fragmented nature of the healthcare system contributed to suboptimal outcomes for the general population and persons with mental health conditions and disorders. Some features of this fragmented healthcare system response are:

- Unilateral and centralized decision-making despite the decentralization of healthcare
- Diminished proactive interest in participating in actions outlined in policies.
- Little connectivity of plans and interventions across different levels of the healthcare system
- Unclear courses of action towards addressing service delivery gaps for vulnerable populations such as patients with mental health disorders

This fragmented response further undermined the mental healthcare system's capacity to care for patients with preexisting mental health conditions. As a result, this subset of patients was at increased vulnerability for adverse health outcomes, including COVID-19 infection. Although there was an effort to open up telephone hotlines and other distance modalities for medical help on an outpatient basis, these were not adequate to provide

continual access to mental health care and support for people living with mental health conditions (Diaz-Castro et al., 2023).

Patients with mental disorders faced significant disruptions to essential care and mental health services. This was due to the diversion of resources towards pandemic response, the reduction in service capacity of facilities (especially hospitals), and imposed lockdowns and mobility restrictions in the interest of controlling local transmission of COVID-19. The World Health Organization's rapid assessment of economies in the Americas, including Mexico, showed complete or partial disruption of 75% of services for mental health, neurological conditions, and substance use disorders in 2020. Outpatient and community-based services were the most impacted by these disruptions. This impact on mental health services continued throughout the pandemic's evolution, with 60% of surveyed economies still reporting these disruptions from January to March in 2021 (Tausch et al., 2021).

It is important to differentiate between the care and psychosocial support provided to the general population, versus the service delivery needed for patients with mental health disorders. Provision of psychological first aid and support to the general population is still necessary, and also very much in line with Mexico's health promotion programs such as the institution of the Grupo Técnico de Trabajo for mental health in emergencies. Population-level interventions for mental health help decrease acute psychological stress among patients, family members and caregivers, while enhancing extant support systems in the family and community levels. These also help ease the burden on the mental healthcare system by building individual resilience and coping skills and reducing the need for primary care and specialized care visits or interventions for emerging psychological needs during a pandemic. Hence the provision of guidelines for the mental health care of the general public became an early intervention during the COVID-19 pandemic but were not sufficient to meet the needs of patients already living with mental health disorders.

The experiences of other member economies' leadership and governance strategies during COVID-19 may inform Mexico's future policy creation and implementation for mental health. One key aspect of such a leadership strategy would have been government wide, multi-level coordination, planning, and monitoring. Economies including but not limited to Brazil; China; Indonesia; Iran; the United Kingdom; and the United States implemented policies for the allocation of health resources, as well as anti-contagion measures. Important features of these policies included the following:

- Cross-sectoral participation of multi-sectoral representatives
- Local leadership
- Ethics and values of cooperative society
- Coordinated and collaborative implementation of strategies
- Integrating equity values
- Reciprocity, protection, and self-care
- Co-responsibility and solidarity

The experiences of these member economies also highlighted a second aspect of an effective leadership and governance policy for pandemics, namely the design of risk communication and community engagement strategies. These include the following processes:

- Disclosure or control of information
- Hazard and threat assessment
- Establishment of crisis information communication channels and health education platforms
- Development and implementation of strategic response plans
- General mobilization of critical resources

Risk communication strategies should also take into account the general risk perception of the public, as well as risks in government policies. These factors play into the design of information control strategies, which are key to managing health emergencies.

A third feature of other economies' leadership and governance strategies was the creation of surveillance and rapid- response teams to facilitate case investigation. Epidemiological investigation forms the basis for external mobility restrictions such as closing borders, and internal mobility restrictions such as lockdowns, school closures, and the disallowing of mass gatherings. Surveillance and case investigation also help in the allocation of resources, including human resources for health. The generation and availability of this information is important for assessing health system capacity, which forms the basis for leadership, governance, and policy creation (Díaz-Castro et al., 2022).

The aforementioned factors were lacking with regard to Mexico's guidelines for mental health and continuity of care for patients with mental health disorders. In this context, the creation of a Mental Health Act would have been a chief facilitating factor to ensure these qualities and ensure better service delivery for this population. Legislation of a standalone Mental Health Act would entail some, if not all, of the following provisions to facilitate access and continuity of mental health care:

- Definition of patients with mental health conditions, or other equivalent terminology
- Specific actors and their responsibilities for service delivery, regulation, and oversight
- Guiding principles for service delivery and continuity of care
- Facilities and mechanisms for continuity of service delivery
- Funding allocation
- Regulatory and oversight mechanisms

These general policy areas would be applicable during times of relative stability as well as during other crises and health emergencies. The existence of a Mental Health Act would also support the integration of mental health interventions into disaster risk reduction and mitigation plans and increase preparedness for future health emergencies.

A second facilitating factor that would have stemmed from the institution of a Mental Health Act is the clear delineation of roles and scope of responsibilities of key actors for mental health service delivery. These roles would include policy formulation and review, collaboration, implementation, service delivery, monitoring and evaluation, as well as oversight, supervision, and regulation.

Since Mexico's healthcare system has multiple actors on its different levels, it would be important to consider the mandate of these individuals and institutions on these levels, and to negotiate any gaps and overlaps especially in service delivery. This factor would also pave the way for vertical channels of communication within the health sector and referral systems that are necessary for continuity of care. This also would facilitate interagency and intersectoral collaboration to address social determinants and barriers to care such as limited financial resources, reduced access to transportation during lockdowns, food insecurity, and livelihood instability due to mental health conditions combined with the pandemic's economic impact.

A third facilitating factor also arising from a policy such as a Mental Health Act and the delineation of roles would be the creation and implementation of specific guidelines for service continuity catering to patients with mental health and substance abuse disorders. Solid legislation would provide the legal basis for interventions in the community setting, as well as outpatient and inpatient services in general hospitals and specialized facilities. Some specificities to consider include but are not limited to:

- Provisions for inpatient and outpatient care even in the setting of hospital conversion
- Provision for the continuity of community-based services
- Provision of emergency mental health services
- Roles, responsibilities, and benefits to be allocated to mental healthcare workers continuing service delivery during the pandemic or health emergency.
- Ensuring access to psychotropic medications and other commodities for mental health services
- Referral systems across levels of mental health care, and to facilities caring for COVID-19 patients whenever necessary.
- Maintenance and protection of patient data such as medical records
- Mechanisms for surveillance for mental health

A fourth facilitating factor for leadership and governance in Mexico's experience of pandemic response would have been the utilization of a participatory approach tapping all levels of government as well as other actors in the healthcare system. This would have included representation or at the very least some input from local/ municipal health authorities, heads of hospitals providing specialized mental health services, and private sector actors such as non-government organizations and professional societies of healthcare workers. Where possible, input should have been solicited from vulnerable groups such as indigenous peoples. This participatory approach would have furthered the development of a more specific service continuity policy for the general population as well as patients with mental health disorders. This also would have increased the proactive interest of actors on different levels for implementing this policy and improved the connectivity of plans and interventions across different levels of the healthcare system.

A fifth facilitating factor, particularly for increasing access to mental health care and other essential services, is the presence of ongoing reforms such as the INSABI program. INSABI and other measures to provide financial protection to more of Mexico's residents helps eliminate financial barriers to accessing mental health services. Given the economic instability arising from the COVID-19 pandemic, the presence of INSABI would promote continuity of care for patients with mental health disorders, by reducing out of pocket expenditure for general and specialized care. Financial protection initiatives also increase access to preventive services for NCDs and other health conditions, thus improving patients' overall health status.

The challenges of Mexico's pandemic response and continuity of care for patients with mental disorders highlights the importance of leadership and governance even prior to health emergencies such as the COVID-19 pandemic. This would ensure a more cohesive and responsive all of society effort to respond to such scenarios, while assuring the continuity of care for vulnerable populations such as persons living with mental health conditions. Ultimately this would improve health outcomes for the general population and the aforementioned vulnerable population groups.

Insights and Lessons

For Government Agencies (Ministry of Health and others)

- Collaborate with the Mexican Congress for the creation and passage of a Mental Health Act
- Promote the streamlining and unification of social protection schemes to broaden coverage for patients with mental health disorders
- Invest in capacity building and training for healthcare workers for mental health, including those from vulnerable populations
- Enhance public messaging and targeted messaging on normalizing mental health seeking behavior, self-care and remaining connected to social support networks
- Explore mental health service delivery using telehealth and other technology to ensure continuity of care even during lockdowns/mobility restrictions
- Provide more points or channels of care to increase access for patients under the INSABI program and other social protection schemes

For Healthcare Providers and Institutions

- Hire and train more human resources for mental health, especially professionals and students from indigenous groups and other underrepresented populations
- Collaborate with public agencies to provide care under the INSABI program
- Strengthen referral systems and networks for mental health services
- Cascade/disseminate important mental health information to patients and providers especially messaging to reduce stigma and promote health seeking behavior
- Engage with public and federal leaders for mental health incorporation into disaster risk reduction and mitigation plans for health emergencies

For Private Sector Organizations

- Increase engagement with communities especially in underserved areas
- Engage with the healthcare sector to provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services
- Collaborate with public agencies to provide care under the INSABI program
- Engage with public and federal leaders for mental health incorporation into disaster risk reduction and mitigation plans for health emergencies

PERU

Introduction of the member economy's healthcare delivery

Peru is the 3rd largest member economy in South America, and one of the most diverse locations in terms of terrain and cultures. As of 2023, Peru's population is at over 34.4 million, and is estimated to exceed 40 million by 2048. About a quarter of the population resides in Lima, the capital city. Peru is also home to several uncontactable Amerindian tribes, residing far inland (United Nations, 2023).

Peru's healthcare system is fragmented into several tiers: the public sector which includes district facilities and government agencies such as the military and the police, the social insurance network (EsSalud), and the private sector which includes for-profit and nonprofit organizations. Oversight is provided by the Ministry of Health, which has jurisdiction over multiple channels of healthcare service delivery. These channels can generally be categorized under the healthcare system tiers as follows:

- **Public Health System**
  - Regional government
  - Local government
  - Public hospitals
  - Military
  - Police
- **Social Insurance/EsSalud**
  - EsSalud network
  - Private network
- **Private Sector**
  - Private network
  - Other service delivery channels

The fragmentation of these channels translates into lack of unification among service providers, and additional complexities for health financing. For instance, although all Peruvians including indigents qualify for the tax-funded public health insurance plan Seguro Integral de Salud (SIS), more health conditions and procedures are provided for by the EsSalud system, which primarily covers formal sector workers and their families. Informal sector workers and some vulnerable populations are not covered in the EsSalud network and can only rely on the SIS. Despite the presence of multiple health service delivery and financing schemes, many patients still must resort to out of pocket payments to augment their access to health services (Carrillo-Larco et al., 2021).

Peru's healthcare system continually contends with inequities in service delivery and the distribution of its human resources for health. Comprehensive care is difficult to provide especially for NCDs and chronic infectious diseases such as tuberculosis and HIV. Although there are 8,900 primary care centers in Peru, only about half of these are regularly staffed with a physician (Carrillo-Larco et al., 2021). The healthcare system has a ratio of 16.455 physicians and 26.126 nursing/ midwifery personnel per 10,000 population. Dentists and pharmacists are even more scarce, with only 2.141 per 10,000 population and 1.519 per 10,000 population respectively (World Health Organization, 2021). These healthcare workers are unevenly distributed, with most practitioners being situated in urbanized areas such as Lima and Arequipa, while fewer practice in more far-flung departments such as Madre de Dios and Tumbes (Statista Research Department, 2020).

A challenge in Peru is ensuring healthcare service delivery to indigenous peoples, many of whom reside in the Peruvian Amazon region to the east. Legislation such as the Sectoral Policy on Intercultural Health, which was enacted in 2016, have yet to be fully implemented and realized. Further complicating the situation is the need to respect some tribes' and communities' wishes to not be contacted, thus effectively putting them beyond the reach of social and health services (Carrillo- Larco et al., 2021). Yet even among the tribes that are in contact with the public health system, many of their communities have higher mortality rates, poorer nutritional status and oral health, and a higher prevalence of infectious diseases compared to communities in other rural areas. The distance

alone between these indigenous peoples' traditional residences and usual points of care in the rural/ community healthcare delivery system poses a challenge to healthcare workers and patients alike. Other barriers for achieving better outcomes in indigenous peoples' healthcare include shortages in human resources for health, cultural insensitivity towards the unique practices and mindsets of these communities, and the tendency to rely on self-care and traditional healers while considering medical care as a "last resort". Community participation in healthcare is a tried and tested strategy to overcome some of these barriers, and currently being used alongside system improvements in infrastructure, healthcare worker capacity building and training, and education efforts (Badanta et al., 2020).

To help address health system inequity and expand the coverage of health service delivery, Peru's Ministry of Health has instituted several programs for reform. These include expanding health insurance coverage programs and schemes and engaging technical assistance to improve outcomes for maternal health and nutrition (USAID, n.d.). However additional investment is needed from the government to sustain these gains as well as close the gaps in healthcare resources and delivery especially in the primary care setting.

Backgrounder or situation before the introduction of the best practice

Mental health conditions pose a significant burden of disease, and account for 3,399.67 disability-adjusted years per 100,000 population in Peru. The suicide mortality rate is at 4.9 per 100,000 population (World Health Organization, 2022).

Common mental health disorders among Peruvian adults include anxiety, depression, self-harm and somatic symptom disorder, which together comprise 38% of the total mental health burden in this member economy. Substance use, especially related to alcohol, accounts for another 16%. Severe mental health disorders such as schizophrenia and bipolar mood disorder account for 10%. Among young children, autism accounts for 47% of the neuropsychiatric burden for patients under the age of 5. Among older children and young adolescents, the mental health burden includes conduct disorders and anxiety disorders. On the other end of the spectrum, the elderly contend with neurocognitive disorders such as Alzheimer's disease. These disorders make up 70% of the mental health burden for adults aged 85 and older (PAHO, 2018).

Key reforms for mental health include the institution of a mental health policy in 2006, followed by a stand-alone law for mental health in 2012. However, there is no separate law to address the mental health of children and adolescents, nor is there legislation addressing the mental health of Peru's indigenous peoples. Nevertheless, this legislation has resulted in the inclusion of mental health services in health insurance schemes, which helps eliminate financial barriers to seeking mental health support and services (World Health Organization, 2022).

