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2022 北京国际模拟联合国大会

Beijing International Model United Nations 2022

Background Guide

World Health Organization

Topic: Addressing Mental Health Issues in Public Crises

Contents

Welcome Letter

Dear Delegates,

Welcome to the World Health Organization (WHO) of BIMUN2022. It is a privilege for us Directors to extend our sincere greetings to all delegates!

Along with the inclusion of mental health in the Sustainable Development Goals, a growing amount of attention has been drawn to the agenda of mental health in recent years. However, the shocking statistics of people suffering mild or severe mental disorders in emergency settings indicate that we still have a long way to go. Due to their direct correlation with external influences, mental health issues prevail among public crises and disaster settings, and severe mental disorders especially favor the marginalized and vulnerable groups of our society. The recent surge of various public crises, represented by the unprecedented pandemic of COVID-19, has further subjected the general public to both physical and mental agony.

Now, the worsening situation is urging us to commit joint efforts, and most importantly, it is urging the younger generation to voice their opinions and brainstorm with insight. Acting as the distinguished diplomats of each member state and the indispensable commissioners of the United Nations, you are now standing not only on the floor of a Model United Nations conference but also at the center of the future international arena. Any flash of innovation could be the key to preventing and reducing human suffering, and safeguarding the well-being of millions.

Tackling a global problem with such prolonged influence, you are guaranteed to get a sense of responsibility and commitment to the shared future of human beings. Considerable progress is not always easy to achieve, yet unremitting attempts have never faded away among the younger generation. The leading role on the international stage will be eventually passed on to the younger generation, at which point we, with responsibility on our shoulders, will embrace the challenges, draft the blueprint of a brighter future, and approach it side by side.

The Background Guide provides you with an extracted collection of essential information that you may find useful. It lists past actions, core problems, and possible solutions. Further researches after finishing reading this Background Guide are strongly encouraged. Should you have any questions concerning the topics or Rules of Procedure, feel free to contact us.

We look forward to seeing you in the beautiful May in Beijing!

Best Regards,

Directors, WHO

BIMUN 2022

Introduction to the Committee

Established in 1948, World Health Organization (WHO) is a special agency in the United Nations structure that champions the health and well-being of all human beings.[1] As the world's biggest intergovernmental organization specialized in health and hygiene, WHO connects its 194 Member States and other partners together to coordinate the global efforts and responses. WHO's six regional offices – for instance, WHO Africa, WHO Eastern Mediterranean and WHO Western Pacific – cover all of its Member States around the globe. Led by its Geneva-based headquarters, WHO's working stations spread on the front lines in more than 150 countries and contain strong connections between each other. The Secretariat and the Director-General are elected by the Member States to lead the organization in setting and achieving its global health goals.[2]

WHO works with all of its Member States to support them to achieve the highest standard of health for all people. With a professional team of more than 8000 leading experts from all over the world, including doctors, epidemiologists, scientists and managers, WHO provides scientific evidence that nations, people and partners can rely on. Its staff working in each country advise health ministries and other sectors on public health issues, support health plans and their implementation, and monitor health programmes. Together, WHO coordinates the world's response to various health emergencies, prevents and reduces disease, and expands access to health care.[3]

WHO's concern covers human beings of all ages, from pregnancy care through old age.[4] Specifically, the Triple Billion targets outline an elaborate plan with science-based policies and programmes to achieve good health for all: to ensure a billion more people have universal health coverage, to protect a billion more people from health emergencies, and to provide a further billion people with better health and well-being.[5]

The United Nations Member States has adopted the 2030 Agenda for Sustainable Development in 2015. Among its 17 Sustainable Development Goals (SDGs), the third one – "Ensure healthy lives and promote well-being for all at all ages" – is closely related to WHO's concern, with its sub-target 3.4 underlining the significance of promoting mental health for reducing premature mortality from non-communicable diseases.[6] And accordingly, WHO addresses noncommunicable diseases prevention and mental health promotion through every sector of its work.[7]

1 WHO, "About WHO," Jan. 10, 2022 Accessed, https://www.who.int/about.

2 WHO, "Who we are," Jan. 10, 2022 Accessed, https://www.who.int/about/who-we-are.

3 Ibid.

4 WHO, "About WHO," Jan. 10, 2022 Accessed, https://www.who.int/about.

5 WHO, "What we do," Jan. 10, 2022 Accessed, https://www.who.int/about/what-we-do.

6 UN Department of Economic and Social Affairs, "Sustainable Development Goal 3," Jan. 10, 2022 Accessed, https://sdgs.un.org/goals/goal3.

7 WHO, "What we do," Jan. 10, 2022 Accessed, https://www.who.int/about/what-we-do.

General Introduction

General Idea of the Topic

Mental health, one of the two important components of overall health, refers to our emotional, psychological, and social well-being.[8] Mental health issues, then, are corresponding disordered conditions. Measured by their severity, mental health issues may exhibit mild symptoms, which may prevail among the general public especially in emergencies, or advanced illnesses, which usually come with cognitive and conduct disorder, and require medication, professional intervention or even hospitalization.

Mental and physical health are equally important yet have received disproportionate attention for long. Recent years have witnessed increasing acknowledgement of the significance of mental health, as demonstrated by the inclusion of mental health in the Sustainable Development Goals and WHO's concern. It gradually gains recognition from international organizations, health ministries and the general public as well.

When it comes to mental health issues in emergency settings, it is a completely different story. Statistics show that a striking 4 to 6 million people among the 125 million in humanitarian emergencies are estimated to have severe mental disorders, and approximately one in every five people in the crisis-affected area suffers from depression, anxiety, PTSD, bipolar disorder or schizophrenia, not to mention the vast majority affected by mild or temporary mental issues.[9] With external instability and the preoccupation with physical health, mental health is seldom given priority in public crises and emergency responses.

8 Centers for Disease Control and Prevention, "About Mental Health," Jun. 28, 2021, Feb. 11, 2022 Accessed, https://www.cdc.gov/mentalhealth/learn/index.htm.

9 WHO, "Supporting people with severe mental disorders in war and other disaster settings: A need to protect the most vulnerable," Nov. 10, 2016, Jan. 11, 2022 Accessed, https://www.who.int/news-room/feature-stories/detail/supporting-people-with-severe-mental-disorders-in-war-and-other-disaster-settings-a-need-to-protect-the-most-vulnerable.

Deteriorating mental health of the masses can evolve into a fatal blow to a society already stumbling in the public crisis. In a direct way, mental health issues contribute to many types of physical health problems, further pressing the burdened medical system in emergency settings – for example, depression increases the risk for a number of long-lasting conditions including diabetes, heart disease and stroke – while the climbing suicide rate caused by severe mental illnesses adds to the death toll of the crisis.[10] In an underlying way, since mental health affects how individuals think, feel and act, it is a fundamental determinant of how people handle stress, relate to others, and make choices.[11] Overloaded stress affects people's daily life, work and study. Poor relations between individuals nurture extreme words, violence and riots, fueling public distrust and disengagement. Ill-judged choices on a grand scale may lead to bank runs, panic purchase and underselling, which further evolve into bankruptcy, price fluctuation, inflation and stock market crash. By increasing political, economic and social instability, mental health issues have a profound impact on almost every aspect of state governance and functioning. Addressing mental health issues in public crises can be a matter of survival – whether for an individual or a state.

Facing public crisis, states may find more difficulties in addressing mental health issues. On the one hand, public crises may significantly increase the number of victims of mental health problems, just as in the post-pandemic era, almost every individual is more or less affected by the pandemic, indiscriminately facing the serious mental challenges described in the previous paragraph. Meanwhile, resources may need to be diverted to other urgent problems arising from the public crisis, which can reduce or even deprive resources that would otherwise be devoted to addressing mental health issues. As a result, when a public crisis occurs, the help available for individuals struggling with mental health problems is greatly diluted. This would affect individuals whether they are involved in the public crisis or not. On the other hand, WHO and its member states cannot afford to backtrack on previous efforts to improve mental health just because they face such challenges. A new balance between these two aspects is required to adjust to scenarios in public crises.

10 Centers for Disease Control and Prevention, "About Mental Health," Jun. 28, 2021, Feb. 11, 2022 Accessed, https://www.cdc.gov/mentalhealth/learn/index.htm.

11 Ibid.

Key Terms

1. Mental Health

Sharing equal importance with physical health, ***mental health*** is the foundation for effective functioning and the well-being of an individual. Although psychological terms are often used interchangeably, mental health is in fact a much larger concept. Mental health is more than the absence of mental illnesses or disorders – it is a state of balance both within and with the environment, and it determines an individual's ability to think, learn, understand one's emotions, and react to others.[12] Physical, psychological, social, cultural, spiritual and other interrelated factors all participate in maintaining mental health, hence the delicate balance can easily topple when any of these factors poorly functions.

2. Public Crisis

Public crisis refers to an urgent situation in which the status of certain public affairs is adversely affected, often with rapid deterioration and profound impact on a grand scale. Public crises include natural disasters, public health emergencies, political unrest and other volatile social situations. It is noteworthy that situations like massive wars or military conflicts are not within the scope of public crisis under this topic.

12 WHO, "Mental health in the Western Pacific," Feb. 11, 2022 Accessed, https://www.who.int/westernpacific/health-topics/mental-health.

Background Information

Current Situation

The prevalence of mental disorders has remained broadly unchanged for decades before 2020. The outbreak of the COVID-19 pandemic, however, has tipped the balance, indicating a direct correlation between mental health and public crises. For example, the prevalence of anxiety and depression – two of the most common mental symptoms – increased significantly from March 2020 onwards. To be specific, in some Member States like Belgium, France, Italy, Mexico, New Zealand, the United Kingdom and the United States, the prevalence level of anxiety in early 2020 has doubled since previous years; while in countries like Australia, Canada, France, Mexico and Sweden, the prevalence of depression in early 2020 has doubled more than once.[13]

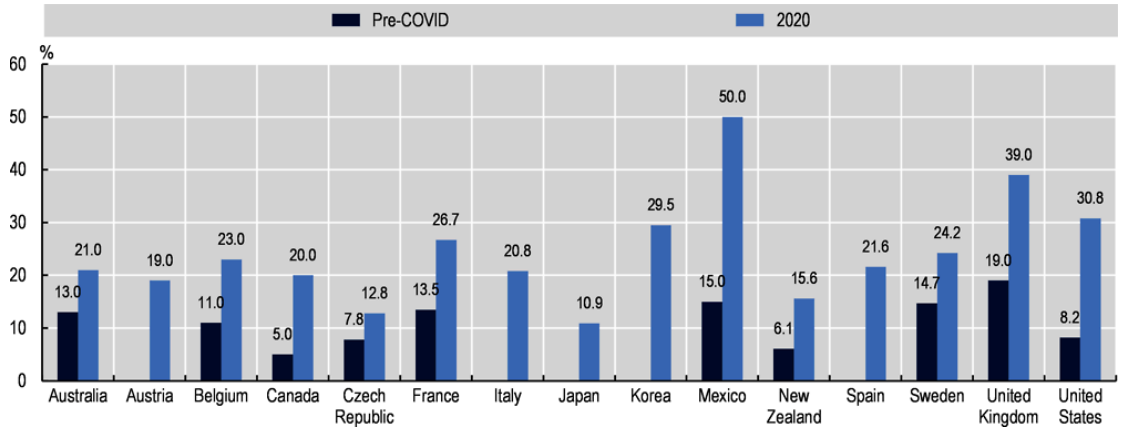

Figure 1 Prevalence of anxiety increased significantly in 2020[14]

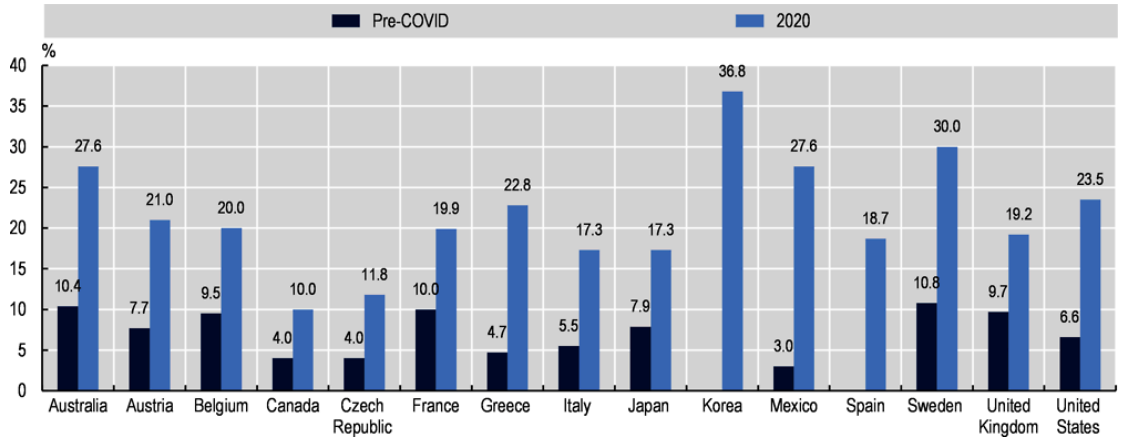

Figure 2 Prevalence of depression increased significantly in 2020[15]

13 OECD, "Tackling the mental health impact of the COVID-19 crisis: An integrated, whole-of-society response," May 12, 2021, Jan. 14, 2022 Accessed, https://read.oecd-ilibrary.org/view/?ref=1094_1094455-bukuf1f0cm&title=Tackling-the-mental-health-impact-of-the-COVID-19-crisis-An-integrated-whole-of-society-response.

14 Ibid.

15 Ibid.

Public crises impact mental health in multiple ways. Most obviously and directly, fear of death and injury shatters the general public in emergency settings, proved by the evident fluctuation in relevant statistics during the COVID-19 crisis. The level of mental distress population reached a striking crest in March to April of 2020 – the peak periods of intensifying COVID-19 deaths – and improved somewhat in the following summer, coinciding with the falling COVID-19 cases and the relaxation of countermeasures in Europe.[16] Also, other risk factors like social instability, unemployment, financial insecurity, considerably increase in crises settings, while protective factors like familiar daily routine, social connection, employment, educational engagement, access to physical exercise and health services, decrease.[17]

If not properly handled, the interaction between public crises and mental health issues will develop. Emerging mental health issues increase the political, economic and social instability, which in turn deteriorates existing public crises. And there begins the vicious cycle.

Albeit past efforts and attempts on addressing the issues, multiple challenges remain. Lack of leadership and thorough policy, the inappropriate leverage of the Internet and the media, insufficient public awareness, limited access to professional mental support, and shortfall in overall protection for patients are hindering the promotion of mental health. Insight and collaboration between the Member States are eagerly anticipated.

16 Ibid.

17 Ibid.

Past Actions

Long-term Programme

WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health

While physical health is guaranteed with the improvement of social living standards and medical technology, mental health problems have gradually become a more prominent cause of disordered life and global economy without receiving enough attention in the international community. Especially in low - and middle-income countries, due to the instability of social and natural environments, people are extremely vulnerable to severe mental health problems in the context of humanitarian crises, natural disasters and other forms of adversity, and are unable to receive effective assistance due to a lack of resources.

In this context, WHO launched the WHO Special Initiative on Mental Health (2019-2023): Universal Health Coverage for Mental Health (the WHO Special Initiative for Mental Health) in 2019, which aims to enable all people to achieve the highest standard of mental health and well-being.[18] This initiative hopes to raise $60 million to realize universal health coverage (UHC), providing quality and affordable mental health care for more than 100 million people in 12 priority countries by 2023.[19]

Unlike previous short-term mental health initiatives, the WHO Special Initiative for Mental Health calls for a more sustainable, scalable and country-by-country approach. Countries, with the support of WHO, will evaluate domestic mental health conditions and come up with designated responsive methods.[20] During concrete implementation, WHO deploys professionals to coordinate the contradictions between WHO and countries' standards, promoting the realization of the program.

The WHO Mental Health Gap Action Programme (mhGAP)

Mental, neurological, and substance use disorders are widespread around the world. According to the statistics, 14% of the global burden of disease can be attributed to these disorders, which are widely affecting every community and age group in all countries.[21]

18 WHO, "The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health," WHO, 2019, Jan. 9, 2022 Accessed, https://apps.who.int/iris/handle/10665/310981.

19 Ibid.

20 Ibid.

21 WHO, "mhGAP Intervention Guide," WHO, Feb. 22, 2010, Jan. 10, 2022 Accessed, https://www.who.int/publications/i/item/9789241548069.

The WHO Mental Health Gap Action Programme (mhGAP), launched in 2008, aims to scale up care for mental, neurological, and substance use disorders in countries, especiall y those in the low- and middle-income categories.[22] Under this program, tens of millions of people could be treated for depression, schizophrenia, and epilepsy with appropriate care, psychosocial assistance, and medication, even in resource-poor settings. Rather than relying on complex and expensive technology and highly specialized staff, this program mainly focuses on improving the capacity of the primary health care system.

The core of mhGAP is collaboration. One of the important documents of the mhGAP, the mhGAP Intervention Guide (mhGAP-IG) is drafted for non-specialist health care providers in resource-poor settings to provide high-quality health care in first- and second-level facilities.[23] [24] According to this guide, training teams from all over the world build relationships and develop cooperation with health centers, so as to train to lay health workers as mental health specialists and provide mental health services to the needs. This money-saving approach improves the quality of care for people with mental health problems.

Emergency Responses – A Case Study of Ebola Outbreak

Ebola virus disease, also known as EVD, is a severe and fatal illness affecting humans and other animals, with its average fatality rate rising up to 50%. 2014-2016 witnessed the most severe EVD outbreak in West Africa since its first detection in Central Africa in 1976.

The mental health issues brought by this unprecedented outbreak are worth attention. Due to the high mortality rate and severe symptoms, Ebola is regarded as a traumatic illness. After witnessing the death of their beloved ones, people in Africa were put on the verge of collapse by the panic of disease and death. In addition, discrimination and stigmatization behind the disease tortured those infected residents. In a small village in the Democratic Republic of the Congo, the cured villagers met the glitch of being threatened tyrannized, and even isolated by other members in the same community.[25]

22 WHO, "Scaling up care for mental, neurological, and substance use disorders: mhGAP," WHO, Jan. 10, 2022 Accessed, https://www.who.int/activities/scaling-up-mental-health-care.

23 Note: First-level facilities include the health-care centres and second-level facilities include the hospital at the first referral level (responsible for a district or a defined geographical area containing a defined population).

24 WHO, "mhGAP Intervention Guide," WHO, Feb. 22, 2010, Jan. 11, 2022 Accessed, https://www.who.int/publications/i/item/9789241548069.

25 WHO, "Psychological support for life after Ebola," Jun. 5, 2019, Jun. 9, 2022 Accessed, https://www.afro.who.int/news/psychological-support-life-after-ebola.

In a bid to untangle those dilemmas, international organizations had made fierce efforts globally and regionally. For example, in 2014, WHO published Facilitation Manual Psychological First Aid During Ebola Disease Outbreaks, providing effective guidelines such as "good communication" and "3L method(Look, Listen and Link)[26]".[27] This publication, together with other leaflets, shed light on measures to pluck the patients from the abyss of mental disorders. Regionally, WHO trained a lot of primary health doctors in the hardest-hit areas and supported care in the community. In Guinea, the disease gave rise to panic and mental disorders among some survivors who constantly dreamed of the dead bodies of their departed family members, found it difficult to sleep well, and had an unusually bumpy and fast heartbeat. Therefore, WHO trained over 300 primary health doctors who would assess the survivors' mental health and shower them with medical and psychological treatments.

Except for international organizations like WHO, some non-governmental organizations offered a helping hand. Given the discouraging link between stigma and Ebola, in 2015, Reverend Bill Jallah established the mental health consumer organization called Cultivation for Users' Hope. Through setting up support groups to train sufferers to establish soap-making industries, this institution successfully erased the stigmatization which claimed sufferers failed to perform their duty.[28]

Be in no doubt that official policies came as a beacon light of hope. During the outbreak, the Liberia government developed a new five-year Mental Health Strategy. It released a comprehensive plan for sustaining the supply of psychotropic medicine, providing robust community services and training psychological doctors and nurses.[29]

In fact, the African region has long been suffering from the intermittent supply of medicine, meaning that patients were less likely to complete the treatment and fully recover. Fortunately, instead of simply emphasizing the provision of psychotropic medicines, Liberia's strategy took the sustainability of medicine supply as the greatest urgency and this could be applied to other countries as boot. Therefore, this strategy provided the paradigm for other countries in which the rate of mental disorders was climbing.

26 Note: Look, Listen and Link (LOOK) are the action principles of psychological first aid (PFA).

27 WHO, "Facilitation manual: Psychological first aid during Ebola virus disease outbreaks," Sept. 10, 2014, Jun.9, 2022 Accessed, https://www.who.int/publications/i/item/9789241548977.

28 WHO, "Mental health services in Liberia: building back better," Mar. 29, 2016, Jun.9, 2022 Accessed, https://www.who.int/news-room/feature-stories/detail/mental-health-services-in-liberia-building-back-better.

29 Ibid.

Problems to be Solved

I. Shortfall in General Investment in Mental Health

a) Absence of Policies on Mental Health

Mental health legislation is a crucial component of good governance and concerns specific legal provisions relating to mental health. According to Mental Health Atlas 2020, the figure for stand-alone mental health laws in the African region fell from 55% in 2014 to 49% in 2020 while that in European Region remained unchanged.[30] As a result, when patients in countries with fewer laws on mental health want to seek professional help, they often wonder whether their behaviors are justified and whether their post-treatment rights can be guaranteed. These concerns detain people with mild mental disorders to seek help.

A multitude of people, not least the young generation, is bearing the brunt of mental disorders owing to a lack of strategies. Against the backdrop of the COVID-19 pandemic, the mental disorders, ranging from depression to anxiety, among adolescents have been intensified, leaving them teetering on the edge of suicide. Although some countries have placed suicide prevention within their priorities, too many of them remain unimplemented. Currently, only 35 countries are known to have a national suicide prevention strategy.[31] Coronavirus variant sets to transmit across the world in the upcoming years, putting more adolescents in a mire of depression and even suicide.

b) Lack of Governance, Financing, and Framework

From the macroscopic point of view, for some governments, investment in governance and finance has been well below par. What is worth mentioning now is that people are crippled by manacles of mental health after the emergencies because their government fails to organize Multisectoral Collaboration. Particularly, the interaction between providers and receivers of mental health services was low globally since 2017, with a significant decrease in the Eastern Mediterranean Region (from 60% in 2017 to 20% in 2020).[32] Loose connection between patients and caregivers is a vivid demonstration that institutions, to a large extent, lack policies to guarantee contact tracing after diagnosis or treatment. In that case, whether or not a patient has reached the level of full recovery is uncertain.

30 Ibid.

31 WHO, "WHO report highlights global shortfall in investment in mental health," Oct. 8, 2021, Jan. 13, 2022 Accessed, https://www.who.int/news/item/08-10-2021-who-report-highlights-global-shortfall-in-investment-in-mental-health.

32 WHO, "Mental Health Atlas 2020," Oct. 8, 2021, Jan. 13, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

Inadequate financial support in terms of expenditure on mental hospitals and related services impinges on the sick. Low- and middle-income countries experienced an incredibly low investment in mental hospitals (generally below 3%), compared with 35% financial input into those hospitals in high-income countries.[33] Patients are in the flames of withering mental disorders. Due to the scarce encouragement for mental hospitals, patients in those areas have limited access to mental healthcare and fail to receive standardized treatment.

Also, as some low-and middle-income countries such as Haiti are more vulnerable to emergencies like natural disasters or unstable domestic politics, it is hardly conceivable that the dilemma of constantly climbing numbers of people with mental disorders can be untangled. Since the gross national income is positively related to per capita expenditure on mental health, the onus is not only on governments to pour money into mental health domains, but on private sectors to invest in experimental research and some research institutions. With these, a wide range of experiments and applications will be conducted. Step by step, it raises public awareness and knowledge about mental disorders.[34]

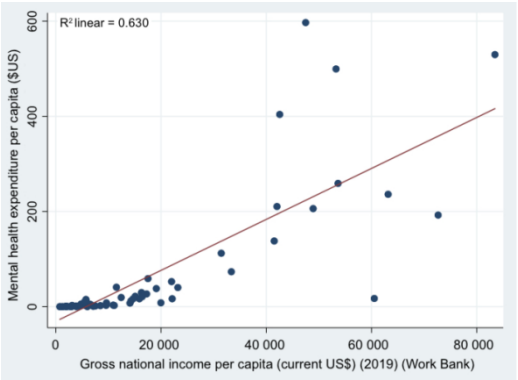

Figure 3 Association between per capita expenditure on mental health and gross national income[35]

The two types of mental health issues differentiate from each otherin two ways. First, patients with poor mental health experience mild symptoms like phobia, anxiety or minor depression, while mental illnesses show severe symptoms such as autism, bipolar disorder and schizophrenia. Second, poor mental health largely results from external environment changes like social mayhem and emergencies. However, mental illnesses such as autism tend to be influenced by genetic factors, and further triggered or aggravated by the external environment.