Policy reforms for mental health are rooted in the following pillars: restructuring mental health services at the primary and secondary levels, creating supporting services to facilitate the recovery and reintegration of patients into society, ensuring that health centers have adequate supply of psychiatric medication, and expanding the coverage of the SIS financing scheme to include mental health care. The following specific strategies are in place to operationalize these pillars:

- Training primary healthcare providers to detect and treat common mental disorders.
- Referral of patients with severe mental disorders to community mental health centers
- Supporting the community mental health infrastructure with the creation of protected homes and halfway houses for patients discharged from inpatient facilities, protected residences for patients needing additional care due to sequelae of disease, psychosocial rehabilitation centers, and vocational rehabilitation centers.
- Additional financial allocations for mental health reform implementation and scaling up.

The “Control and Prevention in Mental Health” program is in place to scale up these aforementioned strategies over a 10-year timeframe (Toyama, 2017).

In more recent years, mental health reforms in Peru have achieved the following gains:

- Decentralization of the mental health service delivery system to the community level
- Construction of more than 200 Community Mental Health Centers, 30 mental health hospitalization units in general hospitals, and 48 sheltered homes throughout Peru
- Equipping more than 1,000 health centers with their own psychologists
- Increasing from one to 15 the list of psychotropic drugs that patients can avail of free of charge.
- Increasing the funding from PEN 179.7 million in 2012 to PEN 558.5 million in 2021
- Installation of the National Mental Health Council to coordinate mental health policy.
- Collaborations with the academe as well as other ministries of health in Latin America

Targets for further expansion of mental health services include the construction of 281 Community Mental Health Centers, 42 mental health hospitalization units and 145 sheltered homes, increasing service delivery for impoverished and underserved communities, and launching a Mental Health Observatory. Channels for service delivery will also be increased through use of telemedicine and articulating the roles of key actors in the public sector as well as private organizations in the community setting (Carrillo-Larco et al., 2021).

Despite the above reforms and gains, shortages still remain with regard to human resources for mental health. The ratio of mental health workers to the 100,000 population in Peru is at 32.03. Most of the healthcare workers handle general mental health services or adults, as there are only 65 registered child psychiatrists working in government and non-government facilities. Psychologists make up the largest proportion of mental health specialists, with a ratio of 9.51 psychologists per 100,000 population. Psychiatrists make up the second largest proportion, with a ratio of 2.95 per 100,000 population. There are few mental health nurses, social workers, occupational therapists, and speech therapists available within the member economy. (World Health Organization, 2022).

A medical worker takes care a patient at the intensive care unit (ICU) of the Emergencias de Villa El Salvador hospital, during the new restrictions as the economy exceeds one million coronavirus disease (COVID-19) cases.
Photo by REUTERS / Angela Ponce

This shortage of mental health specialists makes it more challenging for the Peruvian public sector to promote community-based mental health service delivery throughout Peru, especially in underserved areas. The onset of the COVID-19 pandemic not only disrupted progress towards further mental health reforms, but also shocked Peru's healthcare service delivery system as a whole. Although communicable diseases such as tuberculosis, dengue, cholera, and influenza have affected the population as epidemics or have become endemic, none of these have necessitated the massive health response seen for COVID-19. Peru recorded its first case of COVID-19 on 6 March, 2020. Within a week, stringent mobility restrictions were imposed, making Peru the first among Latin American economies to resort to this measure. The first wave of cases in Peru plateaued by June 2020 and petered out quickly, but the pandemic's second wave in 2021 recorded an alarming mortality rate of 1,200 deaths per 1 million residents. This dire trend was attributed to a plethora of factors stemming from a fragmented health system response and weak health governance. This resulted in shortages in medications, hospital and ICU beds, and other resources for treating severely affected patients, and the insufficiency of socioeconomic relief measures that prompted people's premature return to economic movement and activity — thus driving up case numbers. Difficulties in initiating the mass vaccination program also led to delayed control of the second wave of infections (Schwalb & Seas, 2021).

During the pandemic, health system inequity was further aggravated, with indigenous peoples having a mortality risk from COVID-19 that was three times higher than that of the general population. This increased risk was attributed to indigenous tribes' lack of access to hospitals and other healthcare resources, as well as the difficulty of disseminating protocols for infection control and disease prevention in remote areas. It is likely though that statistics regarding mortality and morbidity due to COVID-19 among indigenous peoples are underreported, due to limitations in reporting case frequencies and deaths in jungle and rural areas (Soto- Cabezas, 2022).

The COVID-19 pandemic also negatively impacted the mental health of much of the population of Peru. Since much of healthcare resources were diverted towards controlling the local transmission of COVID-19, less attention was given to mitigating the psychological impact of the pandemic. Psychological distress was found to have a higher incidence among women, young people, and people with lower educational attainment (Ruiz-Frutos, 2021). The prevalence of moderate depressive symptoms and the proportion of patients treated for mild depressive symptoms also increased during the COVID-19 pandemic. Patients with preexisting mental disorders also reported an increase in their symptoms during the early onset of the pandemic (Villareal-Zegarra, 2023).

Healthcare workers in Peru were significantly impacted by the pandemic, in terms of both physical and mental health. Technicians, health assistants, and nursing staff had the highest risk of mortality from COVID-19 compared to other groups of healthcare professionals. Physicians however had the highest risk for hospitalization due to this illness (Ramos, 2022). Healthcare workers situated closer to the "epicenter" of infection in the capital city of Lima were more likely to experience anxiety and mental distress compared to healthcare workers situated further away. Lower educational attainment was also associated with increased distress levels. However, distance from the epicenter of infections did not affect intention to turnover duty; the strongest predictor of this intent was age and workplace, with turnover intention being highest among young workers in the private sector. These findings about healthcare workers' physical and mental health should help guide the development of support systems for this vulnerable group and be part of policy considerations for the long term welfare of Peru's health workforce (Yañez et al., 2020).

Discussion of the good practices and facilitating factors

Best Practice: PSTHP Psychosocial Support Team for Health Providers

A rapidly emerging concern during the COVID-19 pandemic was the physical and mental wellbeing of healthcare workers or health providers (HPs) involved in pandemic response, especially those within or closest to Lima and other areas with high case rates. One intervention to support HPs was the creation of "Technical Guideline to care for the mental health of HPs in the COVID-19 context", which was published on 6 April 2020. This guideline was designed for use in all facilities attending to patients with COVID-19, regardless of disease severity.

Under this guideline, facilities would be enjoined to create a "Psychosocial Support Team for Health Providers" (PSTHP) composed of the following: physician (preferably a psychiatrist), a psychologist, a nurse, and a social worker. Each PSTHP would design and implement activities centered around the following four provisions: mental healthcare, self-care, identification of mental health problems, and intervention and recovery. Principles and specific strategies for each provision are detailed in the following table:

Table 2: Guideline provision with goals and specific activities

PROVISION	GOAL	SPECIFIC ACTIVITIES
Mental healthcare	Meet basic needs for good mental health	► Meet physiological needs (healthy diet and healthy rest) ► Ensure stability and safety in the workplace ► Ensure easy access to healthcare services ► Identify psychosocial risks
	Enhance resilience	► Group sessions for emotional self-regulation ► Education through books and sessions on biosecurity and mental health ► Promote workplace and family support ► Telephone helplines ► Management of complaints and feedback
Self-care	Promote self-care among HPs	► Assertive communication ► Application of tools and strategies for emotional self-regulation ► Attend to basic needs ► Use of healthy coping strategies ► Limit exposure to media ► Maintain communication with family ► Being conscious of physical symptoms and emotions, knowing when to seek help
Identification of mental health problems	Address as a priority the issue of HPs dismissing mental health concerns	► Observing behaviors ► Individual and group screening ► Corroboration to pinpoint the following syndromes: acute stress, adaptive or anxiety disorders, depressive episode, battered or burnout
Intervention and recovery	Ensuring HPs with mental health problems will receive PSTHP intervention	► Mild cases: continue with interventions ► Moderate cases: individualized intervention plan with psychotherapy and psychological first aid ► Severe cases: referral to specialized services

The main goal of this technical guideline was to protect the mental health of HPs and prevent the exacerbation of mental health problems, thus maintaining the service delivery capacity of Peru's healthcare system (Orellano & Macavilca, 2020).

It is important to remember that these guidelines do not exist in a vacuum, and that the effective implementation of the four principles relies on the following assumptions:

- There are ample human resources for health in facilities who can be tapped to function as PSTHPs to support their fellow HPs. This includes physicians, nurses, and more highly specialized individuals such as psychologists and social workers.
- Leadership in the facility/workplace is receptive to the promotion of healthy behaviors and implementing the necessary engineering and administrative changes to ensure HPs' physical safety as well as mental health.
- The culture in the facility/workplace is healthy, free of stigma regarding mental health, and conducive to communication and mutual support.
- Facilities have systems in place to address complaints and grievances.
- HPs have support networks outside of the workplace such as family and friends.
- HPs will have ample opportunity to attend individual or group sessions, or their schedules may be adjusted to allow for their participation in these activities.
- Appropriate tools are available for screening for mental health conditions, and PSTHP members have been trained to use them. Alternatively, there is training available for PSTHPs who wish to use new tools for these HP assessments.
- Specialized mental health services are readily accessible for HPs needing more complex psychiatric intervention.
- Other resources for social support can be readily tapped by PSTHPs' social workers.

Prior to the implementation of these guidelines, it may be necessary for health facility leadership and/or PSTHPs to assess available resources, and address baseline issues. This may require coordination with other facilities or public health authorities, especially with ensuring the presence of specialized mental health services and a referral system. Given the inequities in the distribution of human resources for health throughout Peru, these baseline assumptions may be difficult to manage in areas with more limited capacity in terms of specialized practitioners, infrastructure, or even just physical access to mental health facilities. Thus, the mechanisms and logistical support needed for PSTHPs' interventions may not always be present for facilities situated in remote areas such as in the Amazonian regions, or in upland territories. Additional interventions may also be needed for individual HPs with more limited support networks, or those situated in less conducive work cultures.

Should the above assumptions be met, the PSTHPs would be able to better provide support to HPs, and ultimately help deload the mental health system. The emphasis on mental health promotion and self-care would better equip HPs to address some of the root causes of psychological distress, anxiety, depressive symptoms, and other mental health impacts from the COVID-19 pandemic. The emphasis on building attitudes and skills for resiliency will help HPs weather not only the COVID-19 pandemic but also subsequent health emergencies and disasters.

The guidelines also facilitate an on-the-ground referral system that would allow more severely affected HPs to receive specialized care at or near their workplaces, after being properly assessed by the PSTHPs. This would then decrease the time and resources needed for HPs to seek mental health care, and also facilitate a more timely return to work. Ultimately this also would lessen the load on specialized mental health services and reduce out of pocket expenses and other resources on the part of HPs who would otherwise have to devote time to travel to specialists and possibly miss out on work.

Another outstanding feature of these guidelines is the freedom it gives for facilities and their respective PSTHPs to choose and design interventions to best support their HPs. This allows for the guidelines to be readily applicable in most communities in Peru, or to accommodate large as well as small facilities. The adaptability of the guidelines to different contexts also may increase its acceptability for practitioners tapped for PSTHPs as well as HPs receiving the interventions.

Although the guidelines stipulate that a psychiatrist is preferred as a member of the PSTHP, this does not totally preclude the involvement of physicians practicing other specialties. The guidelines do not also explicitly state if specialization in mental health care is a requirement for nurses in PSTHPs. While this may encourage the involvement of more interested and capable practitioners while putting less of a drain on specialists in mental health care, the silence regarding minimum competencies and skills for PSTHPs may affect standards of care and psychosocial support being offered. This can be mitigated by offering capacity building and training for PSTHPs, which can be credited as part of continuing professional development or become a path to future specialization.

Another limitation of these guidelines is their lack of clarity on the support and continuity of care that should be provided for HPs who have been previously diagnosed with mental health problems. Literature shows that persons with prior mental health diagnoses may experience a worsening of symptoms, as was seen during the COVID-19 pandemic. Managing this development requires coordinating with patients' primary care physicians or mental health specialists to achieve continuity of care. Activities for these are not specified in the guidelines for PSTHPs and may limit their capability to support HPs who are living with, or have recovered from mental health conditions prior to the pandemic. Referral systems for specialized care should also consider coordination with HPs' own care teams in the interest of maintaining continuity of care for the HPs as patients.

An area that the guidelines are silent about is how PSTHPs can prepare for and manage mental health problems arising from shocks to the work environment itself such as the demise of colleagues, employee turnover, reassignment, and other such events. While it may be reasonable to expect that the PSTHP members themselves are trained in interventions such as grief counseling and team building, a more unified approach to change management and preparation should be articulated in the PSTHP's work.

Strategies for HPs' reintegration in the workplace are also not clearly outlined in these guidelines. Means for assessing HPs' readiness to return to work, and coordinating for reintegration should also be part of individualized care plans, especially if HPs have spent a significant amount of time on leave due to mental health conditions or other medical reasons. Additional coordination is needed with PSTHPs with workplace leadership and community resources to facilitate this transition smoothly for HPs.

The guidelines are also unclear about which persons or agencies will assume supervisory or regulatory functions with regard to PSTHPs. Although oversight may come from the Ministry of Health, the regular monitoring and evaluation for PSTHPs may have to be delegated to local health departments or equivalent agencies. If this would be the case, then these departments or agencies should also be capacitated to perform their supervisory functions for the guidelines' implementation.

Given that the PSTHP members are also HPs and are also likely to be exposed to the same risks faced by their colleagues, some care needs to be taken to see to the mental and physical health of PSTHP. The guidelines are lacking in steps for PSTHPs to protect themselves and engage in their own self-care, which may include task sharing, delegation, and rationalizing their own breaks and availability. Support systems and debriefing are needed for PSTHPs to cope with this undertaking of supporting HPs while also avoiding burnout.

Despite these limitations, the PSTHP and the guidelines supporting their work can be greatly facilitated by extant factors in Peru's healthcare system, particularly the reforms made for mental health. A chief facilitating factor is the decentralized healthcare system in Peru, which allows for some autonomy across departments and also for both the public and private sectors. Decentralization allows for the more refined implementation of public policies such as this set of guidelines in order to better address the unique health needs and contexts of each area or sector.

A second facilitating factor is the community-based mental health system in Peru, particularly the presence of Community Mental Health Centers. These facilities can serve as venues for group psychosocial support programs and screening activities or can receive referrals for more specialized interventions. The widespread distribution of these centers shortens the time and resources that HPs would expend to receive care near their workplaces and would allow them to remain in the community setting during their recovery. Specialists working in these centers may also be tapped for PSTHP capacity building, or to augment human resources for providing individualized care.