To conclude, the causes of poor mental health and mental illnesses cannot be bracketed as the same. Prolonged exposure to negative psychological stimulation and insufficient public awareness of mental health are the major contributing factors of poor mental health, while limited access to mental health support and lack of protection for patients' basic rights are of top urgency for mental illnesses.

33 Ibid.

34 Ibid.

35 WHO, "Mental Health Atlas 2020," Oct. 8, 2021, Jan. 13, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

II. Prolonged Exposure to Negative Psychological Stimulation

a) Distorted Information Communication and Interconnection

Effective communication between the officials and citizens can prevent public panic. People take great efforts in seeking trustworthy and timely information to evaluate their safety, for example, whether they are exposed to the crisis, the specific current policy protecting them, the access to help. Otherwise, guesses and rumors would be promulgated, and even be negatively used by media which may give rise to the wide spread of inaccurate and confusing information, decreasing the level of morale, harming the credit of authorities, and neglecting authority policies.

For instance, in the Chernobyl disaster, inconsistency of information enveloped the public in an atmosphere of insecurity, in which some people overreacted while some others were extremely apathetic. For those 116,000 immediately relocated population, later relocations actually did little in reducing radiation exposure, but brought them with “deeply traumatic experience" because they were forced to abandon their homes.[36] For those who remained in affected areas, they had accepted “paralyzing fatalism", manifesting as negative self-assessments of health and life expectancy.[37] Since then, the Soviet citizens started to doubt Gorbachev's legitimacy and leadership.[38]

Besides, despite scientists' estimation that 3000 among the 600000 residents in the most contaminated areas would die from radiation while others would die a natural death, the majority of citizens distrusted the scientists. Many of them attributed all health problems to Chernobyl radiation, claiming that radiation had rendered them helpless and in poor health. Mental disorders like depression, anxiety and other medically unexplained physical symptoms were reported.[39] To provide them with sufficient health care, the government had afforded a sky-high price over the two decades (the precise costs were incalculable due to the inflation and economic disruptions of the Soviet Union).[40]

36 WHO, "Chernobyl: the true scale of the accident," WHO, Sep. 5, 2005, Feb. 11, 2022 Accessed, https://www.who.int/news/item/05-09-2005-chernobyl-the-true-scale-of-the-accident.

37 Ibid.

38 Abigail Lebovitz, "Chernobyl and its Political Implications," Stanford University, Feb. 18, 2016, Feb. 11, 2022 Accessed, http://large.stanford.edu/courses/2016/ph241/lebovitz1/.

39 WHO, "Chernobyl: the true scale of the accident," WHO, Sep. 5, 2005, Feb. 11, 2022 Accessed, https://www.who.int/news/item/05-09-2005-chernobyl-the-true-scale-of-the-accident.

40 Ibid.

b) Intensified Dissemination in the Digital Age

Owing to the penetration of the Internet, messages spread faster than ever before in the digital age. The speed of dissemination offers both the convenience and the pouring, unscreened information to the public. In the face of a public crisis, people always want to obtain updates as soon as possible. Restricted by the fussy process, there is often a delay for traditional media in reporting emergencies. Meanwhile, the threshold of the network is much lower. Every netizen could report unexpected events through social media and freely express their opinions including the over-personalized and emotional ones. Such behavior decreases the binding force of moral and social norms in the virtual world, causing panic among the public. Vox populi might cause secondary damage to the parties psychologically.[41]

	The degree of trust (%)	Media coverage (%)	Usage frequency (times/day) or (minutes/day)	Average forwarding number (persons)
SMS	41.3	97.2	>10 times	11.8
Microblog	48.3	66.5	7.5 times	132
News portal	57.7	85.0	84.5 min	0
Cell phone	43.3	99.0	>10 times	9.7
Television	79.0	91.7	99.9 min	0
Oral	38.91	100.0		3.9

Figure 4 Comparison of the degree of trust and service condition of six media[42]

WHO uses the word "infodemic" to describe the case, the susceptible groups of which are those frequently surfing the Internet, relying heavily on the Internet to obtain information, lacking information discrimination and self-regulation, or with relatively delicate mental health conditions.[43]

c) Neglect of the Marginalized and Front-line Groups

In 2005, Hurricane Katrina struck Louisiana, Alabama and Mississippi, the three poorest states in the USA. Children and the elderly were the most injured. Approximately 5,000 children were separated from their parents or other family members, and nearly 57% of all deaths in New Orleans were the elderly. Meanwhile, only less than 30% of shelters in this city had American Sign Language interpreters, which means that people hard of hearing or speaking might miss the information of resource allocation, generating extra psychological distress and a higher possibility of mental health problems. This is primarily derived from physical inconvenience and discrimination. They are more vulnerable in public crises because of weak endurance, imperfect personality or different levels of neuroticism.

Besides, the front-line group also requires special mental health care for their experiences of facing higher risks, which can be divided into three processes:

41 刘申辉，“重大突发事件网络舆论的导向问题，”新闻爱好者，no. 9 (2012):19.

42 Nan Zhang, Hong Huang, Boni Su, Jinlong Zhao, Bo Zhang, "Information Dissemination Analysis of Different Media towards the Application for Disaster Pre-Warning," *PLoS* One, May 30, 2014, Jan. 22, 2022 Accessed, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4039515/.

43 Ibid.

1) Feeling panic and anxiety when preparing for rescue. There is little time for rescue workers to prepare both physically and mentally when crises happen. They may be nervous, anxious, afraid or self-doubting;
2) Receiving hypertension in the process of rescue. In a public crisis, rescue workers always work in high intensity and extensity. The symptoms of hypertension include dull expression, pale complexion and motionless;
3) Bearing mental fatigue after working. It is a short-term reflection, that mainly manifests as psychological fatigue, distraction, inefficiency; being sensitive to sound, light and noise; headache, insomnia, etc.

If the marginalized and front-line groups could not receive enough care, they might continuously suffer from emotional strain and psychological stress even a long time after the crisis, giving rise to mental health problems.[44] Quarrels and conflicts may occur among themselves, with the administrators, or with help-seekers.[45]

d) Case Study: Health Care Workers in COVID-19 Pandemic

Health care workers are at the front line in the war against the COVID-19 pandemic. While they are subject to irreversible physical harm, they are also faced with violence, isolation, heavy workload and discrimination.

Primarily, they are afraid of contagion and even spreading the virus to their family members, friends and colleagues. This led them to be isolated from their families and narrow down their social support network. Health care workers may report a higher rate of depression, anxiety, fear and frustration in the COVID-19 pandemic. For instance, in December 2019, the depression rate and anxiety rate of Canadian nurses were 20% and 31%, but in April 2020, they became 31% and 45% respectively.[46] Another global survey regarding 15,000 doctors reported in 2020 that 15%-18% of them experienced depression, 21%-22% had suicidal ideations, 1%-2% of them even had attempted suicide. These problems may affect their attention, understanding and decision-making ability.[47]

44 UN, "COVID-19 and the Need for Action on Mental Health," *UN*, May 12, 2020, Feb. 11, 2022 Accessed, https://www.un.org/sites/un2.un.org/files/un_policy_brief-covid_and_mental_health_final.pdf.

45 Sandeep Grover, Devakshi Dua, Swapnajeet Sahoo, Aseem Mehra, Ritu Nehra, Subho Chakrabarti, "Why all COVID-19 hospitals should have mental health professionals: The importance of mental health in a worldwide crisis!" *ScienceDirect*, Jun. 2020, Feb. 11, 2022 Accessed, https://www.sciencedirect.com/science/article/pii/S1876201820302586.

46 Farinaz Havaei, Xuyuan Tang, Peter Smith, Sheila A. Boamah, Caroline Frankfurter, "Quality and Safety of Patient Care before and during COVID-19 among Canadian Nurses," *Healthcare* 10, no. 2, (2022): 314.

47 Priya Bansal, Theresa A Bingemann, Matthew Greenhawt et al, "Clinician Wellness During the COVID-19 Pandemic: Extraordinary Times and Unusual Challenges for the Allergist/Immunologist," *J Allergy Clin Immunol Pract* 8, no.6, (2020): 1782.

On Jan. 27, 2020, a guideline of psychological crisis intervention was published by the National Health Commission of China. It calls for frontline medical workers and other administrative personnel of disease control to have the same level of protection from psychological guidance and intervention as patients diagnosed with COVID-19. This is the first time that China has proposed guidance to protect the mental health of medical workers. However, concrete implementation or statistics concerning the guideline were scarcely found in subsequent reports. The shortage of medical workers and heavy workload during the peak of the COVID-19 outbreak also hindered the guideline from achieving considerable results.

III. Insufficient Public Awareness of Mental Health

a) Preoccupation with Physical Health and External Circumstances

It is likely for public crises to result in a rocketing number of injuries, disability or death, and the public is more sensitive to their physical health and external circumstances. The earthquake, for instance, embroils the disabled into mental plight. Before the earthquake, patients have already formed a comprehensive impression of their bodies. However, the sudden strike of an earthquake breaks the balance, making accepting a new self-image a thorny dilemma. As a result, deliberately paying minute attention to their body and refusing to accept the unwelcome change of it is common among the injured survivors. To be specific, some may cringe from prosthetic wearing while others tremble before the social encounters because they are panic about the external comments. Overall, the preoccupation with physical health shatters confidence, sparks panic, and hurtles the survivors down into phobia and autism.

b) Population Effect and Social Bias

Human beings develop cognition and conduct behaviors based on, more or less, the perception of the population around them. In emergency settings, the population effect can be the medium and catalyzer of mental health issues among the public. The population effect comes into force in three steps. First, emotional contagion will reduce the activity of people's mental level, forcing them to passively receive messages from others' behaviors or attitudes. For instance, while the snows of pessimism and languishing cover the society during the pandemic, plenty of people may feel exhausted by the indirect influence of the social atmosphere. Then, once a person was affected by others, he or she tends to imitate their behaviors. Finally, venturous actions like losing temper and control will appear, manifesting the worsened mental state.[48]

48 Han Chong, Sun Shiyue, "Review of public emergency psychological stress group," Oct. 9, 2017, Jan. 13, 2021 Accessed, https://www.doc88.com/p-9582843869159.html.

Social bias hinders patients from talking about their mental states or stating their demand for mental health care, thus giving rise to a delayed diagnosis and treatment. A part of people, particularly the old generation, holds bias to patients themselves. They bridle at the sufferers, considering them as incompetent and labeling them as the group who bows to the difficulties readily. This puts more pressure on either conformed people or potential patients, inflaming their panic about talking about mental health and disorders.

Meanwhile, certain stereotype towards minority groups is responsible for deteriorating mental states. In the United States "model minority" stereotype appears among Asian Americans. It regards Asian Americans as resilient, persevering and gentler than their peers. It seems to be a compliment but in fact, according to the psychological phenomenon known as "stereotype threat", invisible pressure has been put on those Asian Americans as they struggle to live up to the standard from stereotypes.[49] Therefore, when public crises erupt, other people would take their resilience and perseverance for granted and are less likely to notice their inner struggles, which would only exacerbate potential mental sufferings.

IV. Limited Access to Mental Health Support

Although there has been steady progress in mental health care worldwide and countries' regular reporting to WHO is on track, mental health support, particularly those for severe cases of mental illness, remains extremely resource-limited compared to physical health support. Based on economic imbalances between countries, huge inequalities exist in the availability and distribution of mental health resources across countries and regions.[50] While WHO has been successful in promoting training and monitoring of mental health interventions, most countries have not integrated these interventions, such as pharmacological and psychosocial interventions, properly into mental health services.[51]

a) Disproportionate Financial and Human Resources

Like any other health care, mental health security requires adequate financial and human support, but one of the problems is the mismatch between the investment and demand within the country. Although the financial and human resources for mental health gradually increase, an enormous gap remains between supply and demand due to inadequate mental health awareness and the difficulty in establishing mental health services. By 2020, government spending on mental health was only 2.13% of total health spending (the global median) and the world median of mental health workers was 13 per 100,000 people, while mental, neurological, and substance use disorders accounted for 10% of the global burden of disease and 30% of the burden of non-fatal diseases, resulting in extremely low effective treatment coverage.[52] [53] Unlike some other financial shortfalls exclu-

49 Stacey J. Lee, *Unraveling the "Model Minority" Stereotype: Listening to Asian American Youth* (New York and London: Teachers College, Columbia University), 12-17

50 WHO, "Mental Health ATLAS 2020," *WHO*, Oct. 8, 2021, Jan. 14, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

51 Ibid.

52 Ibid.

53 WHO, "10 facts on mental health," *WHO*, Oct. 2, 2019, Jan. 15, 2022 Accessed, https://www.who.int/news-room/facts-in-pictures/detail/mental-health.

sive to lower- and middle-income states, the shortfall in mental health expenditure prevails among the Member States with different income levels. In 2020, the mental health expenditure as a percentage of GGHE-D[54] per capita was 1.05% in the low-income group, 1.10% in the lower-middle income group, 1.60% in the upper-middle income group, and 3.80% in the high-income group, only edging up by a tiny amplitude.[55]

Another problem is the uneven financial resources and manpower support among countries because of differences in economic capacity, talent cultivation, and health perceptions. In many low- and middle-income countries, only a minor proportion of total health spending goes on mental health. In 2020, the mental health expenditure, as a percentage of GGHE-D per capita, accounts for merely 2.10% in the WHO African region.[56] In terms of manpower support, although the average number of mental health workers in the world is at a low level, the proportion of mental health workers in high-income countries is more than 40 times that in low-income countries. However, because public crises have a significant impact on people's mental health, in low - and middle-income countries where public crises are common and where adequate mental health resources are not available, the availability of effective treatment for those in need is further reduced.

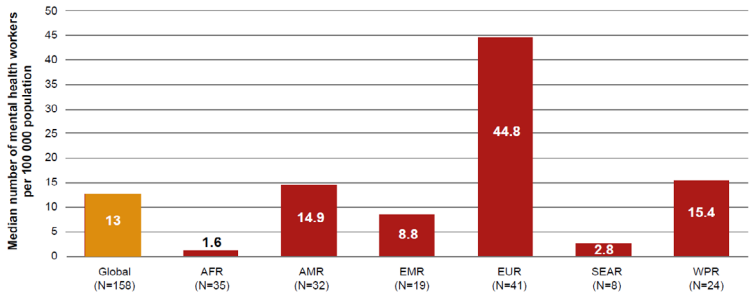

Figure 5 Mental health workers (median number per 100 000 population), by WHO region[57]

b) Under-supply of Indispensable Medical Resources

The availability of essential psychotropic drugs depends on several factors, including the influence of national regulatory and functional supply systems, regional health systems, and community acceptance of mental health treatment. However, there is little access to psychotropic drugs in certain areas. Even when psychotropic drugs are available, they are prohibitively expensive for the public health system and those in need because of intellectual property and patent protection, and competition in the pharmaceutical industry. However, taking psychotropic drugs is a must for specific psychiatric care.

54 Note: GGHE-D refers to Domestic General Government Health Expenditure.

55 WHO, "Mental Health ATLAS 2020," *WHO*, Oct. 8, 2021, Jan. 14, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

56 Ibid.

57 Ibid.

In addition, despite increasingly stringent international standards for the quality of medicines, the problem of substandard medicines has not been solved. As many as 15% of all medicines sold may be of substandard quality, with the figure exceeding 50% in parts of Africa and Asia.[58] Most psychotropic drugs act directly on the central nervous system, which means abuse or overuse can easily lead to side effects or even addiction. Therefore, unqualified psychotropic drugs are likely to cause further mental problems in patients.

c) Insufficient Channels for Diagnosis and Mental Interference

Compared with general physical health problems, mental problems are more difficult to diagnose and carry out a psychological intervention. People in public crisis, which happens more in low- and middle-income countries, are more likely to develop mental health problems that require effective diagnosis and psychological intervention (about one in five people suffer from mental health problems in post-conflict settings). Furthermore, low- and middle-income countries' inadequate response to public crises and post-crisis accommodation means that many people with mental health problems could not receive effective treatment.

Moreover, the possibility of timely and effective diagnosis and psychological intervention for those in need is still not optimistic due to differences in mental health resource input. 92% of high-income countries report to WHO that more than 50% of their inpatients receive timely diagnosis, treatment, and follow-up of their physical health status in psychiatric hospitals, which is almost four times the rate in low-income countries. In addition, despite WHO's ongoing training and promotion of MHGAP-IG, only 21% of responding countries indicated that at least 75% of primary healthcare centers in the country provide psychosocial interventions. A lack of timely diagnosis and treatment in psychiatric hospitals and psychosocial intervention in daily life leaves many patients without the support they need at both the medical and social levels.

V. Lack of Protection for Patient's Basic Rights

When mental health facilities are severely inadequate in most low- and middle-income countries, the poor management and alarming conditions in psychiatric facilities and residential homes exacerbate the situation for patients. In addition, even when good medical conditions and quality psychotropic medication are available, social discrimination and stigma against mental illness prevent many people with mental illness from seeking help in medical institutions.

58 WHO, "Improving access to and appropriate use of medicines for mental disorders," *WHO & Fundação Calouste Gulbenkian*, 2017, Jan. 15, 2022 Accessed, https://apps.who.int/iris/handle/10665/254794

a) Poor Conditions in Psychiatric Facilities and Residential Homes

In addition to concerns that existing health services do not meet the needs of all people with mental illness, concerns about the poor management of many psychiatric facilities and residential homes, the low quality of care and treatment, and human rights violations should also be raised. In many countries, people still do not have access to quality services that respect their rights and dignity. At the national level, existing policies and laws in many countries perpetuate institution-based care, isolation, and coercive and harmful treatment practices in many cases.[59]

The non-standard operation has become the norm in the specific implementation of many psychiatric facilities and residential homes due to the lack of specific regulatory restrictions, which makes the treatment environment for patients extremely difficult and exacerbates their mental problems. In addition, in mental health care settings, many patients continue to experience widespread abuse, face coercive practices such as forced hospitalizations and treatment, experience manual, physical or chemical restraints, and isolation, and are denied the right to make decisions for themselves, which are serious violations of their basic human rights.[60]

b) Social Discrimination and Stigma

Due to the lack of social awareness and regulation of mental health, mental illness discrimination has become a new type of discrimination, which not only seriously hinders patients from seeking health services but also worsens their mental health status. Nowadays, mental health services tend to rely too much on biomedical models, but ignore the social factors that affect people's mental health, resulting in the failure of timely and effective treatment and even human rights violations.[61]

Many people with mental health problems are isolated and marginalized because of outdated legal and policy frameworks with insufficient provisions and policy support on mental health-related issues, coupled with a lack of basic mental health resources in countries. In the social environment, factors that affect people's mental health (including violence, discrimination, poverty, etc.) is often excluded from the existing mental health framework, which leads to a vicious cycle in which many people with mental health problems and psychosocial disabilities also face discrimination in society and daily life because of their mental state while cannot get effective treatment.

59 WHO, "Hospital-based mental health services: promoting person-centred and rights-based approaches," *WHO*, 2021, Jan. 16, 2022 Accessed, https://apps.who.int/iris/handle/10665/341647.

60 WHO, "Strategies to end seclusion and restraint: WHO QualityRights Specialized training: course guide," *WHO*, 2019, Jan. 16, 2022 Accessed, https://apps.who.int/iris/handle/10665/329605.

61 WHO, "Hospital-based mental health services: promoting person-centred and rights-based approaches," *WHO*, 2021, Jan. 16, 2022 Accessed, https://apps.who.int/iris/handle/10665/341647.

Possible Solutions

I. Investment in Mental Health Resources

a) Reinforcement of Financial and Human Resources

The stark reality calls upon governments and other stakeholders to shower plenty of financial investment into mental health. Most importantly, health insurance and coverage should be taken as an urgency. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care. Fortunately, the world has witnessed an increase in national health insurance for patients tortured by psychosis, bipolar disorder and depression, for the data rose from 73% in 2017 to 80%in 2020.[62] However, a wide gap still exists between service coverage for patients in low-income and high-income countries, with mental health systems serving only 12% of patients with psychosis in low-income countries compared with 70% in high-income ones.[63] As a result, governments should not only invest in health insurance but also focus on the coverage of mental services.

Additionally, some regions are in the dire need of hardware facilities like mental hospitals, which are an indispensable part of the mental health system. The WHO divides the mental health system into three categories: mental health services in primary health care, community-based mental health services, and mental hospital institutional services.[64] Each service requires different types of mental hospitals. For instance, dedicated mental hospitals aim at patients with severe mental disorders, so the monetary allocation should be more intensive than that to the community-based mental health hospitals, which are home to patients with mild symptoms. By organizing the services for different types of mental illnesses, policymakers will guarantee that the financing goes to the deserved destinations.

Human resources are a valuable asset of any mental health service. However, health workers involved in public health emergency response are further exposed to exertion from extra working hours and additional safety precautions. As a result, guaranteeing their mental well-being should be put on the agenda. Specifically, stress needs to be put on establishing policies to guarantee the proper and fair duration of deployments, rest breaks and working hours, and minimizing the burden of health workers. Meanwhile, it is of great account to provide access to mental well-being and social support services for health workers, including advice on striking work-life balance and assessing and mitigating the risks by training those workers before they head into the frontline.

62 WHO, "Mental Health Atlas 2020," Oct. 8, 2021, Feb.10, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

63 Ibid.

64 WHO, "Organization of services for mental health," *World Health Organization(2003)*, https://apps.who.int/iris/handle/10665/333104.

In addition, the world is bearing the brunt of insufficient mental health workers and handling its aftermath calls upon urgent actions on increasing the numbers of newcomers as well as keeping the existing workers. For instance, universities are supposed to assume the responsibility of setting up specific courses on mental health instead of only focusing on psychology in an attempt to get students specialized in this field. It stands as a foundation to enlarge the mental health workers' population. However, being aware of the shabby working environment and inadequate living support, some immature medical workers are leery of working in vulnerable countries. Pouring money into infrastructure construction and life support for workers are the ways forward.

When professional workers are not available, self-help plays a significant part. Self-help is a community-based program or interaction between service providers and patients. A self-help program known as "friendship bench" in Zimbabwe has achieved a striking stride. It allows the old generation with mental disorders to communicate with professional nurses at the bench in the park. In some developing countries where mental health services are constantly beyond the reach, self-help serves as an innovation. Specifically speaking, as mild symptoms do not necessitate sufferers in the rural areas to trudge to the mega-city, patient-friendly self-help services allow them to mitigate the problems by finding antidotes through a small group. Hospitals can then avail their resources on patients with severe symptoms in the first place.

b) Systematic Decentralization of Mental Health Care to Community

In the past, mental health services in countries were limited to tertiary-care institutions, resulting in a large gap between mental health treatment and other physical diseases that generate special concern. Also, owing to the limited access to transport connectivity, rural residents were blocked from receiving instant and coherent treatment, leaving them teetering on the edge of suffering. Many member states, including Sri Lanka, Ukraine and Pakistan, have woke up to the urgency of establishing a comprehensive community-based, decentralized service structure, and their decentralization brought light to all corners of society. For instance, it helped enlarge the social workers on mental health as well as promote employment. After the 2004 tsunami, with the assistance of WHO, 42 unemployed university graduates in Sri Lanka received six months of training in psychiatric social work and were deployed as development assistants across the country. In the end, among the original 42 trained, 32 determined to remain there contributing to mental health work.[65] By working in the region where was in dire need of mental health assistance and listening to the patients' grievances, those graduates can easily resonate with those sufferers, thus making them remain to work.

Besides, care is provided via a multidisciplinary team, encompassing the medical officer, psychiatric community nurse and social worker. This multidisciplinary approach allows comprehensive assessment of the medical, psychological and social needs of patients and their families in their own homes.

65 WHO, "Decentralizing provision of mental health care in Sri Lanka," *WHO South-East Asia Journal of Public Health*, 6 (1): 18 - 21.

During decentralization, experiences, successes and glitches may vary from the respective countries. The question was not whether to implement a decentralization strategy but how to design the policy and investigate the prevailing situations in each country to achieve targets stage by stage and ensure the coherence of national health policies.

II. Cooperation and Coordination in Public Crises

a) Determination of Available Resources and Needs

Public crises usually present a big challenge to the government, because they emerge abruptly and catch budgets of the government by surprise. In many countries, public servants are responsible for allocating limited resources. The needs of vulnerable populations should not leave unmet. Vulnerable populations, in public crises, are those who do not have access to available resources. They may be neglected because of age, class, race or other social or economic factors.[66]

To improve such situation, the Center for Disease Control and Prevention (CDC) had established the Centers for Public Health Preparedness (CPHP). CPHP is available for assessing and training the healthcare workforce to better respond to public health emergencies.[67] Originally, it only covered the public health domain. Four years later, experts of CPHP and key partners of the Association of Schools of Public Health (ASPH) formed Collaboration groups, addressing training issues in various topics.[68] They focused on the needs of vulnerable populations in public crises, providing special attention and additional resources in emergencies.[69] The ASPH/CDC Preparedness Education for Vulnerable Populations Collaboration Group had conducted a survey to describe the needs of different kinds of vulnerable people during a public crisis.