A third facilitating factor is the presence of 1,000 additional psychologists in health centers as a result of mental health service delivery reforms. These psychologists are essential to the creation of PSTHPs, and in the conduct of screening, psychological first aid, and non-pharmacological interventions for HPs. This augmentation of the number of psychologists also reduces the workload of psychiatrists, who can then focus on more specialized management of HPs using a biopsychosocial approach.

A fourth facilitating factor that also stems from prior reforms for mental health is the training of primary care physicians to diagnose and treat common mental health disorders. This reform allows for meaningful participation of primary care physicians in PSTHPs and builds their capacity to address most mild and moderate cases of mental illness in the workplace. Tapping primary care physicians for mental health care also lessens the workload of specialists, who can then devote more time and resources to treating patients needing more intensive management. Primary care physicians, be they in PSTHPs or in their own capacity in the workplace or community, can also ensure continuity of care for stable patients living with chronic mental health conditions. They may also play a key part in pinpointing managing hindrances that may lessen the psychosocial support available for HPs, such as chronic illnesses of other family members, misconceptions regarding psychological care, or even anxiety and fear surrounding COVID-19 infection.

A fifth facilitating factor is the increased funding now present for mental health, owing to the previously implemented reforms. This increased funding may be used not only for directly addressing the impact of mental health conditions on Peru's HPs, but also for building the capacities and sustainability of the PSTHPs. Funding also facilitates infrastructure improvements for mental health such as the building of Community Mental Health Centers and in-patient facilities, which form an integral part of the referral systems in these guidelines. Additional funding for mental health can also ensure the retention of mental health practitioners in referral centers and community settings, subsidize more psychotropic medications, and further reduce out of pocket expenditure on the part of affected HPs.

A sixth facilitating factor is the institution of the "Mental Health Council", which takes the lead in coordinating and articulating policies. This council can advocate for support for HPs' mental health, as well as create additional strategies for PSTHPs to deploy in their contexts. This body can also advise the larger health leadership and governance structure of Peru regarding mental health promotion and prevention strategies to implement even outside of crises such as the COVID-19 pandemic. The council can also help evaluate the effectiveness of these guidelines and the PSTHP initiative, also as part of preparedness for future health emergencies.

A seventh facilitating factor in Peru's health system would be collaborations with the academics and other economies' ministries of health. These collaborations would facilitate the sharing of good practices for mental health strategies and supporting HPs. Academic collaborations may culminate in research to assess the effectiveness of the Technical Guideline to care the mental health of HPs in the COVID-19 context, as well as more specific strategies utilized by PSTHPs. Information-sharing with other ministries of health can better inform Peru's health surveillance not only for mental health conditions but for other disease entities and events (e.g. natural disasters) that may also impact the mental health status of HPs and the population.

At present there are no studies directly measuring the implementation and subsequent impact of these guidelines or the work of Peru's PSTHPs. However, data collected a year later in a study in a secondary hospital illustrates the continued need for psychosocial support for HPs throughout the pandemic's evolution. Nurses in this hospital who attended to COVID-19 patients experienced fear of contagion as well as anxiety, which were both related to physical and cognitive fatigue. At the time of data collection, 65.5% of respondents reported not having been infected by COVID-19. These findings show that psychosocial support to address fear and anxiety is still needed when it comes to supporting HPs, even in settings wherein majority of HPs are protected from

COVID-19 through testing and other infection control protocols (Becerra-Medina et al., 2022). Therefore, the work of Peru's PSTHPs is still relevant in continuing to support HPs and building the health system's capacity to withstand further shocks such as the next pandemic.

Insights and Lessons

For Government Agencies (Ministry of Health and others)

- Assess the implementation of the "Technical Guideline to care the mental health of HPs in the COVID-19 context", and the presence of PSTHPs in health facilities at all levels.
- Invest in capacity building and training for PSTHPs.
- Enhance public messaging and targeted messaging for HPs on normalizing mental health seeking behavior, stress management, and self-care.
- Increase funding and support for PSTHPs and other mental health reforms.
- Explore retention schemes and additional means of support for HPs and health facilities catering to indigenous peoples and communities in jungle or rural areas.
- Explore mental health service delivery using telehealth and other technology to ensure continuity of care even during lockdowns/mobility restrictions.
- Streamline health financing and coverage schemes to cover vulnerable populations.
- Facilitate collaboration between the health sector and social services to widen support networks for HPs and other vulnerable groups during health emergencies and other disasters.

For Healthcare Providers and Institutions

- Pinpoint HPs to be trained as PSTHPs and provide capacity building and training.
- Ensure the safety and physical security of HPs through provision of biosafety equipment, infrastructure improvement, and rationalizing schedules and workload.
- Promote a work culture that is supportive, open to communication, and free of stigma regarding mental health and health seeking behavior.
- Strengthen referral systems and networks for mental health services.
- Cascade/disseminate important mental health information to HPs, especially messaging to reduce stigma and promote health seeking behavior.
- Provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services beyond PSTHP engagement.

For Private Sector Organizations

- Engage with the healthcare sector to provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services.
- Collaborate with government agencies for the assessment of the "Technical Guideline to care the mental health of HPs in the COVID-19 context" and pinpointing best practices to incorporate into Peru's further reforms.

THE PHILIPPINES

Introduction of the member economy's healthcare delivery

The Philippines is an archipelagic member economy with a projected population of over 117 million people composed of many ethnolinguistic groups (United Nations, 2023). Two key governance strategies have been implemented for health service delivery: the implementation of the Universal Healthcare Act of 2019, and the devolution of government agency functions to local government units.

The Universal Healthcare Act of 2019 is considered a landmark policy to ensure "health for all" in the Philippines. This law, also known as Republic Act 11223, "An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor", has a two-fold purpose. The first is the delineation of the roles and responsibilities of key actors and stakeholders in the Philippines' healthcare system, and the second is the guarantee that every Filipino will have access to quality healthcare while being protected from financial risk. Thus, a core tenet of this law is the automatic coverage of every Filipino citizen in the "National Health Insurance Program" (NHIP), which would make every individual eligible to avail of both population- based and individual- based health services in accredited local facilities.

The Universal Healthcare Law also has provisions for the creation of local healthcare provider networks and the capacity building of these with ample human resources for health. A health workforce support system should be created to support local public health systems in this endeavor, especially areas that have been assessed as being geographically isolated and disadvantaged (GIDA) localities. To support health service delivery, the creation of health information systems per locality is also mandated in the Universal Healthcare Law. Furthermore, this law delineates specific regulatory functions such as health technology assessment, usage of approved clinical pathways of care. Other important points include the assignment of roles of agencies engaged in health promotion, monitoring and evaluation, and oversight for the full implementation of universal healthcare. (Congress of the Philippines, 2019).

This law has given rise to the creation of specific interventions for healthcare service delivery, especially for individual-based services in primary care. The most prominent of these is the "Konsulta" package, which can be availed of in outpatient and ambulatory facilities. This comprehensive preventive care benefit package covers consultations and health risk assessment including ancillary tests such as complete blood count (CBC) with platelet count, urinalysis, fecalysis, fecal occult blood, pap smear, lipid profile, creatinine levels, fasting blood sugar, oral glucose tolerance test, hemoglobin A1c (HbA1c) test, electrocardiogram (ECG), and TB screening through chest x-ray and acid-fast sputum microscopy.

The Konsulta package also covers several groups of medications such as antimicrobial drugs, fluid and electrolytes, anti-asthma, anti-dyslipidemia, anti-hypertensive, anti- thrombotics, and antihistamines. Patients may avail of these at accredited facilities, provided that they have registered beforehand to a preferred provider for primary care services (Philippine Information Agency, 2023).

Although the Universal Healthcare Act is a key policy to guide health service delivery and public financing in the Philippines, the actual conduct of these services is greatly impacted by local devolution. Devolution has been ongoing since 1991, but recent state directives from the have pushed for devolution transition planning of local government units such as provinces, cities, and municipalities to assume managerial, fiscal, and technical responsibility for services including healthcare. Each local government unit is enjoined to achieve full devolution by 2024 (Department of Budget and Management, 2022). This devolution planning impacts not only the capacity of local government units for health service delivery, but also for the recruitment, training, and retention of human resources for health since devolution would also require local governments to absorb and fund deployed personnel across different facilities and services.

To build the capacities of local health systems for universal healthcare and service delivery while respecting individual devolution plans of each locality, the Department of Health's Bureau of Local Health Systems and Development has helped local government units prepare and implement universal healthcare integration in their

governance systems. To assess benchmarks and progress of this integration effort in the first six years after the implementation of the Universal Healthcare Act, the Department of Health has developed the Local Health Systems Maturity Level (LHS-ML). Under the LHS-ML are several key areas relating to different aspects of the healthcare system and service delivery. These include local governance, strategic planning and investment, as well as more specific health system components such as human resources for health development and information management systems for health. Achievements per site are assessed on three different levels: preparatory, organizational, and functional. Findings from the LHS-ML also serve as references for planning, guidance, and technical support for universal healthcare integration sites in different regions. As of 2022, there were 58 sites assessed using the LHS-ML (Department of Health, 2022).

These two policies for universal health care and devolution also enable already extant legislation and initiatives that positively impact health service delivery. Of note is the Mental Health Act, or Republic Act 11036. This law institutes a public mental health policy and the creation of mental health systems that should be integrated into basic healthcare services. Community-based mental health services alongside more specialized in-patient care in public and private hospitals are part of this proposed integration. Educational institutions are also given an important role in local research and advocacy for mental health.

This legislation also advocates the creation of a Philippine Council for Mental Health, which would serve as a policy-making and advisory body to the Department of Health. The members of this council would include representatives from government bodies, the academe, as well as human rights groups and non-government organizations. (Congress of the Philippines, 2017).

Backgrounder or situation before the introduction of the best practice

The COVID-19 pandemic, which reached the Philippines in the first quarter of 2020, impacted healthcare service delivery throughout the member economy. Stringent mobility restrictions such as community quarantines severely limited the ability of patients to seek timely care at medical facilities. Supply shortages of personal protective equipment for healthcare workers contributed to relatively high infection rates within healthcare facilities, and further stressed the healthcare system (Magsino, 2020). These adverse impacts hampered the delivery of primary healthcare services, thus possibly compromising patients' healthcare status (Moncatar et al., 2023).

Human resources for health, which were already maldistributed even before the COVID-19 pandemic, were even more adversely impacted during this time period. As of 2021, there were an estimated 188,000 licensed healthcare professionals in the Philippines. The greatest proportion of these were nurses, numbering around 88,500, followed by midwives at around 41,500. Physicians numbered at about 28,800, followed by medical technologists at 12,900, then pharmacists at 5,100. There were comparatively fewer dentists, radiology technicians, nutritionists/ dietitians, and physical therapists in the Philippines (Statista, 2023). However, this cohort of professionals has been largely concentrated in urban areas due to greater earning potential and proximity to training institutions, compared to rural areas with fewer resources and support. Even before the signing of the Universal Healthcare Law, the Department of Health has instituted several programs to help address this disparity such as deployment programs for nurses and medical technologists, return service agreements, and the creation of rural health teams. These efforts to resolve health system inequities were not sufficient to address the additional stresses for the healthcare workforce during the COVID-19 pandemic. During the pandemic, healthcare workers faced longer hours under more strenuous and demoralizing workplace conditions, while confronting the risks of being infected on the job. These stressors, combined with delayed hazard pay and reimbursements, prompted mass resignations and out migration of healthcare professionals, thus exacerbating the already present shortage of human resources for health in rural areas (Robredo et al., 2022).

Healthcare workers in a premier hospital called the attention of the authorities on the provision of the special risk allowance during the COVID-19 pandemic
Photo by ABS-CBN News / George Calvelo

Feelings of burnout, exhaustion under inhumane work conditions, and being undervalued have been identified as additional reasons for resignation and outmigration of medical professionals such as nurses, or even causes to leave these fields altogether (Alibudbud, 2022). Issues of compensation and safety on the job have been causes for protest as well as concern in building health providers' mental health resiliency. A study in a tertiary hospital also showed that healthcare workers who recovered from COVID-19 continued to experience distress related to this illness and fear of reinfection, as well as some measures of anxiety and depression (Carascal, 2022). Yet despite the Mental Health Act's delineation of the rights and support for mental health professionals, there has been no specific provision contemplated for mental health support for other healthcare workers and caregivers during long-term crises, an example of which would be the COVID-19 pandemic (Congress of the Philippines, 2017).

Likewise, no such provision for mental health services was given in legislation related to COVID-19 services such as the Bayanihan "We Heal As One" Act and its future iterations. Likewise, there has been no post-recovery mental health support or program mandated by law for healthcare workers who have survived being ill with COVID-19. However, this law has provided increased allocations to the healthcare sector in hopes of addressing acute stresses such as shortages in supplies and deployment of additional human resources for health. Procurement was expedited for key supplies such as personal protective equipment and laboratory equipment. Furthermore, economic relief measures were put in place to cushion the economic impact of the community quarantines on the populace, and thus continue to provide for some basic needs and social welfare services during the pandemic's first few months (Congress of the Philippines, 2020).

Aside from its direct impact on human resources for health, the COVID-19 pandemic also adversely affected efforts for implementation of the universal healthcare law, including the integration efforts in local government units. By 2021, only 5 (9%) of 56 initial sites had successfully completed the preparatory level for the key result areas under the LHS-ML. Progress lagged in areas such as financial management, human resource management and development, disaster risk reduction and mitigation, and health promotion. Under human resource management and development, difficulty was noted in creating and maintaining adequate permanent or "plantilla" positions within healthcare provider networks, ensuring resource sharing, creating registries for local health workforces, and developing plans for human resources for health management, development, and performance assessment. However, there were more local government units who were able to ensure that their healthcare workforce was undergoing certification for primary care to work in designated facilities.

However, it remains to be seen whether mental health support would be considered by other local government units in their plans for management and development of the local health workforce (DOH, 2022).

One area that saw accelerated growth during the pandemic was telemedicine, which was seen as a means of providing individual- based healthcare services during the pandemic. Although only 16 LHS-ML assessed sites showed any significant progress with this endeavor from 2020 to 2021, there was progress seen in terms of engaging providers and creating guidelines for the integration of telemedicine modalities for service delivery (DOH, 2022). This is in contrast to the situation of telemedicine prior to the COVID-19, when efforts to legislate its use and provide guidelines were not signed into enabling laws, and there were limited efforts to pilot telemedicine services in healthcare provider networks. One notable long- standing effort for telemedicine prior to the COVID-19 pandemic was the "Telehealth Service Program", which sought to maximize the use of technology to provide healthcare services and consults to disadvantaged communities.

The program originally envisioned the use of text messaging or email as a means for general physicians or doctors on duty in rural areas to communicate and refer patients to specialists based in tertiary centers such as the Philippine General Hospital. Challenges faced by the program included the lack of specific legislative measures to address the need for privacy and confidentiality in the context of remote consultations, as well as concerns regarding accountability and liability in this form of patient-provider interaction (Patdu & Tenorio, 2016).

However, during the COVID-19 pandemic, different providers in both the public and private sectors, including but not limited to the Department of Health (DOH), Medgate, KonsultaMD, Medifi, HealthNow, AIDE, DOCPH, Yo-Vivo Health, and Lifeline, quickly responded to the need to provide this form of remote service delivery. Other providers used social media or personal webpages to conduct teleconsults. Telemedicine was viewed as a means of reducing the risk of COVID-19 transmission since there would no longer be a need for patients to congregate in health facilities to see their providers. This modality was also deemed useful for chronic disease management, engaging other family members in patient care, and bridging service delivery gaps for underserved communities. Even so, providers still acknowledged the limitations in providing adequate patient assessment and diagnosis during telemedicine consults, owing to limitations in physical examination as well as technical difficulties especially in areas with poor telecommunications services. Other concerns raised about telemedicine at this time included the inherent treatment delay in providing emergency care for patients, as well as the possibility of patient data being illicitly accessed by hackers or compromised when data-sharing with billing services or third-party providers. Despite these issues, telemedicine was generally seen as beneficial especially in situations with limited mobility such as the COVID-19 pandemic (Cordero, 2022).

Further bolstering the continued integration of telemedicine into the Philippines' health service delivery systems is patient satisfaction with telemedicine providers and platforms. Telemedicine is perceived as being most useful for non- urgent consults with less need for physical examination. Factors contributing to increased acceptability of telemedicine include safety from infection with COVID-19, perception of patient privacy, accessibility of telemedicine services, and the availability of multiple platforms for consults. However negative perceptions and concerns regarding telemedicine including connectivity difficulties due to technological limitations, and differences in the quality of patient-provider interactions on these platforms. Perceptions regarding the cost of telemedicine are variable, with some patients deeming this modality as cost-efficient, while others find the cost to be rather high especially for mental health related services and conditions (Noceda et al., 2023).

Although telemedicine continues to remain an accepted modality for healthcare service delivery in the Philippines, there is little documentation as to the extent of its use for mental health support and interventions. Likewise, there is a paucity of documentation for the use of telemedicine specifically to support the needs of healthcare workers, especially for mental health. There remains a need to document and expand both face to face and remote avenues for supporting human resources for health, in preparation not only for universal healthcare service delivery but as part of building resilience against future stressors to the healthcare system.

Discussion of the good practices and facilitating factors

Best Practice: The Wellness Movement Program

The Wellness Movement Program is a multi-stage intervention that utilizes behavioral design to promote mental health and wellness in a target population such as healthcare workers. This program operates on four levels of intervention, beginning with addressing the target group's basic needs and security, before progressing to psychological first aid and community support, as well as the provision of specialized services such as focused therapy on the highest/fourth level.

The Wellness Movement Program was developed over four years, beginning from the creation of behavioral prototypes or "nudges" for behavioral change, all the way to widespread rollout and the impact of healthcare workers' behavioral change on patient level outcomes. The timeline of this program is summarized in the figure below:

The first year or stage of the program focused on pinpointing which critical moments and mental health issues were regularly encountered by healthcare workers in their usual duties along the pre duty-duty- post duty schedule, and what target behaviors may be used to address these. This led to the development of behavioral prototypes, also known as "nudges", which consisted of possible solutions to these key moments, as well as behavioral tools such as breathing, grounding, or checking in to support these interventions. The nudges were tested in five different hospitals throughout the year. It was found that these interventions not only decreased stress among healthcare workers, but also increased positive affect and work-related support.

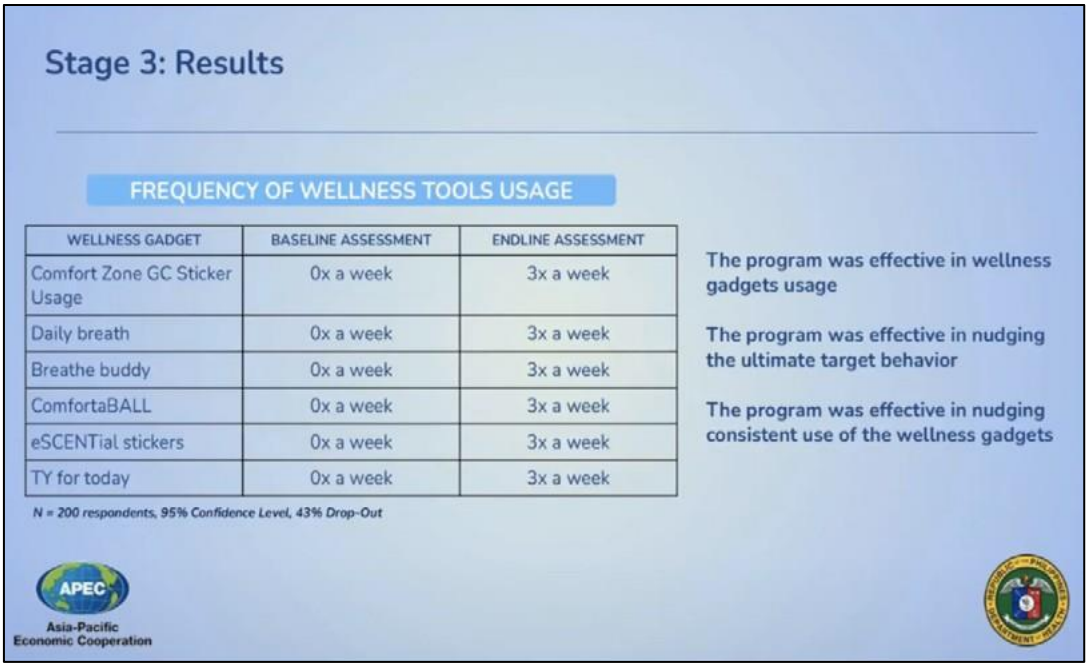
Stages of Program Development (Mantaring, 2023)

During the program's second year, scaled up testing in 21 hospitals to assess the larger impact of these interventions. Participants were enrolled into one of two groups, wherein one group tested support strategies in the workplace while the second group tested resilience strategy behaviors across the pre-duty-duty-post duty cycle. It was found that use of these interventions was associated with better well- being (regression coefficient of 0.726 with $p < 0.05$). Insights from this stage were used to develop a playbook for mass roll-out.

In the program's third year, an additional 28 hospitals were enrolled in the scale up, scale out, scale deep expansion efforts. Insights and communication strategies from the developed playbook were deployed at this stage. Stage 3 also introduced the concept of "community pods" which consisted of 10 hospitals in a region, with each hospital having 100 participants. This strategy was a means of creating pockets of communities of healthcare workers championing mental health and wellness in their unique settings. The use of wellness gadgets such as stickers, apps for breathing exercises, and affirmation tracking was also introduced at this stage. Consistent use

of these gadgets was found to increase the likelihood of practicing the target behaviors, thus attaining a better quality of life and wellbeing. A summary of the wellness tools used is presented in the graphic below.

Onwards to the program's fourth year, a large-scale rollout was planned to target an additional 72 hospitals, with four to five hospitals per region. This last stage of the Wellness Movement Program aimed to mainstream the developed behavior design interventions, since these were proven to have overcome the barrier of inadequate time for healthcare workers to access much needed mental health services. This stage of the program will assess if improved mental health and wellbeing among healthcare professionals will also translate to better patient-level outcomes. As of the time of writing this compendium, this fourth stage is still undergoing its six-month-roll-out.



Results of wellness tools usage among healthcare workers in the Wellness Movement Program (Mantaring, 2023)

The development of this Wellness Movement Program followed a co-creative, iterative process as opposed to a more prescriptive one to better address the stresses encountered by healthcare workers. This would ensure a better fit of the target behaviors to the contexts of the target population, while also promoting eventual ownership of the interventions. The co-creative approach was further emphasized with the use of community pods that would deploy the mental wellness program while taking into account each region's unique sociocultural context. This allows for wellness interventions to better draw on each community's shared experiences and growth, and ultimately become more acceptable and accessible to other healthcare workers and institutions who can be recruited into future roll-outs.

A chief facilitating factor for the Wellness Movement Program was its grounding in public policies, specifically the Universal Healthcare Law and the Health Promotion Framework Strategy of 2030. These policies emphasize the importance of healthy settings and strategies geared towards prevention, and ultimately reducing the burden of the healthcare system. The Health Promotion Framework Strategy of 2030 recognizes workplaces as healthy settings, and thus an avenue for health promotion initiatives such as resilience building for healthcare workers.

The health promotion framework also emphasizes communication, education, and the support from other community members — all of which can be readily tapped in most occupational settings such as the participating healthcare institutions.

A second facilitating factor is the willing participation of tertiary hospitals, beginning from the first phase of the intervention leading up to the large-scale rollout. These institutions have city-wide or region-wide catchments, as well as diverse teams of healthcare professionals. This factor lends more strength to the findings at each stage, and further inspires confidence in communities and institutions for the scaled up rollouts. Furthermore, the wide range of experiences and insight from participants allows for more creative input in the problem-solving and behavior change processes.

A third facilitating factor is the strength of communication and support within each institution's healthcare worker hierarchy, which becomes necessary in the design of behavioral change related to workplace affirmation and support. Nurturing, or at the very least amicable communication with supervisors and their teams forms the core of some of the interventions, and also provides a venue for feedback necessary to develop the playbook in the program's later stages. Emphasis on communication strategies and support also help modify the workplace environment to encourage healthy behaviors and consistency with the behavioral design interventions, thus promoting individual resiliency.

A fourth facilitating factor is the integration of wellness gadgets in the behavioral design interventions, especially in the third and fourth stages of the program. These gadgets not only reinforce the consistency of the target behaviors, but also help simplify the interventions during the roll-out. The judicious use of these wellness gadgets provides venues for future app development that can be used for other interventions for mental health.

Ultimately this Wellness Movement Program demonstrated the impact of behavioral design in modifying a workplace environment to address chronic stress while building resiliency. It is greatly hoped that this health promotion strategy will result not only in better mental health and wellbeing for healthcare workers, but more positive patient-level outcomes in tertiary institutions.

Insights and Lessons

For Healthcare Institutions

- Engage healthcare workers and different departments in pinpointing key areas for interventions and proposed target behaviors for healthier workplaces.
- Positively reinforce healthy behaviors in the workplace through apps, gadgets, or another incentive system
- Integrate healthy behaviors and wellbeing in internal programs for healthcare worker development and performance improvement.
- Assess the feasibility and coverage of telemedicine services for clients or the surrounding community, even outside of crisis situations such as pandemics.
- Engage trained professionals to provide or expand telemental health services to fellow healthcare providers or the institution's client base.

For Government Agencies (Department of Health and others)

- Integrate mental health wellness in strategies for developing human resources for health.
- Implement check-in and support systems using telemental health services for healthcare workers deployed in rural or GIDA areas.
- Assess and monitor the extant coverage of telemedicine services as a whole throughout the member economy, and pinpoint localities to prioritize expansion of coverage.
- Allocate more resources for research and development for mental health interventions and telemental health services.
- Provide training in good practices for telemedicine as part of capacity building for human resources for health.
- Partner with other agencies to coordinate support for telemedicine services as well as referrals for other concerns, especially during disasters and calamities.
- Partner with consulates, embassies, and agencies for migrant workers to expand telemental health coverage to overseas Filipino workers and other migrants.

For Local Government Units

- Introduce mental health wellness strategies in local plans for human resources for health.
- Engage healthcare workers and other local government agencies in pinpointing key areas for interventions and proposed target behaviors for healthier workplaces.
- Partner with the private sector to capacitate healthcare provider networks for the delivery of telemental health services.

For Private Sector Organizations

- Engage with government agencies and local government units for capacity building of healthcare provider networks for telemental health services by training key personnel, innovating with apps and telemental health, and promoting good mental health and wellness practices.
- Form partnerships for research and development for better mental health service delivery to the general public and vulnerable populations (e.g. migrant workers, communities affected by disasters, etc.)

Other mental health initiatives

NCMH 24/7 Crisis Hotline, Telemental Health Response

The "National Center for Mental Health" (NCMH) is one of the best- known avenues for service delivery and health promotion in mental health in the Philippines. This specialized institution provides comprehensive preventive, supportive, therapeutic and rehabilitative services, and has also been designated as an avenue for mental health research and development under the Mental Health Act of 2017. The coverage of its services has also been expanded under the Universal Healthcare Law of 2019.

As part of the expansion of NCMH's services, the institution launched 24 hours/7 days a week crisis hotline to provide urgent free mental health support to Filipinos. In particular, this hotline was geared towards suicide prevention and crisis management. Eventually this hotline was integrated with an online platform to provide Telemental Health services. The Telemental Health services could also be readily tapped by other government agencies during crises such as natural disasters and calamities as part of providing psychological first aid and support.

During the COVID-19 pandemic, the Telemental Health service was also utilized to provide psychosocial support to healthcare workers and frontliners. This led NCMH to adopt a phased approach to expanding the platform first to the staff of NCMH and select healthcare institutions, and then to other healthcare workers all the way up to the general public. A range of services such as psychological support, psychiatric consultation, and counseling interventions were offered on the platform. A summary of the phased approach is presented in the chart below.

In the first three years of the Telemental Health program, 578 frontliners in 2020, 684 participants in 2021, and 138 frontliners in 2022 availed of its psychological first aid. The decrease in the number of clients by 2022 is attributed to better control of the COVID-19 pandemic situation and thus less urgent need for this intervention.

Phases of implementation of the telemental health services

Telemental Health services were also offered to be repatriated and deployed overseas Filipino workers, especially those situated in Lebanon during the bomb explosion incident in Beirut in 2021.

Aside from psychological first aid on this remote platform, NCMH also conducted psychological first aid seminars and psychological processing for healthcare workers and other clients. Another notable intervention was the conduct of harmonized mental health training on Mental Health and Psychosocial Support Program (MHPSS) to first responders to integrate mental health interventions with disaster response measures. These first responders included personnel from the Armed forces of the Philippines and the Philippine Coast Guard, healthcare workers from Saranggani province, and healthcare workers that were sent as responders in the Turkey earthquake of 2023.