	General topics					
Population	*Planning/ policy*	*Courses available for responders*	*Training exercises and drills*	*Consumer-oriented information aids*	*Collaboration with government or other organizations*	*Measurement and evaluation*
Economically disadvantaged populations	X	X		X		X
Ethnic and racial minority populations	X	X	X		X	X
Mentally ill populations	X		X	X	X	X
Older adult populations	X		X	X	X	X
Pediatric populations	X	X	X		X	X
Populations with disabilities	X	X	X		X	X
Rural populations	X	X	X		X	X
Spanish-speaking populations	X			X		X

Figure 6 Needs in Specific Populations[70 71]

66 Martha S. Wingate, Emily C. Perry, Paul H. Campbell, Prabu David, Elizabeth M Weist, "Identifying and Protecting Vulnerable Populations in Public Health Emergencies: Addressing Gaps in Education and Training," *Public Health Reports* 122, no. 3 (2007): 422.

67 Martha S. Wingate, Emily C. Perry, Paul H. Campbell, Prabu David, Elizabeth M Weist, "Identifying and Protecting Vulnerable Populations in Public Health Emergencies: Addressing Gaps in Education and Training," *Public Health Reports* 122, no. 3 (2007): 423.

68 Ibid.

69 McGough M, Frank LL, Tipton S, Tinker TL, Vaughan E, "Communicating the risks of bioterrorism and other emergencies in a diverse society: a case study of special populations in North Dakota," *Biosecur Bioterror* 3, no. 3 (2005):235.

70 Martha S. Wingate, Emily C. Perry, Paul H. Campbell, Prabu David, Elizabeth M Weist, "Identifying and Protecting Vulnerable Populations in Public Health Emergencies: Addressing Gaps in Education and Training," *Public Health Reports* 122, no. 3 (2007): 424.

71 Note: X here means there is a need for this population.

The table above provides an initial framework for resource determining so that the public crisis workforce could meet the needs of different groups of people during a crisis. The collaboration group is still working on, and they will address the needs of more variable populations in the future.[72]

b) Construction of Links and Referral Mechanisms

A referral is a process of transferring a client to another service provider if the initial organization is not capable of helping this client.[73] Thus, functional links or referral mechanisms should be built to ensure the patient gets appropriate health care. In Australia, the Beyond Blue project has been providing mental support to people for 20 years.[74] This project connects people with mental health services and had offered the whole process of referral.

According to Beyond Blue, the first step of mental health treatment is to visit the general practitioner (GP) or call a mental health helpline.[75] The mental health care professional might give a brief interview to assess the client's mental health, and then might refer the client to a counsellor if he or she could not deal with it.[76] Counsellors help people to define their mental problems. If the patient needs a different approach, he or she can be referred to a psychologist or psychiatrist based on their symptoms. Psychologists provide support with anxiety, depression, stress and eating disorders without medications, while psychiatrists deal with mental health problems and emotional issues sometimes with medications.[77] [78]

Based on the referral mechanism of Beyond Blue, a more thorough link of mental health care in public crises could be constructed. When people are not feeling well, they would have an idea on who they could seek for; and if the initial treatment makes no difference, the mechanism could help them find a superior treatment. Patients could just follow the steps and receive corresponding mental health care. Therefore, medical resources could be utilized effectively.

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72 Martha S. Wingate, Emily C. Perry, Paul H. Campbell, Prabu David, Elizabeth M Weist, "Identifying and Protecting Vulnerable Populations in Public Health Emergencies: Addressing Gaps in Education and Training," *Public Health Reports* 122, no. 3 (2007): 425.

73 IASC, "IASC Inter-Agency Referral Guidance Note for Mental Health and Psychosocial Support in Emergency Settings, 2017," *OCHA*, Feb. 2, 2017, Jan. 20, 2022 Accessed, https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/content/iasc-inter-agency-referral.

74 Beyond Blue, "About Beyond Blue," *Beyond Blue*, Jan. 20, 2022 Accessed, https://www.beyondblue.org.au/about-us/who-we-are-and-what-we-do.

75 Better Health Channel, "Referrals and access to mental health services," *Better Health Channel*, Jan. 20, 2022 Accessed, https://www.betterhealth.vic.gov.au/health/servicesandsupport/referrals-and-access-to-mental-health-services.

76 Ibid.

77 Better Health Channel, "Psychologist," *Better Health Channel*, Jan. 20, 2022 Accessed, https://www.betterhealth.vic.gov.au/health/serviceprofiles/psychologist-service.

78 Better Health Channel, "Psychiatrist," *Better Health Channel*, Jan. 20, 2022 Accessed, https://www.betterhealth.vic.gov.au/health/serviceprofiles/psychiatrist-service.

c) Cooperation with Professional Organizations and Agencies

For the population with mental illness, communication gaps exist among professional organizations and national agencies. In public crises, community-based organizations and non-governmental organizations could help in responsiveness and recovery, especially among rural populations, since people living in rural areas are relatively distant from national agencies than urban residents.[79]

The Frontline Service had cooperated with the Cleveland Division of Police in reaching out to residents in Ohio to overcome trauma, including homelessness and mental disorders.[80] The police are committed to mental health crisis intervention. For example, if someone tries to suicide or faces a life-threatening emergency, the Crisis Intervention Team Officer would handle it.[81] For other mild mental health problems, the Frontline Service can text, make a phone call or chat online with the help seeker.[82] The Mobile Crisis Team of this organization could move to wherever people in crisis need help. They would listen and identify how to resolve the problem in a crisis. Since 1996, they have responded to more than 20,000 calls, covering adults, adolescents and children. Help seekers do not need to provide medical insurance, and the Mobile Crisis Team would give its best to prevent unnecessary hospitalization.[83]

Such organization-police co-response provides a way of collaboration and communication among professional organizations and agencies. They are all critical pieces in public crisis preparedness, response and recovery, meeting the needs of people with different backgrounds.

III. Social Penetration of Mental Health Care

a) Inclusion of Mental Health in Education

According to WHO, approximately 20% of the world's children and adolescents suffer from mental health problems.[84] A favorable educational environment with obvious mental health support can provide children and adolescents with stable routines and structures and enable them to obtain the support of peers and adults, which can promote their mental health development. Therefore, it is necessary to incorporate mental health into education. However, in low - and middle-income countries, lack of educational resources is also a serious problem, so the inclusion of mental health in education has been slow to take off.

79 Martha S. Wingate, Emily C. Perry, Paul H. Campbell, Prabu David, Elizabeth M Weist, "Identifying and Protecting Vulnerable Populations in Public Health Emergencies: Addressing Gaps in Education and Training," *Public Health Reports* 122, no. 3 (2007): 425.

80 Division of Police, "Mental Health & Crisis Intervention," *Cleveland*, Jan. 14, 2022, Jan. 20. 2022 Accessed, https://www.clevelandohio.gov/CityofCleveland/Home/Government/CityAgencies/PublicSafety/Police/MentalHealth.

81 Ibid.

82 FrontLine Service, "Resolving Crises," *FrontLine Service*, Jan. 20, 2022 Accessed, https://www.frontlineservice.org/resolving-crises.

83 FrontLine Service, "Mobile Crisis Team," *FrontLine Service*, Jan. 20, 2022 Accessed, https://static1.squarespace.com/static/5db32e5877f2ea6116996514/t/5ea97cb2a4f55b486c2d1f7f/1588165811637/Mobile+Crisis+Team+Brochure+2020.pdf.

84 WHO, "Mental health," *WHO*, Jan. 19, 2022 Accessed, https://www.who.int/health-topics/mental-health#tab=tab_2.

Integrating mental health into education is a long-term process that requires the support of government and national education authorities, as well as coordination among education participants. At the level of national policy, mental health education needs to be encouraged and specifically regulated in education policies. On this basis, the talent training for mental health education should also be further promoted under the policy and economic support. In the process of education landing, on the one hand, it is necessary to further promote the cultivation of mental health education talents under the policy and economic support; on the other hand, to strengthen people's correct cognition of mental health education and promote their education acceptance is also very important. In the absence of mental health education personnel in the country, short-term mental health education in specific areas or situations can be promoted through a series of international and domestic cooperation programs and non-governmental organizations, so as to achieve short-term relief of mental health status.

Gradually integrating psychological education into the education system is a more cost-effective but sustainable way to reduce current and future mental health problems. Schools and non-formal learning spaces are key places for psychosocial support and socio-emotional learning interventions for children and adolescents in need.[85] Integrating mental health into education enables children and adolescents to receive more psychosocial support as they mature, thereby promoting their mental health development and reducing their psychological vulnerability in public crises. In addition, they can have correct cognition and response to mental health after appropriate psychological education, which can improve their ability to cope with adversity and create a better social environment for the promotion of mental health.

b) Construction of Social Channels for Mental Health Support

The widespread socio-economic losses and human casualties caused by public crises have both increased the likelihood of people suffering from mental illness under intense stress and reduced the number of mental health professionals. In public crises, because of limited health interventions in low - and middle-income countries, mental health professionals are more likely to be deployed to fill other health gaps, further reducing or even disrupting mental health resources that are already limited in these countries and making it harder for people to access timely treatment and assistance.

85 INEE, "INEE Guidance Note on Psychosocial Support," *INEE*, Jun. 29, 2018, Jan. 19, 2022 Accessed, https://inee.org/resources/inee-guidance-note-psychosocial-support.

In this case, the establishment of social support channels for mental health is a more realistic and sustainable approach. Most mental health problems originate from social problems, so social channels should be the first channel for communication and treatment. Trained social workers (have knowledge in both psychological counseling and social work), as people who go deep into people's lives, can assess the mental state of people in need more specifically and accurately according to their problems and living conditions and can also participate in follow-up support and treatment. This is conducive to the better linkage of community, government, and medical resources and point-to-point social or psychological support for these people, which can better help individuals to recover after the crisis that has disrupted their lives. In addition, it is necessary and effective to establish national and international mental health assistance (for example, psychological hotlines and online help portals) through modern technological means. In a public crisis, remote mental health assistance channels can effectively avoid the limitations of regional mental health resources and human resources, and further mobilize resources from different regions for support, so as to alleviate the mental health of people in need.

However, as a kind of nontherapeutic intervention, psychosocial support still has a long way to go. Although the WHO Mental Health Gap Action Programme Intervention Guide (mhGAP-IG) has been designed to guide psychological interventions in lay health care settings, while mhGAP-IG details what we should do and provides personnel training and implementation materials, it does not specify how to accomplish them.[86]

c) Proper Guidance on Social Dissemination

In addition to inadequate mental health resources, inappropriate social dissemination is part of the reason why people with mental health problems have difficulty accessing social support. In the past decades, with the development and progress of science and technology, the power of media and the frequency of its use rendered it one of the most influential factors in society.[87] In daily life, a large part of our social cognition comes from media and publicity guidance, hence the proper guidance on mental health through media and publicity is crucial to the development of mental health in the world.

A large number of studies have shown that the media is the most important source of information for the public about mental illness, so if the media presents mental illnesses in a negative way, it will further hinder the advancement of mental health in the world.[88] Therefore, it is helpful to change people's wrong perception of mental health by establishing reasonable media ethics, encouraging communication and reporting under the condition of respecting objective facts, and vigorously cracking down on false and improper speech transmission. In addition, with the development of the Internet, WHO and other non-governmental organizations are using a variety of traditional and new media to spread the proper message about mental health (such as World Mental Health Day), such as filming documentaries and organizing World Mental Health Day, and linking it to real life to strengthen people's participation in mental health social work.

86 WHO, "mhGAP Intervention Guide," *WHO*, Feb. 22, 2010, Jan. 19, 2022 Accessed, https://www.who.int/publications/i/item/9789241548069.

87 Brian Smith, "Mental Illness Stigma in the Media," *The Review: A Journal of Undergraduate Student Research*, Vol. 16 [2015], Art. 10.

88 Ibid.

IV. Long-term Improvement of Mental Health Systems

Case Study: Before & After Crises – Mental Health Systems in the Middle East and Southeast Asia

Although astonishing at first sight, crises and emergencies – the initial cause of mental health issues – are none other than the momentum and catalysts for improving the mental health care system. To some extent, public crises test the existing framework, expose lurking threats, and, most importantly, heighten the awareness of both the public and the authorities to recognize the irreplaceable role which mental health plays in human well-being.