The aforementioned hospital also aims to expand the operation of the Telemental Health services, and to provide a model for other local mental health facilities to increase accessibility of mental health services throughout the member economy by the year 2025. There are also plans to continue extending the Telemental Health services to overseas Filipino workers. Furthermore, NCMH also seeks to partner with local government units as well as non-government organizations to expand the coverage and access of mental health services to the general public.

A chief facilitating factor for the Telemental Health service and other interventions was the Mental Health Act of 2017, which mandated the role of NCMH as a research and development institution for mental health and service delivery modalities. The emphasis on community-based mental health services also further drives the development of avenues of care that are readily accessible, private, and free of discrimination and stigma, such as a round the clock platform for psychological first aid.

A second facilitating factor is the proposed expansion of the Telemental Health platform and other services through public partnerships, as was seen in the harmonized training on MHPSS given to members of the uniformed services and healthcare workers from Saranggani province. This collaboration provides a model for capacity building and service delivery for other local government units as well as agencies who are regularly tapped to provide some form of psychosocial interventions. This model is also bolstered by the Universal Healthcare law and devolution planning, which would give agencies and localities the freedom to choose how to integrate mental health into local contexts.

A third facilitating factor is the expansion of telemedicine services, especially during the COVID-19 pandemic. The diversity of other extant platforms also provides an avenue for NCMH to innovate and improve its own Telemental Health services, particularly for the general public. The directive to build health information systems, which are part of the LHS-ML assessment for universal healthcare integration, also supports the integration of telemedicine platforms such as the Telemental Health service for service delivery outside of the centralized context of NCMH.

A fourth facilitating factor, which is also related to universal healthcare integration, is the institutionalization of disaster risk reduction and mitigation plans at different levels of governance, as well as international aid during responses to crises. This factor allows for the training of key personnel in MHPSS, which can be integrated into response plans for various disasters. This training allows for the ready access of individuals in crisis situations to psychological first aid and other key mental health services that are part of recovery and rehabilitation. Furthermore, this also increases the readiness and resilience of first responders deployed to these mentally taxing and stressful situations.

A fifth facilitating factor is the increased acceptance of telemedicine services, both by healthcare workers and by the general public. This drives the further development and expansion of telemedicine services and platforms for mental health, not only in NCMH but in other institutions providing mental health services.

A sixth facilitating factor was the presence of means or channels to expand the Telemental Health services to overseas Filipino workers and migrants caught in disaster situations such as the bombing in Beirut. This shows not only the proof of concept for the utility of Telemental Health for the Philippines' substantial cohort of deployed workers, but also opens up the possibilities for international or multinational collaboration to expand these services in other economies.

With plans for the continued improvement and expansion of the NCMH's Telemental Health services, it is hoped that this will not only increase access to specialized mental health care, but also provide a model for universal health service coverage in this field. This can be made more feasible not only with the recruitment of

skilled professionals and the conduct of training, but also with partnerships with other government agencies and the private sector.

CHINESE TAIPEI

Introduction of the member economy's healthcare delivery

Led by their Ministry of Health and Welfare (MOHW), Chinese Taipei has a public health insurance system that offers universal health coverage for its people since 1995 (Wu et al., 2010).

Chinese Taipei's public health insurance system is similar to the British publicly funded healthcare system. However, the British system is based on tax, and Chinese Taipei's system is based on insurance premiums. One of the most notable changes in Chinese Taipei's health insurance program was to offset the rising healthcare costs by increasing the premiums in 2020 and 2021, which has not been adjusted since 2016 (International Research-Based Pharmaceutical Manufacturers Association, n.d.). The program has also expanded its coverage to include more preventive services such as cancer screening and vaccinations. Co-payments have been introduced in some services, such as outpatient drug prescriptions, to discourage over- consumption of healthcare services.

The government has also invested heavily in developing electronic medical records (EMRs), making it easier for healthcare providers to access patient information and provide timely and accurate care. These EMRs have also improved care coordination among healthcare providers, improving patient outcomes (Lin et al., 2020). In addition, the pharmaceutical pricing system has been reformed for transparency and efficiency to reduce the cost of prescription drugs. The Family Doctor Integrated Care Program (FDICP) that was launched in 2017 has been strengthened in recent years with increased funding and a focus on quality improvement to continue improved coordination of care for patients with chronic diseases (Liang, 2019). The Hospital Patient-Centered Integrated Care Program (HPCICP) was also launched in 2021 to improve the care of outpatient elderly patients with at least two chronic diseases (Commonwealth Fund, 2020).

All these changes to the public health insurance system were met with mixed reactions from the people, with some seen as positive steps towards the prevention of diseases and reduction of healthcare costs overall, but some with concerns about the undue burden on low- income families, discouragement to avail services, privacy implications, possible shortage on essential medications, and with the implementation of these changes, overall (Ku et al., 2018; Chu et al., 2005; Hwang and Lin, 2020; I-chia, 2023).

The MOHW has been working to create a patient safety culture in Chinese Taipei's healthcare system by promoting communication and teamwork among healthcare providers, encouraging patients to be involved in their care, and reporting and learning from medical errors (Wang et al., 2022). They have also implemented three main safety practices to reduce medical errors: using checklists to prevent medication errors, implementing bar-coding systems to prevent medication mix- ups, and using patient safety bundles to improve the care of high-risk patients. Furthermore, the MOHW has been working on enhancing the education and training of healthcare providers in patient safety.

Addressing the nursing shortage is also a priority for the government. They have implemented various strategies to address this shortage, including, offering financial incentives to attract nurses to work in rural areas, expanding telemedicine to allow nurses to provide care to patients in remote areas, investing in new technologies to automate tasks and freeing nurses to provide more direct patient care, and improving the working conditions for nurses by reducing their workload and providing more support staff (Turton, 2022).

In 2002, the severe acute respiratory syndrome (SARS) epidemic affected 29 economies, with at least 8,000 probable cases and 774 deaths, with Chinese Taipei among them with the most cases and mortalities (Stadler et al., 2003; Hsieh et al., 2004). Having been blocked off from participating in the World Health Assembly and lack of access to epidemic information have greatly impacted their SARS response, which impact would influence how they addressed the COVID-19 pandemic (Lin, 2020). Their center for disease control has since established the Communicable Disease Control Medical Network (CDCMN) to be responsible for isolating and treating patients with emerging infectious diseases (EID).

The citizens of Chinese Taipei have high regard for their physical health, lifestyle behaviors, family and finances as key domains to their health and wellbeing (Espinosa et al., 2020). Religion and spirituality can also influence their health and wellbeing as seen in their observance of festivals and superstitions tied to the Lunar New Year (12th lunar month and 1st lunar month of the following year) and Ghost Month (7th lunar month) (Chiu, 2018).

Overall, Chinese Taipei's healthcare delivery system is high-performing, and provides universal coverage, comprehensive benefits and affordable care.

Backgrounder or situation before the introduction of the best practice

Learning from the SARS pandemic in 2003, Chinese Taipei acted swiftly after the notification of the first case of SARS-CoV-2 (COVID-19) in December 2019. In January 2020, their CDC set up a COVID-19 response team, along with the activation of the Central Epidemic Command Center (CECC) as the situation progressed.

In terms of surveillance and laboratory diagnosis, they have identified those with fever, cough, or other respiratory symptoms, especially those who traveled in the past 14 days or were in contact with one. The list of symptoms monitored was expanded as the situation developed. Along with this, a community surveillance system was set-up.

To control transmission, everyone was instructed to isolate themselves in their homes for at least 14 days, wherein they were checked twice daily. Those who developed symptoms were sent to hospitals to be isolated. As more people were put in quarantine, along with decrease in revenue from hotels, a subsidy plan was put in place for hotels to provide more rooms where the people could quarantine. In collaboration with telecommunication companies and local police agencies, an electronic security monitoring system was set-up where people can be tracked through their mobile phones. The opening of schools was delayed in 2020, with established rules on when to prevent classes, in order to prevent school closure due to uncontrolled cases. All these were complemented by social distancing policies put in place.

The CDCMN was made responsible for isolating and treating patients with emerging infectious diseases, including COVID-19. Medical facilities were mobilized to collect specimens, as well as treat confirmed mild and severe cases. In these medical facilities, COVID-19 wards were established to prevent further transmission of those with confirmed mild or severe cases with the rest of the hospital.

From the SARS pandemic, they have also learned to respond quickly by stockpiling and allocating personal protective equipment (PPE) and other medical supplies to prevent shortages. Ban on exporting face masks was implemented, along with the order to increase their production. Alcohol solutions were made to be as available as possible in pharmacies, convenience stores, and supermarkets.

For health education, both mass media and social media were utilized to deliver essential information on COVID-19 as the situation progressed, with daily press briefings by the CECC. The CECC also coordinated with all line ministries and law enforcement agencies to manage disinformation.

While there was no explicit mention of the mental health and wellbeing of their general population and healthcare workers in their COVID-19 response, mental health services have been available in Chinese Taipei post-World War II, with the enactment of their Mental Health Act drafted in 1990 (Wu and Cheng, 2017). Although mental health was initially downplayed due to the focus on dealing with other epidemics, the destruction caused by the war, and the presumption that it is unimportant, it is eventually given recognition with the establishment of their Taipei City Psychiatric Center (TCPC) in 2005. Their Mental Health Act started the shift of the role of psychiatry for the citizens from passive custody to active treatment. It was later revised in 2007 with the involvement of more disciplines, and the emphasis on the patients' rights and welfare. By then, mandatory community treatment was implemented to enhance preventive mental health and support the patients' autonomy.

Currently, non-government organizations, grassroots movements, legal, industrial, pharmaceutical and administrative institutions be involved in mental health planning. There is strong communication and integration with private organizations leading to improved crisis response during disasters and more made known information on trauma psychology. Other achievements when it comes to mental health include the destigmatization of

schizophrenia and the canceling of the need for psychiatric certification for sex reassignment surgeries.

Although there are visible improvements to an already well-functioning mental health service model, the prevalence of psychiatric disorders has still been increasing for the health service of Chinese Taipei, with the traumatic stress they experienced found to be comparable with those from other economies (Huang et al., 2023). This may be attributed to factors such as worsening labor conditions, widening gap between the rich and poor, bad employment markets, and disasters such as the COVID-19 pandemic (Wu and Cheng, 2017).

Discussion of the good practices and facilitating factors

Best Practice: COVID-19 Mental Hygiene Guidelines for Staff in Healthcare Facilities that provides guideline for psychological support and assistance for medical staffs during pandemic by their Central Epidemic Command Center (CECC).

Central Epidemic Command Center.

To complement the general strategy for addressing the COVID-19 pandemic, and the rising prevalence of depression and anxiety in the people, especially their healthcare workers, the CECC released guidelines to support the mental wellbeing of healthcare workers as they serve the frontlines to address the pandemic. The guidelines for medical institutions also recommend the following:

(1) Establishing In-hospital Care Mechanisms
(2) Providing Guidance and Education
(3) Conducting surveys and interviews
(4) Providing psychological care services
(5) Taking care of employees' physical and mental health
(6) Providing Supervisor Action Support

These measures were meant to provide psychosocial support and assistance for the staff of medical facilities.

(1) Establish an in-hospital care mechanism

- To organize the task force on mental health services, it is recommended to set it under existing healthcare mechanisms in medical institutions, or other institutions responsible for epidemic prevention and response (e.g., Chinese Taipei's CECC).
- It is suggested for the task force to include members from various units such as Medicine, Nursing, Physical Therapy, Occupational Therapy, Psychology, Social Work, Psychiatry, Human Capital, among others to assist in taking practical and feasible actions to provide employees with a working environment that supports their physical and mental health.
- Appoint senior executives from different medical units to serve as the persons-in-charge for mental health services for employees, commanding the cooperation of the whole hospital or medical institution. This is expected to have a better promotional effect than having only a certain unit be responsible.

(2) Planning advocacy and education

- The top executives of medical institutions can play a leading role in creating a safe and healthy working environment under the epidemic situation.
- Usually, supervisors should be trained to have employee care skills, so that they can devote themselves to employee care work during the epidemic.
- The organization's epidemic prevention policies and information should be transparent, so as to provide employees with instant access to news and various policy information.
- Collect online epidemic information and provide references for colleagues in the hospital. Suggested methods include setting up an epidemic prevention area, staff Q&A, closing lazy bags, among others.
- Regularly send caring texts to staff.
- Produce epidemic-related literature or short promotional videos, etc.
- Send documents to promote the service methods, time and content of various physical and mental health support programs.
- Utilize multiple channels, such as the Internet to provide employees with various service channels such as self-care resources (news), dedicated telephone lines, online services, and consultation mailboxes.

(3) Conduct surveys and interviews

- Investigate the physical and mental stress of employees and arrange the priority order according to the risk of the unit and implement measures starting from the priority unit, eventually expanding to the whole institution.
- Design or adjust care service content based on survey results.
- After the epidemic is over, evaluate the physical and mental trauma and mental health needs of employees, and plan follow-up service measures.

(4) Provide psychological care services

- Evaluate whether it is necessary to set up a psychological care task force and plan the psychological support service plan for employees in the hospital at various stages of epidemic prevention.
- Formulate the workflow and graded service content of the psychological support service plan in the hospital.
- The methods of providing psychological support service programs are suggested to be:
- Assessment of physical and mental status
- Interviews with supervisors
- Referrals
- Lectures
- Individual talks
- Group psychological support services

According to the psychological needs of different employees (confirmed patients, those with high risk of suspected infection, those in close contact with the case, those with high stress or symptoms of physical and mental distress, those with travel history, and those in other clinical and administrative units), formulate care measures. Confirmed patients, those at high risk of suspected infection, and those who are in close contact with individual cases should have the same problems, but to different degrees:

Table 3: Employee category with corresponding issues and care measures

EMPLOYEE Category	Reported ISSUES	CARE MEASURES
Diagnosed person	► Physical discomfort ► Worry about disease progression ► Anxiety and fear of death ► Family care issues ► Worry about affecting colleagues, family, relatives and friends	► Explanation of epidemic prevention and treatment regulations ► (Timed) letter/telephone or video care ► Physical and mental stress assessment ► Provide self-care information ► Referrals to related resources ► Counseling ► Include follow-up care
High-risk persons suspected of infection	► Anxiety, fear, uneasiness, worry about diagnosis ► Intense emotional reaction to knowing the outcome ► Worried about privacy exposure and being discriminated against	► Timely publicity of epidemic prevention and correct protection ► Letter/telephone or video care at least once ► Physical and Mental Stress Assessment ► Teach how to reduce stress and relieve stress ► Provide self-care information
Front-line Workers	► Increased workload ► Fear of being infected, fear of being quarantined ► Personal and Professional Ethical Conflicts ► Insufficient or unskilled protection ► Discomfort caused by protective equipment ► Stressful or difficult to deal with emotional problems of patients/family members	► Correct concept and technology of protection ► Pay attention to shift schedule ► Early psychological construction ► Letter/telephone or video care ► Physical and Mental Stress Assessment ► Stress relief groups provide self and case care information ► Provide support channels for patients' families
People with travel history	► Encounter strange eyes ► Accused of going abroad during epidemic prevention ► Worry about being a spreader of disease or a breach in your defense	► Letter/telephone or video care ► Physical and Mental Stress Assessment
Other clinical and administrative units	► Worry about being infected ► Rejected by the outside world (takeout orders are rejected, considered to be a virus spreader) ► Increased workload	► The whole hospital sends out leaflets, texts of care and encouragement, and publicizes the service methods, time and content of various physical and mental health support programs. ► Production of epidemic-related literature or filming promotional videos, etc. ► Through multiple channels, such as the Internet platform, provide employees with self-care resources (news), dedicated telephone line, online service and consultation mailbox, etc. ► Conduct lectures ► stress relief group ► Physical and Mental Stress Assessment

(1) Taking care of employees' physical and mental health needs

- To care about the mental health of employees in medical institutions, not only teach them how to reduce stress or develop resilience, but also how to cope with anxiety. Specific support can make employees feel safe and secure in the working environment to avoid the possible physical and mental damage caused by the epidemic.
- Medical institution executives must understand/concern/try to reduce the root causes of employee anxiety.
- Provide sufficient personal protective equipment (PPE) to protect/prevent employees from severe specific infectious pneumonia (COVID-19) infection as much as possible, and to ensure that employees work safely and do not have to worry too much about themselves, their family members or friends being infected.
- Provide effective and adequate training in medical services, especially for junior or support workers.
- Meet the individual needs of employees and their families as much as possible.
- Provide the meal service of the responsible unit for missing meals.
- Provide temporary housing for employees at risk of infection and their dependents.
- Encourage employees to take into account daily epidemic prevention measures and their quality of life and develop healthy psychological relief from leisure and entertainment.
- Organize anti-epidemic related stress-relief activities.
- Provide relevant information on personal rights and interests such as government subsidies and loss subsidies, and actively issue certificates or assist in application procedures.

(2) Supervisor Action Support

- The director of the medical institution regularly inspects the unit to express condolences to the hard work of the employees.
- Pay attention to whether employees are tired, burnt out, overworked or overwhelmed.
- Pay attention to whether employees and their families are discriminated against or excluded.
- Let employees' voices be heard, professional knowledge be seen, and hard work and dedication be affirmed.
- Let employees know that there is a back-up or on file, that competent personnel have been deployed and will assist in resolving issues quickly.
- Listen to and confirm the requirements of employees and take care of what is needed for their physical and mental health as much as possible.
- Properly handle cases that the news media pays attention to
- Send medical institution incentives or compensation, etc.
- After the end of the epidemic, public recognition activities, etc.

Insights and Lessons

All these measures are guidelines or suggestions on implementing a program to support the wellbeing of healthcare workers in medical institutions as what they did for Chinese Taipei. Not all items may apply and can be modified depending on the needs of the institution. These guidelines can also be adapted and modified in preparation for other disasters. It is still recommended that a mental healthcare program is complemented by strong leadership, open communication, timely education, and supportive work settings.

THAILAND

Introduction of the member economy's healthcare delivery

Thailand is situated on the mainland of Southeast Asia, and has a projected population of approximately 71,815,000 (United Nations, 2023). Thailand has implemented its own system for universal healthcare coverage since 2002, in hopes of rectifying service delivery inequities attributed to fragmented benefit and welfare schemes. Prior to the inception of universal healthcare coverage, four different schemes were simultaneously in play for health financing and service delivery: tax financing for civil and public servants, tax financed medical welfare schemes for indigents, contributory social welfare financing for employees in the private sector, and voluntary health card financing for households. However, inequities seen in service delivery, particularly for the informal sector, helped prompt a shift to a universal healthcare coverage scheme that is financed from general government taxation. This scheme is primarily non-contributory in nature and co-exists with contributory schemes under the ministry of labor and a separate financing scheme for civil servants (Sumriddetchkajorn et al, 2019). A THB30-copayment contribution has been imposed, removed, and reinstated at different times since the universal healthcare coverage implementation. The reinstatement of the copayment was not found to have an adverse impact on individual utilization of public health services (Paek et al., 2016).

The present universal healthcare coverage public system in Thailand includes primary care services in sub-district centers, secondary hospitals per district, tertiary hospitals per province, and advanced referral centers per region. Services included in universal healthcare coverage are primary care and outpatient services such as anti-retroviral therapy for HIV/AIDS, renal replacement therapy, management of NCDs such as diabetes and hypertension. Also included are some specialized inpatient services such as thrombolytic therapy for stroke patients, transplantations (heart, liver, stem-cell), knee arthroplasty, and long-term care for psychiatric patients and the elderly. In urban centers that are independent of the district set-up, private providers fill in the gap especially for primary care services. These private clinics may be contracted by government agencies to join a network of providers catering to a specific catchment population. Private healthcare providers should be able to provide the same comprehensiveness of care if they are to be contracted for the universal healthcare coverage scheme (Marshall et al., 2023). Independent of this universal health coverage is medical tourism, which primarily caters to patients from high-income as well as low- and middle-income economies. Thailand has consistently been among the preferred destinations to avail of cosmetic procedures, as well as orthopedic implants and gastrointestinal surgeries. It is estimated that medical tourism provides about 0.4% of the member economy's gross domestic product (Noree et al., 2016).

Thailand's universal healthcare coverage system faces several particular challenges such as managing the costs of care vis-a-vis the needs of the population. Although general taxation is currently seen as the most manageable way of funding universal healthcare, there have been concerns raised regarding the sustainability of this measure considering the annual rises in healthcare expenditure. The current three-tier healthcare coverage scheme also represents inefficiencies in using revenue, especially given the differences in conformity of benefits among beneficiaries. There is a need to diversify robust funding and nurture partnerships for innovation in order to continue to provide quality healthcare services for the general public without unduly burdening the member economy's resources (Sumriddetchkajorn et al., 2019).

Despite Thailand's public sector's intent to provide quality comprehensive health services to residents regardless of income standing, some patients still care in non-designated or out-of-network facilities. This includes utilization of private sector facilities, as well as resorting to traditional medicine, use of over the counter medications, or other informal health-seeking behavior. Utilization of non-designated or out-of-network services was more common among employed beneficiaries or those with higher income, while unemployed beneficiaries or those with lower income were more likely to utilize their designated facilities. Patients with chronic health conditions also preferred seeking care from designated facilities. While these findings showcase the responsiveness of Thailand's healthcare system from a vertical equity standpoint, the preference for non-designated care may signify difficulties with accessing care from designated facilities, or unmet health needs from the public health system. Ultimately this results in 100% out-of-pocket expenditure for some beneficiaries'

healthcare needs, signifying pitfalls in policy strength and access for universal health care coverage (Paek et al., 2016).

Another challenge encountered in Thailand's universal healthcare coverage program is the inequitable distribution of human resources for health. It has been estimated that there are over 176,000 nurses and 36,400 physicians in Thailand. Pharmacists and dentists formed a significantly smaller portion of human resources in the healthcare system (Statista, 2023). Overall it has been estimated that there are about 2.04 healthcare workers in public facilities per 1,000 population. The distribution of healthcare workers, especially doctors in provincial and regional hospitals, tends to favor slightly the more economically well-off areas. Interestingly though, the distribution of human resources in district hospitals favors slightly less well-off areas. Rural infrastructure development and retention policies contribute positively to the distribution of healthcare workers in rural areas, however it remains to be seen whether the current healthcare workforce will be adequate to serve the needs of a rapidly urbanizing Thailand (Witthayapipopsakul, 2019).

Although universal healthcare coverage has resulted in the decline of all-cause mortality in Thailand, this has not translated into a reduction in the prevalence of some diseases such as hypertension and diabetes (Sumriddetchkajorn et al., 2019). One notable challenge is addressing the HIV/AIDS situation, with over half a million persons living with HIV (PLHIV) and approximately 11,000 deaths due to AIDS annually in Thailand. Efforts to step up screening and early initiation of antiretroviral therapy have improved the health status of PLHIV and helped eliminate vertical or mother-to-child transmission of HIV. Nevertheless, there still exists significant stigma against HIV care, thus hindering efforts to complete the cascade of care for PLHIV (UNAIDS and WHO, 2022).

Backgrounder or situation before the introduction of the best practice

Mental health services have been integrated into Thailand's primary health care system since 1982, well before the institution of the member economy's universal healthcare coverage model. This initial integration shifted mental health services to community-based care, which remains a mainstay for service delivery to this day. Thailand's public mental health policies to further organize mental health care in service areas were first implemented in 1995, followed by the legislation of a Mental Health law in 2008. Despite these gains in policy, accessibility and capacity of mental health services continue to be a challenge for most of the population. Presently there are 13 regional mental health centers that help organize community mental health networks in their respective jurisdictions. The member economy's infrastructure for mental health also includes 20 inpatient facilities with attached outpatient departments, some of which specifically cater to children and adolescents. However, none of these specialized facilities have mobile teams to help increase access to service users (Wannasewok et al., 2022).

Further limiting access is the inequitable distribution of psychiatrists, with most of them practicing in urban areas such as Bangkok. This is somewhat mitigated by the training of general practitioners in preventive medicine focusing on health promotion and community mental health interventions. There is also a shortage of trained nurses, psychologists, social workers, and occupational therapists to fulfill mental health needs in the community setting (Wannasewok et al., 2022). It was noted that the areas of Trat, Phrae, Samut Songkhram, Sing Buri, Nong Bua Lamphu and Ang Thong did not have a single psychologist in the public hospitals, while in the area of Loei there was only one psychologist for a catchment of over 52,000 patients. This shortage is attributed to the cost and length of time needed to train mental health professionals especially psychiatrists, as well as the lack of standards to properly capacitate non-medical specialists such as counseling psychologists.

The dearth of mental health specialists in public facilities has resulted in long waiting lists for scheduling consults, thus prompting some patients to seek help from private providers. This results in large out of pocket expenditure for initial consults, follow-up appointments, and medications (Thai PBS World, 2022).

Stigma related to mental health and seeking care also persists in some communities, thus further hindering health seeking behavior for mental health conditions. Overly religious understandings of mental health conditions, including the association of psychosis and other mental health symptoms with spiritual possession are still fairly common (Kim, 2018). This is also related to preferences for spiritual or supernatural remedies to mental health conditions, as well as the rise of holistic healing centers to provide some psychological interventions without the prevailing stigma associated with conventional mental health services. More importantly, the persistence of stigma and misconceptions about mental health signify the need for increased literacy surrounding these healthcare concerns and the available resources in the healthcare system (Rhein, 2023).

Aside from the aforementioned barriers to care, both within the universal healthcare coverage system and more specifically to the mental health system, additional difficulties have been noted in catering to the mental health needs of Thailand's aging population. Stress was identified as a mental health concern for elderly residents in Thailand and was associated with alcohol consumption and the presence of chronic illnesses such as hypertension and diabetes (Seangpraw, et al, 2019). Other factors related to mental health concerns in this population group include family relationships especially among household members, financial status, as well as social and community environments. Limited mental health literacy and adherence to superstition also posed challenges in meeting the mental health needs of Thailand's elderly, especially in rural areas with more limited access to mental health professionals (Rhein, 2023).

Another growing mental health concern in Thailand is an increase in the prevalence of depression as well as suicide rates. The number of patients being treated for depression rose from 4,295 in 2013 to 259,467 in 2017. Suicide rates also rose in the northern provinces of Mae Hong, Chiang Mai, Chiang Rai, Phrae, Nan and Lampang between 2016 and 2020. The province of Mae Hong Son, which had the highest suicide rate during this time period, reported a ratio of 17.44 suicides per every 100,000 people in 2020 (Thai PBS World, 2020).

Depression and suicide are of particular concern for the youth, with one out of seven adolescents between the ages of 10 to 19 being diagnosed with mental health problems. Up to 17.6% of youth between the ages of 13 to 17 had seriously considered suicide, as per the 2021 Global School-based Student Health Survey. Suicide is also the third leading cause of adolescent mortality in Thailand. Suicide and mental health problems among adolescents were related to bullying, loneliness, and uncertainty, and were further exacerbated by the impact of the COVID-19 pandemic (UNICEF, 2022).

The increase in mental health problems and suicide rates during the COVID-19 pandemic was seen in other demographics aside from the youth. Throughout the member economy, diagnoses for mental health disorders rose from 1.3 million in 2015 to 2.3 million in 2021. Aside from stress, anxiety, and depression related to the pandemic, patients reported increased use of substances such as alcohol and psychoactive substances (Rhein, 2023). Patients with long COVID, which is associated with sleep disorders, anxiety, and depression, also pose an additional challenge to Thailand's mental health services especially in the community setting (Wannasewok et al., 2022).

During the earlier months of the COVID-19 pandemic, most of Thailand's healthcare resources were allocated to quickly responding to this public health threat. As early as 3 January 2020, screening was already implemented at Thailand's borders for passengers with symptoms of acute respiratory infection. The first COVID-19 case detected outside China was screened in Thailand on 13 January 2020. Local transmission of COVID-19 was confirmed by 31 January 2020. The public health response to the pandemic included rapid contact tracing and isolation of confirmed cases in facilities, and mandatory 14-day quarantine of international travelers. Thailand's laboratory network was quickly capacitated to provide RT-PCR tests in most of Thailand's provinces. Mobility restrictions, curfews, and closures in schools and non-essential businesses were implemented when cases peaked during March 2020, but the concerted public health efforts led to the control of local transmission by April 2020 (WHO, 2020).