When wills from all sides exist, public crises can be the most favourable occasion for building quality mental health services. In Syria, one of the most conflict-affected areas, mental health care was scarcely available outside the mental hospitals in a few major cities like Damascus and Aleppo. With about 1200 beds in total, a low number of mental health professionals (1 per 100,000 population), and very few specialists in child and adolescent mental health or other subspecialties, proper mental health care has long been an extravagance for citizens of this lower middle-income country.[89] Though not instantly, turnaround is indeed taking place. Through years of conflict, mental health and psychosocial support have been gradually introduced in primary and secondary health facilities, in community and women's centres, and in school-based programmes.[90]

Analogous cases are also taking place in Lebanon, only in a more proactive way compared to its neighbour. Affected by the unremitting conflicts in Syria, more than one million of its population have crossed the border and entered Lebanon as refugees. Compared with its original 4 million population, the pouring refugees have become a considerable burden on social services. Promptly recognizing the sharp increase in needs for mental health care, the Lebanon government has been using the originally adverse situation as an opportunity to refine its mental health care system. Today, it is delightful to see that these improvements benefit not only the new arrivals but also the local population.[91]

Syria and Lebanon are not the only two Member States who have sought turnarounds in emergency settings. The solution of "systematic decentralization of mental health care to the community", as previously mentioned, has been taking place in Southeast Asia with the catalyst of frequent natural disasters. After Sri Lanka and Indonesia being struck by the tsunami in 2004, and the Philippines being hit by a typhoon in 2013, a considerable amount of mental health care has been decentralized to the community level, where it was most desperately needed.[92] And what ensures a profound impact lies in the fact that in most cases, the infrastructure put in place for mental health remains after the crises have passed.

89 Abou-Saleh, M., & Mobayed, M. (2013), "Mental health in Syria," *International Psychiatry*, 10(3), 58-60. doi:10.1192/S1749367600003854

90 Mark van Ommeren, "Mental health conditions in conflict situations are much more widespread than we thought," *WHO*, June 11, 2019, Jan. 18, 2022 Accessed, https://www.who.int/news-room/commentaries/detail/mental-health-conditions-in-conflict-situations-are-much-more-widespread-than-we-thought.

91 Ibid.

92 Ibid.

Similar to many of the major revolutions and development in human history, a considerable number of the biggest leaps forward in mental health service development have been made amid or after public crises, continuously changing the global landscape of the mental health system.[93]

93 Ibid.

Bloc Positions

African States

As a large continent, Africa is prone to various health issues, not least the south of the Sahara. Most of the African countries are tortured by low income, constantly prevailing communicable diseases and poorly run services. The dilemma forces governments to put mental health at the bottom of their national priorities. Mental Health Atlas 2020 reports that African Region is far lagging behind other continents in terms of policy and legislation, financial investment and services.[94] Except for those challenges commonly faced by the whole world, some specialized problems in Africa make the situation even worse.

Firstly, policy availability and its compliance in Africa are well below par. Up to 2020, the African Region had the lowest percentage of stand-alone policies for mental health (76%) while the South-East Asia region reported 100%. Also, African Region witnessed a decrease in compliance from 2017 to 2020 (from 80% to 68%).[95] The policy availability and compliance are probably affected by other overwhelming challenges in Africa. For instance, the booming unemployment rate caused by the COVID-19 pandemic, long-lasting malnutrition, prevalent communicable diseases, domestic upheavals and coups coalesces into the failure in timely responding to mental disorders. Nevertheless, even the African states cannot directly circumvent the crisis, earmarking sufficient resources for mental health beforehand will do some good. Initiative and support from other leading powers are also crucial for advocating for mental health in developing countries. In recent years, NGOs have played a significant role in mental health issues.

Also, African Region consists of tribes and communities with traditional beliefs and specialized local culture. Among some indigenous groups, people's attitudes towards mental illness are still largely influenced by those traditional concepts, leaving them relying on supernatural causes and remedies.[96] There is no denying that believing in supernatural powers is a representative feature for some minority groups in Africa, yet applying them to mental health without distinction may backfire. Such beliefs, to some extent, may render health-damaging responses to mental disorders, delay in diagnosis and even reluctance to seek treatment. Erasing there-born misapprehension and imparting scientific knowledge should be given predominance in mental health policies. An issue worth contemplating is how to implement a scientific understanding of mental health while shielding them from damaging the original belief system and culture.

94 WHO, "Mental Health Atlas 2020," Oct. 8, 2021, Jan. 21, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

95 Ibid.

96 Gureje, O., Alem, A., "Mental health policy development in Africa," *Bulletin of the World Health Organization*, 78, no. 4 (2000): 475-482.

American States

The WHO Region of American States contains 51 countries and territories.[97] Before the COVID-19 pandemic, the Americas is already undertaking acute mental health problems. Depressive is the largest cause of disability, accounting for 7.8%, followed by 4.9% of anxiety.[98] Each year, there are estimated 100,000 people die by suicide. Guyana and Surinam are two of the 10 countries with the highest suicide rate globally.[99] Afro-descendants, indigenous people and people living in poverty have less access to mental health services.[100]

As a region with culture and ethnic diversity, ethnicity considerations are of great importance in the Americas. Different languages between indigenous communities can be a direct barrier to the smooth circulation of key information for mental health. Cultural norms and the belief in traditional therapies conflicting with modern medicine also increase the difficulty in implementing mental health support. In addition, how to engage indigenous and Afro-descendent leaders in decision-making and exert their influence remains a burning question for American states.

During the COVID-19 pandemic, the Pan American Health Organization (PAHO), a regional health organization specialized for the American States and the Regional Office for the Americas of WHO, emphasises the devastating impact on mental health in the Americas aiming to protect people's health within the region.[101] Members of PAHO cooperate to enhance health systems and respond to emergencies.

PAHO has a particular focus on promoting health equity in public crises. It suggested that the Member States should identify vulnerable groups by reviewing data on local ethnic groups to figure out the reason for health inequalities and take emergency measures.[102]

97 Amy Tausch, Renato Oliveira e Souza, Carmen Martinez Viciana, Claudina Cayetano, Jarbas Barbosa, Anselm JM Hennis, "Strengthening mental health responses to COVID-19 in the Americas: A health policy analysis and recommendations," *ScienceDirect*, Nov. 15, 2021, Jan. 23, 2022 Accessed, https://www.sciencedirect.com/science/article/pii/S2667193X21001149?via%3Dihub.

98 PAHO, "The Burden of Mental Disorders in the Region of the Americas, 2018," *PAHO*, Mar. 6, 2019, Jan. 23, 2022 Accessed, https://iris.paho.org/bitstream/handle/10665.2/49578/9789275120286_eng.pdf?sequence=10&isAllowed=y.

99 WHO, "Suicide rate estimates, age-standardized," *WHO*, Feb. 9, 2021, Jan. 23, 2022 Accessed, https://apps.who.int/gho/data/view.main.MHSUICIDEASDRREGv?lang=en.

100 Amy Tausch et al, "Strengthening mental health responses to COVID-19 in the Americas: A health policy analysis and recommendations," *ScienceDirect*, Nov. 15, 2021, Jan. 23, 2022 Accessed, https://www.sciencedirect.com/science/article/pii/S2667193X21001149?via%3Dihub.

101 PAHO, "Who We Are," *PAHO*, Jan. 19, 2022, Jan. 23, 2022 Accessed, https://www.paho.org/en/who-we-are.

102 Ibid.

Eastern Mediterranean

Stretches from Morocco in the west to Pakistan in the east, the Eastern Mediterranean Region contains 21 Member States and occupied Palestinian territory. There are nearly 679 million people in this region.[103] In recent decades, Eastern Mediterranean countries have experienced a rapid change in society, politics or economy, resulting in civil unrest. Violence has exposed many habitats to stress. From 2000 to 2019, the rates of mental, neurological, and substance use disorders (MNS) have risen from 7% to 9.8%.[104] Different from other regions in the world, it is a region with some of the world's biggest emergencies and crises, especially political conflicts, causing forced displacement among millions of people. Their mental health is severely impacted. More than 20% of people living in conflictual areas have mental health disorders, but the availability of mental health specialists is limited.[105] Mental health services such as psychotropic medicines are inadequate. Furthermore, the health systems are almost disrupted in public crises, creating more barriers for people to access health care.[106] The action on promoting mental health in the Eastern Mediterranean Region and the globe remains uneven.

With the outbreak of COVID-19, mental health issues in the Eastern Mediterranean Region have been intensified. Rates of mental illness exacerbated but access to treatment decreased. A rapid assessment carried out by WHO in June 2020 shows high levels of essential mental and neurological services disruption in the Eastern Mediterranean Region. However, the assessment also points out that public crises urge countries to innovate approaches to overcoming service disruptions. 85% of the countries provided mental health and psycho-social support (MHPSS) through helplines, 80% of them took telemedicine and teletherapy, 65% had set up self-help or digital psychological interventions.[107] The WHO Regional Office for the Eastern Mediterranean updates the COVID-19 situation in the region every day on its official website, as well as mental health care policies in each Member State.[108] It had published many special mental health training packages for schools, community health workers and people who celebrate Ramadan.[109] It also opened a psychological support platform to help people better manage psychosocial difficulties.[110]

103 Ibid.

104 World Federation for Mental Health, WHO Regional Offices, "Regional Position Statements," *World Federation for Mental Health*, Jan. 24, 2022 Accessed, http://www.emro.who.int/images/stories/mnh/documents/wmhd_21_emr_position_statement.pdf?ua=1&ua=1.

105 Fiona Charlson, Mark can Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, Shekhar Saxena, "New WHO prevalence estimates of mental disorders in conflict settings: s systematic review and meta-analysis," *The Lancet* 394, no. 10194 (2019): 241.

106 WHO Regional Office for the Eastern Mediterranean, "Mental health in emergencies," *WHO*, Jan. 24, 2022 Accessed, http://www.emro.who.int/mnh/mental-health-in-emergencies/index.html.

107 World Federation for Mental Health, WHO Regional Offices, "Regional Position Statements," *World Federation for Mental Health*, Jan. 24, 2022 Accessed, http://www.emro.who.int/images/stories/mnh/documents/wmhd_21_emr_position_statement.pdf?ua=1&ua=1.

108 WHO Regional Office for the Eastern Mediterranean, "Efforts made in countries: new ways of providing mental health care," *WHO*, Jan. 24, 2022 Accessed, http://www.emro.who.int/mnh/campaigns/efforts-made-in-countries-new-ways-of-providing-mental-health-care.html.

109 WHO Regional Office for the Eastern Mediterranean, "Entity," *WHO*, Jan. 24, 2022 Accessed, http://www.emro.who.int/entity/mental-health/index.html.

110 WHO Regional Office for the Eastern Mediterranean, "Mental health and psychosocial support," *WHO*, Jan. 24, 2022 Accessed, http://

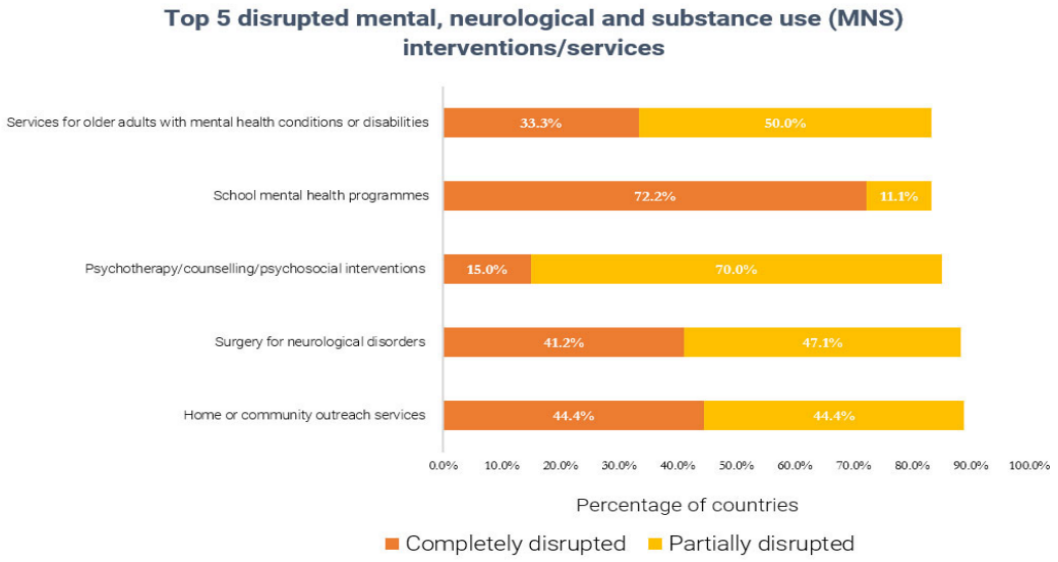

Figure 7 Top 5 disrupted mental, neurological and substance use (MNS) interventions/services[111]

Scholars from this region had made a few suggestions for ministries of health care in public crises: a) integrating MHPSS into national emergency response plans; b) developing national guidelines for providing MHPSS in emergencies; c) strengthening the management of mental disorders in public crises; d) utilising the emergency response to develop sustainable mental health services.[112] The managers of Eastern Mediterranean countries still need efforts to realise a self-contained mental health care system.