A second wave of infections was reported in December 2020, resulting in a caseload that was seven times greater than that of the first wave. This time, the public health system utilized a more targeted approach to infection control owing to the negative economic impacts of the more stringent lockdown measures during the first wave of infections. A zoning system was implemented to classify provinces according to the outbreak situation and risk for infection. More stringent mobility measures were implemented in areas classified as hotspots. Since the

caseload for the second wave was larger and with more reported cases of asymptomatic transmission, infection control strategies shifted from individual contact tracing to active case finding through mass testing in workplaces and other areas with higher risk of transmission.

Field hospitals were once again put up in temples, camps, and warehouses to better isolate asymptomatic cases, while patients needing more specialized medical care for moderate to severe COVID were transferred to tertiary hospitals. Volunteers from villages as well as medical personnel mobilized from other provinces helped boost human resources for health in the most severely affected areas. Scaled up resources from the first wave as well as the agile response for the second wave were able to control the spread of COVID-19 in Thailand by April 2021 (Rajatanavin et al., 2021).

People take the swab test for COVID-19 in Bangkok, Thailand.
Photo by Xinhua / Rachen Sageamsak

At present, attention has turned to addressing the gaps in mental health services that became more apparent during the pandemic. One intervention is the formulation of solid regulations to capacitate the practice of clinical psychologists in the community setting. However, this endeavor is expected to take a number of years owing to the necessity of a multi-player approach (Thai PBS World, 2022). Additional training opportunities for promising students in the mental health field, scholarships, and mandatory service agreements are also among the strategies being studied and deployed to boost human resources for mental health in Thailand (Kim, 2018).

Strengthening community mental health services is also seen as key to addressing the increased prevalence of depression, anxiety, and other disorders. In line with this is increased cooperation with community leaders for mental health promotion and education. One measure already in place even before the COVID-19 pandemic was a collaboration with the Department of Mental Health and local monks to come up with programs to recognize persons with mental health problems, as well as integrating Buddhist concepts of spirituality and mindfulness with Western mental health treatments Such collaboration was also a way to reduce the stigma around mental health (Kim, 2018). Efforts to reduce stigma around mental health and improve health seeking behavior have also been utilized in the School Health HERO project to help students reintegrate in the formal schooling system in the aftermath of the COVID-19 pandemic. This approach not only provides mental health services to students and integrates mental health in the curriculum, but also empowers teachers to take an active role in the school community's mental health care (WHO, 2022).

Another approach to strengthening community mental health services emphasizes the importance of self-care as an initial mental health intervention. This includes early childhood development monitoring within families, self- monitoring of symptoms and mental health concerns, and empowerment for decision making regarding mental health care. This is seen as a prelude to seeking mental health services at the primary care level, where early detection, community rehabilitation, and adherence to treatment are emphasized. The primary care level is also where referral to higher levels and more specialized services can take place. Integration of mental health services into care and follow up for NCDs, antenatal care, and vaccination appointments also provide opportunities for early detection and intervention for various population groups (Wannasewok et al., 2022).

Discussion of the good practices and facilitating factors

Best Practice: MH Care Model for the People in Pandemic 2020

An important aspect of Thailand's and other economies' COVID-19 response was the recognition of several "waves" or times of high impact from the ongoing pandemic. Apart from the initial impact of mortality and morbidity related to the virus, the following impacts were also observed: resource restriction for conditions outside of COVID-19, interruption of care for chronic conditions, and psychic trauma accompanied by burnout, mental illness, and economic injury. It is believed that the impact of the "fourth wave" is longer reaching and can affect even those who did not fall ill from COVID-19. This leads to an overall rise in mental health disorders, both in vulnerable populations such as healthcare workers and caregivers, as well as the general population (Ketphan et al., 2020).

Thailand's Department of Mental Health quickly recognized the following emerging mental health concerns, even as the transmission of COVID-19 was already under control:

- Much of the general population experienced stress, anxiety, and depression especially during the times when strict infection control measures were in place.
- Older people were at higher risk for anxiety related to the pandemic situation.
- Reported symptoms of mental health problems included the following: bad feelings, frustration, anger, losing concentration, not being able to eat and sleep, and physical illness. Emotional exhaustion, loss of motivation, and burnout were also reported among healthcare workers.
- Suicide rates were rising in the general population, with a rise of more than 20% from between 2019 and 2020.
- Work-related factors were a major source of stress for many in Thailand, with eight out of ten public health employees and four out of ten Thai people reporting suffering from stress and pressure from their work.
- The following population groups were most at risk for mental health problems: healthcare staff working closely with COVID-19 patients, chronic NCD patients, alcoholics, and drug users.
- Insufficient communication of accurate information about the pandemic situation leads to miscommunication and increased stress and anxiety even among healthy individuals.
- Mental health problems were also triggered by the unpredictable nature of COVID-19 transmission combined with improper or ineffective countermeasures. A common fear was that of bringing the virus to family members and other vulnerable individuals at home, at work, or in the community.
- The increasing prevalence of mental health disorders in the general population would put additional stress on the healthcare system, and also have negative effects on the economy and society at large.

Addressing the rise in mental health disorders would then require a multi-level approach or mental health model engaging individuals, families, and communities. The proposed mental health model would foster the following three qualities on the individual and the family level: positivity regarding the capacity to cope with pandemic-related problems, flexibility to adapt and create solutions for the situation, and unity. Support, communication, and information sharing would be promoted on the community level as part of mental adaptation and independently reducing stress and depression.

These qualities would be at the center of the creation of a "Mental Vaccine" that would prepare the population for the "New Normal" as Thailand moved through the evolution of the COVID-19 pandemic (Ketphan et al., 2020).

The following stages and interventions for Thailand's mental health model are summarized in the following table:

Table 4: Mental health interventions with corresponding goals and objectives

OBJECTIVE	INTERVENTIONS	TARGET/GOALS
Integrate extensive support and protection of mental health, and control the factors causing mental health problems	► Integrating mental health services under the following four dimensions: ► Support ► Protection ► Treatment ► Curing ► Control the quality and release of information regarding COVID-19	► Directly address factors affecting mental health, specifically the type and flow of information regarding the pandemic ► Foster multi-sectoral cooperation for mental health interventions
Improve the quality of mental health services and psychiatry	► Creation of the following for mental health services: ► Personnel plan ► Location plan Medical instrument/supplies plan ► Limitation of service system plan ► Academic plan	► Adaptation of mental health services and psychiatry to meet the increased demand
Improve the communication system regarding the risks for mental disorders and educate people about mental health	► Enlist skilled communicators from the medical/mental health field as well as from communities ► Develop messaging to educate about the factors affecting mental health, and the importance of mental health support and follow-up	► Creation of an uninterrupted sharing and networking system for educating the people, utilizing current technology
Develop staff to increase work efficiency during the COVID-19 pandemic	► Provide training in mental health skills such as interviewing, examination, and collecting information ► Improvement of internal medicine training	► Increased work efficiency both for mental health services as well as medical services for the COVID-19 pandemic
Develop a synthesis of information systems to propose a policy recommendation for mental health	► Mapping flow of information from message senders (healthcare authorities and professionals) all the way to the community level (leaders and volunteers)	► Increased trust among the people regarding received information ► Support awareness and the importance of fact-checking
Develop and provide the "Mental Vaccine" to individuals, their families, and their communities in preparation for the "New Normal" life	► Individual level: supporting, protecting, curing, and recovering. ► Family level: positivity, flexibility, unity ► Community level: communication, problem solving, and networking	► Build resiliency and prepare for the "New Normal"

This mental health model would have the following benefits:

- Training people in problem-solving
- Positive outlook on the unstable situation
- Self-emotion management to reduce stress and depression
- Self-understanding and self-motivation (Ketphan et al., 2020).

The heart and chief facilitating factor of this mental health model is Thailand's community mental healthcare system, which seeks to address the root causes of stress and mental health disorders and their impact on the community level. Although this model necessitates the participation of mental health professionals and government institutions, the key interventions are designed towards laypersons and patients in their respective settings. Patients seek more support from their families and communities, and not necessarily from the mental healthcare system. These would lessen the burden on mental health providers and facilities, and on the healthcare system as a whole.

A second facilitating factor is the use of self-care as a forefront strategy for mental health during the pandemic. This mental health model focuses on the development of skills and mindsets necessary for resilience and adaptation in an unstable situation such as the COVID-19 pandemic. This model also emphasizes the capacity of individuals to engage in critical thinking regarding the information being circulated during the pandemic and seeks to equip them to handle this in a healthy manner.

A third facilitating factor is the institutional capacity to manage the quality and flow of information and key messaging regarding the pandemic situation. This serves to lessen miscommunication and the circulation of fake news, thus reducing anxiety and misunderstandings on the individual and interpersonal levels.

A fourth facilitating factor is the institutional support for interventions such as training medical frontliners, multi sectoral collaborations, and designing networks to educate the general public about mental health. The top-down support from government institutions to local volunteers and leaders, as well as the horizontal support among agencies, healthcare providers, and institutions allows for a robust response and coordinated deployment of this model.

Thailand's mental healthcare model for the general population aims to equip or "vaccinate" the people with skills, mindsets, and social ties that will help them adjust to a "new normal". This approach is key for improving mental health status not only during the COVID-19 pandemic but also in the face of future developments and upheavals. This preventive approach on the community level will not only build resiliency, but also lessen the burden of stress, depression, and other mental health conditions on the public mental health system.

Insights and Lessons

For Government Agencies (Department of Mental Health and others)

- Expand platforms and venues for self-assessment and self-care for the general public, with more robust pathways for seeking further help in the primary care setting and other mental health providers or facilities.
- Streamline the regulation and training of healthcare workers for mental health in order to build the human resources for this field.
- Explore recruitment, deployment, and retention programs for the mental health workforce in provinces and territories with a paucity of trained professionals in public facilities.
- Invest in additional human resources for health, facilities, and services for child and adolescent mental health, as well as mobile resources for elderly mental health.
- Contract private institutions and organizations to provide mental health services in urban areas that are not under the public district system, as well as underserved rural areas with limited public health resources.

- Shift public mental health messaging to promote everyday resilience and preparedness even without crises such as the COVID-19 pandemic.

For Healthcare Providers and Institutions

- Provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services.
- Strengthen referral systems and networks for mental health services from the primary care level in districts up to tertiary hospitals and specialized centers in the regions.
- Engage in mental health outreach or community engagement programs through mobile facilities and health promotion efforts outside of the facility setting.
- Integrate mental health and wellness check ins into other pathways of care such as NCD follow ups, antenatal visits, well child checkups, etc.
- Participate in mental health surveillance systems and networks.
- Engage in research and development activities for mental health.

For Community Leaders

- Participate in mental health awareness and capacity building activities geared towards laymen and leaders on the community level.
- Coordinate referrals to the primary care level for individuals at risk or vulnerable groups for mental health problems
- Cascade/disseminate important mental health information to the community, especially messaging to reduce stigma and promote health seeking behavior.

For Private Sector Organizations

- Engage with the healthcare sector to provide specialized training for medical and allied health professionals to increase the human resources capacity for mental health services
- Conduct mental health outreach or community engagement and advocacy programs in the community setting
- Collaborate in research and development activities for mental health

Other mental health initiatives

MHPSS platform for mental support for health care workers

Burnout was among the main mental health problems identified among healthcare workers during the COVID-19 pandemic. Other mental health problems experienced by this vulnerable group included distress, depression, suicidality, and psychophysiological changes such as insomnia, eating habits, and exercise. Work-related factors such as organizational issues (e.g. tensions between staff, policy challenges, etc.) and adjustment to workloads and environmental conditions were considered the main stressors for healthcare workers. To help address these issues, a Mental Health and Psychosocial Support (MHPSS) platform was rolled out specifically for healthcare workers from 2020 to 2030.

The MHPSS platform focused on addressing burnout and decreased productivity through offering a range of interventions for psychological support and self-care. Another important aspect of this platform was the Positive After-Action Review (PAAR) that allowed for rapid assessment of problems in the workplace, followed by examination of solutions and the sharing of acquired learning and knowledge. To facilitate the implementation of this platform, healthcare workers were also trained in online counseling, crisis management, and team leadership. The structure of the rollout of this MHPSS platform is illustrated in the figure below:

Actual MHPSS interventions on the platform consisted of the following:

- Training program for leaders addressing burnout and productivity on HCW
- Creating positive mental health support: PAAR
- Online self-care, telecounseling service
- Outreach crisis counseling service team
- Psychiatric service

As part of creating a more positive environment for mental health, the following support interventions were also rolled out:

- Leadership participations; Walking team, appreciation
- Positive environment; social welfare, safety, positive communication, outreach team
- Service integration; Buddy system, PAAR, MHCI self-screening application
- Individual literacy; Stress management skill, family care, work balance

With the help of this MHPSS platform, healthcare workers had better opportunities to reduce their risk of burnout without compromising their busy schedules. The platform also was a means to build health literacy and impart skills related to self-assessment and self-care, which were deemed as important factors to prevent burnout. These individual interventions were supported by environmental change in the form of support from colleagues and team leadership, as well as through fostering positive communication and appreciation in the workplace.

Figure 3: Mental Health Support Teams and Environment

The initial rollout of the MHPSS platform recruited 200 healthcare workers, but this increased to a total of 460 by 2023. Coverage of mental health provision in this group was at 94.09%. More than half of the participants availed of basic psychological support services. About 33% needed additional follow up visits, while only 13% necessitated referral to a physician. By the end of the intervention, the incidence of increased risk of mental health problems was reduced to 14.67%.

A main facilitating factor for this intervention is the agility of Thailand's health system, which allowed for rapid recognition of the problem of burnout among healthcare workers and the timely rollout of an MHPSS platform. The presence of strong institutional support for MHPSS interventions also helped with the program's expansion over the years as well as the formation of teams for mental health service delivery to the healthcare workers.

A second facilitating factor related to the strength of the healthcare system is the presence of infrastructure for mental health service delivery. This includes telecommunications and information technology to facilitate online interventions such as telecounseling and consults, as well as provisions for outreach mobile services. The extant health infrastructure in Thailand also allows for a diversity of mental health interventions to address the

needs of healthcare workers in their different workplaces.

A third facilitating factor is the emphasis on self-care in Thailand's mental healthcare system. Self-care is considered a means of empowering individuals regarding their mental health care, as well as a way to reduce the burden on the health system. In the case of this MHPSS platform, the emphasis on self-care also allowed healthcare workers to learn skills regarding self-assessment for mental health, teamwork, and support, but without compromising their busy schedules and workload. Self-care also facilitates the PAAR aspect of the MHPSS platform and can be used to continue to solve workplace related problems that may contribute to burnout.