European

The attention and resources devoted to mental health in Europe cannot be ignored. Almost all countries in the European region have independent or integrated mental health policies or plans, and in about half of the countries, there are institutions to conduct regular inspections of national mental health facilities and to report to relevant stakeholders.[113] In addition, due to its strong economic strength, the European region has abundant mental health resources, both physical and human. In 2016, the average government expenditure on mental health in Europe has already reached $22 per capita[114] (the annual global median government expenditure per capita on mental health $7.49 in 2020), and the European region has the largest number of mental health workers in the world. [115]

www.emro.who.int/mhps/index.html.

111 Ibid.

112 M. van Ommeren, F. Hanna, I. Weissbecker and P. Ventevogel, "Mental health and psychosocial support in humanitarian emergencies," *Eastern Mediterranean Health Journal* 21, no. 7 (2015): 498.

113 The Regional Office for Europe of the World Health Organization, "Fact sheet – Adolescent mental health in the WHO European Region," *WHO*, 2018, Jan. 21, 2022 Accessed, https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/fact-sheet-adolescent-mental-health-in-the-who-european-region-2018.

114 Ibid.

115 WHO, "Mental Health ATLAS 2020," *WHO*, Oct. 8, 2021, Jan. 21, 2022 Accessed, https://www.who.int/publications/i/item/9789240036703.

However, it should also be noted that despite the high standard of living and happiness in Europe, the overall rate of mental health illness in Europe is among the middle levels in the world because of its lifestyle habits and social pressures. In Europe, mental disorders are the third leading cause of the total burden of disease, reaching 12% of the population (2015), and six of the 20 countries with the highest suicide rates in the world are located in the European region.[116] [117] Even in Europe, an area rich in mental health resources, there are still significant gaps in the availability and access to services for people at risk of mental health problems or with mental health or psychosocial problems. Moreover, even if overall mental health resources are abundant, the gap in resources between countries within the European region should not be overlooked.

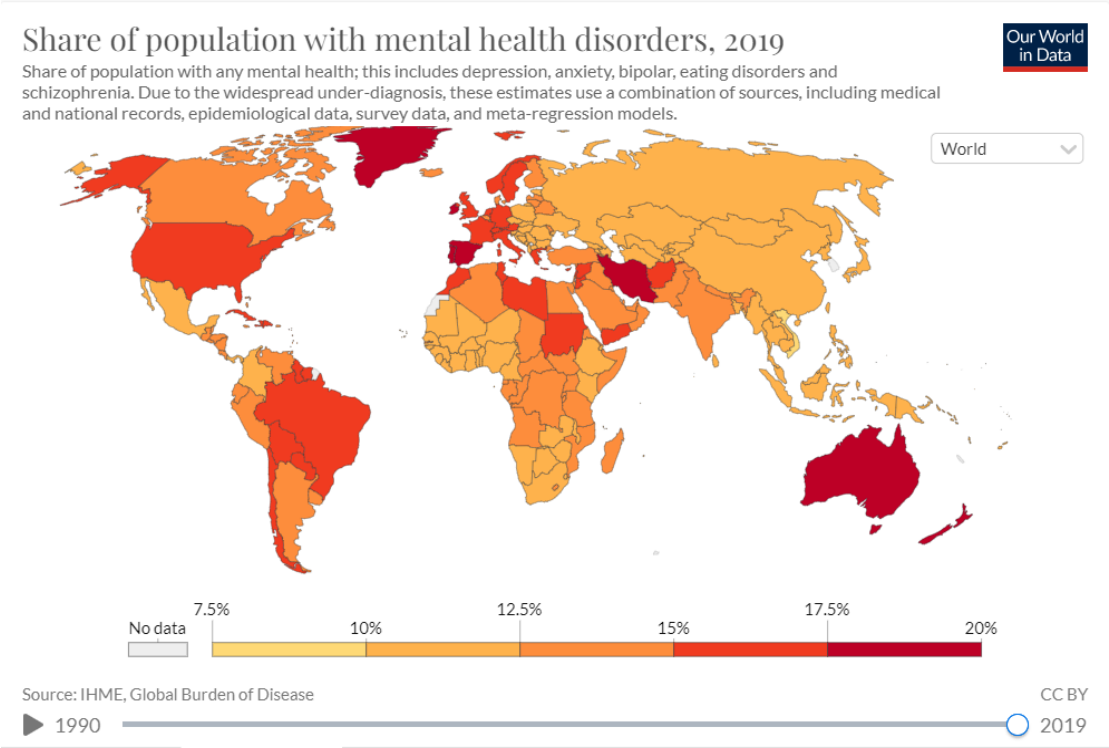

Figure 8 Share of population with mental health disorders, 2019[118]

For the past few years, while following the guidelines of WHO Comprehensive Mental Health Action Plan 2013-2030, The European region also put forward the European Mental Health Action Plan 2013-2020, which is a more detailed and specific mental health plan tailored to European conditions. This plan focuses on seven interlinked objectives and analyzes the background of these goals, the specific goals to be achieved, and the recommendations for action. Based on this plan, European countries strengthened the mental health of domestic planning, further improved the mental health environment in Europe through progress in periodic reporting, measures taken, assessments, and infor-

116 The Regional Office for Europe of the World Health Organization, "Mental health," *European Health Information Gateway*, Feb. 10, 2022 Accessed, https://gateway.euro.who.int/en/themes/mental-health/.

117 The Regional Office for Europe of the World Health Organization, "Fact sheet – Adolescent mental health in the WHO European Region," *WHO*, 2018, Jan. 21, 2022 Accessed, https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/fact-sheet-adolescent-mental-health-in-the-who-european-region-2018.

118 United States: Institute for Health Metrics and Evaluation (IHME), "Global Burden of Disease Study 2019 (GBD 2019)," *Institute for Health Metrics and Evaluation*, Oct. 4, 2021, Feb. 11, 2022 Accessed, http://ghdx.healthdata.org/gbd-results-tool.

mation sharing, and increased its capacity in terms of policy measures to provide further support to the necessary personnel.

The WHO European Framework for Action on Mental Health 2021-2025, which fit the current COVID - 19 pandemic that emerged in the mental health service under the gap between the status quo, has been further proposed based on the effective progress made in the previous plan, in order to further advance mental health in terms of government, resources, and measures. In 2021, WHO/Europe launched a new Pan-European Mental Health Coalition to address gaps in mental health services within Europe through multi-channel collaboration. This initiative not only focuses on the sharing of knowledge and data at all levels of organizations but also more effectively brings together the forces of government, organizations, and society to ensure that everyone has access to the mental health support they need.

In Europe, where most of the countries are developed and attach great importance to mental health, vigorously promoting the coverage of mental health services from various aspects such as policies, resources and services will undoubtedly promote the improvement of mental health effectively. However, it remains to be discussed whether services alone can fundamentally solve mental health problems.

Asia

Most Asian countries are developing countries and vulnerable to public crisis. In southeast Asia, people are panic about natural disasters like earthquakes and tsunamis, while residents in the Middle East and Central Asia are harnessed by social upheavals and issues related to refugees. Therefore, untangling this dilemma in Asia calls upon thorough cooperation among different countries.

Generally speaking, like the African States, some traditional concepts and behaviors nurtured by Asian countries' rich history may be outdated, hindering the treatment of mental disorders. For instance, "pasung", the physical restraint and confinement by families of people with mental illness, is known to occur in many parts of the world, especially in Asia.[119] The human rights violation represented in pasung is not only the consequence of ruinous community tradition but also the vivid demonstration of the government's oversight. Policymakers should aware of the damage of improper traditions on mental health and form the relevant strategy and advocacy. If possible, NGOs, multilateral agencies in Asia and Africa could cooperate on imparting scientific knowledge.

Since Asia is the largest continent containing a hierarchy of countries and landscapes, different parts experience different challenges. South-East Asia and East Asia witnessed the loss of life due to natural disasters. In 2004, a tsunami in the Indian Ocean swept across countries, resulting in the number of casualties reaching over 250,000.[120] Since then, expunging the negativity of natural disasters is the focal point of coastal Asian countries. After the disaster, WHO proposed setting up resilient and sustainable commu-

119 Harry Minas, Hervita Diatri," Pasung: Physical restraint and confinement of the mentally ill in the community," *International Journal of Mental Health Systems* 2, Article number: 8 (2008).

120 UN, "Economic Recovery after Natural Disasters," Jan.19 Accessed, https://www.un.org/en/chronicle/article/economic-recovery-after-natural-disasters.

nity healthcare for people affected by the calamity. Except focusing on rehabilitation of mental health, those services should be responsible for conducting training in daily life, getting people prepared for the non-scheduled earthquake or tsunami.

In central Asia and the Middle East, mental health among refugees is counted as a serious health concern. Traumatic and stressful experiences during their migration and settling in the host countries can all result in poorer mental health outcomes. Refugees are prone to face uncertainty about their applications for asylum and their future, are likely to be held in detention and encounter significant barriers to accessing mainstream health care. Besides, services and supports may have reduced applicability to refugees and migrants because of cultural and language differences. In the short run, humanitarian aid should include comprehensive mental healthcare services and adequate medical substances to solve the burning issues. In the long run, host countries are advised to gradually erase the contempt and discrimination against refugees and finally create an inclusive society. Developed countries can collaborate with the governments in conflict-affected regions to improve the application of lingua franca in the local region in the hope that refugees will encounter fewer communication obstacles.

Questions to Consider

1. In a global public crisis, how to guarantee the fair distribution of drugs on mental health among developing and developed countries?

2. How to relieve people from discrimination against mental disorder patients?

3. Mental health problems in public crises are very difficult to address in low - and middle-income countries when overall mental health resources are insufficient. From a world perspective, how can we alleviate mental health problems in public crises in the short term? What sustainable mental health initiatives can we come up with in the long term?

4. In the era of new media, how should countries correctly guide people to recognize mental health issues through media?

5. How does the globe promote the active participation of non-government entities in addressing mental health problems in public crises?

6. In the digital age, what can countries do to protect people from negative psychological stimulation?

Bibliography

Bansal P, Bingemann TA, Greenhawt M et al. “Clinician Wellness During the COVID-19 Pandemic: Extraordinary Times and Unusual Challenges for the Allergist/Immunologist." J Allergy Clin Immunol Pract 8, no.6 (2020): 1781-1790.

Better Health Channel. “Psychologist." Better Health Channel. Jan. 20, 2022 Accessed. https://www.betterhealth.vic.gov.au/health/serviceprofiles/psychiatrist-service.

Better Health Channel. “Referrals and access to mental health services." Better Health Channel. Jan. 20, 2022 Accessed. https://www.betterhealth.vic.gov.au/health/servicesandsupport/referrals-and-access-to-mental-health-services.

Beyond Blue. “About Beyond Blue." Beyond Blue. Jan. 20, 2022 Accessed. https://www.beyondblue.org.au/about-us/who-we-are-and-what-we-do.

Brian Smith. “Mental Illness Stigma in the Media." The Review: A Journal of Undergraduate Student Research, Vol. 16 [2015], Art. 10.

Charlson, Fiona. Ommeren, Mark van. Flaxman, Abraham. Cornett, Joseph. Whiteford, Harvey. Saxena, Shekhar. “New WHO prevalence estimates of mental disorders in conflict settings: s systematic review and meta-analysis." The Lancet 394, no. 10194 (2019): 241-248.

Christiansen D M, Hansen M. “Accounting for sex differences in PTSD: A multi-variable mediation model." European Journal of Psychotraumatology 26, no. 6 (2015): 260-292.

Division of Police. “Mental Health & Crisis Intervention." Cleveland. Jan. 14, 2022. Jan. 20. 2022 Accessed. https://www.clevelandohio.gov/CityofCleveland/Home/Government/CityAgencies/PublicSafety/Police/MentalHealth.

FrontLine Service. “Mobile Crisis Team." FrontLine Service. Jan. 20, 2022 Accessed. https://static1.squarespace.com/static/5db32e5877f2ea6116996514/t/5ea97cb2a4f55b486c2d1f7f/1588165811637/Mobile+Crisis+Team+Brochure+2020.pdf.

Frontline Service. “Resolving Crises." FrontLine Service. Jan. 20, 2022 Accessed. https://www.frontlineservice.org/resolving-crises.

Gureje, O., Alem, A.. “Mental health policy development in Africa." Bulletin of the World Health Organization, 78, no. 4 (2000): 475-482.

Han Chong, Sun Shiyue. “Review of public emergency psychological stress group." Oct. 9, 2017. Jan. 13, 2021 Accessed. https://www.doc88.com/p-9582843869159.html.

Harry Minas, Hervita Diatri. “Pasung: Physical restraint and confinement of the mentally ill in the community.” International Journal of Mental Health Systems 2, Article number: 8 (2008).

IASC. “IASC Inter-Agency Referral Guidance Note for Mental Health and Psychosocial Support in Emergency Settings, 2017.” OCHA. Feb. 2, 2017. Jan. 20, 2022 Accessed. https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings/content/iasc-inter-agency-referral.

INEE. “INEE Guidance Note on Psychosocial Support.” INEE. Jun. 29, 2018. Jan. 19, 2022 Accessed. https://inee.org/resources/inee-guidance-note-psychosocial-support.

Kang Lijun, Li Yi, Hu Shaohua, Chen Min, Yang Can, Yang Bing Xiang et al. “The mental health of medical workers in Wuhan, China dealing with the 2019 novel coronavirus.” The Lancet. Feb. 5, 2020. Jan. 15, 2022 Accessed. https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30047-X/fulltext.

Lea, Martin. “Disaster Communication: Tips for Effective Communication.” Dr Martin Lea. Jan. 14, 2022 Accessed. https://martinlea.com/disaster-communication/.

Leifer R. “It has disrupted my entire life.” Global Action on Aging. Feb. 2, 2006. Oct. 2, 2006 Accessed. www.globalaging.org.

Li, Dandan. Study on Group Psychological Stress and its Simulation under Sudden Public Crisis. Dissertation in Management Science and Engineering: Yanshan University, 2018.

Ma Jun, Meng Xianyong, Li Quanchao. “Analysis on psychological stress of rescue officers and soldiers and its intervention during the ‘Oriental Star’ wreck rescue mission.” Chinese Journal of Disaster Medicine 7, no. 3 (2015): 369-371.

McGough M, Frank LL, Tipton S, Tinker TL, Vaughan E. “Communicating the risks of bioterrorism and other emergencies in a diverse society: a case study of special populations in North Dakota.” Biosecur Bioterror 3, no. 3 (2005):235-45.

N.N. Wig. “WHO and mental health -- a view from developing countries.” Bulletin of the World Health Organization 78, no. 4 (2000): 502-503.

National Center for Missing & Exploited Children. “Last of unaccompanied children in Katrina shelters reunited with families.” Missing Kids. Oct. 10, 2005. Dec. 19, 2006 Accessed. http://www.ncmec.org/missingkids/servlet/NewsEventServlet?LanguageCountry=en_US&PageId=2150.

National Organization on Disability. “Report on Special Needs Assessment for Katrina Evacuees (SNAKE) project.” National Organization on Disability. Dec. 19, 2006 Accessed. http://www.nod.org/Resources/PDFs/katrina_snake_report.pdf.

Ommeren, Mark van. Hanna, F. Weissbecker, I. Ventevogel, P. “Mental health and psychosocial support in humanitarian emergencies." Eastern Mediterranean Health Journal 21, no. 7 (2015): 498-502.

Ornell, Felipe et al. “The impact of the COVID-19 pandemic on the mental health of healthcare professionals." Cadernos de Saúde Pública 36, no. 4 (2020): 1-6.

PAHO. “Mental Health and COVID-19." PAHO. Apr. 1, 2021. Jan. 23, 2022 Accessed. https://www.paho.org/en/mental-health-and-covid-19.

PAHO. “The Burden of Mental Disorders in the Region of the Americas, 2018." PAHO. Mar. 6, 2019. Jan. 23, 2022 Accessed. https://iris.paho.org/bitstream/handle/10665.2/49578/9789275120286_eng.pdf?sequence=10&isAllowed=y.

PAHO. “The PAHO COVID-19 Response Fund." PAHO. Jan. 16, 2022. Jan. 23, 2022 Accessed. https://www.paho.org/en/paho-covid-19-response-fund.

PAHO. “Who We Are." PAHO. Jan. 19, 2022. Jan. 23, 2022 Accessed. https://www.paho.org/en/who-we-are.

Sherman A, Shapiro I. “Essential facts about the victims of Hurricane Katrina, Global Center on Budget and Policy Priorities." Center on Budget and Policy Priorities. Sep. 19, 2005. Jan. 19, 2022 Accessed. www.cbpp.org/9-19-05pov.htm.

Stacey J. Lee. Unraveling the “Model Minority” Stereotype: Listening to Asian American Youth. New York and London: Teachers College, Columbia University.

Tausch, Amy. Souza, Renato Olivera e. Viciana, Carmen Martinez. Cayetano, Claudina. Barbosa, Jarbas. Hennis, Anselm JM. “Strengthening mental health responses to COVID-19 in the Americas: A health policy analysis and recommendations." ScienceDirect. Nov. 15, 2021. Jan. 23, 2022 Accessed. https://www.sciencedirect.com/science/article/pii/S2667193X21001149?via%3Dihub.

The Regional Office for Europe of the World Health Organization. “Fact sheet – Adolescent mental health in the WHO European Region." WHO. 2018. Jan. 21, 2022 Accessed. https://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-resources/fact-sheet-adolescent-mental-health-in-the-who-european-region-2018.

The Regional Office for Europe of the World Health Organization. “Mental health." European Health Information Gateway. Feb. 10, 2022 Accessed. https://gateway.euro.who.int/en/themes/mental-health/.

UN. “Economic Recovery after Natural Disasters." Jan. 19 Accessed. https://www.un.org/en/chronicle/article/economic-recovery-after-natural-disasters.

United States: Institute for Health Metrics and Evaluation (IHME). “Global Burden of Disease Study 2019 (GBD 2019)." Institute for Health Metrics and Evaluation. Oct. 4, 2021. Feb. 11, 2022 Accessed. http://ghdx.healthdata.org/gbd-results-tool.

WHO Regional Office for the Eastern Mediterranean. “About us." WHO. Oct. 28, 2021. Jan. 24, 2022 Accessed. http://www.emro.who.int/entity/about-us/index.html.

WHO Regional Office for the Eastern Mediterranean. “Efforts made in countries: new ways of providing mental health care." WHO. Jan. 24, 2022 Accessed. http://www.emro.who.int/mnh/campaigns/efforts-made-in-countries-new-ways-of-providing-mental-health-care.html.

WHO Regional Office for the Eastern Mediterranean. “Entity." WHO. Jan. 24, 2022 Accessed. http://www.emro.who.int/entity/mental-health/index.html.

WHO Regional Office for the Eastern Mediterranean. “Mental health and psychosocial support." WHO. Jan. 24, 2022 Accessed. http://www.emro.who.int/mhps/index.html.

WHO Regional Office for the Eastern Mediterranean. “Mental health in emergencies." WHO. Jan. 24, 2022 Accessed. http://www.emro.who.int/mnh/mental-health-in-emergencies/index.html.

WHO. “Comprehensive mental health action plan 2013-2030." Sept. 21, 2021, Jan.19, 2022 Accessed. https://www.who.int/publications/i/item/9789240031029.

WHO. “Decentralizing provision of mental health care in Sri Lanka." WHO South-East Asia Journal of Public Health, 6 (1): 18 - 21.

WHO. “Facilitation manual: Psychological first aid during Ebola virus disease outbreaks." Sept. 10, 2014, Jun.9, 2022 Accessed. https://www.who.int/publications/i/item/9789241548977.

WHO. “Mental Health Atlas 2020." Oct. 8, 2021, Jan. 21, 2022 Accessed. https://www.who.int/publications/i/item/9789240036703.

WHO. “Mental Health Atlas 2020." Oct. 8, 2021, Jan.19, 2022 Accessed. https://www.who.int/publications/i/item/9789240036703.

WHO. “Mental Health Atlas 2020." Oct. 8, 2021. Jan. 13, 2022 Accessed. https://www.who.int/publications/i/item/9789240036703.

WHO. “Mental health services in Liberia: building back better." Mar. 29, 2016, Jun.9, 2022 Accessed. https://www.who.int/news-room/feature-stories/detail/mental-health-services-in-liberia-building-back-better.

WHO. “Psychological support for life after Ebola." Jun. 5, 2019, Jun. 9, 2022 Accessed. https://www.afro.who.int/news/psychological-support-life-after-ebola.

WHO. “WHO report highlights global shortfall in investment in mental health." Oct. 8,2021. Jan.13,2022Accessed. https://www.who.int/news/item/08-10-2021-who-report-highlights-global-shortfall-in-investment-in-mental-health.

WHO. “10 facts on mental health." WHO. Oct. 2, 2019. Jan. 15, 2022 Accessed. https://www.who.int/news-room/facts-in-pictures/detail/mental-health.

WHO. "Coronavirus disease (COVID-19) outbreak: rights, roles and responsibilities of health workers, including key considerations for occupational safety and health." WHO. Mar. 19, 2020. Jan. 15, 2022 Accessed. https://apps.who.int/iris/bitstream/handle/10665/331510/WHO-2019-nCov-HCWadvice-2020.2-eng.pdf.

WHO. "Hospital-based mental health services: promoting person-centred and rights-based approaches." WHO. 2021. Jan. 16, 2022 Accessed. https://apps.who.int/iris/handle/10665/341647.

WHO. "Improving access to and appropriate use of medicines for mental disorders." WHO & Fundação Calouste Gulbenkian. 2017. Jan. 15, 2022 Accessed. https://apps.who.int/iris/handle/10665/254794.

WHO. "Mental Health ATLAS 2020." WHO. Oct. 8, 2021. Jan. 14, 2022 Accessed. https://www.who.int/publications/i/item/9789240036703.

WHO. "Mental Health ATLAS 2020." WHO. Oct. 8, 2021. Jan. 21, 2022 Accessed. https://www.who.int/publications/i/item/9789240036703.

WHO. "Mental health." WHO. Jan. 15, 2022 Accessed. https://www.who.int/health-topics/mental-health#tab=tab_2.

WHO. "Mental health." WHO. Jan. 19, 2022 Accessed. https://www.who.int/health-topics/mental-health#tab=tab_2.

WHO. "mhGAP Intervention Guide." WHO. Feb. 22, 2010. Jan. 10, 2022 Accessed. https://www.who.int/publications/i/item/9789241548069.

WHO. "mhGAP Intervention Guide." WHO. Feb. 22, 2010. Jan. 11, 2022 Accessed. https://www.who.int/publications/i/item/9789241548069.

WHO. "mhGAP Intervention Guide." WHO. Feb. 22, 2010. Jan. 19, 2022 Accessed. https://www.who.int/publications/i/item/9789241548069.

WHO. "mhGAP training manuals." WHO. Mar. 20, 2017. Jan. 10, 2022 Accessed. https://www.who.int/publications/i/item/WHO-MSD-MER-17.6.

WHO. "Strategies to end seclusion and restraint: WHO QualityRights Specialized training: course guide." WHO. 2019. Jan. 16, 2022 Accessed. https://apps.who.int/iris/handle/10665/329605.

WHO. "Suicide rate estimates, age-standardized." WHO. Feb. 9, 2021. Jan. 23, 2022 Accessed. https://apps.who.int/gho/data/view.main.MHSUICIDEASDRREGv?lang=en.

WHO. "The WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage for Mental Health." WHO. 2019. Jan. 9, 2022 Accessed. https://apps.who.int/iris/handle/10665/310981.

Wingate, Martha S. and Perry, Emily C. and Campbell, Paul H. and David, Prabu and Weist,

Elizabeth M. “Identifying and Protecting Vulnerable Populations in Public Health Emergencies: Addressing Gaps in Education and Training." Public Health Reports 122, no. 3 (2007): 422-426.

World Federation for Mental Health. WHO Regional Offices. “Regional Position Statements." World Federation for Mental Health. Jan. 24, 2022 Accessed. http://www.emro.who.int/images/stories/mnh/documents/wmhd_21_emr_position_statement.pdf?ua=1&ua=1.

World Health Organization. “COVID-19: Occupational health and safety for health workers: interim guidance, 2 February 2021." WHO. Feb. 2, 2021. Jan. 15, 2022 Accessed. https://www.who.int/publications/i/item/WHO-2019-nCoV-HCW_advice-2021-1.

Xiang Yu-Tao, Yang Yuan, Li Wen, Zhang Ling, Zhang Qinge, Cheung Teris et al. “Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed." The Lancet 7, no. 3 (2020): 228-229.

Zhang N, Huang H, Su B, Zhao J, Zhang B. “Information dissemination analysis of different media towards the application for disaster pre-warning." PLoS One. M ay 30, 2014. Jan. 22, 2022 Accessed, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4039515/.