The MHPSS platform is a recommended practice to build resilience and promote self-care in the workplace. It is also a way to aid healthcare workers in their respective contexts, while giving them the tools to cope with workplace stresses and make positive changes to their work environment. The MHPSS platform's emphasis on problem solving and self-assessment also allows for more sustainable change that would prevent burnout in future crises.

Mental Health Check-In

Early in the COVID-19 pandemic, Thailand's Department of Mental Health recognized the importance of data gathering and surveillance in understanding the prevalence of mental health conditions and their associated factors. In 2020, the "Mental Health Check-In" digital platform was rolled out to provide self-assessment related to the following problems: stress levels, symptoms of depression, burnout, and suicidality. From January 2020 to April 2022, a total of 3,186,935 cases were assessed using this system (Wannasewok et al., 2022).

This platform was available to the general public, but specific population groups such as village volunteers and the elderly made up only a minority of cases, at 17% and 16% respectively. After receiving the results of their self-assessment, individuals were given advice on next steps to take such as seeking additional mental health support (Promchertchoo, 2021).

Data gathered from the platform was used for mental health surveillance, yielding the following findings:

- 8.83% of cases had a risk of depression
- 7.48% of cases had a self-reported high level of stress
- 4.87% of cases were at risk for suicide
- 4.19% of cases were at risk for burnout (Wannasewok et al., 2022).

A main facilitating factor for the Mental Health Check-In platform is the capacity for self-care and self-assessment that is in line with a key principle of Thailand's community mental health system. Self-care, which includes self-recognition of symptoms and decision making for mental health, is the frontline intervention in the community mental health system and is a prelude to seeking care at the primary care level or at more specialized facilities. The check-in platform provides an opportunity for individuals to practice this self-care at their own pace, without worrying about stigma or discrimination at this stage of intervention.

A second facilitating factor is the presence of a robust internet and telecommunications structure that allows for this platform to be readily deployed to the general population. Without the presence of adequate connectivity in most if not all areas of Thailand, this platform would not only be less utilized but also less useful for mental health surveillance.

A third facilitating factor is the agile public health response from Thailand's healthcare system. This allowed for the self-assessment platform to be rolled out in the early months of the pandemic, thus increasing the opportunities for data gathering and mounting timely responses for mental health.

The Mental Health Check-In platform is an easily deployed and efficient way to assist individuals with self-assessment and self-care, while gathering vital data on mental health conditions. Its confidentiality and anonymity make it preferable for individuals who would want to take the first steps towards care but are worried about

experiencing stigma for their symptoms and conditions. Ultimately the use of this platform and similar checklists should only be a prelude to care and should be followed up with primary care and referral systems for more specialized services.

POLICY KEY RECOMMENDATIONS

This section presents ten key recommendations for the consideration of policy makers and implementers of member economies. These recommendations may serve as references to improve policies and initiatives to promote mental health among healthcare workers amidst emergency situations.

Risk Mitigation and Reduction

(1) Institution of a domestic mental health law that is rights-based, culturally sensitive, and participatory in approach

- An overarching law for mental health serves as the basis for mental health service delivery across different levels of care, including inpatient and community-based care. Legislation also obligates resources such as funds, facilities, and human resources for mental health services. This law also clarifies the mandates of different agencies and actors for mental health, such as the Ministry of Health (or its equivalent), healthcare institutions, community leaders, educational institutions and the academe, and the private sector.
- Such legislation should uphold the rights of patients for autonomy and shared decision making in their care and protect these patients from discrimination within the healthcare system and in their communities. Culturally sensitive mental health care, including the provision of more diverse mental health practitioners, should be available especially in communities with minorities or vulnerable populations. Lastly, the voices of patient advocates, healthcare practitioners, and other sectors such as the elderly and the youth should be included in the crafting and amendments of mental health policies, and the implementation of such in points of care.

(2) Institution of policies for psychologically safe workplaces, including policies against workplace bullying, harassment, and discrimination

- The creation and implementation of psychologically safe workplaces is an effective means of reducing work-related stressors and fostering an environment of support and communication. These policies would also sanction bullying, harassment, discrimination, and other hostile workplace behaviors, and provide channels for victims to raise their complaints for resolution. Psychologically safe workplaces also are more conducive for health promotion initiatives to prevent burnout, anxiety, and depressive symptoms during extended emergencies and crises. These should be created in cooperation with occupational health experts and practitioners.

(3) Conduct of regular assessment of workplace conditions and stressors to pinpoint persistent and emergent concerns regarding psychological safety in the workplace

- Assessment of workplace conditions contributes to psychological safety by pinpointing regular stressors that may become compounded or exacerbated during a crisis or emergency. Such assessment should be conducted at least once a year to identify new stressors and examine the impact of old ones. These stressors should be examined in the context of healthcare workers' regular routines such as the pre-duty-duty-post duty schedule, as well as take into account the workload in different departments or specialties. Addressing or managing these workplace stressors early improves the baseline mental health status of healthcare workers and fosters more cooperative dynamics within teams and departments. Occupational health practitioners may also be tapped for this assessment activity.

(4) *Integration of psychological support teams or healthcare workers trained in psychological assessment and support as part of occupational health services*

- The presence of support teams or specially trained healthcare workers facilitates the ready provision of psychosocial support and other interventions in the workplace. This allows healthcare workers to access preventive services or psychosocial interventions more conveniently, without the additional need to take time off or make other arrangements in order to seek care during usual working hours. The integration of mental health resources into occupational health services frames the importance of psychological health as a component of occupational health and facilitates a more holistic approach to wellbeing in the workplace. Lastly, these psychological support services may be readily tapped for intensified mental health services during crises and emergencies.

(5) *Capability building of managers, superiors, and leaders in the workplace on communication, strategies to support team members, and reduction of stigma around mental health seeking behavior*

- Support from leaders such as managers and other superiors is an important component of the psychologically safe workplace. Strategies that emphasize communication and supporting teams are deemed to be effective in resolving interpersonal workplace stressors and fostering a more positive environment. The role of leadership in addressing stigma around mental health seeking behavior is important in creating a non-judgmental atmosphere conducive to mental health and wellness. Modeling positive health seeking behavior may encourage healthcare workers to avail of psychosocial support in the workplace setting or assessment and referral to specialized services.

Preparedness for Crises and Emergencies

(6) *Optimizing the number and distribution of human resources for health to better address workload and scheduling in crises and emergencies*

- A main factor for burnout is the persistence of long working hours and large patient to staff ratios due to shortages in human resources for health during crises and emergencies. Drafting schedules and tasking/division of labor to be activated during contingencies would allow for healthcare workers to be prepared for these events and permit necessary adjustments to be made to protect healthcare workers who are at increased risk of mortality and morbidity. Arrangements should be made in advance to augment human resources for health wherever necessary, and logistical support such as transportation provided to sustain these setups.

(7) *Optimizing resources to fulfill healthcare workers' basic needs for food, rest, physical security in the workplace (including biosafety), and security of employment*

- Poor and unsafe working conditions were also implicated in the rise of burnout among healthcare workers during the COVID-19 pandemic. Meeting basic health needs for food and rest improves healthcare workers' physical health status, and positively impacts mental wellbeing. Ensuring physical security through infection control measures, infrastructure improvement, and other related measures reduces mortality and morbidity due to disease, and also removes stressors related to safety and biosafety. Lastly, security of employment also reduces financial stressors and demotivation in the workplace. Allocation of resources for these fundamental needs, as well as ample time for healthcare workers to take care of themselves, is not only essential from an occupational health standpoint, but also increases their productivity while reducing burnout. Occupational health experts and resources should be consulted to help meet.

(8) Strengthen referral systems for healthcare workers needing specialized mental health care

- Lack of knowledge on where and how to access specialized mental health services is an important barrier to care. Providing discreet and efficient referral systems for healthcare workers eliminates this roadblock and allows them to pursue care in a timely manner. Respect for privacy and confidentiality should be upheld in the referral process, and care should be provided at locations and times that are readily accessible to busy healthcare workers.

(9) Intersectoral partnerships and collaboration to broaden access and financial protection for healthcare workers seeking mental health services

- Although healthcare workers may be covered by public health insurance schemes, not all of these have comprehensive coverage for mental health services (including medications and some procedures). Intersectoral collaboration with the healthcare sector, the labor sector, and other agencies is important for broadening coverage of mental health services and decreasing out of pocket payments. Partnerships with private sector providers may also be explored to also address gaps in coverage, and come up with more sustainable financial protection schemes.

Response and Mental Health Service Delivery During Crises and Emergencies

(10) Conduct of brief support sessions and other psychosocial interventions in the workplace, during time windows that are more accessible for healthcare workers

- Providing psychosocial support during a crisis is protective against burnout, anxiety, depression and other stress-related responses among healthcare workers. Support in the workplace through formal sessions or other informal interventions can increase mental health awareness, provide a means for affected healthcare workers to make contact with care, and improve overall well-being. Using the workplace as a setting or point of care also allows healthcare workers to access care on their own schedule, without compromising workload or patient care.

(11) Implementation of regular check-ins to help identify healthcare workers in need of psychological first aid or other interventions

- Although not all healthcare workers will require psychological first aid or more specialized mental health care, it is still important for all healthcare workers to become aware of their mental health status during a crisis or emergency.
- Implementation of a check-in system for mental health provides the opportunity for self-awareness and early detection of stressors, psychological distress, and other problems. The results of these check-ins may be used as a basis for further assessment, psychosocial interventions, referral to more specialized services, or implementation of other occupational health interventions to improve healthcare workers' wellbeing.

(12) Using technology such as telehealth channels for specialized consults, as well as for wider interventions for self-care and self-assessment

- The use of technology such as telehealth channels for consults can also be used for healthcare workers to seek more specialized mental health care even while on duty in remote or understaffed areas. These may also be preferred to protect healthcare workers' privacy. Use of apps for breathing, mindfulness, stress management and other self-care practices can also help other healthcare workers develop habits for better mental health.

Rehabilitation and Reintegration

(13) Conduct of assessment and debriefing of healthcare workers post-crisis or emergency

- As a crisis or emergency evolves, the mental health status of healthcare workers may improve, worsen or stabilize depending on the response and the nature of the situation. Likewise, the types and intensity of mental health responses would also change to adapt to the ongoing crisis or emergency. Once a state of stability has been established or the state of emergency has been lifted, there is a need to assess the impact of the mental health response for healthcare workers. This would help determine which good practices should be implemented in future crises, while pinpointing any mental health concerns that have remained unaddressed at this time.

(14) Evaluation of private sector/ intersectoral collaborations for future mental health service delivery during crises and emergencies

- The roles and nature of established partnerships for mental health services may change or become more fluid during a crisis or emergency. In the aftermath of such events, it is important to review these working relationships to explore areas for further or improved collaboration, as well as troubleshoot any pain points, overlaps, or gaps with service delivery that these partnerships and collaboration failed to address adequately. The occupational health sector should be considered as a priority stakeholder in this form of collaboration.

CONCLUSION

This comprehensive plan for improving mental healthcare and supporting healthcare workers emphasizes the importance of sensitivity and respect in addressing negative experiences faced by healthcare workers. It advocates for equipping healthcare workers with self-care tools and creating spaces that cater to their diverse psychosocial needs. The MHPSS pyramidal framework is proposed to provide healthcare workers with a full spectrum of care, from promotive to specialized recovery support. The plan also focuses on systems-oriented interventions, including ensuring psychological and physical safety, promoting social innovations, and enhancing communication for quality, equity, and sustainability. Integrated individual and systems-level interventions aim to create a supportive work environment, enhance education and training, strengthen health systems, and promote research and innovation. Additionally, the plan stresses the importance of preparedness and resilience in addressing future crises and calls for collective action, including bridging gaps in mental healthcare, changing funding models, and fostering a common language and collaboration among various stakeholders.

Healthcare Worker-Empowering interventions

- In the face of insults, processes and negative experiences of HCWs, sensitivity and respect are important.
- Self-care is powerful and healthcare workers deserve to be equipped with tools and provided with spaces that suit their diverse psychosocial needs.
- Using the MHPSS pyramidal framework, healthcare workers deserve to be provided with their basic health needs and be able to access the full spectrum of care — from promotive, preventive, therapeutic, to specialized recovery support.

Systems-Oriented Interventions

- Systems to provide, sustain, and implement enabling ergonomics and spaces to ensure psychological and physical safety are within reach.
- Social innovations using scenarios, tools and resources and based on appropriate research designs that capture the essence and realities of mental health resiliency among healthcare workers.
- Better communication & collaborative values and tools at all levels towards attaining quality, equity and sustainability.

Integrated Individual and Systems Level Interventions

- Promoting a supportive work environment by creating a culture of support and awareness around mental health.
- Enhancing education and training by providing know-how and skills.
- Strengthening health systems through investments in mental health.
- Promoting research and innovation through research on challenges, barriers and opportunities on mental health care services.

Creating our shared future

- Pandemics like COVID-19 and other highly unexpected and impactful crises will happen. These will highlight existing gaps in our mental health care system.
- Address with urgency the complex mental health needs of our people. Preparedness and resilience are essential to move forward. New paradigms, new approaches are needed but these should be coherent, collective and innovative.

Strengthen Both Ends of the Spectrum

Take a Ground-Up Approach

- Actively seek out community, peer to peer and informal support networks to identify successful practices, understand and learn from them and bring the system to the community.
- Actively learn from and support effective approaches and practices and speed up knowledge to action cycles.

Strengthen Both Ends of the Spectrum

Bridge the Solitudes

- Engage strategic conversation between public and private system actors.
- Identify "whole system" mission objectives and revisit and redesign funding structures, initiatives.
- Acknowledge and integrate the perspectives of people seeking support, to identify and build on relative strengths and capacities.
- Build on innovative and effective approaches and integrate into the health system.
- Share the data widely.

Change Discourse on Funding Models

- Strengthen and increase access to funding support for applied and action centric research.
- Directly fund inclusive knowledge translation activities and situate and expand research activity and funding in community mental health settings.
- Develop appropriate and applicable measures for evaluating situated mental health activity and context.

Galvanize Collective Impact

- Develop a common language and definition of mental health and develop shared outcomes and accountability.
- Incentivize collaboration through funding that requires partnerships can also be done.
- Integrate service delivery and maximize collective resources to create spaces where governments, policymakers, care providers, families, schools, private companies, community support groups, and people seeking support can collaborate.
- Build on inherent potential within the system.

Core Values and Processes

- Innovation
- Communication
- Equity
- Sustainability

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